eAppendix. Learning From Medicare Care Coordination Programs: Program Design Considerations to Maximize Success of Care Coordination Programs for CSHCN in Medicaid[a]

Program Design Considerations Based on Insights From Literature on Medicare Care Coordination Programs	Relevance to CSHCN in Medicaid
1. Target specific subgroups. Successful Medicare care coordination programs typically targeted care coordination to high-risk beneficiaries.[b]	• For care coordination programs for CSHCN in Medicaid managed care, it is important to first articulate whether the eligible population should reflect the broader population of CSHCN per the federal Title V definition, which includes children "at risk" of having a chronic condition, or children with medical complexity (who may be in specialty plans that serve only populations with special health needs). This important distinction does not exist in Medicare. While children with medical complexity comprise a subgroup of all CSHCN, children in either group may include high-cost utilizers who may benefit from care coordination. • Whether focused on the broader population of CSHCN or subset of children with medical complexity, states and managed care plans may want to consider targeting care coordination services to children based on the presence of specific conditions. This may facilitate delivery of evidence-based care and enumeration of goals and metrics, which in turn facilitates measurement of whether care coordination had beneficial outcomes. However, this targeting strategy may miss many CSHCN who are high utilizers of expensive medical care services and may greatly benefit from care coordination services. Thus, states and plans may want to consider strategies similar to those used in many Medicare programs to identify beneficiaries with either high recent utilization of EDs or inpatient care, or high predicted future medical care spending, in addition to or instead of condition-specific criteria.
2. Set clear goals for outcomes that are feasible to achieve in the time period examined. Several Medicare care coordination programs aimed to and were successful in reducing hospitalizations or ED	• Program goals may be multifaceted, encompassing reduced Medicaid spending, improved health, functioning, and/or quality of life, improved quality of care and patterns of service utilization, and improvements in parental outcomes, such as reductions in stress and lost time from work.

visits over a designated time period. Several were associated with lower mortality and/or improvements in healthcare use or functional status. Few were associated with reductions in net Medicare spending once the cost of the care coordination was included.	But they must be specific and the connections between goals and program activities must be clear. • For some outcomes, the care coordination–related investments in CSHCN may not be realized for many years. Thus, the timeline to observe impacts must be appropriate to the outcomes studied. • For programs trying to reduce Medicaid spending, care coordination may initially increase healthcare utilization and associated spending before reducing use of avoidable, expensive services. • As part of goal-setting activities, states and plans may also want to set interim goals related to care coordinators' caseloads, activities, and interactions with patients, and measure these interim outcomes to better understand why care coordination programs may or may not be meeting their ultimate goals.
3. Ensure care coordinators actively engage with primary care providers. Effective Medicare programs facilitated strong, trusting working relationships between care coordinators and primary care providers, often embedding care coordinators in practices.	• The literature on care coordination for CSHCN finds some programs with care coordinators embedded in clinics or practices, but others where care coordinators worked independently, separate from patients' medical care providers. Both types of models showed positive impacts, although the quality of the analytic methods varied across studies, making it difficult to determine whether close collaboration between care coordinators and providers is more or less critical for pediatric populations. • To the extent that states and plans want to encourage active collaboration between care coordinators and providers, they can consider various models for financing and delivery, such as having the Medicaid program or managed care plan fund the care coordinators and related staff, and either embed the coordinators (in large practices) or share care coordinators across smaller practices. Alternatively, states or plans may consider funding primary care practices to hire their own care coordination staff.
4. Require at least some in-person contact between care coordinators and patients. Effective Medicare programs involved in-person contact between care coordinators and patients in addition to other forms of contact.	• States and managed care plans should consider developing requirements for ongoing, periodic in-person visits, either in the office or at home, to build strong relationships and trust between patients and care coordinators. For example, states or plans could set requirements for in-person contact in addition to telephonic care coordination, and could also develop oversight

	mechanisms to ensure that coordinators operationalize such a requirement in a satisfactory way.
5. Facilitate information sharing. Several Medicare care coordination programs either shared real-time data between medical providers and care coordinators or designed the program so that care coordinators had access to EHRs and patient registries.	• Use of a shared EHR between primary care providers, specialists, and care coordinators may greatly facilitate information sharing and the effectiveness of care coordination. Incentivizing providers' use of interoperable HIT may benefit CSHCN who do and do not receive formal care coordination services. Alternatively, in the absence of EHRs and/or interoperable EHRs, programs may still find ways for care coordinators to facilitate information sharing between providers through, for example, patient registries and other existing databases.
6. Supplement care coordinators' capabilities with other clinical experts, as relevant. Several successful Medicare programs used care coordination teams that included clinical pharmacists, behavioral health experts, and staff to assist patients in accessing social services to leverage expertise in multiple domains.	• Ensuring that care coordinators have access to other clinical experts (for example, dieticians for children with feeding tubes) to facilitate care coordination may be particularly effective for CSHCN in Medicaid, given the need to coordinate care among medical, behavioral and pharmacy providers and other important entities (for example, early intervention programs or schools, juvenile justice systems, and social service agencies). As with the relationship between care coordinators and primary care physicians, it is important that care coordinators develop active, trusting relationships with these other clinical experts to maximize effectiveness of the collaboration.

CSHCN indicates children with special healthcare needs; ED, emergency department; EHR, electronic health record; HIT, health information technology.

[a]There is no one definition of care coordination. For this study, we focused on programs that perform coordination functions such as organizing or linking multiple services and engaging the patient regardless of whether these studies use the terms "care coordination" or "care management."[30]

[b]The definition of high-risk varied across studies. Example definitions of "high-risk" include beneficiaries with selected chronic conditions; beneficiaries with multiple, recent hospitalizations and/or ED visits; beneficiaries with high hierarchical condition category scores; or various combinations of these criteria.