

**PARAMETERS OF A STATEWIDE CARE COORDINATION SYSTEM**

**Draft Financing & Organizational Proposal**  
**Prepared by the Care Coordination Work Group of the**  
**Massachusetts Consortium for Children with Special Health Care Needs**  
*June 2, 2005; revised October 6, 2005*

**I) Financing of System**

**A) How will money come in to the system?**

- 1) **AAP defines medical home as standard of care and care coordination as a central feature of medical home -- all health care payers should be responsible for covering CC as part of pediatric care**
  - (a) Private payers
  - (b) Medicaid
- 2) **Several agencies provide CC already -- should distinguish CC as defined by CCWG from gate keeping, and then move state-funded CC into medical home**
  - (i) DMR case management
  - (ii) DPH care coordination
  - (iii) EI care coordination
    - Substitute for current EI CC?
    - Supplement current EI CC?
    - Integrate current EI CC?
  - (iv) DMH
  - (v) MCB
  - (vi) DSS
    - What about DSS policing role?
- 3) **How should responsibility be distributed among payers? Options:**
  - (a) By overall share of state insured caseload
  - (b) By overall share of pediatric caseload
  - (c) By estimated caseload of CSHCN (via MD office)
  - (d) By caseload of identified CSHCN weighted to reflect intensity of need in some fashion
  - (e) Prorated based on care coordinator time (a sort of modified unit rate)

**B) Given money in the system from the sources above, how will care coordinators be paid?**

- 1) **Money should go to practices based on:**
  - (a) Qualifying as a medical home (this determines if you qualify for funding)
  - (b) CSHCN caseload (this determines amount of funding)
    - (i) Based on use of screener to identify a caseload within the overall patient panel
      - Administration of screener and development of some form of registry should be one criterion for qualification as a medical home

- (ii) Funds should be provided based on increments of a full caseload (e.g. .25, .5, .75) for practice to purchase cc time
  - See below re: definition of full caseload
- 2) **Practices can then recruit a care coordinator one of two ways**
  - (a) Hire certified individual directly
  - (b) Hire certified individual through a vendor
    - (i) Vendors might include many current state vendors
      - DMR, EI, DSS, other
  - (c) What are plusses, minuses of options (a) and (b) from system, practice, provider and vendor perspectives
- 3) **Care coordinator then paid a flat salary based on increments of FTE**
  - (a) Providers should not be paid on a unit rate (at least initially)
    - (i) We don't have enough data on what the appropriate "units" would be
      - How much time is required on average per child/family
      - What factors determine variation in time per child/family
    - (ii) We want CCs to have substantial flexibility to spend time on:
      - Learning about systems and services
      - Getting to know other service providers
      - Training of other practice staff
      - Organization of or participation in community meetings that are not focused on a particular child
      - Advocacy that is not focused on a particular child

### **C) How much money are we talking about?**

- 1) **Relevant factors:**
  - (a) How many CYSHCN are there in the state
    - (i) There are an estimated 250,000 CYSHCN in the state
  - (b) How many pediatricians are there in the state
    - (i) There were approximately 2,100 pediatricians in MA in 2000
      - Of these 98% participate in Medicaid
      - Approximately 92.3% are engaged in general pediatrics
      - Approximately 83% of pediatrician time spent on direct patient care
      - So estimate  $2000 \times .98 \times .92 \times .83 = \sim 1,500$  FTE potential providers (PP) in system
    - (ii) How are PP distributed across practices in MA
      - 6% solo; 4% two-person; 50% group; 40% other
        - Note that there is probably bias towards Medicaid enrollment in larger practices (e.g., health centers)
      - Assume average 4 PP per practice
    - (iii) How many CYSHCN are there per practice on average
      - Estimate average 150 CYSHCN per PP
      - Estimate average 600 CYSHCN per practice
    - (iv) How many CCs will be needed for an average practice
      - Can we start with assumption of one CC/average practice?
        - Results in caseload of 600 CYSHCN/CC
        - Results in 375 CCs in system
    - (v) How much will it cost per CC on average?
      - Can we assume average salary of \$40,000 and 25% fringe/overhead
        - Cost per CC ~ \$50,000/year
    - (vi) How much is total cost of system?
      - $375 \text{ CCs} \times \$50,000/\text{year} = \$18,750,000$

2) **Is that a lot?**

- (a) DPH currently spends around \$2,000,000
- (b) What are costs of current system to other providers?
- (c) Other examples of current costs by way of comparison?

**II) Structure of System**

**A) Local-state linkage**

1) **Practice role**

- (a) Direct management of staff - options:
  - (i) Direct employment by medical home
  - (ii) Employment via vendors
  - (iii) Choice of direct or vendor
- (b) Identification/registry of CYSHCN
  - (i) Screener
  - (ii) Other options?
- (c) Record keeping
  - (i) Documentation of CC role
  - (ii) Documentation of outcomes
- (d) Integration of CC into medical home model of care

2) **Vendor role**

- (a) Hiring
- (b) Training
- (c) Supervision
- (d) Evaluation
- (e) Fiscal interaction with providers
- (f) QA/QI
- (g) Other?

3) **State role: oversight of system**

- (a) General policy oversight
  - (i) Creation of integrated oversight body
    - All stakeholders represented
    - Early Intervention ICC is model
  - (ii) Interaction with payers
  - (iii) Interaction with policymakers
  - (iv) Overall system documentation
  - (v) Overall QI
  - (vi) Overall evaluation
- (b) Credentialing of medical home
  - (i) Confers right to subsidization of CC
  - (ii) Options
    - Formal certification by some standard?
      - Measurement via Med Home index
      - Designation based on set of minimum standards
    - Could be based on ranking
      - Via RFR

- (c) Credentialing of individual care coordinators
  - (i) Options
    - National credentialing system
    - State-specific criteria drawing on national models
    - May want to grandfather in some current personnel of different systems
    - Key issues
      - Knowledge of service systems
      - Family sensitivity
      - Cultural competence
      - Disability awareness
- (d) Certification of vendors
  - (i) Is this needed if CCs are credentialed
  - (ii) Would call for criteria based on role of vendors in system
    - Financial viability
    - Payment systems
    - Supervisory track record
    - QI track record
    - Record keeping

### **III) Operational Components Of System: What Has To Get Done?**

- A) **Direct service within Medical Home practice**
- B) **Ongoing staff education with practice**
- C) **Ongoing system monitoring and troubleshooting**
- D) **Pre-service training**
- E) **Credentialing**
- F) **In-service training**
- G) **Monitoring**
  - 1) **Provider performance**
  - 2) **Provider satisfaction**
  - 3) **Practice performance**
  - 4) **Child outcomes**
  - 5) **Family outcomes**
  - 6) **System changes**
  - 7) **System costs**
- H) **Financial oversight**
  - 1) **Payment of practices, vendors, CCs**
- I) **Evaluation**
  - 1) **Aggregate outcomes**
  - 2) **Aggregate costs**
  - 3) **Cost benefit/cost effectiveness**

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