



# How States Structure Medicaid Managed Care to Meet the Unique Needs of Children and Youth with Special Health Care Needs

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## Executive Summary

States are transforming their health care delivery systems to reduce health care costs and improve the delivery and quality of care for Medicaid beneficiaries. Most states serve Medicaid beneficiaries, including adults and children with chronic and complex needs, in managed care health delivery systems, where states contract with organizations or providers to manage the services and care Medicaid enrollees receive. As of June 2017, 47 states and Washington, DC, used some form of managed care to provide services to all or some of their Medicaid enrollees.<sup>1</sup> States with Medicaid managed care delivery systems enroll some or all of their children and youth with special health care needs (CYSHCN) into Medicaid managed care systems. Risk-based managed care, when a managed care organization (MCO) is paid a set rate to provide services to enrollees, is the most common system used by 37 states.

Nearly 20 percent of all US children ages birth to 18 years (representing 14.6 million children) have a chronic and/or complex health care need (e.g., asthma, diabetes, spina bifida, autism) requiring physical and behavioral health care services and supports beyond what children normally require.<sup>2</sup> A smaller group of children, which is increasing in number, have *complex* health care needs, with 3 million (about 4 percent) estimated to be medically complex.<sup>3</sup> Medicaid and the Children's Health Insurance Program (CHIP) play a significant role in the financing of care for 44 percent of all CYSHCN.<sup>4</sup> Health care costs for CYSHCN are significantly higher than for children without special needs. Annual Medicaid spending per enrollee is more than 12-times higher for children who use long-term care services (\$37,084) compared to those who do not (\$2,863).<sup>5</sup>

Medicaid managed care provides states with a unique opportunity to strengthen the structure and delivery of health care, particularly for beneficiaries with chronic and complex health care needs. The National Academy for State Health Policy (NASHP), with support from the Lucile Packard Foundation for Children's Health, studied how six states (Arizona, Colorado, Minnesota, Ohio, Texas, and Virginia) designed their systems to serve CYSHCN, and explored some of their best practices and strategies to meet the unique needs of these children. This issue brief identifies key state strategies and innovative policies in the areas of managed care eligibility for subpopulations of CYSHCN, identification and assessments of CYSHCN enrolled in managed care, access to care and network adequacy, quality measurement and improvement, and state agency partnerships. It also summarizes unique managed care program characteristics in Appendix A.

NASHP found that while there is variation in the design of managed care programs, the populations they enroll, and the scope of benefits provided, there are common approaches to how states ensure that MCOs provide quality care to CYSHCN. The Medicaid and CHIP Managed Care Final Rule, finalized in 2016, requires states to take certain steps to improve the enrollee experience in Medicaid managed care, however, states have been working to improve their managed care delivery systems for years. Establishing network adequacy requirements for specialty providers, implementing policies to promote

continuity of care during times of transition, and creating quality measures around processes and outcomes are all strategies that states are actively incorporating into their managed care programs.

State strategies to improve how Medicaid managed care delivery systems serve CYSHCN are summarized below and described in detail in the issue brief.

- **Be clear in contracts about the role of the MCO in identifying CYSHCN** and the criteria used. States can facilitate and guide the identification of CYSHCN by including specific language in managed care contracts that clearly defines criteria for identification and establishes a standard process for MCOs to use.
- **Create a standardized assessment tool** to identify CYSHCN and establish the timing of these assessments. States can help plans achieve ambitious assessment timeliness goals by ensuring contact information for enrollees is up-to-date and that assessment forms are clear, understandable, and available in all needed languages.
- **Establish separate network requirements** for providers who serve CYSHCN and include those requirements in Medicaid managed care contracts. By establishing specific network requirements, states can monitor the adequacy of networks and take corrective action with MCOs if needed to expand provider capacity within networks.
- **Ensure continuity of care during transitions.** These policies can include guarantees of coverage for specific time periods, suspension of prior authorization requirements during transition periods, and requirements that specific providers be included in provider networks if they are the only source of those services.
- **Strengthen systems of care coordination** for CYSHCN. States can set up a strong care coordination system by clearly defining the requirements and qualifications of care coordinators and establishing quality care coordination-related measures.
- **Advance quality measurement strategies tailored to CYSHCN.** These strategies include stratifying general pediatric measures for specific CYSHCN populations; implementing condition-specific measures for high-prevalence conditions such as asthma, ADHD, and diabetes; and population-based measures of care coordination and the medical home.

### **Methodology**

NASHP studied how six states (Arizona, Colorado, Minnesota, Ohio, Texas, and Virginia) structured their Medicaid managed care delivery systems to meet the unique needs of CYSHCN. States were selected based on:

- The presence of active delivery system reform;
- Diversity of managed care program structures and enrollment policies; and
- The number of CYSHCN enrolled in Medicaid managed care.

Information for this study was obtained through interviews with representatives from state Medicaid agencies, Title V CYSHCN programs, Medicaid MCOs, providers, and families of CYSHCN. Site visits were conducted in Ohio and Virginia.

NASHP used a structured questionnaire, tailored to each group, to guide the interviews. It captured state approaches to enrollment of CYSHCN in Medicaid managed care, use of quality monitoring and improvement, financing mechanisms, fiscal accountability tools, and how families were involved in system design.

The [National Standards for Systems of Care for CYSHCN](#),<sup>6</sup> which outline the core components of a quality system of care for CYSHCN, was used to develop the questionnaires. Additional analyses of state Medicaid managed care contracts are included in a companion issue brief, [State Medicaid Managed Care Enrollment and Design for Children and Youth with Special Health Care Needs](#), and a [50-state map and state-by-state table](#).

## State Medicaid Managed Care Delivery System Structures

States typically use one or more types of managed care delivery systems to provide services to Medicaid beneficiaries. These models include risk-based MCOs, primary care case management (PCCM), and/or a prepaid ambulatory health plan (PAHP) system. Of the states with managed care delivery systems serving CYSHCN, 36 states and Washington, DC, rely exclusively on risk-based MCOs to deliver Medicaid services, eight states exclusively use a PCCM delivery system, and one state relies exclusively on a disease-specific PAHP model. The PAHP model serves children and adults with complex health care needs enrolled in Medicaid in North Dakota who have asthma, chronic obstructive pulmonary disease, diabetes, and/or heart failure.<sup>7</sup>

“We want to create a model in which there is a single organization that is in charge of meeting the needs of the [CCYSHCN] and family and has all the necessary resources.” - State Medicaid official

Risk-based managed care is the most common model used by states to provide services to Medicaid beneficiaries, including CYSHCN. Many have implemented innovative service delivery systems and financing strategies to incentivize providers to manage risk and to offer an incentive to provide coordinated care. (See the table in Appendix A for a summary.) These strategies include:

- **Colorado:** Under the state’s Accountable Care Collaborative (ACC) program, Regional Care Collaborative Organizations (RCCOs) receive per-member, per-month payments to coordinate the physical health care of Medicaid beneficiaries and to provide support to medical practices. ACC Phase II is currently under development and the state is now selecting Regional Accountable Entities (RAEs) that will replace RCCOs. RAEs will include behavioral health organizations and oversee the coordination of both physical and behavioral health services. Outside of the ACC program, to coordinate care Colorado utilizes a PCCM model with payment for services made on a fee-for-service basis.
- **Ohio:** In Ohio, MCOs have voluntarily entered into agreements with one state children’s hospital to serve as an ACO provider to CYSHCN. Ohio’s Office of Health Transformation and Department of Medicaid have set a goal to have 80 to 90 percent of Ohio’s pediatric population in a value-based payment model within five years.
- **Minnesota:** Provider-led ACOs contract with all of the state’s Medicaid MCOs. The ACOs are paid contracted rates (typically fee-for-service) for the patients they serve, but at the end of the year they undergo a reconciliation process with the state Medicaid agency to determine shared savings or losses compared to a total cost-of-care target. While these ACOs serve children with and without special health care needs, the ACOs that are operated by children’s specialty hospitals primarily serve children with complex conditions.

## Managed Care Delivery Systems

These are the key managed care health delivery systems used by state Medicaid agencies for CYSHCN.

- **Risk-based managed care organizations (MCOs):** In this model, states contract with MCOs to provide comprehensive services for Medicaid beneficiaries in exchange for a set amount of money on a per-member, per-month basis or through a capitation rate. The MCO assumes the risk of providing services and must meet federal and state requirements and the terms of their state contracts.
- **Primary care case management (PCCM):** Under this model, Medicaid agencies contract directly with primary care providers who then provide, coordinate, and monitor services for Medicaid enrollees. Participating providers receive a case management payment for each Medicaid enrollee they coordinate care for and they bill Medicaid on a fee-for-service basis for the services they provide. The primary care providers do not assume any risk, unlike providers in full risk-based managed care models.
- **Prepaid health plans (PHIP/PHAP):** This model is typically used to provide a set of benefits or services, such as dental or treatment for a specific disease. States pay health plans on a capitated basis only for services contracted by the agency and provided by the plan. Plans are either Prepaid Inpatient Health Plans (PIHP) that cover only certain inpatient services or Prepaid Ambulatory Health Plans (PAHP) that cover only certain outpatient services.

**Source:** Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. June 2015.

## Eligibility for Managed Care

In designing Medicaid managed care delivery systems, states can define:

- Which populations to enroll in managed care;
- Whether enrollment is on a voluntary or mandatory basis; and
- Whether beneficiaries have the option to select a managed care plan upon enrollment.

There are several CYSHCN populations that a majority of states typically enroll in Medicaid managed care:

- Children enrolled in the federal Medicaid aid category for aged, blind or disabled individuals;
- Children enrolled in Medicaid solely based on their income eligibility; and
- Children enrolled in Medicaid as a result of their foster care placement or receipt of adoption assistance.<sup>8</sup>

Federal regulations govern the enrollment of Native Americans and Alaska Natives in managed care. In general, states cannot mandatorily enroll Native Americans and Alaska Natives in managed care without a federal Medicaid waiver, and can only voluntarily enroll them if certain protections are in place to ensure the cultural competency of care.

## What is a Medicaid accountable care organization (ACO)?

State Medicaid agencies are increasingly developing ACOs to manage costs, improve the quality of care, and keep patients healthy. In an ACO, a provider organization, such as a hospital or health system, accepts risk-based payments for the care of their patients, and are rewarded for value rather than volume. The goal of an ACO is to improve health, enhance the patient experience of health care, and control costs by linking payment to health outcomes. ACOs address their goals by implementing value-based payment structures, measuring and improving quality, and collecting and analyzing data to monitor accountability, measure quality, and calculate financial incentives.

**Source:** Medicaid Accountable Care Organizations: State Update. Washington, D.C.: Center for Health Care Strategies, Inc., June 2017.

A majority of states enroll CYSHCN into managed care on a mandatory basis,<sup>9</sup> but there are exceptions in every state. For example, in Minnesota, certain groups of CYSHCN, including children with serious emotional disturbance, children eligible for Supplemental Security Income (SSI), and children receiving adoption assistance, are not required to enroll in managed care, but can do so voluntarily. In Ohio, children enrolled in the Home and Community Based Services waiver administered by the Department of Developmental Disabilities can opt out of managed care.

These states, with the exception of Minnesota, have either phased-in enrollment of CYSHCN into Medicaid managed care or have enrolled CYSHCN after first serving other groups of Medicaid beneficiaries in managed care. States typically phased in enrollment to ensure that there was adequate time for planning, stakeholder engagement, and development and testing of the managed care model, and that protections and safeguards were in place for children with complex needs. Highlights of enrollment strategies and policies include the following.

- In **Arizona**, prior to 2013, children with qualifying conditions had historically been served by the Title V Children's Rehabilitative Services (CRS) program rather than the state's Medicaid managed care program. As of 2013, children in the CRS program are enrolled in a single Medicaid managed care program that provides both physical and behavioral health services to reduce fragmentation and better coordinate their care.
- In **Colorado**, enrollment in RCCOs is voluntary. However, nearly all eligible CYSHCN and their families chose to enroll – while only a small percentage of families elected to keep their children enrolled – in the state's fee-for-service system. Under the new Accountable Care Collaborative Phase II program to be implemented in 2018, CYSHCN (and all Medicaid enrollees) will be automatically enrolled in a Regional Accountable Entity (RAE).
- In **Ohio**, children enrolled in Medicaid Aged, Blind, and Disabled category – which represents the majority of CYSHCN enrolled in Medicaid in the state – were enrolled in Medicaid managed care plans in 2013, while children in foster care were not required to enroll in Medicaid managed care until January 2017.
- In **Texas**, the majority of Medicaid-eligible children, including those with conditions such as diabetes and asthma, are enrolled in managed care under the STAR program, a managed care program for all Medicaid beneficiaries implemented in 1993. Children in foster care were enrolled in their own managed care program, STAR Health, in 2008. STAR Kids, the managed care program for children receiving SSI or enrolled in the state's Medicaid waiver program for medically-dependent children, began enrolling individuals in November 2016.
- In **Virginia**, CYSHCN who are enrolled in a Medicaid waiver program and those who are enrolled under the Aged, Blind and Disabled Medicaid eligibility category are enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) program, which began phased-in enrollment in August 2017. The CCC Plus program is designed specifically to better manage and coordinate the long-term services and supports provided to children and adults with complex health care needs. All other CYSHCN will remain enrolled in the Medallion managed care program, which is Virginia's traditional managed care program for all other Medicaid populations.

### **Pathways to Medicaid Eligibility for CYSHCN**

CYSHCN can be enrolled in Medicaid through a variety of pathways, some of which are federally required and others that are optional. Medicaid-eligibility for CYSHCN varies by state. The general federal Medicaid eligibility categories that cover CYSHCN include:

- **Income-based eligibility:** Under federal Medicaid law, states must cover children with family incomes at or below 138 percent of the federal poverty level (FPL). Many states cover children, including CYSHCN, at much higher income levels.
- **Supplemental Security Income (SSI) eligibility:** Children who meet the disability standard and income limits of the federal SSI program are eligible for Medicaid.
- **Aged, blind and disabled:** Individuals who are age 65 and older, blind, or disabled are eligible for Medicaid if they meet certain income requirements. Some states use more restrictive eligibility criteria for blind and disabled individuals, which predate SSI disability standards, to determine eligibility for Medicaid.
- **Home- and community-based services waivers:** All states provide home- and community-based long-term care services using either the “Katie Beckett” option or a similar waiver program, which allows beneficiaries to receive these services (such as personal care attendants, private duty nursing, and assistance with activities of daily living) at home rather than in an institution. These waivers may cover children with developmental disabilities, autism, HIV/AIDS, or mental illness. Waiver programs may have limited enrollment and may only cover the services related to the qualifying condition.
- **Foster care:** Children who are in foster care or adopted through the foster care system are eligible for Medicaid in all states regardless of family income. Many of these children have physical, developmental, or behavioral health needs that require ongoing care.

#### **Sources:**

*Medicaid and Children with Special Health Care Needs.* Washington, DC: Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured; January 2017.

*State Medicaid Managed Care Enrollment and Design for Children and Youth with Special Health Care Needs: A 50-state Review of Medicaid Managed Care Contracts.* Washington, DC: National Academy for State Health Policy; October 2017.

## **Identification of Newly-Enrolled CYSHCN**

Identification of CYSHCN enrolled in Medicaid managed care is an important part of developing comprehensive systems of care that are responsive to a child’s health care needs. It is also a federal Medicaid requirement under the Medicaid and CHIP Managed Care Final Rule (MACRA) as of May 2016. Additionally, federal Medicaid managed care regulations requires states with managed care systems to set up a mechanism for the state or the managed care plan to identify enrollees with special health care needs. States and plans are using a variety of strategies to identify adults and children with special needs in managed care.

In cases where a child’s eligibility for a specific public program or Medicaid eligibility category is the basis of their managed care enrollment, identification of CYSHCN is straightforward. In Arizona, Texas, and Virginia, CYSHCN are identified based on their Medicaid eligibility category and enrolled in the appropriate managed care program(s). In Arizona, children who are eligible for the Children’s Rehabilitative Services (CRS) program, the state’s Title V CYSHCN program, are enrolled in a dedicated managed care plan. In Texas, children enrolled in SSI or in the state’s medically-dependent Medicaid waiver are enrolled in the STAR Kids program.

In states that use a standard managed program for all Medicaid enrollees, it is necessary for states to identify enrollees with special health care needs in order to differentiate these enrollees from the larger managed care population. In Colorado, Minnesota, and Ohio, the Medicaid agencies and MCOs proactively identify CYSHCN based on their service use and diagnoses – information that is available in Medicaid claims databases. MCOs have developed their own algorithms, which are a set of well-defined rules or procedures based on utilization data or other identifiers – such as a history of foster care – to identify high-need enrollees based on claims, diagnoses, and referrals.

## Federal Medicaid Managed Care Regulations and CYSHCN

In May 2016, the Centers for Medicare & Medicaid Services (CMS) released the Medicaid and CHIP Managed Care Final Rule, which became effective July 2016 with rolling implementation dates for specific provisions over a four-year period.<sup>10</sup> The regulations cover all beneficiaries enrolled in Medicaid and CHIP managed care arrangements. Specific provisions impact how care is delivered to CYSHCN as highlighted below.

- **Network adequacy standards:** Requires states to develop and implement network adequacy standards, including time and distance standards, for certain types of providers, including pediatric, specialty, and behavioral health providers, hospitals, and long-term services and support providers.
- **Care coordination:** Expands federal standards for care coordination to include coordination between settings, community services, and services provided by other MCOs or through fee-for-service arrangements.
- **Identification of enrollees with special health care needs:** Requires states to set up a mechanism for MCOs to identify enrollees with special health care needs. Requires plans to assess these enrollees' needs within 90 days of enrollment and create a treatment plan that is updated regularly based on need.
- **Enrollment process:** Requires states to establish enrollment processes that preserve existing provider-beneficiary relationships. States can establish additional criteria to include family preference for plan or provider, previous plan assignments, and accessibility of the provider offices for children and adults with special needs.
- **Medical necessity definition:** Establishes a definition of medical necessity and requires states to specify in managed care contracts the extent to which the plan is responsible for covering these medically-necessary services.
- **Continuity of care:** For enrollees who are at-risk for negative impacts on their health from transitions from fee-for-service to managed care, states must have a continuity-of-care policy to ensure continued access to services for a period of time, including being allowed to retain current providers regardless of network.
- **Improving quality of care:** Requires plans to have quality programs that measure care provided to CYSHCN and that CMS establish a new Medicaid and CHIP Quality Rating System to promote quality of care and improved consumer engagement.

**Source:** Medicaid and Children's Health Insurance Program Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (81 FR 27497).

## Assessment of CYSHCN

Assessments play a crucial role in identifying and describing the care needs of CYSHCN. The importance of assessments is underscored in the 2016 federal Medicaid managed care rule whereby MCOs are required to assess the needs of CYSHCN within 90 days of enrollment and create a treatment plan that is regularly updated. Once CYSHCN are identified, MCOs typically conduct a targeted assessment in order to assign children to risk levels or tiers, based on their level of need, to ensure that those children with the most complex needs are seen first and receive an appropriate level of care coordination.

States and MCOs typically conduct assessments using assessment forms that are administered by case management staff within the MCO and completed by families or caregivers. The assessment forms vary in their level of detail and use by states. Ohio and Texas require MCOs to use a standard form that can be administered over the phone, by mail, or in-person for those families who have children with complex needs. Colorado plans to implement such a form under its ACC Phase II Program. Ohio's standard pediatric assessment tool contains 20 questions about the needs of children and parental concerns, and the Texas STAR Kids Screening and Assessment Form contains more than 40 pages of detailed questions about children's physical health and psychosocial risk factors.<sup>11</sup> In Arizona, Minnesota, and Virginia, MCOs and providers have developed their own tools to assess the needs of enrollees and assign them to levels of risk to guide their ongoing care.

## Access to Care

The transition of CYSHCN from fee-for-service systems to managed care can raise significant concerns among families about continuity of care and access to providers, hospitals, medications, and vendors for supplies and equipment. Many CYSHCN, especially those with complex needs, have existing networks of providers, multiple prescriptions, and relationships with community-based providers that they want to maintain in a new system. For this and other reasons, Medicaid managed care contracts and systems include multiple provisions to ensure continued access to care for CYSHCN.

## Provider Network Adequacy

State Medicaid agencies and MCOs make it a priority to ensure that provider networks can meet the needs of CYSHCN. Additionally, the federal Medicaid Managed Care regulations require that states establish time and distance standards for a range of specialties, including pediatric primary care providers and specialists.<sup>12</sup> The regulations also require timely access to care, linguistically and culturally competent care, and access for people with disabilities.

State Medicaid agencies typically include network adequacy requirements in their contracts with MCOs as one strategy to ensure compliance. All of the states include time and distance standards for generalist, specialist, and behavioral health care providers and these standards vary for urban, rural, and frontier areas in geographically diverse states. For example, Colorado's Accountable Care Collaborative Phase II Request for Proposals specifies that enrollees must have access to primary care providers within 30 miles or 30 minutes in urban areas, 45 miles or 45 minutes in rural areas, and 60 miles or 60 minutes in frontier areas. In other cases, states specify the required provider capacity of the medical practices. The Ohio Medicaid managed care contract requires that each primary care provider agree to serve at least 50 managed care enrollees per site, and not more than 2,000 enrollees per primary care provider (PCP). In addition, the total PCP capacity of MCOs in Ohio must be 5 percent higher than the number of Medicaid enrollees in the county. Similarly, Texas requires that enrollees in its STAR Kids program have access to two age-appropriate PCPs within 30 miles (or 20 miles in more densely populated areas). Texas also requires that MCOs contract with telehealth providers to ensure access to specialty care in rural areas. Except in programs that serve children exclusively, state contracts do not appear to specify separate standards for pediatric providers.

In addition to contractual requirements, state Medicaid agencies and MCOs use other strategies to help ensure that CYSHCN have access to specialty providers. One such approach is analysis of fee-for-service claims data to identify providers whom enrollees have used in the past and make efforts to enroll these providers in MCO networks. This strategy is used by MCOs in Ohio and by the Texas Medicaid agency, which has used the method to help ensure that "significant traditional providers" are included in its MCO networks. Virginia's Medicaid agency worked with the state's 13 hospital health systems to ensure that they contracted with at least three of the participating MCOs, including tertiary care providers, in their geographic area.

Many state Medicaid agencies cover health care services provided by out-of-state providers, in cases where specialty providers are not available or located within the state. Texas requires that if a provider of a service is the only one available, plans must include this provider in their networks and in some cases this includes out-of-state providers. The Colorado Medicaid agency covers services provided by an out-of-state provider if necessary, as this may be the most accessible option especially in the state's frontier areas.



## Access to Existing Providers and Specialists

In addition to provisions regarding network adequacy, many states have policies and practices to ensure CYSHCN can access their current primary care and specialty providers. For example, CYSHCN may need primary care providers who have expertise in their particular conditions and can address preventive and acute care needs appropriately.<sup>13</sup> Some managed care contracts and policies allow families of CYSHCN to choose a specialist as a PCP; this is the case in Arizona, Colorado, Minnesota, and Ohio. In Colorado, specialists may not be designated as PCPs, but enrollees may see any provider for any reason, thereby enabling specialists to ultimately fulfill the functions of a PCP. In general, Colorado enrollees who do not actively choose a PCP will be assigned to one based on previous utilization or family history. In Texas, officials noted that they review an enrollee's past records to identify a PCP before assigning one at random, and in Colorado, the state uses a similar process to "attribute" enrollees to PCPs they have seen in the past.

Requiring prior authorization in order to receive health care services can be a barrier to care for CYSHCN and their families. In general, plans are allowed to determine prior authorization requirements, but many state Medicaid agencies set limits on the scope of these requirements. In Texas, prior authorization requirements cannot be used to limit the amount, duration, or scope of services. Consistent with this approach, states typically only require prior authorization for residential services (Minnesota) or out-of-network or out-of-state services (Arizona and Virginia).

## Continuity of Care

Continuity of care at times of transition – at initial enrollment, between plans, and at discharge from a hospital – is critical to CYSHCN and their families. Because CYSHCN often have established providers, maintenance medications, regular therapy visits, and other ongoing services, it is especially important that they maintain access to these existing providers and services during transitions without incurring problems related to coverage and reimbursement. Establishing policies that promote continuity of care policies for enrollees with special needs is also a requirement of Medicaid and CHIP's Managed Care Final Rule.

State Medicaid agencies use a variety of strategies to help ensure continuity of care for CYSHCN. Many states include contract provisions that allow for a period after initial enrollment in managed care during which plans must continue to cover services from current providers and all current prescriptions. In Virginia, this period is 90 days during the phased-in rollout, and in Minnesota, state statute requires payment for up to 120 days for services and 90 days for prescriptions. In Ohio, new populations, such as foster care youth, enrolling in managed care on or after Jan. 1, 2017, are required to receive continuous care for 90 days. In addition to a 90-day transition coverage period, Arizona's CRS managed care contractors are required to employ a transition coordinator to oversee transition activities. The coordinator serves as an advocate for members during transitions, assists PCPs and other providers with care coordination during transitions, facilitates communication, and assures continuity of care.

Transition planning is also needed when children are discharged from the hospital to ensure that follow-up plans are maintained and complications do not arise that lead to readmission. State Medicaid agencies, plans, and providers have implemented provisions for transition after hospital discharge to ensure continuity of care. In Arizona, the managed care plan is required to collaborate with hospitals to implement "person-centered planning" at discharge and to use data to improve the quality of care at discharge. Similarly, Ohio's contract requires that MCOs have a process to evaluate the risk of readmission, participate in discharge planning, arrange for services included in the discharge plan, and follow up

with members and their PCPs to ensure that the planned services have been provided. The Texas STAR Kids program similarly requires MCO care coordinators to work with the PCP, the hospital, the attending physician, and the child and family to create and implement a discharge plan.

## Care Coordination

Care coordination is a critical element in managed care systems for CYSHCN. For families, a care coordinator can be a valued partner in their child's care, helping them to organize care, arrange appointments, and facilitate communication among providers. For MCOs and PCPs, the care coordinator is an important part of managing services, ensuring that care is not duplicated, and that children's needs are met.

In general, state Medicaid agencies leave the responsibility of providing care coordination to MCOs, who then employ social workers, nurses, and other trained individuals to provide care coordination to enrollees. MCOs participating in the Texas STAR Kids program hired large numbers of care coordination staff in order to meet the specific care coordination responsibilities required by the state Medicaid agency. The Texas STAR Kids program requires that participating MCOs employ service coordination teams to evaluate each member's needs, develop an individual service plan, connect members to services within and outside the plan, coordinate services, and intervene on behalf of members if necessary. In some states, however, while managed care plans remain contractually responsible for care coordination, they can pass this responsibility on to ACOs, primary care medical homes, or other provider agencies, as they have the most direct contact with their patients and are the most familiar with their needs. In Arizona, for example, CYSHCN enrolled in the managed care program may be enrolled in a multi-specialty interdisciplinary clinic for their health care, including care coordination. In Minnesota, where CYSHCN enrolled in managed care plans are served by hospital-based ACOs, the ACOs have contracts with some of the plans to provide care coordination for the children in their care.

A major challenge of coordinating care for CYSHCN is managing the services provided across a diverse range of organizations and systems used by these children. Early intervention programs, special education systems, Medicaid waiver programs, and long-term services and supports (LTSS) programs generally provide care coordination to their enrollees. In such a complex system, states and plans need to designate a lead care coordinator to avoid duplication and confusion. MCOs in Colorado, Texas, and Virginia, under its CCC+ program, consider their care coordinators to be in this lead role, although plans and providers in some cases allow families to choose a primary care coordinator. This is the case in Virginia's CCC+ program, where plans may contract with community-based agencies to provide care coordination to families who choose them as their lead. In Arizona, the clinic that serves as the health home is the lead care coordinator, while in Minnesota, no consistent lead care coordinator is designated.

"I have had a dedicated service coordinator for a couple months now ... and I have one person to call when I do have an issue and she is a problem-solver and has helped me navigate. So, when I do have an issue, I now have somebody to call to help me navigate it."  
- Parent of a child with special health care needs in Medicaid managed care

## Long-term Services and Supports

LTSS refers to the range of services, including personal care services, home modifications, services in alternative care facilities, transportation, and medication monitoring, that provide children with health care and help with daily living activities. These services are provided to children with developmental disabilities and other complex needs under Home and Community-Based Services waivers or through traditional Medicaid as home health care and personal care services are covered under state plans.

Some states specify these services within Medicaid managed care contracts for CYSHCN. In Texas, the STAR Kids' MCOs are responsible for contracting with nursing facilities. The MCOs are required to coordinate with these providers and LTSS services are included in their capitation rate. In Virginia, LTSS services are fully integrated into the CCC Plus program for CYSHCN, including children on waiver programs, as of August 2017.

Within their Medicaid managed care programs, Arizona, Colorado, Ohio, and Minnesota carve out LTSS services from the responsibility of MCOs. In Arizona, for example, children with developmental disabilities receive their long-term care services through a separate managed care system under the Department of Economic Security. In Colorado, LTSS services are provided through the Office of Community Living and are excluded from the RCCOs' responsibility. Minnesota carves out care in nursing facilities, and LTSS services are currently excluded from managed care in Ohio.

## Quality Measurement and Improvement Strategies

Quality measurement and improvement is a core component of Medicaid managed care. Over the past two decades, considerable work has gone into developing and testing reliable and valid measures of quality, including measures for special populations such as children and adults with various types of special needs. Until passage of the Children's Health Insurance Program (CHIP) Reauthorization Act (CHIPRA) of 2009, no uniform system for assessing the quality of care for children across states existed for Medicaid and CHIP. In response to CHIPRA, the Secretary of Health and Human Services through the CMS and the Agency for Healthcare Research and Quality (AHRQ) released the Children's Health Care Quality Measures for Medicaid and CHIP<sup>14</sup> (known as the Child Core Set) after input from experts in the field of quality measurement and other stakeholders.<sup>15</sup> As part of the Bipartisan Budget Act passed in February 2018, by 2024 states will be required to report on the Child Core Set which states currently submit on a voluntary basis.

Several other efforts also are underway to advance children's health quality measurement in public and private insurance coverage programs. CMS and AHRQ are leading the Pediatric Quality Measurement Program (PQMP), which was established under CHIPRA. The goal of PQMP is to strengthen the Child Core Set, and develop, strengthen and/or test new measures that public and private payers can use to improve children's health care quality. One area of focus under PQMP is the development of measures specific to children with complex needs.<sup>16</sup> Additionally, CMS, private and public health plans, purchasers, physicians, and other care provider organizations, and consumers have come together through the Core Quality Measures Collaborative (CQMC), led by the America's Health Insurance Plans (AHIP), to establish core sets of measures across several domains, including pediatrics. CQMC aims to promote measures alignment across public and private payers.<sup>17</sup>

Federal Medicaid regulations require that states with Medicaid managed care develop and implement a state quality strategy that assesses and improves the quality of care across all enrollees, which includes CYSHCN. States with specialized managed care programs for CYSHCN may be well positioned to develop tailored approaches to measurement quality specifically for CYSHCN populations. In Arizona's CRS program, for example, a selection of Healthcare Effectiveness Data and Information Set (HEDIS) measures, including participation in the Early and Periodic Screening, Diagnosis, and Treatment (EPS-DT) program and receipt of developmental screening in the first three years of life, are required of a CRS contractor, in addition to the standard set of HEDIS measures required from all AHCCCS plans. Under Virginia's CCC Plus program, a set of 25 measures is collected from MCOs, including standard measures of well-child care as well as specialized measures, such as the asthma medication ratio, metabolic monitoring for children and adolescents on antipsychotics, and the CAHPS Item Set for Children with Chronic Conditions.

States can also use performance incentives and Performance Improvement Projects (PIPs) to improve the quality of care provided to this population. In Texas, the STAR Kids contract includes a requirement for plans to develop a strategy for value-based contracting with their providers, and the state will implement a “pay-for-quality” initiative in the second year of the contract using a funding pool made up of 3 percent of the plans’ capitation payments. In Minnesota, the performance incentive structure includes measures of appropriate treatment for pediatric asthma, dental care, and well-child visits during the first 15 months, and pays plans that perform well on these measures from a pool of funds withheld from their capitation payments.

In states that integrate CYSHCN into mainstream managed care plans, CYSHCN are included in general measures of pediatric care, such as receipt of well-child care, immunization rates, and obesity testing and intervention. In Virginia, under the Medallion 3.0 managed care program, state officials noted that they do not specifically emphasize CYSHCN for the evaluation of preventive and acute care services, because CYSHCN should receive the same preventive and acute care services as other children.

In addition to measures of care within managed care plans, state Medicaid agencies conduct targeted studies on specific issues across their systems. In Ohio, for example, the Medicaid agency conducted a study of the use of antipsychotic medications in children under age six and the use of four or more psychotropic medications in children under age 18. This study led to the creation of an episode of care value-based payment model for attention-deficit/hyperactivity disorder (ADHD) as well as new practice guidelines and ongoing monitoring of MCOs for the use of first-line psychosocial care for children and adolescents on antipsychotics.

## Plan and Provider Implementation of Quality Measures for CYSHCN

MCOs and providers use data for continuous ongoing quality improvement in addition to reporting requirements and contract oversight. Plans may analyze the performance of individual providers on specific measures in comparison to a benchmark or to the average provider performance on a measure across the plan, and they use this data to suggest improvements and/or offer incentives to address gaps or improve performance. For example, an Ohio MCO analyzes data on readmissions and emergency department use in addition to standard HEDIS measures. The MCO’s quality improvement team evaluates plan performance in comparison to its goals, discusses which interventions are effective, and makes changes in real time to improve performance. Data are analyzed by enrollees’ eligibility category as well, thereby providing MCOs and the state with information on the care that certain populations with special needs are receiving. In Virginia, a Medallion 3.0 plan uses the SF-12<sup>18</sup> to assess quality of life for CYSHCN at the time of enrollment, after six months, and at the end of treatment.

Minnesota’s MCOs and providers participate in Minnesota Community Measurement, which collects and analyzes quality indicators across systems. These measures<sup>19</sup> include rates of depression screening, child and adolescent immunization rates, optimal asthma control, and follow-up for children who are prescribed medication for ADHD.

## State Agency Partnerships

State Medicaid agencies partner and collaborate with other state agencies and programs in the design and implementation of Medicaid managed care systems for CYSHCN. State Title V CYSHCN programs have long provided clinical and support services such as care coordination to CYSHCN. In Minnesota and Virginia, Title V representatives served on the advisory committees that oversaw the transition of CYSHCN to managed care, and in Virginia, Title V representatives will also play a key role in the implementation of the Medallion 4.0 program. In Colorado and Texas, Title V representatives attended meetings of managed care implementation committees and shared information. Roles of Title V during managed care implementation for CYSHCN include:

- Serving as a resource to answer questions about the CYSHCN population;
- Reviewing contract language; and
- Providing information about available standards – such as the National Standards for Systems of Care for CYSHCN<sup>20</sup> – to guide program design.

Title V CYSHCN programs are also involved as Medicaid providers in managed care service delivery systems in some states and can provide input from this perspective as well.

In some states, state Title V programs are assisting in the design of quality monitoring strategies for CYSHCN in Medicaid managed care. In Texas, the Medicaid agency is involving the Title V program in the development of quality metrics for STAR Kids. In Colorado, the state Title V CYSHCN program advised the Medicaid agency on pediatric measures, such as developmental screening rates or appropriate asthma treatment, to include in Phase II of the Accountable Care Collaborative.

Families of CYSHCN are also valuable partners to state Medicaid agencies as they make managed care policy decisions for this population and can serve a valuable role in educating and guiding their peers through these new systems. Families are included on managed care advisory committees in Texas and Virginia, and the Arizona Medicaid agency specifically asked family advocates for input about their managed care contract language. In Ohio, a family organization was engaged to provide information to families of CYSHCN about the transition to managed care. Arizona and Texas have an ombudsman with whom families can register complaints. In Arizona, the ombudsman position is specifically designed to serve the CYSHCN population.

## Lessons Learned

State Medicaid officials, MCOs, and providers identified numerous important lessons learned and recommendations to better serve CYSHCN in Medicaid managed care. State officials unanimously emphasized the need to:

- Take time to design all aspects of the system;
- Include stakeholders, such as providers and families in planning;
- Be “open and transparent” in the planning process;
- Have strong data and analytical systems to support the system; and
- Develop program champions on the administrative, legislative, and community levels.

Medicaid officials also offered specific recommendations to better serve CYSHCN through Medicaid managed care:

- **Arizona** officials noted that they did not allow their contracted plan to subcontract to other organizations in order to avoid fragmentation and over-specialization and to keep the plan’s management under a single entity.

- **Colorado** officials stressed the need to remember that children's needs are different from those of adults and that the Early and Periodic Screening, Diagnosis, and Treatment program (EPS-DT) is a key component in the system of care for CYSHCN.
- **Minnesota** officials noted that their flexible ACO model was helpful in serving a high-risk population with variable needs, as the payment structure of this model, in which risk is shared and the ACO is accountable for quality measures, allows the state and the ACO to meet halfway in the management of cost and risk.
- **Virginia** officials recommended that states hire a lead staff person who has a passion for this population and will be a strong advocate for their needs.

MCOs and providers identified lessons learned that are specific to the challenges of serving children with complex needs as well. MCO representatives commented on the benefits and challenges inherent in bearing responsibility for the full range of children's physical and behavioral health needs. Arizona's MCO officials reported that this integration has allowed for better coordination of care and strengthened each family's team. In Ohio and Texas, MCOs and providers supported state decisions to enroll CYSHCN into managed care in phases, to ensure that the systems are well-established before enrolling the children with the most complex needs. MCOs and providers from Colorado and Texas noted that the success of managed care for CYSHCN cannot be focused solely on financial measures -- the primary goal should be improving the quality and coordination of care. This point was expressed by state Medicaid officials as well.

MCOs also emphasized the challenges associated with data collection and information sharing. A Texas MCO recommended the state invest in a system that allowed providers to share information securely to better coordinate care, and Ohio and Minnesota MCOs noted the problem of variations in data systems across their counties, increasing the burden on plans in communicating with county-based service providers. Families emphasized the need to involve consumers in planning, education of new enrollees, and providing feedback on where the system is working and when and where changes are needed.

## State Recommended Strategies

**Be clear in contracts about the role of the MCOs in identifying CYSHCN and the criteria to be used.** By consistently identifying new enrollees who have special health care needs as soon as possible and tailoring outreach materials to this population, states and MCOs are better able to provide needed services quickly, inform families about the value of managed care for their children, and assure continuous, coordinated, high-quality care. States can facilitate and guide the identification of CYSHCN by including specific language in managed care contracts that clearly defines the criteria for identification and establishes a standard process for MCOs to use. By having clear and standard processes for identification and outreach, the first interaction with an MCO for CYSHCN and their families can be a positive one and MCOs can have valuable information that properly recognizes enrollees who will require specialized attention.

**Create a standardized assessment tool to identify CYSHCN and issue guidance about the timing of these assessments.** States can ensure that assessments are comprehensive by creating a standardized assessment tool or by requiring that standard elements be included in an assessment through managed care contract language. States can also ensure the timeliness of assessments by setting timelines for completion by MCOs even within the 90-day federal requirement. States can help plans reach ambitious assessment timeliness goals by ensuring contact information for enrollees is as up-to-date as possible and that assessment forms are clear, understandable, and available in all necessary languages.

**Establish separate network requirements for providers who serve CYSHCN and include the requirements in Medicaid managed care contracts.** Being able to access primary care and pediatric specialty providers is critically important to ensure CYSHCN receive timely and necessary care. States and MCOs play a valuable role in ensuring that provider networks are robust enough to meet the needs of their enrollees. By establishing specific network requirements for providers who typically serve CYSHCN, states can monitor the adequacy of networks and take corrective action with MCOs if needed to expand provider capacity within networks. The Medicaid and CHIP Managed Care Final Rule requires that states establish time and distance standards for a number of specific provider types, including pediatric primary care and specialty providers, pediatric dentists, and behavioral health care providers who serve children. However, other standards, such as wait times for appointments and provider-to-population ratios can be implemented as well, and evaluations of provider networks to confirm wait times, locations, and participation in plans can also be used to monitor and enforce these requirements.<sup>21</sup>

**Ensure continuity of care during transitions.** Transitions in coverage and care can be difficult for CYSHCN and their families. By implementing policies that pre-emptively recognize this, states and MCOs can provide consistent care to enrollees. These policies can include:

- Guarantees of coverage for specific time periods;
- Suspension of prior authorization requirements during transition periods; and
- Requirements that specific providers be included in provider networks if they are the only available source of their services.

**Strengthen systems of care coordination for CYSHCN.** States can set up a strong care coordination system by clearly defining the requirements and qualifications of care coordinators. Care coordination also requires a documented list of the types of services that care coordinators are responsible for managing, including those outside of the services managed by the MCO. States can also improve care coordination systems by establishing measures to evaluate the quality of the care coordination received by families of CYSHCN. Other tools that can strengthen care coordination systems include standard forms for care planning, systems for communication and information-sharing across systems, and mechanisms to formally involve families in the coordination of their children's care.

**Advance quality measurement strategies that are tailored to CYSHCN.** States can use a range of strategies to measure the quality of care specifically for CYSHCN. These strategies include stratifying general pediatric measures for the CYSHCN population; implementing condition-specific measures for high-prevalence conditions, such as asthma, ADHD, and diabetes; and population-based measures of care coordination and medical home functionality. Implementing a selection of these measures will help states to assure that CYSHCN receive comprehensive, high-quality, coordinated care through managed care systems.

## Conclusion

State Medicaid agencies, MCOs, and providers are using innovative methods to identify the children at highest risk, provide and finance care coordination to manage and improve their care, and to monitor the quality of care and create incentives for high-quality care delivery. In designing and implementing these strategies, states and health plans are balancing management of financial risk with the need to provide comprehensive, coordinated, and family-centered care.

As managed care systems expand and evolve to cover CYSHCN, states are continuing to innovate and implement new models of care, operationalize and implement quality monitoring systems, and create effective incentives that target aspects of care that are susceptible to intervention. The experience of states that are taking the lead in these areas will be critical as these systems evolve.

## Additional Selected Resources

- [State Medicaid Managed Care Enrollment and Design for Children and Youth with Special Health Care Needs: A 50-state Review of Medicaid Managed Care Contracts](#)
- [State Strategies for Medicaid Quality Improvement for Children and Youth with Special Health Care Needs](#)
- [Standards for Systems of Care for Children and Youth with Special Health Care Needs: Version 2.0](#)
- [Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs: A White Paper from the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project](#)
- [Identification and Assessment of Children and Youth with Special Health Care Needs in Medicaid Managed Care: Approaches from Three States](#)
- Kaiser Family Foundation: [Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts](#)

## Notes

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**About the National Academy for State Health Policy:**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).

## Appendix A

Key Terms	
<p><b>1915(c) Waivers</b> – States develop home- and community-based services waivers for children who receive services in their home or community.</p> <p><b>ABD</b> – Aged, blind and disabled</p> <p><b>ACO</b> – Accountable care organization</p> <p><b>AI/AN</b> – American Indians and Alaskan Natives (Native Americans)</p> <p><b>BHO</b> – Behavioral health organization</p> <p><b>CRS</b> – Children’s Rehabilitative Services</p> <p><b>CYSHCN</b> – Children enrolled in Medicaid based on income eligibility who have special or chronic health care need(s)</p> <p><b>FC/AA</b> – Children who are in Medicaid as a result of their foster care placement or for adoption assistance</p> <p><b>FFS</b> – Fee for service</p> <p><b>ID/DD</b> – Intellectual disabilities/developmental disabilities</p>	<p><b>MCO</b> – Managed care organization</p> <p><b>MLTSS</b> – Managed long-term services and supports</p> <p><b>MMC</b> – Medicaid managed care</p> <p><b>N/A</b> – Not applicable</p> <p><b>PCCM</b> – Primary care case management</p> <p><b>PCMP</b> – Primary care medical provider</p> <p><b>PIHP</b> – Prepaid inpatient health plans</p> <p><b>RCCO</b> – Regional care collaborative organization</p> <p><b>SED</b> – Serious emotional disturbance</p> <p><b>SSI</b> – Children who receive Supplemental Security Income (SSI)</p> <p><b>Title V CSHCN</b> – Children with special health care needs enrolled in state programs funded by Title V Maternal and Child Health funding</p>

Overview of Selected State Medicaid Managed Care Program Characteristics						
	Arizona <sup>1</sup>	Colorado	Minnesota	Ohio	Texas	Virginia
<p><b>Type of Medicaid Managed Care Plan for CYSHCN (Standard or Specialized) and Managed Care Model Type (MCO, PCCM, PIHP)</b></p>	<p>Standard – MCO</p> <p>Specialized MCO for CYSHCN whose conditions qualify for <a href="#">Children’s Rehabilitative Services program</a></p>	<p>Standard – PCCM – <a href="#">Accountable Care Collaborative</a><sup>2</sup></p>	<p>Standard – <a href="#">MCO</a></p>	<p>Standard – MCO</p>	<p>Standard – MCO - <a href="#">STAR</a><sup>3</sup></p> <p>Specialized MCO for FC/AA – <a href="#">STAR Health</a><sup>4</sup></p> <p>Specialized MCO for ABD/1915(c) – <a href="#">STAR Kids</a><sup>5</sup></p>	<p>Standard - MCO - <a href="#">Medallion 3.0</a><sup>6</sup></p> <p>Specialized MCO for ABD, SSI, and 1915(c) – <a href="#">CCC Plus</a><sup>7</sup></p>
<p><b>Inclusion of Specific Definition of CYSCHN in MMC Contract</b></p>	<p>Yes<sup>8</sup></p>	<p>No</p>	<p>No</p>	<p>No</p>	<p>No</p>	<p>Yes<sup>9</sup></p>

		Arizona	Colorado	Minnesota	Ohio	Texas	Virginia
<b>CYSHCN Enrollment by Population Type: Voluntary, Mandatory, Exempt, or Not Specified in the Contract (N/A)</b>	<b>ABD</b>	Mandatory – Standard plan	Voluntary	Exempt	Mandatory	Mandatory – STAR Kids	Mandatory – CCC Plus
	<b>CYSHCN</b>	Mandatory – Standard plan	Voluntary	Voluntary	N/A	Mandatory - STAR	Mandatory - Medallion
	<b>FC/AA</b>	Mandatory – Standard plan	Voluntary <sup>10</sup>	FC: Mandatory AA: Voluntary	Mandatory	Mandatory – STAR Health	Mandatory - Medallion
	<b>AI/AN<sup>11</sup></b>	Exempt under both plans <sup>12</sup>	Voluntary	Mandatory	N/A	N/A	Exempt
	<b>SSI</b>	N/A	Voluntary	N/A	Mandatory	Mandatory – STAR Kids	Mandatory – CCC Plus
	<b>Title V CYSHCN</b>	Mandatory – Specialized CYSHCN program <sup>13</sup>	Voluntary	N/A	Mandatory	N/A	Mandatory - Medallion
	<b>1915(c)</b>	N/A	Voluntary	N/A	Individuals enrolled in a 1915(c) administered through Ohio Department of Developmental Disabilities – voluntary/exempt	Mandatory – STAR Kids	Mandatory – CCC Plus
<b>Other</b>		--	Exempt – ID/DD waiver and ID/DD who live on a reservation <sup>14</sup> Voluntary -Children with SED	--	--	--	
<b>Risk Structure of Delivery System</b>		Managed care plans receive capitated payments and are responsible for all contracted services.	RCCOs receive per-member-per-month payments to coordinate the care of their respective beneficiaries.	Managed care plans receive capitated payments. Dept. of Human Services also establishes a total cost of care target for ACOs, and managed care plans pay a portion of their capitated payment to ACOs that achieve savings (or receive payment back if the ACO has losses).	Managed care plans receive monthly capitation rates and are responsible for all contracted services.	Managed care plans receive capitated payments and are responsible for all contracted services.	Managed care plans receive capitated payments and are responsible for all contracted services.

	Arizona	Colorado	Minnesota	Ohio	Texas	Virginia
<b>Services Carved out of Medicaid Managed Care (e.g., Behavioral Health, LTSS, Care in Nursing Facilities – what are nursing facilities?)</b>	LTSS	Behavioral health services are currently provided through a BHO carve-out <sup>5</sup> with the following populations mandatorily enrolled: ABD, CYSHCN, FC/AA.	LTSS and care in nursing facilities	LTSS, behavioral health <sup>6</sup> , and care delivered in nursing facilities	Children enrolled in Medicaid waiver programs receive their acute care through the STAR Kids program but receive waiver services separately.	Non-traditional behavioral health services (state plan option) are currently carved out, but will be integrated in 2018. <sup>17</sup>  LTSS are carved out of Medallion programs only.
<b>Structure of Care Coordination under Medicaid Managed Care</b>	Managed care plans pay a supplemental fee to multi-specialty, interdisciplinary clinics, which may serve as the health home for CRS enrollees, to conduct care coordination.	RCCOs provide care coordination services, or they contract with a PCMP or community-based organization for care coordination.	Managed care plans provide care coordination, or a health care home or ACO provides care coordination.	Managed care plans or comprehensive primary care practices provide care coordination. <sup>18</sup>	Managed care plans serve as the lead care coordinators.	Managed care plans serve as the lead care coordinators in both Medallion and CCC Plus programs.
<b>Availability of Specific Quality Measures for CYSHCN in MMC Contracts (Yes/No)</b>	Yes <sup>19</sup>	No	Yes <sup>20</sup>	Yes <sup>21</sup>	Yes <sup>22</sup>	Yes (for Medallion <sup>23</sup> and CCC Plus <sup>24</sup> )

## Notes

1. In addition to its standard MMC program and CRS, Arizona has an MLTSS program - Arizona Long Term Care System (ALTCS). Children with developmental disabilities may qualify for ALTCS, in which case they are enrolled in a MLTSS health plan that includes all acute, behavioral health and LTSS services.
2. "Utilizes a network of Regional Care Collaborative Organizations (RCCOs) to coordinate acute, primary, and specialty care, pharmacy, and select behavioral health services to most Medicaid beneficiaries in the state." – [Managed Care in Colorado](#)
3. [Texas Medicaid and CHIP – Uniform Managed Care Manual](#), Texas Health and Human Services
4. [STAR Health – A Guide to Medical Services at CPS](#), Texas Department of Family and Protective Services
5. [STAR Kids Contract Terms](#), Texas Health and Human Services Commission
6. [Medallion 3.0 Managed Care Contract](#), Commonwealth of Virginia Department of Medical Assistance Services
7. [Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports](#), Commonwealth of Virginia Department of Medical Assistance Services
8. "Children under age 19 who are blind, children with disabilities, and related populations (eligible for SSI under Title XVI). Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett); in foster care or other out-of-home placement; receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS)" – p. 10 – [Managed Care Contract Amendment](#), Arizona Health Care Cost Containment System
9. "Children and Youth with Special Health Care Needs (CYSHCN) include children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CYSHCN consist of at a minimum, children in the eligibility category of SSI, children identified as Early Intervention (Part C) participants, Foster care or Adoption Assistance (includes any individuals who have been enrolled in a particular health plan under a nondisabled or Foster Care/Adoption Assistance when the individual becomes enrolled in a disabled or Foster Care/Adoption Assistance) and others as identified through the Contractor's assessment or by the Department." – p. 91 – [Medallion 3.0 Managed Care Contract](#), Commonwealth of Virginia Department of Medical Assistance Services
10. As of Spring 2017, Colorado is in the procurement process for Phase II of their ACO managed care program which will include a shift from voluntary enrollment to mandatory.
11. Under federal Medicaid regulations, states are not authorized to mandatorily enroll AI/ANs in managed care unless they are approved to do so through a 1915(b) or 1115(a) waiver, or the MCO is operated by the Indian Health Service, a tribe, or an urban American Indian health program.
12. American Indian Health Program enrollees or Arizona Long Term Care System for the Elderly and Physically Disabled Tribal (ALTCS EPD) program enrollees
13. [Overview of Five States' Programs for Children and Youth with Special Health Care Needs](#), 2015, California Children's Services Program Redesign
14. American Indians living on a reservation per the choice of the tribal government are exempt from managed care enrollment
15. Colorado is currently in a procurement process to integrate behavioral health services into managed care - [Accountable Care Collaborative Phase II](#), Colorado Department of Health Care Policy and Financing
16. On July 1, 2018 behavioral health will be carved-into managed care
17. Virginia currently carves out non-traditional behavioral health service of both Medallion and CCC Plus. However, beginning in January 2018, these services will be integrated into CCC Plus. Virginia also plans to integrate the non-traditional behavioral health services in Medallion 4.0 (the next iteration of its managed care program), which is expected to launch in August 2018.
18. In the state of Ohio, the Patient-Centered Medical Home model is called the [Comprehensive Primary Care Program](#). CPC practices take the lead care coordination role for members enrolled in managed care.
19. [Managed Care Contract Amendment](#), Arizona Health Care Cost Containment System - p. 73
20. "The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.4(A), the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval." [Contract for Medical Assistance and MinnesotaCare Services](#), Minnesota Department of Human Services - p. 153
21. Ohio Department of Medicaid uses the same quality measures across populations. The managed care contract specifies that, "each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP must specify the mechanisms used in the annual submission of the QAPI program to ODM." The Ohio Department of Medicaid, [Ohio Medical Assistance Provider Agreement for Managed Care Plan](#), Revised July 2016.
22. For both STAR Kids and STAR Health, their contracts require that they develop and implement Quality Assurance and Program Improvement programs, which is designed to monitor and assess their clinical and non-clinical processes and outcomes, for their respective populations of CYSHCN. STAR Health and STAR Kids plans are also required to address and report on the measures identified by the state as part of the Performance Indicator Dashboard for Quality Measures, which is designed to assess "many of the most important dimensions of MCO performance, and include measures that, when publicly shared, will also serve to incentivize MCO excellence." The STAR Health [Performance Indicator Dashboard](#) has been implemented, while the Performance Indicator Dashboard for STAR Kids is under development.
23. The Medallion 3.0 contract requires MCOs to assess quality of care of CYSHCN in the following areas: 1) program development; 2) enrollment procedures; 3) provider networks; 4) care coordination; and 5) access to Specialists. [Medallion 3.0 Managed Care Contract](#), Commonwealth of Virginia Department of Medical Assistance Services – p. 92
24. The CCC Plus contract specifies that MCOs must report on the "CCC Plus Core Performance Measures List" that covers the following domains: 1) enhance Member experience and engagement in person-centered care; 2) improve quality of care; 3) improve population health; and 4) reduce per capita costs. MCOs participating in CCC Plus must also identify and implement behavioral health outcome measures (e.g., recidivism, employment or school attendance, utilization measures, member satisfaction, etc.). [Commonwealth Coordinated Care Plus MCO Contract](#), Commonwealth of Virginia, Department of Medical Assistance Services – p. 146 & 154