NATIONAL COUNCIL for Mental Wellbeing

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INTEGRATED CARE FINANCING SERIES
MODULE 3

CARE COORDINATION

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Background

This brief is part of a series that aims to accelerate implementation of evidence-based integrated care interventions across a myriad of organization settings. It also provides context for and complements the Integrated Care Financing Decision Support Tool which provides billing, reimbursement and aggregate financial modeling guidance to support implementation. Like all its counterparts, this Care Coordination and Care Management module can be used independently or in conjunction with the other modules. Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

Introduction

The integrated care movement strives to provide person-centered approaches to support the comprehensive wellness of patients. The movement serves as a solution to the historical fragmentation of physical health, mental health and substance use treatment services. Care coordination is a well-documented approach to improving measurable population health outcomes such as reductions in all-cause hospitalizations[1] and emergency department utilization[2] and improvements in patient satisfaction,[3] among other favorable outcomes. In this context, deployment of evidence-based care coordination

models can advance integrated care by helping clients navigate fragmented service delivery systems. This brief will provide practical guidance on Care Coordination and Care Management financing strategies, including:

- Care coordination and care management billing landscape
- Coding considerations
- Addressing social determinants of health
- Preparing for value-based payment

Application and Limitations

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage policies and payer priorities. The information herein is as specific as possible while acknowledging these variations in local payment and delivery landscape and operational diversity across organization settings. Guidance on how to adapt this information to your local landscape is highlighted throughout this brief in the Implementation Considerations subsections.

This brief and this series overall will primarily focus on fee-for-service (FFS) financing considerations for care coordination and care management. Despite this FFS lens, the guidance that follows is broadly applicable to organizations that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, acknowledging that FFS costing considerations are often the financial benchmark to structure alternative payment mechanisms.

Please note this module is accurate as of publication date (November 2022).

Defining Care Coordination and Care Management

Evidence-based care coordination and care management models vary widely across organizations, payer preferences, local policy and regulatory environments, target patient population and staffing mix. For the sake of consistency, this brief utilizes the Agency for Health Research and Quality's definitions:

- **Care coordination**[4] – The deliberate organization of patient care and sharing information among all the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the patient.
- **Care management**[5] – A team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively. It also encompasses those care coordination activities needed to help manage chronic illness.

In summary, care coordination and care management are similar in that they are patient-centered collaborative care approaches that seek to improve patient outcomes. They are different in that care management specifically addresses complex medical conditions, while care coordination is more broadly applicable to all biopsychosocial conditions and focuses on the timely exchange of personal health information to support services. Finally, though there are slight differences in the two definitions, it is important to note that billing and coding considerations can be similar depending on your local payer landscape. For this reason, the brief will use the term "care coordination" to encompass care management and case management. These and other implications are discussed in greater detail later in this brief.

Payer Mix and Patient Eligibility

Discerning patient eligibility for care coordination is integral to organizations sustaining services. Coverage varies widely by payer. The complicated nexus of patient needs and patient accessibility through health insurance compels organizations to examine the extent to which individuals eligible for services. Service eligibility is generally available across several sources:

- **Payer Contracts**. Payer contract will outline the services that are available to their members.
- **Model Medicaid-managed Care Contract**. Medicaid is administered through managed care organizations in 39 of 51 states including the District of Columbia. States generally publish a model contract that outlines specific coverage requirements and beneficiary eligibility considerations.[6]
- **State Essential Health Benefit (EHB) Plan**. State EHB plan generally can serve as an informal proxy of the extent to which care coordination services are covered in their respective jurisdiction. However, it is important to note that coverage does not necessarily mean access, as patients must still navigate out-of-pocket costs and utilization management techniques such as prior authorization.

Care Coordination/Management in Medicaid

Care coordination and case management are most broadly available within Medicaid's financing infrastructure under two programs: Targeted Case Management (TCM) and the Health Homes model.

The TCM definition, eligibility, availability, billing increments and additional considerations are noted in Table 1 below.

Table 1. Targeted Case Management in Medicaid Overview

CONSIDERATION	EXPLANATION
Definition	Services which help beneficiaries gain access to needed medical, social, educational and other services. "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.[7] Coverage includes services that support beneficiaries gaining access to needed medical, social, educational and other services.[8]
Eligibility	Determined by the state through a state plan amendment or waiver. Find more information can be found on the Kaiser Family Foundation webpage.
Availability	As of 2018, 36 states offer TCM. Of these, 17 limit services to specific populations based on acuity, diagnosis and/or age.[9]
Billing Increment	15-minute increments with states having discretion over the treatment of how interim thresholds are determined.
Exclusions	Services for individuals under the age of 65 residing in institutions for mental illness and/or for individuals involuntarily living in the secure custody of law enforcement, judicial or penal systems (inmates of public institutions).
Additional Considerations	Payment may not duplicate other public funding sources.[10]

Health Homes

State Medicaid agencies can also choose to provide enhanced and/or alternative reimbursement for care coordination and other services through Health Homes. Health Homes are intended to target beneficiaries with:

- One chronic condition and are at risk for a second.
- Have one serious and persistent mental health condition.

States can seek approval from the Centers for Medicare and Medicaid Services (CMS) to target specific chronic conditions through Health Homes. Conditions listed in the legislation include mental health, substance use, asthma, diabetes, heart disease and obesity.[11] As of fiscal year 2019, 22 states have implemented Health Homes.[12]

Mental Health and Substance Use Integration Other than Collaborative Care Model

Codified by CPT code 99484, these services can be billed monthly if services are delivered using BHI models of care other than a collaborative care model (CoCM). While different from the CoCM, the billing threshold includes service elements such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately and a continuous relationship with a designated care team member.

Local Medicaid Landscape Considerations

Organizations are encouraged to examine considerations in their state Medicaid agency and payer contracts to adapt the insights noted in this brief to their local landscape. Payers and/or your state's Medicaid agency may have specific care coordination performance standards, eligibility criteria and funding opportunities based on their respective priorities. These priorities are often implemented using Medicaid waivers. Salient state Medicaid waiver examples are noted in Table 2 below.

Table 2. Selection of State Medicaid Waivers Related to Care Coordination

STATE	TARGET POPULATION	CARE COORDINATION PRIORITY
Alabama 	Individuals in need of long-term services and supports (LTSS)	Recognizing utilization growth in its LTSS coverage, Alabama Medicaid implemented a 1915(b) waiver to establish primary care case management entity to conduct case management, serve as a single point of entry supportive services, conduct outreach and education activities and provide home and community-based services care coordination.[13]
California 	Individuals with HIV	California executed a 1115 waiver that includes enhanced case management and other supports for beneficiaries living with HIV/AIDS.[14]
Missour 	Postpartum women with SUD	Leveraging a 1115 waiver, Missouri provides targeted benefits involving care coordination tasks to postpartum women living with a substance use disorder, including assertive community treatment, community support and psychosocial rehabilitation.

Care Coordination/Management in Medicare

Medicare is organized across four alphabetized programmatic areas (Parts A, B, C and D) and each have care coordination functions embedded. Health care organizations that serve Medicare beneficiaries can also form accountable care organizations (ACOs), which build networks to provide a constellation of services to improve care delivery, reduce costs and improve coordination of care. Care coordination functions for Parts A through D are included in Table 3 below followed by dedicated content on ACOs.

Table 3. Care Coordination Functions Across Medicare Parts

PART	COVERAGE	CARE COORDINATION FUNCTIONS
A	Inpatient hospitalization, skilled nursing facility, home health care and hospice care.	Medicare transitional care management services covers care coordination in the hand-off period between inpatient and residential facilities and other settings of care within 30 days of discharge. Provider requirements include: • Contact within two days post-discharge. • •Contact modalities include telephone, email or face-to-face visit. • A follow-up visit must occur within seven (99495) or 14 days (99496) of discharge based on medical complexity. • Review of discharge summary and medications reconciliation. • Patient education and assistance with follow-up visits where applicable.
B	Outpatient primary, specialty and behavioral health, and durable medical equipment, home health, ambulance, therapy, diagnostic and chiropractic services.	Covered under categories: 1. Chronic care management that provides reimbursement for providers for beneficiaries with two or more chronic conditions that are expected to last 12 or more months. 2. Collaborative care is an interdisciplinary model that allows attending physicians to receive reimbursement for care coordination with a patient's psychiatrist. Applicable services include: a. Tracking patient follow-up and progress and weekly caseload consultation with the psychiatric consultant. b. Ongoing collaboration with and coordination of the patient's treating physician and any other treating mental health providers. c. Review of progress and recommendations for changes in treatment as indicated, including medications, based on recommendations provided by the psychiatric consultant. d. Brief interventions using evidence-based techniques. e. Monitoring of patient outcomes using validated rating scales. f. Relapse prevention planning with patients.

PART	COVERAGE	CARE COORDINATION FUNCTIONS
C	Services provided through third party entities (commonly referred to as Medicare Advantage plans), such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), special needs plans (SNPs), provider sponsored organizations (PSOs) and medical savings accounts (MSAs).	Medicare Part C must cover all services afforded to beneficiaries in all other parts. Plans may elect to deliver care coordination function in house or contract with providers. Organizations are encouraged to review their payer contracts to determine the extent to which services are covered.
D	Prescription medications	Medicare Part D, the prescription drug benefit, is the part of Medicare that covers most outpatient prescription drugs.[1] While care coordination is not an explicit part of the Part D benefit, prescription drug plans are rated by the Centers for Medicare & Medicaid Services (CMS) on a series of quality measures that may involve care coordination, such as medication adherence and the ability of Medicare beneficiaries to obtain needed prescription drugs. Additionally, care coordination services related to maximizing access and clinically-appropriate utilization of prescription drugs such as psychosocial support with medication induction and titration, and insurance navigation may be reimbursable.

Accountable Care Organizations

ACOs are groups of medical facilities, providers and managed care organizations that voluntarily partner together to provide quality care to Medicare beneficiaries. ACOs deploy a myriad of reimbursement mechanisms and service delivery models for care coordination and organizations are encouraged to explore partnership opportunities to sustain care coordination.

Qualified Health Plans

Care coordination is not one of the 10 mandated essential health benefits prescribed by the Affordable Care Act, meaning that commercial plans are not required to reimburse for such services. However, these plans may elect to cover care coordination services. Organizations are encouraged to review reimbursable care coordination services in their payer contracts.

[1] Part D prescription drug benefits can be offered through private companies as a stand-alone plan for those enrolled in the traditional Medicare program (i.e., Medicare Part A and Part B) or as a set of benefits included in Medicare Part C.

Care Coordination across Federally Designated Health Care Program Categories

In addition to the Medicaid and Medicare care coordination/management programs, care coordination models are prevalent throughout other federal health care programs. Most of these programs allow for subcontractor relationships in support of care coordination for their respective constituencies. Table 4 outlines a selection of federally designated health care programs.

Table 4. Care Coordination Review of Select Federally-designated Health Care Programs

PROGRAM	DEFINITION	CARE COORDINATION CONSIDERATIONS
Certified Community Behavioral Health Clinic (CCBHC)	CCBHCs[15] are non-profit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine types of services with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners and integration with physical health care.	Care coordination is a required CCBHC service[16] and is the linchpin of the program.
Federally Qualified Health Centers (FQHC)	FQHCs are community-based health care organizations that receive funds from the Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas.	Case management is a mandatory FQHC service and includes "assessment of factors affecting health (e.g., medical, social, housing or educational), counseling and referrals to address identified needs and periodic follow-up of services."[17]
Indian Health Service (IHS)	IHS is an agency within the Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives.	Care coordination is a mandatory service for individuals for IHS and can be delivered directly by the agency or subcontracted to external partners.
Ryan White HIV AIDS Programs	Ryan White provides services to low to moderate income individuals living with HIV through partnerships with states, cities and health care organizations.	Medical case management is a required service and is defined as "a range of client-centered services that link clients with health care, psychosocial and other services provided by trained professionals, including both medically credentialed and other health care staff."[18]
Veteran's Health Administration (VHA)	The VHA provides health care services to eligible veterans through medical centers, outpatient clinics and community living centers.	Care coordination is available to any veteran and/or VHA provider who requests it.[19]

Implementation Considerations

The aforementioned considerations aim to define and review mandatory care coordination coverage across Medicare, Medicaid and other federal programs. Given the diversity of payer prerogatives, state policies and individual provider contracts, organizations are encouraged to review the following considerations for adaptation to the local landscape:

- Conduct a payer mix assessment to determine the health insurance coverage trends of your target patient population. Review payer contracts to assess coverage of care coordination.
- Assess partnership opportunities with federal program in your area.

Coding Considerations

Payer Mix and Patient Eligibility

Discerning patient eligibility for care coordination is integral to organizations sustaining services. As noted above in the Coverage Landscape section, coverage varies widely by payer. The complicated nexus of patient needs and patient accessibility through health insurance compels organizations to examine the extent to which individuals are eligible for services. Service eligibility is available across several sources:

- **Payer Contracts**. Payer contracts will outline the services that are available to their members.
- **Model Medicaid-managed Care Contract**. Medicaid is administered through managed care organizations in 39 of 50 states, as well as the District of Columbia. States publish a model contract that outlines specific coverage requirements and beneficiary eligibility considerations.[20]
- **State Essential Health Benefit (EHB) Plan**. State EHB plans can serve as an informal proxy of the extent to which care coordination services are covered in their respective jurisdiction. However, it is important to note that coverage does not necessarily mean access, as patients must still navigate out-of-pocket costs and utilization management techniques such as prior authorization.

Patient Complexity and Chronicity Considerations

In addition to health insurance coverage, eligibility for care coordination services may be dependent on patient diagnosis(es) and complexity and/or chronicity and can vary in specificity. Function codes (also known as G-Codes) are often used by payers and health systems as proxies for patient chronicity, complexity and need, as they refer to a patient's functional (physical, mental and/or intellectual) limitations.

Spotlight on the Collaborative Care Model

An example of chronicity-based eligibility for care coordination is the collaborative care model (CoCM). The CoCM allows organizations to seek reimbursement for care coordination services for Medicare beneficiaries across the treating provider, a consulting psychiatrist and care manager. In CoCM, eligibility is defined as, "any mental, behavioral health, or psychiatric condition treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billingpractitioner, warrants behavioral health integration (BHI) services. Beneficiaries may but are not required to have comorbid, chronic or other medical condition(s) that are managed by the billing practitioner."[21] In this example, any Medicare billing organization can leverage their clinical judgement to designate a beneficiary as needing CoCM services if they have been diagnosed with a mental health or substance use challenge.

Client chronicity and complexity can also have billing and reimbursement implications. Special modifier codes exist for individuals who have been diagnosed or have observed conditions that increase the complexity of services. For example, CPT code 90785 acknowledges interactivity difficulties during a standard psychiatric evaluation. Therefore, it can only be used in conjunction with other codes and for individuals who have communication difficulties and/or the following:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions/behavior that interfere with implementation of the treatment plan.
3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers.

Provider Eligibility

The professional discipline of providers also has eligibility and reimbursement implications. While the state licensing board dictates scope of practice, individual facility credentialing and privileging and payer contracts also limit the extent to which providers may seek reimbursement. Additionally, providers may receive different rates depending on their education and health care specialty. For example, a psychiatrist, licensed clinical social worker and licensed psychologist can all receive different reimbursement for the same services. Health insurers can also, within the parameters of federal and state regulations, prohibit specific provider types from reimbursement by service. Organizations are encouraged to explore provider eligibility and reimbursement for care coordination services.

Timing Considerations

While ramping up care coordination, organizations are also encouraged to consider service delivery timing considerations that may be salient to billing reimbursement. Prevalent examples include:

1. **Same-day Billing Restrictions**. Services and billing codes that may or may not be allowed to be provided within a 24-hour period. For example, according to longstanding Medicare guidance CPT code 99490 (under chronic care evaluation and management services) is the only evaluation and management code that can be billed per day unless a modifier .25 is utilized.[22] The general intention of same-day billing restrictions is to prevent service and billing duplication. Organizations are encouraged to examine their payer contracts to determine the extent to which modifier codes can be used to navigate same-day billing restrictions.
2. **Time-limited Service Provision Restrictions**. Service and billing codes that are only eligible to be provided within a specified timeframe. For example, in Medicare Transitional Care Management (TCM) codes are used to support warm hand-offs for patients from inpatient/residential services to community-based/outpatient settings. An example of a time-limited services provisions restriction is CPT code 99495 (under transitional care evaluation and management services), which can only be used for patient exhibiting moderate complexity and require a face-to-face visit within 14 days (about two weeks).

Collectively, these timing considerations present organizations with pertinent service delivery and billing implications. Failure to understand these implications may result in lost revenue opportunities. Organizations are encouraged to examine the extent to which staffing and clinical workflows can accommodate timing considerations.

Implementation Considerations

Implementation considerations-related coding include:

- Identifying the payers of your client base.
- Assessing provider eligibility to provide care coordination.
- Determining any additional complexities of your clients that make them eligible for special programs. Understanding billing limitations (e.g., same-day billing) and their impact on workflow and reimbursement. Assessing client eligibility for care coordination coverage based on health insurance and clinical need.
- Assessing payer contracts for reimbursement of care coordination, care management and case management services.
- Cross walking organization's staffing mix with provider reimbursement eligibility.
- Exploring active Medicaid waivers in your state for care coordination financing opportunities.
- Examining payer contracts for timing considerations such as same-day billing and time-limited service provision restrictions.

BUILDING SUSTAINABLE PARTNERSHIPS

While the direct provision of any or all care coordination services may be appealing to some organizations, others may be interested in delivering specific services or extending their existing capacity to patients in need. There is enough room for all organizations to discern a plausible route to financially sustaining care coordination services. Examples include:

Collaborative Care Codes

In 2017, the CMS approved Medicare payment for patients living with mental health and substance use challenges who are participating in psychiatric collaborative care management (CCM) programs. This interdisciplinary care model allows for attending physicians to receive reimbursement for care coordination with a patient's psychiatrist. Within the context of care coordination services, a primary care physician can consult with a psychiatrist to prescribe medication with both parties have a reimbursement mechanism. Collaborative care codes also allow for initial and subsequent care management visits. Applicable services include:

- Tracking patient follow-up and progress using the registry with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant.
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician, primary care, women's health or other QHP and any other mental health treatment organization.
- Additional review of progress and recommendations for changes in treatment as indicated, including medications, based on recommendations provided by the psychiatric consultant.
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.
- Monitoring of patient outcomes using validated rating scales.
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Chronic Condition Management Codes

Under Medicare, chronic care management services provide reimbursement for providers to care for clients with two or more chronic conditions that are expected to last 12 or more months. For eligible Medicare beneficiaries, organizations can receive reimbursement for clinical coordination with other providers.

Please note that FQHCs and RHCs are ineligible to utilize the CoCM and CCM codes.

Transitional Care Management Codes

Transitional care management codes are used to coordinate services that transition Medicare beneficiaries from inpatient and residential care settings to outpatient and community-based care. The codes can be used within 14 days of discharge from an inpatient or residential facility. States can authorize nonphysicians to bill under these codes.

Functional Reporting Codes (G-Codes)

Functional reporting dodes, or G-Codes, are used by Medicare[23] to convey information regarding a beneficiary's functional ability and/or medical complexity and severity. Complexity and severity codes can be used to indicate current, projected or actual complexity at the time of discharge. Organizations that leverage G-Codes are required to document their clinical necessity in the patient's medical record. Providers should also include a rationale for use of the codes for each date of service.

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

The Centers for Disease Control and Prevention (CDC) defines the social determinants of health (SDOH) as "conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes."[24] The CDC organizes SDOH across five categories noted in Table 5 below:

Table 5. Social Determinants of Health Categories, Definitions and Examples

SDOH CATEGORY	DEFINITION	EXAMPLES
Health care access and quality	The extent to which people are connected to and understand services impacting their health.	• Access to insurance • Distance/access to a primary care organization • Access to culturally responsive health care
Education access and quality	Educational considerations such as educational attainment, literacy and human development that impact health outcomes.	• Educational level • Literacy
Social and community context	The context in which people live, play and work and the cohesion of these factors.	• Civic engagement • Racism • Justice system involvement
Economic stability	The connection between financial resources, socioeconomic status and health.	• Poverty level • Food security • Employment status
Neighborhood and built environment	The connection between where a person lives – housing, neighborhood and environment – and their health and wellbeing.	• Access to outdoor space • Crime rate • Housing stability

While each of the categories is rooted in structural inequity and complex societal norms, care coordination holds great promise to connect individuals to services that can contribute to their overall health and wellbeing. The following four subsections provide examples of billing and reimbursement opportunities to support addressing SDOH:

1. Health Care Access and Quality

Health insurance is an important tool in addressing health care access challenges. Uninsured individuals are more likely to receive an initial diagnosis in the advance stage of a disease, have a lower life expectancy and live with an untreated chronic condition as compared to those who are insured.[25] Once someone acquires insurance, the utility of their coverage may depend on their health insurance literacy. A recent study revealed that 51% of the insured general public possess an inadequate knowledge of basic insurance terms.[26] Thus, health insurance navigation presents an opportunity to address SDOH. While there are no health insurance navigation codes, there may be reimbursable opportunities – depending on your local payer landscape – to connect patients to health insurance and provide insight into improving the utility of their coverage. One example includes HCPCS code T1016, a case management code that, depending on payer policy, can be used to provide:

- Assistance in maintaining, monitoring and modifying covered insurance services.
- Coordination of care activities related to continuity of care between levels of care.
- Assistance in finding and connecting to necessary resources other than covered services to meet basic needs. Of note, it is possible for this code to be billed more than once per day.

2. Economic Stability and Education Access and Quality

Numerous studies have shown that unemployment is linked to negative health care outcomes.[27] Therefore, addressing unemployment can improve economic and health outcomes. Medicaid offers rehabilitation and habilitation services to support individuals living with temporary or permanent disabilities as an optional benefit. As of 2018, 43 states have exercised this option for beneficiaries living with mental health and substance use disorders. By utilizing a home and community-based services Medicaid waiver, habilitation can include the following:

- Employment services such vocational/job-related discovery or assessment
- Person-centered employment planning
- Job placement
- Job development
- Negotiation with prospective employers
- Job analysis
- Job carving
- Training and systematic instruction
- Job coaching
- Benefits support
- Training and planning
- Transportation
- Asset development
- Career advancement services
- And other workplace support services that enable the participant to be successful integrating into the job setting[28]

Where authorized, coordination and management of these services can be billed using HCPCS code H2017 (psychosocial rehabilitation services, per 15 minutes).

3. Neighborhood and Built Environment

Research indicates that housing is linked to favorable health outcomes. While Medicaid cannot pay for housing directly, care coordination and care management can expedite access to housing outcomes for individuals. All the CPT and HCPCS mentioned throughout this brief can be applied to support access to housing where authorized by state Medicaid agencies and contractually approved. Additionally, recognizing the dearth of affordable and permanent supportive housing, some states are implementing programs to address unhoused people:

- **Louisiana**. Louisiana Medicaid used a waiver to create the residential options waiver to support individuals living with developmental disabilities so they can live and thrive in the community. Covered services include psychosocial support, access to supported employment, housing stabilization and vocational services.[29]
- **California**. California's whole person care (WPC)[30] pilots target high-need Medicaid beneficiaries with enhanced care coordination and psychosocial support for unhoused individuals. WPC also partners with HUD Continuums of Care to provide expedited access to housing choice vouchers.
- **Minnesota**. In Minnesota, Medicaid beneficiaries living with disabilities, including substance use and mental health disorders, can receive services that help them find and keep housing. This service was made possible through a 1115 waiver to extend home and community-based services.[31]

4. Preparing for Value-based Payment

While this brief primarily focused on FFS reimbursement for care coordination services, it is important to note that the prevalence of value-based payment (VBP) is growing exponentially. In 2008, only one state Medicaid agency offered a VBP mechanism. As of 2018, 48 states offer value-based payment. While VBP is likely the future of most payment arrangements, organizations providing care coordination services in an FFS environment have an opportunity to garner insight, refine processes and analyze data that will be crucial negotiating informed VBP arrangements with payers. Emerging and prevalent VBP models for care coordination financing include:

- **Pay-for-oerformance**. Payers can offer incentive payment above FFS rates for specific clinical process or outcomes data.
- **Per member per month**. Payers may offer organizations an all-in monthly rate for all care coordination services provided instead of individual reimbursement per service.
- **Shared savings**. Providers offer organizations the opportunity revenue share for overall reductions in cost associated with providing care services.

Delivering care coordination in FFS environments can serve as a proving ground for organizations to hone clinical and operational processes and collect data to discern the alignment or dissonance with VBP mechanism that are available in the local payer landscape.

Closing

Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

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