Access to Care for Children with Special Health Care Needs: The Role of Medicaid Managed Care Contracts

Final Report to the Medicaid and CHIP Payment and Access Commission

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About the Funder

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

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Summary of Key Findings

This report summarizes research on provisions that address access to care for children and youth with special health care needs (CSHCN) in state Medicaid managed care contracts.[1] CSHCN have or are at risk for a chronic physical, developmental, behavioral, or emotional condition; have an above-routine need for health and related services; and are disproportionately enrolled in Medicaid.[2,3] The research team examined contract provisions in the 34 states where managed care organizations (MCOs) enroll CSHCN in their standard Medicaid plans.[4] We searched the contracts for 29 pre-selected access-to-care provisions considered relevant to access to services and providers for CSHCN, related to: 1) Identification, Screening and Outreach; 2) Care Management; 3) Network Adequacy and Standards; 4) Care Continuity and Relaxing of Authorization Rules; and 5) Expertise, Provider Education, and State Monitoring.

Based on this review—supplemented by interviews with researchers and advocates, surveys of and interviews with key informants in Medicaid agencies and MCOs, and a review of the literature—this report describes the frequency with which states include contract provisions intended to promote access to needed services and providers by CSHCN. It examines the extent to which state contracts with MCOs specifically target such protections to CSHCN. If the contracts did not address CSCHN, we noted which populations were addressed, usually all individuals (including adults and children) with special health care needs (ISHCN) or the general enrollee population. This report also presents considerations for enhancing access for CSHCN. With increasing numbers of CSHCN enrolling in managed care, the study's findings may inform how state and MCO contracts could be written to promote improved access to needed services. A summary of our key cross-cutting findings appears below.

Stakeholders are divided on whether and when general contract provisions that apply to all enrollees afford sufficient protections for CSHCN. Medicaid officials and MCO representatives suggest that some access provisions broadly applied to the entire enrollee population may provide adequate protection for CSHCN, although the consequences of any gaps in protections (or poor adherence to them) are likely to be magnified for this more vulnerable group. However, experts and advocates stress that challenges facing CSHCN differ from challenges facing adults with special health care needs and the general enrollee population, and thus require different considerations and standards. They argue that specific language targeting CSHCN in contracts would promote focus on these enrollees and better protect them, particularly because serving this population is new to many MCOs.

The majority of state MCO contracts do not specifically target CSHCN in most access-related contracted provisions and are more likely to address the general population or all enrollees with special health care needs. There is considerable variation in the presence and specificity of access provisions across states. The most common access provisions that address CSHCN specifically are requirements for: identification of CHSCN (22 states), care coordination across children's agencies and programs (16 states), inclusion of pediatric providers in networks (13 states) and inclusion of pediatric centers of excellence in network (12 states). Access provisions focusing more broadly on ISHCN cluster in the domains related to identification, assessment, and care management. While all states have some provisions targeting CSHCN, four states were identified as offering the largest number of CSHCN-specific access provisions; they are Michigan (14 provisions), Virginia (12), Maryland (9) and California (9).

The requirement that MCOs identify CSHCN is the only provision found in the majority of contracts. Identification of CSHCN appears in the majority (22) of state contracts reviewed, reflecting a federal rule that requires identification of all enrollees with special health care needs.[5] For each of the remaining provisions that are the subject of this study, fewer than half of state contracts specifically target CSHCN.

Care management provisions mostly refer to ISHCN and only infrequently address CSHCN specifically. Requirements related to care management commonly refer to ISCHN, and expand beyond the federal requirements for care monitoring and a treatment plan.[6] Contracts target ISHCN in requiring assignment of a care manager (16 states), development of a care plan (21 states), and a care team approach or provider information exchange (18 states).

Access-related provisions related to network adequacy and timely access to care typically apply to all enrollees. Other than requiring pediatric providers and centers of excellence in networks, the contracts we reviewed do not establish or require different provider geo-access (travel time/distance) standards for CSHCN.

Continuity of care provisions, expedited authorizations, and standards for timely referrals to out-of-network providers typically do not address CSHCN or ISHCN specifically, but often affect these populations. Most contracts use general language (rather than targeting CSHCN or ISHCN) in requiring MCOs to extend out-of-network provider relationships during transitions to managed care (21 states), and conduct expedited authorizations (29 states) and/or ensure out-of-network coverage (28 states) under certain circumstances. Provisions allowing new enrollees to continue with an existing provider or an active course of treatment are generally time limited, though some contracts suggest or require that health plans establish single case agreements or invite non-network providers into their networks. The specified period for which MCOs must honor the prior authorization/active course of treatment is most often 90 days, but ranges from 30 days to 180 days after the member enrolls in the MCO.

MCO contracts generally do not require CSHCN-specific access-to-care reporting and monitoring. Many contracts require MCOs to track and/or report data (e.g., grievances, utilization) on CSHCN (6 states) or ISCHN (16 states). However, very few contracts require reporting to the state on network adequacy for CSHCN (3 states) or surveying of families of CSHCN about their satisfaction or access-to-care experiences (3 states).

States and MCOs can face challenges in operationalizing certain contract requirements and otherwise ensuring access for CSHCN, but many states and MCOs interviewed report implementing strategies for overcoming obstacles. Stakeholders cited shortages of pediatric specialists, difficulty coordinating across multiple programs and providers, and other barriers to maintaining adequate networks and effectively managing children with varied and complex needs.

As more children and other individuals with special or complex health care needs are enrolled in Medicaid managed care, state contracts with MCOs are an important vehicle for shaping managed care practices and policies. The findings of this report provide information about existing contract provisions, the degree to which they are targeted to CSHCN (including sample contract language), challenges and strategies by states and MCOs in operationalizing the contract provisions and ensuring access for CSHCN. The contracts we assessed reflect existing Medicaid managed care rules. The Centers for Medicare and Medicaid Services (CMS) issued proposed revisions to the rules in June 2015, which, if finalized could require contract changes. However proposed changes to the rule do not directly address CSHCN. We note that services such as behavioral health or long term services and supports that are

required by a subset of CSHCN are carved out of managed care in some states; in such cases, managed care contract provisions would not apply to these services.

Further research is needed to evaluate the extent to which managed care contract provisions are fully implemented and monitored, and the impact of CSHCN-specific versus general provisions on the health and welfare of CSHCN and their families.

I. INTRODUCTION

Objectives

The principal objective of this study is to review and analyze the extent to which states with full-risk Medicaid managed care programs incorporate general provisions or specific protections for ensuring access to care for CSHCN into their standard contracts with MCOs.[7] The study team conducted a literature review, surveys of and interviews with state Medicaid officials and MCO staff, and a detailed review of contract documents to better understand the range in contract provisions and language targeting CSHCN, the challenges and best practices by states and MCOs in implementing these protections, and other strategies for promoting appropriate access to care for this vulnerable population. These findings could also be used to inform policymakers regarding the use of Medicaid contract provisions to shape or promote optimal access to care policies and practices by MCOs.

Background

The federal Maternal and Child Health Bureau defines children and youth with special health care needs (CSHCN) as "those who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[8] CSHCN are a diverse group representing a range of diagnoses. More than 9 of ten CSHCN experience at least one functional difficulty, and 72 percent experience two or more functional difficulties.[9] CSHCN are disproportionately covered by Medicaid or CHIP. Thirteen to 17 percent of children and youth are reported to have special health care needs, while 36 percent of children and youth with special health care needs are enrolled in Medicaid or CHIP, and 83 percent of these enrollees have three or more functional difficulties.[10] While individuals with disabilities and complex conditions have historically been "carved out" of Medicaid managed care (i.e., so that they receive their care on a traditional fee-for-service basis), states are increasingly enrolling these populations in managed care arrangements.[11]

Managed care has potential advantages as well as risks for these vulnerable individuals. MCOs' sophisticated data systems and infrastructure can be used to identify CSHCN, assess utilization patterns, strengthen care management, integrate medical care with behavioral and social services, enhance access to a network of providers, and monitor quality of care and health outcomes. Managed care can be designed to offer more comprehensive health services than fee-for-service, and to assist and incentivize providers to create medical homes and provide enhanced care coordination. These efforts can potentially reduce or prevent emergency room visits, hospitalizations, and days of work lost to parents.[12]

On the other hand, there are concerns about managed care organizations' ability to optimally serve CSHCN. Examples of concerns that have been raised by researchers, advocates, and experts include the following: capitated managed care organizations have a financial incentive to control utilization, which could result in barriers to access to certain health care providers and services; MCOs may have inadequate provider networks and/or insufficient accommodations for ongoing or very specialized care needs; some MCOs may not have deep experience serving children with a wide array of medical,

developmental, emotional, and/or behavioral issues; and enrollment in health plans with defined provider networks could disrupt CSHCNs' care with longstanding providers who are most familiar with their complex conditions or who are best equipped to serve them, if those providers are not in the health plan's networks.[13]

The literature also describes ways that CSHCN differ from adults with disabilities, and therefore require special efforts in managed care settings. For example, disability or severe illness can affect a child's normal development, and the impact may vary depending on the developmental stage and children's health and development depend largely on family socioeconomic status and health. Additionally, the epidemiology of childhood disabilities differs from those of adults.[14]

Existing federal regulations pertaining to Medicaid managed care (42 C.F.R. § 438, Managed Care) do not specify requirements for *children* with special health care needs, per se. However, they contain requirements that Medicaid MCOs implement a number of policies including identifying, assessing, and producing a treatment plan for *individuals* with special health care needs, and providing direct access to specialists under certain conditions. The federal rules require states to ensure that MCOs offer timely access to covered services, have provider networks that are adequate and appropriate to meet the needs of enrollees, and include policies such as expedited authorizations and out-of-network coverage when network providers are unable to provide necessary services.[15] The federal rules do not establish specific standards for timeliness or network adequacy, allowing states to define their own standards. Studies by the Department of Health and Human Services Office of Inspector General found significant gaps in federal and state oversight of Medicaid MCO network adequacy and access standards.[16]

In June 2015, the Centers for Medicare and Medicaid Services (CMS) issued proposed revisions to the federal Medicaid managed care regulations, that would retain much of the existing rules while strengthening or expanding some network, access, care coordination and continuity/transition of care standards. Like the existing regulations, the proposed rules do not specifically address CSHCN, but many of the new standards that recognize higher levels of need by certain enrollee populations. For example, the rule would change the timeframe in which MCOs must make expedited authorization decisions from three working days to 72 hours; expand care coordination activities to include services that are not considered "health care" and that are provided outside the MCO require states to submit to CMS an assurance with documented analysis that MCOs meet the state's requirements for availability of services; and require states to establish *separate* adult and pediatric time and distance standards for primary care providers and for specialists.[17, 18]

State Medicaid MCO contracts are an important vehicle for shaping managed care practices and policies. A few states have been highlighted in the literature for addressing potential access problems especially for CSHCN by incorporating specific pediatric provider network requirements and other protections for CSHCN in their Medicaid contracts.[19] It is not clear, however, how widespread or comprehensive such contractual requirements are in other states. Further, the degree to which states are monitoring access specifically for CSHCN is not well documented. Given the continuing trend toward shifting CSHCN into Medicaid managed care, the federal government, states, MCOs, advocates, and families of CSHCN could greatly benefit from improved knowledge about current MCO contract practices and protections to promote appropriate access to care for this at-risk group of beneficiaries.

Methodology

This study had multiple components, including: surveys of Medicaid officials and MCOs; interviews with experts, advocates, Medicaid officials and MCO representatives in a sample of states with more extensive access provisions for CSHCN; and a review of managed care contracts or other relevant documents from 34 states. These activities were conducted between February and November 2015. This reports presents a synthesis of the findings across all components of the study. The methodology for each component of the study is summarized below.

Surveys of Medicaid officials and MCOs

To efficiently obtain information from Medicaid officials and MCO representatives about managed care contract provisions related to access to care for CSHCN, the project team developed and incorporated questions into surveys that HMA was fielding for another project.[20] In early 2015, we emailed one survey to 39 state Medicaid agencies, and another similar survey to a Medicaid MCO in each of 30 states.[21] After sending email reminders, PDF and Word versions, and personal outreach to facilitate a response, we received responses from 17 Medicaid agencies (44 percent response rate), and responses from six MCOs (20 percent response rate). The findings from these surveys were used to develop a checklist for our detailed contract review, identify states and MCOs with promising provisions and policies to interview under another task of this project, and identify issues to probe further in those interviews.

Interviews with Experts, Advocates, Medicaid officials, and MCO representatives

To augment survey findings, the project team conducted semi-structured telephone interviews with a range of stakeholders connected with CSHCN in managed care (listed in Appendix A). For each set of key informants, we developed an interview protocol to guide our discussions, which lasted from one to one and one-half hours. In Spring 2015, we interviewed 11 individuals identified as experts on CSHCN, representing academic research, policy analysis, federal government, and advocacy organizations. The interviewees were selected based on literature reviews, recommendations from colleagues, and discussions with MACPAC. We sought experts' views on the benefits and barriers to care for CSHCN in Medicaid managed care, contract provisions that they thought are most important to ensure access (to consider for the contract checklist), and recommendations of states and MCOs that have had a track record for successful or innovative service of this population to recruit for interviews[22]

Later in the study, the project team also interviewed Medicaid officials in five states, and representatives at five Medicaid MCOs, to gain a better understanding how they operationalize state Medicaid managed care contract requirements related to access to care for CSHCN; challenges in monitoring or complying with these provisions; and other strategies they pursue to ensure appropriate access for this population.[23] We selected states and MCOs that have numerous provisions in their standard Medicaid managed care contract, or MCO policies, respectively, that target CSHCN.

Contract review

Finally, the research team reviewed managed care documents in 34 states (including the District of Columbia and Puerto Rico) that enroll CSHCN into their standard Medicaid managed care plans.[24] Some states also enroll certain subsets of CSHCN into specialty plans or cover them through fee-for-service arrangements, but these were beyond the scope of this study.[25]

When possible, we evaluated the most recent standard managed care model contracts available (14 states) or recent contract with a specific MCO (3 states).[26] When it was either unclear that a contract was the most recent, or a contract lacked sufficient information about the MCO's responsibilities, we examined the most recent state solicitation or request for proposals (RFPs) (16) for managed care services.[27,28] All of the materials we evaluated (referred to as "contracts" in this report) were either publicly available, or obtained from state Medicaid officials.[29] (See Appendix E for list of state documents examined.)

With MACPAC input, the research team developed a checklist of 29 contract provisions considered relevant to access to services and providers for CSHCN (Appendix D). The checklist is based on a review of literature (including recently published proposed standards of care[30]), interviews with experts and advocates about access provisions they believe would benefit or protect CSHCN, surveys of Medicaid officials and MCOs, and a preliminary review of selected states' MCO contracts. Nine of these provisions are federal requirements for Medicaid managed care, and these are noted in the Findings section and Appendices. The provisions are grouped into five domains:

1) Identification, Screening and Outreach;

2) Care Management;

3) Network Adequacy and Standards;

4) Care Continuity and Relaxing of Authorization Rules; and

5) Expertise, Provider Education, and State Monitoring.

Examples of checklist provisions include: allowing pediatric specialists to serve as primary care physicians for CSHCN, relaxing prior authorization requirements for CSHCN, assigning care managers and requiring the development of care plans for CSHCN, and requiring that MCOs collaborate and coordinate their care with other agencies and community organizations that serve CSHCN.

In each of the 34 contracts, we searched for language related to each item on the checklist and identified whether there was a provision that:

1) Applied specifically to CSHCN (or a subset of CSHCN);

2) Applied to ISHCN (not specifically children, and occasionally certain diagnostic categories);

3) Generally applied to all enrollees;[31] or

4) Was not included in the contract.

The absence of a relevant provision was also noted. We also note that MCOs may establish special policies for CSHCN even when the MCO contract does not require them, and we cite examples learned through our interviews throughout the Findings section. In addition, we documented whether provisions address the existing federal requirements on managed care, and discuss provisions relevant to the CMS proposed regulations.

It is important to note that state contracts vary widely in how CSHCN are defined and in the specificity of their requirements. Some of the contract provisions were vague and/or required interpretation and judgment by the research team as to how to categorize them. Further, it was beyond the scope of this study to examine all of the state contracts' supporting documents or state regulations that may have

contained relevant or clarifying provisions. For these reasons, we suggest that the numbers of states adopting the checklist provisions reported here be interpreted as approximations, intended to relay when use of provisions is rare, common, or nearly universal across the 34 state contracts examined.

It was also beyond the scope of this study to compare specific benefits covered in the contracts, and note that some services such as long term services and supports and behavioral health, which some CSHCN need, are often carved out of managed care. In such cases, the MCO contract access provisions do not apply to carved-out services.

II. FINDINGS

This section synthesizes the findings from our contract review, interviews, and surveys. We begin by summarizing stakeholders' views on the potential benefits and risks of managed care for CSHCN. We then present general findings about the frequency and specificity of contract access provisions related to CSHCN, and then highlight findings for each of the five domains described above. We also provide select excerpts from the contracts that exemplify language targeting CSHCN or are otherwise noteworthy. The survey responses from Medicaid and MCO representatives are presented in Appendices B and C, respectively. Appendix F contains a set of tables that categorizes individual checklist items as: 1) specific to CSHCN, 2) applying more broadly to ISHCN, 3) applying to both CSHCN and ISCHN, 4) applying generally to all enrollees, or 4) not included in the contract.[32] The contracts we assessed reflect existing Medicaid managed care rules. CMS issued proposed revisions to the rules in June 2015, which, if finalized could require contract changes.

Benefits and Risks of Managed Care for CSHCN

There is widespread agreement among stakeholders interviewed that managed care offers many potential benefits for CSHCN enrolled in Medicaid. Interviewees pointed out that managed care can provide a framework for providing holistic care to CSHCN, offer a single point of accountability and care coordination, increase access to a network of providers who can potentially communicate directly with each other (through electronic information exchange), and utilize data analytics to identify and track CSHCN and the quality of the care they receive.

Researchers and advocates interviewed cite risks and barriers to access in managed care, and the need for greater measurement of the impact of managed care on CSHCN. Risks include: some MCOs' inexperience serving CSHCN; lack of common definitions, policies, and standards around CSHCN; and lack of understanding of the different and varied needs of CSHCN. Potential barriers to access include: insufficient pediatric specialist, subspecialist, and centers of excellence capacity in networks and insufficient out-of-network allowances; lack of continuity of care and coordination across the many programs touching CSHCN; inadequate risk adjustment and reimbursement for high-need children; and the fact that Medicaid agencies are stretched very thin, face competing priorities and have limited resources.

States and Provisions Targeting CSHCN

While acknowledging that CSHCN represent children with a wide array of needs, advocates and experts interviewed pointed out that challenges facing CSHCN differ somewhat from challenges facing adults with special health care needs, and differ even more from challenges facing the general enrollee population. These interviewees generally thought that specific contract language targeting CSHCN would help ensure that MCOs focus on this population, thereby providing better protections and accommodations. However, Medicaid officials and MCO interviewees suggest that some contract provisions broadly applied to the entire enrollee population may give adequate or occasionally better protection to CSHCN than specific provisions. For example, a *general* contract provision requiring preliminary outreach to and screening of *all* enrollees could identify CSHCN who were not identified by the state or referred by clinicians for further assessment and care management.

Our review revealed that Medicaid managed care contracts vary significantly in the existence, scope and specificity of access-to-care provisions, as detailed below.

States with the Most Provisions Specific to CSHCN or ISCHN

Nearly all states' Medicaid managed care contracts have some provisions targeting CSHCN (only three state contracts do not refer to CSHCN in the provisions examined; See Appendix F-6). However, frequent use of CSHCN-specific or ISHCN-directed access provisions is concentrated in a small number of the states' contracts. The states with the most provisions that specifically target CSHCN are Michigan (14 provisions), Virginia (12), Maryland (9) and California (9). Michigan, New York, Pennsylvania and Virginia have the largest number of provisions targeting children or all enrollees with special health care needs (14 provisions each).

Most Common Checklist Provisions Targeting CSHCN or ISCHN

Only one provision targeting CSHCN specifically (MCOs must identify children with special needs) appears in the majority of state MCO contracts (22). For all other access provisions examined, fewer than half of state contracts specifically target CSHCN, and instead apply more broadly to individuals with special needs of all ages or to all enrollees, or do not appear at all. For seven of the 29 provisions we examined, contracts refer to either CSHCN or ISHCN in the majority of states. Most of these provisions are related to assessment and care management, expanding beyond the federal requirements for care monitoring and a treatment plan.[33]

Table 1 presents the checklist provisions most commonly applied to CSHCN and/or ISHCN, and the number of states using them under each level of specificity. (See Appendix F to identify which states have noted provisions.)

Table 1. Number of States with Managed Care Contracts Addressing Selected Access to Care Provisions

Access to Care Provision	Reflects a Federal Require-ment	I. Provision Addresses CSHCN Specifically	II. Provision Addresses ISHCN (not specifically children)	I +II Provision Addresses CSHCN and/or ISHCN	Provision Addresses General Enrollee Population	Contract Does Not Include Provision
Most commonly addressing CSHCN specifically						
Identification of children with special health care needs	x	**22**	10	**32***	2	0
Requires care coordination collaboration across children's agencies and programs		**16**	4	**20***	11	3
Requires pediatric providers (PCPs and/or specialists) in network		**13**	NA	13	11	10
Requires pediatric centers of excellence in network		**12**	NA	12	2	20
Most commonly addressing CSHCN or ISHCN (in addition to items above*)						
Developing a care plan	x	6	21	**27**	6	1
Assigning a care manager		9	16	**25**	7	2
Outreach/screening/assessment	x	8	14	**22**	11	1
Separate tracking or reporting		6	16	**22**	2	10
Requiring care team approach or provider information exchange		3	18	**21**	11	2

Five checklist provisions were *not* linked directly to CSHCN in any of the 34 states. These provisions either applied to ISCHN, to the general enrollee population, or they were not found in the contracts (see Table 2). Medicaid and MCO interviewees generally felt that CSHCN are adequately protected by more general provisions in these areas, though advocates and experts did not always agree.

Table 2. Number of States with Managed Care Contracts for Provisions that do not Specifically Target CSHCN in contracts

Checklist Provisions not Targeted to CSHCN in Any States	I. Provision Addresses CSHCN Specifically	II. Provisions Addresses ISHCN (not specifically children)	I+II Provision Addresses CSHCN and/or ISHCN	Provision Addresses General Enrollee Population	Contract Does Not Include Provision
Specialist to enrollee ratios	0	1	1	15	18
Maximum appointment wait times	0	1	1	28	5
Requires experience with special health care needs on MCO committees (e.g., appeals, credentialing, P&T), Medical Directorship	0	4	4	NA	30
Inform/educate providers about special access provisions	0	9	9	2	23
State enforcement actions for breaching network standards	0	0	0	4	30

Domain #1. Identifying, Screening, and Outreach to CSHCN

States are required to have a mechanism to identify enrollees with special health care needs and may use MCOs to do so.[34] More than half of the states reviewed (22) require identification specifically of *children* with special needs; another ten states require identification of ISCHN (and not specifically children).

The contracts describe criteria for defining CSHCN, most commonly by eligibility category (e.g., children in foster care, children eligible for SSI), service type (e.g., children receiving home health services, behavioral health services), and diagnosis (e.g., asthma, autism spectrum disorder, hemophilia). See Appendix G for a full list by category. Federal rules require MCOs to assess enrollees with special health care needs. Most contracts (22) require a health screening (also referred to as an initial assessment) of CSHCN (8 states) or ISHCN (14 states) to identify the need for further assessment and care management. Eleven other contracts refer to screenings for enrollees more generally.

While not a federal requirement, most contracts define a timeframe for completing the initial assessment of new members with special health care needs (or in a few cases for all new members). The initial assessment timeframe ranges from 30 days to 120 days after enrollment but is most commonly 60 to 90 days.[35] Several states require that assessments take place sooner for certain eligibility groups, such as seniors and people with disabilities (including children with disabilities, a subset of CSHCN).

Interviewees underscored that screening, as well as stratification of enrollees by level of acuity or complexity, are critical to identifying those with special needs and to ensuring that they receive the right level of care coordination. The MCOs interviewed for this study reported being proactive in identifying any child with special needs using methods beyond the initial screening or eligibility category. The MCOs explained that CSHCN would be identified by diagnosis, utilization data, provider referral, or predictive modeling. These additional methods also help identify children with needs that emerge after they enroll in a plan. Our review found that many contracts delineate a variety of sources or methods to identify CSHCN or ISHCN. Table 3 presents the most common sources and methods specified in the contracts:[36]

Table 3. Sources and methods for identifying CSHCN and ISCHN in MCO contracts

Sources Cited in Contracts to Identify CSHCN or ISHCN	Number of States with Source in Contract Language
Screening/initial assessment	22
Eligibility category	16
Diagnosis	15
Current or historical utilization and claims data	12
PCP referral	6
Predictive modeling	5
Member self-referrals	4

A minority of contracts requires outreach to educate families about services, plan procedures, or other aspects of managed care. Just three states specifically target families of CSHCN for outreach and education (Maryland, Michigan, and Virginia). Another five states have broader outreach requirements for enrollees of all ages with special health care needs, and another eight states mention outreach/education more generally for all enrollees.

A small minority of contracts discusses customization of durable medical equipment (DME) and/or home health arrangements for CSHCN; however it appears that such provisions are more often included in MCO policies and procedures.

Domain #2. Care Management

Care Management and Care Coordination Services

In addition to identifying ISHCN, federal rules require that if states require MCOs to develop treatment plans for enrollees with special health care needs, that the treatment plans be "…developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee."[37] Nearly all of the contracts reviewed for this study have provisions for assigning care managers, developing a care plan, and sharing of information across providers. Most often these provisions encompass all enrollees with special health care needs, but occasionally they refer specifically to CSHCN or more broadly to the general enrollee population.

The states vary in how specific the contract language is on what care management entails, with comprehensive assessment and care coordination generally representing key activities. Virginia's contract contains substantial detail on requirements for care management for CSHCN as well as for all enrollees with special health care needs:

> *"Case managers serving children with special health care needs and children requiring special assistance shall assist these members in scheduling appointments, providing referrals to appropriate medical providers, offering assistance in identifying resources, other appropriate treatment options, referrals to resources, and shall make contact with the member or his family on a regular basis. The Contractor shall assess, and provide if necessary, members' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services. 'and to hand' service includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported 'hand-to-hand.' "* (Virginia MCO contract, Section 7.1(O)(iii)(d)

Our interviews suggested that the ways MCOs operationalize contract provisions, sometimes doing more than is required by the contracts, are critically important to effective care coordination. For example, some Medicaid and MCO representatives interviewed described care coordination strategies for CSHCN that they believe are effective and go above and beyond contract requirements. These include efforts to:

- use regional or local community-based care coordinators who know the local resources and environment well, and who know the communities they serve;
- use integrated team-based clinical approach when possible, and include behavioral health and social services providers in the care team;
- involve parents/caregivers of CSHCN in care coordination planning;[38]
- embed health plan care coordinators in inpatient settings to coordinate inpatient or emergency services and follow-up, and send a health plan representative into schools to assess and help resolve any issues or gaps;
- use "social care managers" who support the member and clinical care manager by identifying and coordinating non-medical resources they may need;
- establish policies for frequent communication among coordinators (and with family), including sharing of medical records to the extent possible so that key information can be accessed across agencies and providers; and
- provide additional reimbursement for care coordination activities.[39]

Coordination Across Multiple State Programs and Systems

Nearly all contracts (31) require coordination/collaboration across programs and government agencies, and many of these (16) delineate child-focused systems such as schools, Title V programs, child protection services, and others. The following contract provisions clearly state the coordination/collaboration expectations of MCOs serving CSHCN:

> *"The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services."* (Georgia MCO RFP, Section 4.11(8)(8)(2))
>
> *"[The Contractor shall have] Satisfactory methods for interacting with school districts, preschool services, child protective service agencies, early intervention officials, behavioral health, and developmental disabilities service organizations for the purpose of coordinating and assuring appropriate service delivery…"* (New York MCO contract, Section 10.20(a)(i))

Although contracts require coordination across programs, advocates, Medicaid and MCO representatives interviewed were concerned that CSHCN often lack effective coordination across the many programs and systems serving them. They emphasized the importance and challenges of "coordinating the coordinators" when children are served by different entities across a spectrum of medical and social services.[40]

Medical and Health Homes

While state managed care contracts describe a variety of medical home or health home initiatives, these are typically broadly defined for the general enrollee population or for individuals with multiple chronic conditions. Eight states encourage or require medical or health homes specifically for children with special or multiple needs.

- Michigan's contract explicitly requires MCOs to pay PCPs extra per member per month fees for serving CSHCN according to acuity level:

  "Family Centered Medical Home: Contractors must make the following per member per month payments to contracted primary care providers who serve CSHCS [Children's Special Health Services Program[41]] Enrollees: a. $4 to each primary care provider serving a TANF [Temporary Assistance for Needy Families] CSHCS Enrollee b. $8 to each primary care provider serving an ABAD [Aid to Blind and Disabled] CSHCS Enrollee."[42] (Michigan MCO RFP, Section F(8))

- A Virginia MCO interviewee described medical homes that specifically focus on identifying and tracking CSHCN. The MCO sends each newly contracted family practice or other pediatric provider, including specialists, a questionnaire asking whether they are willing to serve as a medical home for CSHCN, as well as any age limitations, services they offer—including any ancillary providers such as social workers—and any extended hours or other access accommodations. The plan includes this information in a database for use by its care coordinators. Every month, the plan conducts geo-access mapping by population and age group to identify any gaps or shortages of providers willing to serve as medical homes for CSHCN. Providers who agree to serve them, whether as a medical home or to a lesser extent, receive an orientation packet specific to CSHCN.

Domain #3. Network Adequacy and Standards

Network adequacy for CSHCN

Federal rules require networks to have providers "sufficient to provide adequate access to all services covered," and most contracts include similar statements.[43] Children comprise a large portion of Medicaid MCO enrollment; the majority of states (24) require MCOs to have pediatric providers in their

networks, often as primary care providers. However, fewer than half (13) of the Medicaid managed care contracts explicitly require pediatric specialists or providers that serve CSHCN to be in their MCOs' networks; the remaining contracts do not specify that pediatric providers be included in the network. Fourteen states require that children's hospitals (2) or pediatric specialty centers (12) be included. A few states stand out in contract language or policies that illustrate consideration for CSHCN in establishing networks:

- Delaware's contract acknowledges differences in the needs of children versus adults, and explicitly calls for agreements with subspecialists for CSHCN when not included in the network:

  "Pediatric Specialists: The Contractor must use specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for adult specialists (e.g. a pediatric cardiologist for children with congenital health defects). The Contractor must ensure that Children with Special Health Care Needs have access, when needed, to pediatric subspecialty care in a wide range of fields through participation agreements and single case agreements and other provider arrangements and procedures for accessing non-participating pediatric subspecialty providers." (Delaware MCO RFP, Section 3.9(16))

- Pennsylvania's contract requires that CSHCN have a choice of at least two pediatric specialists or subspecialists:

  "For children with special health needs, the PH-MCO[44] must offer at least two (2) pediatric specialists or pediatric sub-specialists." (Pennsylvania MCO contract, Exhibit AAA(1)(e))

- New Jersey's model contract requires "access to specialty centers in and out of New Jersey for diagnosis and treatment of rare disorders,"(Section 4.5(2)(B)(3)(3) — and includes a listing of such specialty services (e.g., pediatric ambulatory tertiary centers, regional cleft lip/palate craniofacial anomalies centers, hemophilia treatment centers, genetics centers, and HIV treatment centers)

- Michigan's Medicaid program added CSHCN to managed care in 2012, and required MCOs that met the state's readiness review process to develop a network of primary care providers and pediatric subspecialists that would attest to meet the specific needs of this population. As noted above, the state's contract requires MCOs to pay contracted primary care providers who serve CSHCN enrollees an administrative payment of $8 per member per month for CHSCN aged, blind and disabled members, and $4 per member per month for CSHCN TANF members, to support the coordination of care for this population.[45]

- Virginia has a "network development plan" that includes pediatric specialists for MCOs expanding into additional markets within the state:

  "… a network development plan must also include the following specialties: … Pediatric Allergy & Immunology, Pediatric Critical Care, Pediatric Development, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Genetics, Pediatric Hematology/ Oncology, Pediatric Nephrology, Pediatric Orthopedics, Pediatric Physical Medicine and Rehab, Pediatric Pulmonology, Pediatric Specialist…" (Virginia MCO contract, Attachment XI)

Interviewees described some challenges for developing provider networks that are adequate for CSHCN. Some experts and advocates are concerned that because CSHCN are generally a small percentage of the

MCO's overall population, building an infrastructure of pediatric specialists and centers of excellence is not deemed cost effective by some health plans. Advocates, Medicaid, and MCO interviewees cited shortages of certain pediatric specialists, such as pediatric psychiatrists, which make it difficult for MCOs to include all needed providers. They also noted the greater difficulty MCOs face in building sufficient networks in largely rural states than in states with large metropolitan areas. Florida's contract specifically notes telemedicine as a potential strategy to address pediatric specialties not listed in its network standards:

> *"For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code."* (Florida MCO contract, VI(4)(b))

Geo-Access Standards

Existing federal rules require MCOs, when developing provider networks, to consider "distance, travel time, the means of transportation used by enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities" (42 C.F.R. § 438.206(b)(1)(v)). The June 2015 proposed Medicaid managed care rules require states to establish *separate* geo-access standards for *pediatric* and adult primary care providers and specialists, presumably acknowledging different needs for different populations.

All of the state contracts examined establish time and distance standards, but most do not have separate geo-access standards specifically for CSHCN or enrollees with special needs. Two exceptions are noteworthy:

- Michigan allows for an exception to their general network 30 mile/30 minute standard if "the Enrollee is CSHCS-eligible and a PCP over 30 miles or 30 minutes travel time to the Enrollee's home is the most appropriate for the Enrollee." (Michigan MCO RFP, Section A(10))
- Similarly, Washington's MCO contract allows "special considerations for pediatric specialists" (Section 6.11) with regard to its geo-access requirements of high volume specialties.

While states aim to provide enrollees with access to providers that are located a reasonable travel distance from their home, these exceptions acknowledge that some enrollees may derive greater benefit when they can access providers qualified to serve their special needs, even when the provider's travel distance exceeds what would otherwise be considered reasonable. However, these exceptions may inadvertently hinder access, if they preclude CSHCN from using an out-of-network provider within the 30 miles or 30 minutes standard if there is not one in-network who is appropriate to their needs.

The various stakeholders interviewed had mixed views about geo-access standards. Some expressed that such access standards are important, while others gave reasons to move away from distance requirements for CSHCN, or at least establish clear out-of-network arrangements. For example, stakeholders commented that:

- Access problems are typically an issue with specialists or subspecialists whose supply does not meet demand in certain regions or states, so time/distance/ratio requirements are not useful.

- Sometimes a network provider's patient panel is full and is not accepting more children with special needs; this is not monitored or considered but can limit a CSHCN ability to see that provider.
- There is a need to look at and evaluate referral patterns and where people actually get care, as the time/distance standards may not accurately reflect utilization.

Domain #4. Care Continuity and Relaxing of Prior Authorization and Network Requirements

Out-of-Network and Out-of-State Allowances

Current federal rules require that when a network is unable to provide necessary services, MCOs must "adequately and timely cover these services out-of-network for the enrollee."[46] However, some experts and advocates were concerned that allowances for CSHCN to get care out of the network and in some cases, outside of the state, were too narrow. One said that out-of-network exceptions are needed when a network provider's patient panel is full and/or not accepting more children with special needs; and that these situations are generally not monitored. Another stated that the lack of pediatric specialists in many regions make access to out-of-state providers and children's hospitals providing specialty care critical, particularly for families living near state borders.

We found that states typically use general language for promoting out-of-network coverage when indicated, but the contract review and interviews revealed some states that focus on CSHCN:

- One state (Maryland) requires timely referrals to out-of-network providers specifically for ICSHCN:

  "When a child, who is an MCO enrollee, is diagnosed with a special health care need requiring a plan of care which includes specialty services, and that health care need was undiagnosed at the time of enrollment, the parent or guardian of that child may request approval from the MCO for a specific out-of-network specialty provider to provide those services when the MCO does not have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same service and modality…" (Maryland Code, Section 10.09(65)(05)(K))

- Pennsylvania requires out-of-network coverage if the network does not have at least two qualified specialists and requires a system for informing affected enrollees of how to request such authorization:

  "If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services." (Pennsylvania MCO contract, Exhibit AAA(1)(e))

Sixteen states require out-of-*state* coverage when the network is not adequate as a general rule for all enrollees. New York applies this provision to ISHCN, and Minnesota targets this exception to children in residential mental health facilities. New Jersey's contract requires access to specialty centers including pediatric ambulatory tertiary centers out of the state for diagnosis and treatment of rare disorders. A Virginia health plan noted that when an authorization request is made for a child to go out of state, the health plan first checks whether there are comparable services that would be available in or out of network within the home state "without impeding the [child's] care." If such a provider is not found, the MCO authorizes out of state care.[47]

Continuity of Care during Transitions

Breaking relationships with existing providers and disrupting ongoing courses of treatment when CSHCN enroll in managed care or change managed care plans are major concerns among nearly all stakeholders, and contract provisions are viewed as critical protections during the transition. Current federal rules require a process to "seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries," but do not specify methods or time periods.[48, 49, 50]

A large majority (28) of state contracts reviewed explicitly require MCOs to honor new members' (regardless of CSHCN status) existing/established prior authorizations, continue an active course of treatment, and/or allow the enrollee to stay with their treating provider, even if that provider is not in the network. Nine contracts specifically address providers with which new members had existing "relationships" (regardless of being in an active course of treatment or not) – a key consideration and priority for families of CSHCN according to advocates.

Thirteen states specify the minimum time period for which MCOs must honor the prior authorizations (from prior health plans or providers) for active courses of treatment, while nine states do not specify a time period. The most common time frame specified is 90 days, but ranges from 30 days to 180 days after the member enrolls in the MCO (See Table 4).

Table 4. Standards for Continuity of Care Timeframes

Minimum Days to Honor Prior Authorization	States
30	*Georgia*
60	*Florida, New York, South Carolina*
90	*Illinois, Iowa, Louisiana, New Mexico, Ohio (under some circumstances) Rhode Island, Tennessee, Texas*
180	*Ohio (under limited circumstances)*
Days not specified	*Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, Pennsylvania, Virginia*

Following are examples of the small number of states that direct continuity-of-care provisions to enrollees with special health care needs:

- Three states have continuity of care language directed at ISHCN, and four states target CSHCN. Michigan's contract provides the most detail in continuity of care procedures specifically for CSHCN members. In fact, Michigan Medicaid officials reported that MCOs are required to maintain provider relationships with no designated time limit, but rather until the child and the care team could agree to transition to another provider. In practice, the provider generally contracts with the new MCO:

  "Contractor must have separate, specific PA [prior authorization] procedures for CSHCS Enrollees (1) In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, Contractors must accept prior authorizations in place when the CSHCS Enrollee is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractors must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization. (2) Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services. iv. Contractors must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of such equipment." (Michigan MCO RFP, Section D(g)(iii))

- California's contract directs MCOs to identify prior relationships with providers among new members with disabilities through fee-for-service utilization data, and requires coverage of such providers of CSHCN for up to one year after enrollment.

- A few Medicaid and MCO interviewees shared that when a new member has a longstanding relationship with a non-network provider – which is often the case with CSHCN – the MCO often tries to add that provider to its network. Rhode Island's contract obligates the MCOs to make such offers to the non-network providers:

  "For members, with the exception of PCP as defined in this contract, this may require the Contractor's inclusion of providers who practice or are located outside of the State and/or allowing such members to retain established relationships to preserve continuity of care with non-network providers, including traditional Medical Assistance providers. Contractor shall be obligated to offer a provider agreement to become a Participating Provider to any such providers." (Rhode Island MCO contract, Section 2.09(1))

Specialists as PCPs

Many stakeholders interviewed for this study underscored the importance of requiring MCOs to give families of CSHCN the option of having a specialist with extensive knowledge of and ability to manage the child's complex health situation serve as the child's PCP. One interviewee noted that allowing specialists to be PCPs offers "better access to the highest touch needs [CSHCN] may have."

Six states specify that MCOs must allow specialists to serve as PCP for CSHCN. Another 10 states apply this option to all ISHCN, and nine additional states have more general provisions applying to all enrollees when deemed necessary or appropriate, but without defining specific criteria.[51]

Relaxed Prior Authorization Policies

Frequent or ongoing need for specialist care makes repeated requests for authorization a burden for families and providers of CSHCN, and expensive for MCOs and the state, according to interviewees. Federal rules address this issue by requiring direct access to specialists – for example, through a standing referral or an approved number of visits – for "enrollees with special health care needs determined…to need a course of treatment or regular care."[52] Many states use this language in their contracts to relax prior authorization requirements.

A few states' contract language and MCO policies appear particularly beneficial for CSHCN:

- California and Michigan require timely access to specialists specifically for children with special health care needs; California's language details the kinds of services relevant to this population:

  "Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following: B. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by Contractor." (California MCO contract, Exhibit A, att. 11(9))

- New York's contract has special authorization provisions for medically fragile children, acknowledging that clinical standards for medical necessity for children are different than those for adults:

  "For medically fragile children, contractor must:

  A) develop procedures for the arrangement and authorization of services consistent with the SDOH guidance document 'Principles for Medically Fragile Children.'

  B) ensure medical necessity determinations are not based solely upon clinical standards designed for adults and that such determinations consider the specific needs of the child and circumstances pertaining to their growth and development.

  C) develop effective mechanisms to accommodate unique stabilization needs and discharge delays which may be necessary to: respond to the Enrollee's sudden reversals of condition or progress; identify appropriate specialized facility care; identify appropriate home or home-like environment for specialized care; or ensure informal and formal caregivers have had the training necessary to meet the specialized care needs of the Enrollee." (New York contract, Section 10.20(b)(i)(A))

- A Virginia MCO interviewee reported that many MCOs in her state do not require referrals to specialists. They found that in most cases, enrollees do not over-utilize specialists and visit only when recommended by their PCP; the administrative burden of referrals were not "worth it." There are authorization requirements for specialist-ordered tests and procedures. However, if during a semi-annual review the MCO finds that a certain service is never denied, then the authorization requirement is discontinued.

- A Michigan MCO also does not require a referral or prior authorization for specialists, nor for an out-of-network provider as long as the provider is willing to bill the health plan.[53] They find that these policies improve continuity of care.

Expedited Authorizations

Experts interviewed pointed out that CSHCN with complex or fragile conditions would commonly require faster MCO authorization for services than is typical, and some call for separate authorization policies for this population. One advocate noted that rehabilitation services are particularly time-sensitive for children due to developmental issues, yet current authorization standards are still based on adult needs in nearly all states.

Federal managed care rules require expedited authorizations: "For cases in which a provider indicates, or the [health plan] determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the [health plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service."[54]

The majority of the contracts reviewed for this study use the language from the current federal rule for expedited authorizations when indicated. A few states use shorter timeframes or more targeted approaches:

- Georgia, Mississippi, and New Jersey require expedited authorizations in just 24 hours.
- Kentucky specifies two business days for its standard authorization as well as an expedited process for "urgent" services.

The CMS proposed rule would modify the deadline to 72 hours – requiring a change in most contracts.

Domain #5. Expertise, Provider Education, and State Monitoring

MCO Staff Expertise

Federal rules require that MCO staff making decisions on grievances and appeals are health care professionals "who have the appropriate clinical expertise…in treating the enrollee's conditions or disease."[55] Indeed, most state contracts reviewed include language regarding utilization management that is similar or identical to this language. Four state contracts specify that certain MCO personnel must have experience serving ISCHN, but these roles vary. They include transition of care team personnel (Illinois), medical director (New Jersey), and care management director (Ohio). Pennsylvania's contract requires MCOs to have a unit whose primary responsibility is to address issues related to members with special needs:

> *"The PH-MCO will be required to develop, train, and maintain a unit within its organization structure whose primary responsibility will be to deal, in a timely manner, with issues relating to Members with Special Needs. This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director."* (Pennsylvania MCO contract, Section V(N))

Most states and MCOs interviewed felt that existing staff qualification requirements are adequate and expected that any clinical decisions related to CSHCN would be made by staff with appropriate expertise. However, some health plans did highlight identifying and supporting provider expertise as a priority:

- MCOs in Michigan and Virginia noted that they survey their providers about their experience with and willingness to treat CSHCN (as described above).
- Virginia has a particularly detailed questionnaire that asks providers to confirm whether they can serve as a medical home for CSHCN.
- Michigan provides a $4 to $8 PMPM to providers who attest that they are willing and qualified to care for these members.

MCO Education for Providers on Access, Special Provisions

Nine state contracts explicitly require MCOs to educate network providers about the provisions and protections for members with special needs (though not children, specifically), to help ensure that members gain access to these protections and services. Pennsylvania's contract is perhaps the most comprehensive:

> *"Provider Education: The PH-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating Members with Special Needs. The PH-MCO must submit an annual Provider Education and Training plan to the Department that outlines its plans to educate and train Providers. This training plan can be done in conjunction with the SNU training requirements as outlined in Exhibit NN to this Agreement, Special Needs Unit, and must also include Special Needs Recipients, advocates and family members in developing the design and implementation of the training plan."* (Pennsylvania MCO contract, Section V(R)(2))

Separate Tracking, Monitoring, and Reporting

Very few state contracts require health plans to report on network adequacy for special populations or to survey families of CSHCN about satisfaction and access-to-care experiences. Six states require separate tracking or reporting (for example, of grievances or utilization data) on CSHCN specifically, and another 16 states require such tracking or reporting on ISHCN (see Table 5). We present language from Virginia's contract because it targets CSHCN on all three of these monitoring provisions:

> *"The Contractor must develop and maintain a system of policies and procedures for identifying children with special health care needs, including children with disabilities or chronic or complex medical and behavioral health conditions including obesity. These policies and procedures should be submitted to the Department upon creation and thereafter when changed or upon request by the Department. The Contractor shall assess the quality of care of CSHCN in the following areas:*
>
> *Enrollment Procedures – Identify and collect data on children with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs. The Children with Chronic Conditions Satisfaction Survey described in Section 8 (CAHPS – Child Supplemental Questions) is sufficient in meeting this Satisfaction survey requirement.*
>
> *Provider Networks – Assure the availability of providers who are experienced in serving children with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.*
>
> *Care Coordination – Provide care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN.*

Access to Specialists – The Contractor shall have a mechanism in place for members determined to have ongoing special conditions that require a course of treatment or regular care monitoring, that allows the member direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member's condition and identified needs." (Virginia MCO contract, Section 7.1(O)(III)(b))

Table 5. State Contracts with Monitoring Requirements for CSHCN or ISHCN

CSHCN Contract Requirement	Number of States Targeting CSHCN	Number of States Referring to ISCHN
Separate tracking or reporting	6	16
Reporting on network adequacy	3	3
Surveying of families of regarding access, satisfaction	3	1

None of the state contracts contained separate state enforcement actions for breaching access-to-care standards for CSHCN. In fact, state sanctions for breaching general network/access provisions were not typically specified in the contracts. States and health plans we interviewed expressed that they are more reliant on stakeholder input and member complaints to identify access barriers.

We learned from Medicaid officials interviewed that a few states have piloted bonus payments to MCOs for meeting their access performance requirements. Michigan reported improvements in 2013 when it tied bonuses to MCOs' performance on network adequacy and providing transportation services. The state has since discontinued this program, although it is prepared to reinstate the bonus dollars in the future if MCO access performance declines. The Virginia Medicaid program introduced a performance incentive in July 2015 to improve the rate of timely assessments of foster care children by MCOs. Such incentives, whether tied to CSHCN or the broader enrollee population, require tracking and monitoring by MCOs and states.

III. SUMMARY AND CONCLUSION

Several key points emerge from this research and raise issues for consideration in future managed care contracting.

Stakeholders are divided on the need for CSHCN-specific contract provisions related to access to care, and these differences are reflected in access provisions in state MCO contracts. Many advocates and experts interviewed for this study expressed the view that, because CSHCN have greater health care needs and face unique challenges in accessing services (e.g., related to developmental stages, epidemiology, prevalence, role of family, etc.), they would benefit from Medicaid MCO contract provisions that specifically address this population. In their view, such specificity could promote greater focus on CSHCN needs and appropriate accommodations, potentially leading to better access to care and better health outcomes. However, many Medicaid officials and MCO representatives suggest that some contract provisions, when applied to all individuals with special health care needs (ISCHN) or to the entire enrollee population, may give adequate or perhaps better protection to CSHCN. We note that some CSHCN require services (such as long term services and support or behavioral health) that are carved out of managed care in some states would not be affected by managed care contract provisions.

For all of the access provisions examined for this study --except requiring identification of CSHCN -- fewer than half of state contracts specifically target CSHCN. The findings demonstrate that there is significant variation across standard, state Medicaid managed care contracts in the scope, specificity, and targeting of CSHCN in access-related provisions. Some states target CSHCN in some contract provisions, such as those relating to identification and care coordination, but it is more common for states' contracts to either address individuals (not just children) with special health care needs or the general enrollee population. Additionally, contract provisions that address special needs populations cluster around certain focus areas related to identification, assessment, and care management.

The majority of state contracts do not explicitly require MCOs to consider the specific needs and challenges of CSHCN in building networks, establishing access standards, or in monitoring CSHCN access to care. Geo-access standards such as time travelled and distance to network providers are the most common (and federally required) metrics for assessing access to care, but the contracts do not require separate geo-access standards for CSHCN.

Care continuity, specialist-as-PCP, prior authorization, and out-of-network allowances are common and considered essential for CSHCN though they typically are not limited to or directed specifically to CSHCN in the contracts examined in this study. The contracts do not generally require MCOs to educate network providers about special provisions for CSCHN. While contracts often require separate monitoring of utilization for enrollees with special needs, they do not typically require tracking of access or quality measures for this population.

Contracts are important for identifying what is required of MCOs; however, Medicaid agencies and MCOs may face challenges to implementing contract requirements. Experts, advocates, state officials, and MCO staff interviewed commented that there can be numerous challenges in operationalizing contract provisions and developing provider networks to meet CSHCN needs. For example:

- Provider shortages challenge health plans' ability to meet geo-access standards. Despite state and federal requirements that MCO networks demonstrate adequate access to all covered services (typically with travel time and distance standards), certain specialties and

subspecialties—such as pediatric psychiatry and dentistry—are in short supply, particularly in rural areas.

- Coordinating services across programs remains a challenge. Even when relationships across state entities that serve CSHCN are strong, it is difficult to "coordinate the coordinators." These challenges are exacerbated by data sharing limitations (and lack of knowledge about what data sharing is permitted) across state agencies and across service providers.

The interviewees also suggested ways to address operational and policy barriers through contract requirements and other, innovative strategies. They stressed the importance of regular meetings among Medicaid, other state agencies, MCOs, and families/caregivers to: improve the understanding of issues facing CSHCN; identify gaps in access, care coordination, and quality; develop appropriate contract provisions and policies; receive timely feedback; and share successful strategies and solutions.

Monitoring and further study are necessary to understand whether CSHCN are achieving the access to care they need, and how CSHCN-specific contract requirements affect that access. Lack of consensus around the need for CSHCN-specific contract provisions, the differences among states in their inclusion of such provisions in MCO contracts, and the challenges states and MCOs face in implementing access-related contract provisions suggest that monitoring and assessing access to care by this population, both in states that use CSHCN-specific contract provisions and in states that do not, will be important. Managed care data systems and infrastructure offer opportunities for data collection and tracking of CSHCN service utilization, family engagement and satisfaction, and outcomes. Further study could shed light on questions such as the following:

- Do CSHCN-specific contract requirements improve access to care and health outcomes for these children? If so, what access standards are most appropriate for this population?
- What contract provisions and strategies to ensure access to care in specialty MCOs that serve only certain, complex CSHCN can be applied to the broader group of CSHCN in standard managed care plans that also serve the general Medicaid population?
- What can be learned from strategies used to promote access for other vulnerable populations in managed care? For example, is there evidence of the impact of special contract provisions for managed long term services and supports (MLTSS) or behavioral health that could be applied to CSHCN? How could state monitoring and enforcement activities promote compliance with contract provisions that benefit CSHCN?
- Should current network and performance measures for CSHCN take into account whether members are actually getting into care, and the effectiveness of that care in terms of functionality and long-term goals?
- Are MCOs operationalizing other contract provisions and implementing other strategies that improve access and outcomes for CSHCN?
- What role could state and federal policymakers play in identifying, disseminating, incentivizing, and providing technical assistance for replicating best practices in managed care contracting, monitoring, and serving CSHCN?

Further research is also needed to evaluate the extent to which managed care contract provisions – both general and specifically targeted to CSHCN -- are fully implemented and monitored, and their impact on the health and welfare of CSHCN and their families.

Appendix A: Key Informants Interviewed for this Study

CSHCN Experts and Advocates

Sarah Bachman, Ph.D., Principal Investigator and Director of Research, the Catalyst Center

Margaret Comeau, MHA, co-principal Investigator, the Catalyst Center

Don Blanchon, formerly Vice President for Strategic Planning for Health Services for Children with Special Needs, and CEO of Maryland Physicians Care; currently Executive Director, Whitman-Walker Health

Treeby Brown, MPP, Associate Director, Association of Maternal and Child Health Program (AMCHP)

Lynda Honberg, Director of Strategic Partnerships, Family Voices

Neva Kaye, Managing Director, National Academy for State Health Policy (NASHP)

Marie Mann, M.D., MPH, Health Resources and Services Administration (HRSA)

Meredith Pyle, Senior Program Manager, Association of Maternal and Child Health Program (AMCHP)

Edward Schor, M.D., Senior Vice President, Programs and Partnerships, Lucille Packard Foundation for Children's Health

Karen Van Landeghem, MPH, Senior Program Director, National Academy for State Health Policy (NASHP)

Barbara Wirth, M.D., M.S., Project Director, National Academy for State Health Policy (NASHP)

State Medicaid Officials

Indiana
Gary Parker, Hoosier Healthwise Director, State CHIP Director, Family and Social Services Administration
Cara Parsons, Hoosier Care Connect Manager, Family and Social Services Administration

Kentucky

Stephanie Bates, Branch Manager, Disease and Case Management Branch, Division of Program Quality & Outcomes, Department for Medicaid Services, Cabinet for Health and Family Services

Massachusetts
Nelie Lawless, Director, MassHealth Office of Providers and Plans, Executive Office of Health and Human Services
Thomas Emswiler, Contract Manager, MCO Program, MassHealth
Karen Powell, Contract Manager, MCO Program, Providers and Plans, MassHealth
Alison Kirchgasser, Director of Federal Policy Implementation, Massachusetts Office of Medicaid
Griffin Doherty, Federal and National Policy Analyst, Massachusetts Office of Medicaid

Michigan
Kim Hamilton, Director, Managed Care Plan Division, Bureau of Medicaid Care Management and Quality Assurance, Medical Services Administration, Michigan Department of Health and Human Services

Virginia
Kayla Anderson, Policy and Planning Specialist, Department of Medical Assistance Services
Joanne Boise, Senior Policy Analyst, Maternal and Infant Health Division, Department of Medical Assistance Services
Todd Clark, Manager, Managed Care Operations, Division of Health Care Services, Department of Medical Assistance Services
Adrienne Fegans, Senior Program Operations Administrator, Department of Medical Assistance Services
Cheryl J. Roberts, Deputy Director – Programs, Department of Medical Assistance Services

Medicaid Managed Care Organization Representatives

Kentucky – WellCare Kentucky
Leann Magre, Manager for Foster Care, Adoption and Adult Guardianship
Rebecca Randall, Director of Regulatory Affairs
Howard Shaps, MD, Medical Director

Massachusetts – Neighborhood Health Plan of Massachusetts
Richard Dropski, Vice President, Regulatory Affairs & Compliance
Deb Bonin, Vice President, Clinical Operations
Margaret Flynn, BSN, CCM, Clinical Manager, Care Partnership Program
Ellen Rathke, RN, BSN, Manager, NICU/Pediatrics Team Leader, Care Partnership Program
Elisa Caruso, MassHealth Project Manager
Priscilla Meriot, RN, MS, Executive Director, Community Medical Alliance
Leslie Lailer, RN, MA, CCM, Director, Care & Disease Management

Michigan – Meridian Health Plan
Danielle Devine, Deputy Director of Operations
Dr. Patricia DeLoof, Medical Director of Utilization Management
Jill Howard, Manager of Care Coordination
Kellie Rice, Director of Network Development

Rhode Island – Neighborhood Health Plan of Rhode Island
Dolores Burke, Director of Care Management, Medical Management
Yvonne Heredia, Manager of Care Management, Medical Management
Loren Sidman, Director of Behavioral Health, Behavioral Health
Brenda Whittle, Chief Marketing Officer/Vice President Exchange, Marketing and External Affairs

Virginia – Virginia Premier Health Plan
Linda Hines, Acting Chief Operating Officer and Vice President, Health Services

Appendix B. Summary of Medicaid Managed Care Survey Responses

	CA	W-Mtn	S-Atl1	FL	S-Atl2	N-Cntl	IN	KY	MA	S-Atl3	MI	MS	NM	NY	N-W	TN	S-Atl4
Q1. Carve out CSHCN to specialty contractor?	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	Yes	No
Q2. Different access standards for CSHCN specialty plans?	No	No	No	Yes	No	No	No	No	No	No	Yes	No	No	No	N/A	No	No
Q4-1. MCO required to cover services of new members with out-of-network provider?	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Q4-2. Standard time for continuity?	Other	60 days	Based on plan	60 days	N/A	N/A	N/A	90 days	Other	90 days	90 days	N/A	Based on plan	60 days	Based on plan	90 days	Other
Q5-1. Requires relaxing network/referral rules for CSHCN?	No	No	No	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Don't Know	No	No
Q5-2. Requires Centers of Excellence?	Yes	No	Yes	Yes	No	No	Yes	No	No	No	Yes	No	No	Yes	Don't Know	Yes	Yes
Q5-3. Customize DME and home health provider arrangements?	No	No	Yes	Yes	No	Yes	No	No	Yes	No	Yes	No	No	Yes	Don't Know	No	Yes
Q5-4. Provider access standards differ from other enrollee populations?	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	No	Don't Know	No	No
Q6-1. Educate families of CSHCN about special proivder access provisions?	No	N/A	Yes	Yes	No	No	No	No	No	No	Yes	Yes	No	No	Don't Know	No	Yes
Q6-2. Delegate education to vendor?	No	N/A	Yes	Yes	No	N/A	No	No	No	No	No	No	No	No	Don't Know	No	No
Q6-3. Require MCO to educate families of CSHCN about special provider access provisions?	No	N/A	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes	No	No	Don't Know	No	No
Q6-4. Require MCO to inform providers about special provider access provisions?	No	N/A	Yes	Yes	No	No	No	No	Yes	No	Yes	No	No	No	Don't Know	No	Yes
Q7. Does state agency plan to add/change provider access standards for CSHCN in any MCO next year?	No	No	No	Don't Know	No	Yes	No	No	Don't Know	No	No	No	Yes	Yes	Don't Know	No	No
Q8. Does state agency have network monitoring metrics for CSHCN and providers?	No	No	No	Yes	No	No	Yes	No	No	No	No	No	No	No	Don't Know	No	No

Note: Seven Medicaid survey respondents did not want their states identified; they are presented here as West Mountain; South Atlantic 1, 2, 3 and 4; North Central; North West.

Appendix C. Summary of Medicaid Managed Care Organization Survey Responses

	CareSource	WellCare - Georgia	Indiana	NYC	Molina- Texas	Tufts
Q1. Enroll CSHCN?	Yes	No	Yes	Yes	Yes	Yes
Q2-1. Ability to bypass referral requirements for in-network specialty care?	Yes	Skipped	No	No	Yes	No
Q2-2. Includes Centers of Excellence?	Yes	Skipped	Yes	Yes	Yes	No
Q2-3. Customizes DME and HH for CSHCN?	No	Skipped	Yes	Yes	Yes	No
Q2-4. Provider access standards for CSHCN differ from other enrollees?	No	Skipped	No	No	No	No
Q3. Cover services of new members in active treatment with out-of-network provider for minimum period of time?	Yes	Yes	Yes	Yes	Yes	Yes
Q4. Standard coverage for continuity of care by non-network provider?	90 days	90 days	60 days	60 days	120 days	90 days
Q5-1. Have policies/systems to educate families about special provider access provisions?	No	Skipped	Yes	No	Yes	No
Q5-2. Leave education to state/state vendor?	Yes	Skipped	No	No	No	No
Q5-3. Have policies/systems to inform network providers about special access provisions?	No	Skipped	Yes	No	Yes	No
Q6. To monitor network access, has MCO recommended contract revisions, changed practices, or plans to do so?	Yes	Skipped	Yes	No	Skipped	No
Q7. Have network monitoring metrics/practices specific for CSHCN and their providers?	Yes	No	No	No	Skipped	No

Note: State or city is used for survey respondents who did not want their health plan identified by name.

Appendix D. Checklist of Managed Care Contract Provisions on Monitoring Access for CSHCN

Identification, Benefits, Outreach

1. Identification of CSHCN; indicate whether it is required, whether state or MCO defines criteria, process, sources of identification
2. Outreach to CSCHN and initial screening/assessment within defined time frame after enrollment; indicate whether this may be the mechanism for identifying CSHCN
3. Require MCOs to customize durable medical equipment (DME) and/or home health service provider arrangements for CSHCN
4. Require education, notification, communication w/families of CSHCN about special provider access provisions, additional covered services, care coordination, grievance/appeals

Care Management

5. Assignment of care/case manager or care coordinator. Indicate whether care managers specialize in children with complex needs; in-person vs. telephonic; lists specific activities
6. Development of care plan/"plan of care" and periodic re-assessments and updates (may specify time frames)
7. Policies/procedures for communication, collaboration, information exchange across care providers and family; e.g., integrated care team, interdisciplinary care team
8. Require coordination with behavioral health and other programs (e.g. Title V agencies, EPSDT services, schools [education, IEPs], early intervention, protective service agencies, housing, transportation, or DD service organizations)
9. Medical home to address needs of children with chronic illness (who may not be actively identified as CSHCN but who have conditions that warrant ongoing care management, e.g., diabetes, asthma)

Network Adequacy, Timely Access Standards

10. Require the MCO to create and maintain a network development plan describing development of network for ensuring access
11. Require network inclusion of pediatric PCPs and pediatric specialists (listing types)
12. Require network inclusion of pediatric ‘centers of excellence’ (such as cardiac, regional genetics, end stage renal disease, perinatal care, transplants, hematology/oncology, pulmonary, craniofacial, and/or neuromuscular specialists, cleft palate clinics, hemophilia treatment centers, cystic fibrosis centers, rare disease specialists, autism treatment centers, developmental disabilities centers)
13. Standards for ratio of in-network pediatric specialists to enrollees. Note whether contract includes specs or leaves it to MCO to establish and report

14. Capacity: Monitoring and standards for network providers that are taking/accepting new patients; indicate whether accepting any patients versus CSHCN
15. Geo-access standards: State sets (or requires MCO to set) limits for distance and travel time to in-network pediatric PCPs, specialists. Indicate whether contract includes specs or leaves it to MCO; specifications differ for CSHCN versus other/adult populations; specifications differ in rural areas; exceptions are delineated
16. State sets (or requires MCO to set) standards for appointment wait times for existing or new patients, primary or specialty care. Note whether specifically for CSHCN or if the general standards are applicable to CSHCN as well
17. Coverage of telehealth (telemonitoring, telemedicine); note criteria if allowed, and any special provisions for CSHCN

Care Continuity and Relaxing Authorization and Network Requirements

18. Continuity of Care: Require policies for new MCO enrollees in active treatment to continue care from out-of-network providers, indicate whether for a specified transition time
19. Allow Pediatric Specialists to be PCP; indicate whether only if had existing relationship
20. Allow or require waive or bypass of prior authorizations from PCP or health plan for specialists and under what conditions
21. Requires expedited authorizations and under what conditions
22. Standards or policies re: timely referrals to out-of-network providers (physical, mental and dental care providers, pediatric primary care and pediatric subspecialists, children's hospitals, pediatric regional centers where available, and ancillary providers)
23. Provisions that allow or exclude out-of-state providers for CSHCN or general population.

Reporting, Monitoring, Enforcement

24. Require experience serving special needs populations in provider credentialing committee, medical necessity determination, Pharmacy and Therapeutics committee, grievances and appeals, or serving as a medical director
25. MCO informs/educates network providers about the plans' special provider access provisions or options for CSHCN
26. Separate tracking/monitoring/reporting for CSHCN re: Grievances/Appeals, service utilization, encounter data, other
27. Reporting to state of network adequacy for special needs populations
28. Separate surveying of families of CSHCN or ISHCN re: access and network adequacy including member satisfaction surveys for CSHCN, MCO administered CAHPS or mini version of CAHPS. Include measures
29. Specify state enforcement actions for breaching network standards; may include "corrective action plans" with timelines, penalties/sanctions or rewards

Appendix E. State Documents Reviewed for Inclusion of Checklist Provisions

Note: the documents reviewed were the most recent contracts, RFPs, etc., publicly available.

State	Contract/Request for Proposal/Regulation
Arizona	Acute Care/Children's Rehabilitative Services Request for Proposals, Arizona Health Care Cost Containment System, Issued November 1, 2012
California	Medi-Cal Regional/Imperial/San Benito/Two Plan Model Contract , California Department of Health Care Services, Accessed on ca.gov August 2015
District of Columbia	Managed Care Organizations Request for Proposal, Office of Contracting and Procurement, Issued 2012
Delaware	Delaware Medicaid Managed Care Organizations Request for Proposal, Division of Medicaid and Medical Assistance, Issued April 4, 2014
Florida	Statewide Medicaid Managed Care Program Model Contract, Agency for Health Care Administration, Updated July 15, 2015
Georgia	GA Families & GA Families 360◦ Care Management Organization Request for Proposal, Georgia Department of Community Health, Issued September 2015
Hawaii	QUEST Integration (QI) Managed Care to Cover Medicaid, and Other Eligible Individuals Request for Proposal, State of Hawaii Department of Human Services, Issued August 5, 2013
Iowa	Iowa High Quality Healthcare Initiative Request for Proposal, Iowa Department of Human Services, Issued February 16, 2015
Illinois	State of Illinois Model Contract for Furnishing Health Services by a Managed Care Organizations, Department of Healthcare and Family Services, 2015
Indiana	Risk-Based Managed Care Services for Medicaid Beneficiaries (Hoosier Healthwise/HIP) Request for Services, State of Indiana, Family and Social Services Administration/Office of Medicaid Policy and Planning, Due Date April 1, 2010
Kansas	KanCare Medicaid and CHIP Capitated Managed Care Services Request for Proposal, State of Kansas, Issued November 16, 2011
Kentucky	Medicaid Managed Care Services Solicitation, Commonwealth of Kentucky, Issued April 10, 2015
Louisiana	Bayou Health Managed Care Organizations Request for Proposal, Louisiana Medicaid Program, Issued July 28, 2014
Maryland	The Code of Maryland Regulations, Title 10, Department of Health and Mental Hygiene, Accessed at www.dsd.state.md.us September 2015
Massachusetts	MassHealth Managed Care Organization Contracts By and Between the Executive Office of Health and Human Services and Tufts AND Network Health, Both Contracts with Operational Start Dates of July 1, 2010
Michigan	Comprehensive Health Care Program for the Michigan Department of Health and Human Services Request for Proposal, Issued May 8, 2015
Minnesota	Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare Medical Care Services, 2015

Missouri	MO HealthNet Managed Care – Central, Eastern, and Western Regions Request for Proposal, State of Missouri Office of Administration, Issued November 26, 2014
Mississippi	The MississippiCAN Program Request for Proposals, Mississippi Division of Medicaid, Issued October 4, 2013
Nebraska	Nebraska Physical Health Managed Care AmeriHealth and Coventry Contracts, Order Dates August 28, 2014 and May 30, 2014, respectively
New Hampshire	Medicaid Care Management Services Request for Application, State of New Hampshire Department of Health and Human Services, Issued April 1, 2015
New Jersey	New Jersey Managed Care Model Contract ,Department of Human Services, July 2014
New Mexico	Centennial Care Request for Proposals, New Mexico Human Services Department, Issued August 31, 2012
New York	Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan Model Contract, New York State Department of Health, March 1, 2014
Ohio	Ohio Medical Assistance Provider Agreement for Managed Care Plan, The Ohio Department of Medicaid, July, 2015
Pennsylvania	HealthChoices Physical Health Agreement, January 1, 2015
Puerto Rico	Model Contract for the Provision of Physician & Behavioral Health Services Under the Government Health Plan Program, Administracion De Seguros De Salud De Puerto Rico (ASES), June 24, 2014
Rhode Island	Contract Between the State of Rhode Island and Providence Plantations Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services for an Integrated Population, Draft July 12, 2015
South Carolina	Contract for the Purchase and Provision of Medical Services Under the South Carolina Medicaid MCO Program, Department of Health and Human Services, July 1, 2014
Tennessee	Request for Proposals for Managed Care Organizations State of Tennessee Department of Finance and Administration, October 2, 2013
Texas	Uniform Managed Care Terms & Conditions, Texas Health & Human Services Commission, Version 2.16
Virginia	Medallion 3.0 Managed Care Contract, Commonwealth of Virginia Department of Medical Assistance Services, July 1, 2014 - June 30, 2015
Washington	Washington Apple Health 2015 Managed Care Contract, Washington State Health Care Authority, Contract represents all Incorporated Amendments from January 2015 through May 2015
Wisconsin	Model Contract for BadgerCare Plus and/or Medicaid SSI HMO Services, The Wisconsin Department of Health Services January 1, 2014 through December 31, 2015

Appendix F. Checklist Provision Designation for State Contracts

Key: * Indicates provision is based on a federal rule.

S= Provision is **S**pecific to Children with Special Health Care Needs (CSHCN)

A= Provision refers to enrollees of **A**ll ages with Special Health Care Needs (SHCN), not specific to children; may relate to certain diagnoses or risk categories

S+A= Provision refers to CSHCN or ISHCN (Adds number of 'S' and 'A')

G= Provision applies **G**enerally to enrollee population

N= Provision is **N**ot included in contract

NA= Provision itself pertains to special heath care needs and is **N**ot **A**pplicable for the ISHCN or general enrollee population

Appendix F-1. Identification and Outreach Provisions

IDENTIFICATION/OUTREACH				
STATE	Identification of CSHCN*	OUTREACH/ SCREENING/ ASSESSMENTS*[1]	CUSTOMIZE DME & HOME HEALTH	EDUCATE/NOTIFY/ COMMUNICATE W/FAMILIES
AZ	S	A	N	G
CA	S	S	N	N
DC	S	A	N	G
DE	S	G	N	G
FL	A	G	N	N
GA	A	G	N	N
HI	S	G	N	G
IL	S	S	N	N
IN	S	S	N	N
IA	S	G	N	N
KS	A	A	N	N
KY	S	A	N	A
LA	A	A	N	N
MD	S	G	S	S
MA	A	A	N	A

[1] Federal rules include requirements for identifying, assessing, and producing a treatment plan (if required by the state) for an individual with special health care needs (42 C.F.R. § 438.208(c)(1) – (3)), but do not require targeted outreach to CSHCN.

MI	S	S	S	S
MN	S	N	N	G
MO	A	A	N	A
MS	G	G	N	G
NE	S	A	N	N
NH	S	A	N	A
NJ	S	S	A	G
NM	G	G	N	N
NY	S	G	A	N
OH	A	A	N	N
PA	A	S	N	A
PR	A	G	N	N
RI	S	S	N	N
SC	A	A	N	G
TN	S	G	N	N
TX	S	A	N	N
VA	S	S	N	S
WA	S	A	N	N
WI	S	A[2]	N	N
TOTALS				
Specific to CSHCN (S)	22	8	2	3
All Ages ISHCN (A)	10	14	2	5
A+S	32	22	4	8
General enrollee population (G)	2	11	NA	8
Not in contract (N)	0	1	30	18

[2] Limited to members with SSI.

Appendix F-2. Care Management

CARE MANAGEMENT					
STATE	MCO MUST ASSIGN CARE MANAGER	MCO MUST DEVELOP CARE PLAN *	REQUIRE INTEGRATED CARE TEAM APPROACH AND INFORMATION EXCHANGE	REQUIRE COLLABORATION W/ OTHER PROGRAMS (S=pediatric programs, agencies)[3]	REQUIRE USE OF MEDICAL HOMES
AZ	A	N	N	S	S
CA	S	A	A	S	N
DC	A	S[4]	S	S	N
DE	G	A	G	N	N
FL	S	A	A	A	N
GA	N	G	G	G	G
HI	S	A	G	G	N
IL	S	A	A[5]	N	G
IN	S	G	G	G	N
IA	A	A	G	G	S
KS	N	A	G	G	G
KY	S	S	A	S	S
LA	A	G	G	S	N
MD	S	S	A	S	N
MA	G	A	A	A	N
MI	S	S	G	G	S
MN	A	A	A	G	S[6]
MO	A	A	A	A[7]	N
MS	A	A	A	S	G
NE	A[8]	A	A	G	G[9]

[3] For this provision, “S” refers to coordination with pediatric programs such as Title V, schools, foster care, etc.
[4] DC employs the term children with more complex needs.
[5] Specifies members receiving HCBS waiver services.
[6] MN refers to children with "high-cost conditions".
[7] Limited to members in health homes (for behavioral health care).
[8] Additional provisions were given for children who are in out-of-home placements and wards of the state.
[9] Intended for individuals who need disease management.

NH	A	A	S[10]	S[11]	A
NJ	A	A	A[12]	G	S
NM	G	G	G	S	G
NY	G	S[13]	A	S	A
OH	A	A	A	N	G
PA	A	A	A	G	G
PR	G	G	G	G	N
RI	G	G	G[14]	S[15]	S
SC	G	A	S	S	G
TN	A	A[16]	A	S	G
TX	A	A	A	S	G
VA	S	S	N	S	S
WA	A	A	A	A	G
WI	A[17]	A[18]	A[19]	S	A[20]
TOTAL CATEGORIES					
Specific to CSHCN (S)	9	6	3	16	8
All Ages ISHCN (A)	16	21	18	4	3
A+S	25	27	21	20	11
General enrollee population (G)	7	6	11	11	12
Not in contract (N)	2	1	2	3	11

[10] Provision requires integrated team approach or information exchange only for children requiring behavioral health care services.
[11] Contract requires that for children with serious emotional disturbances, MCOs integrate services among multiple providers and organizations working with the child, and ensure that its providers, families and members participate in the development of a system of care model.
[12] Limited to MLTSS members of which a small fraction is children.
[13] Limited to children with HIV.
[14] Focuses on use of Health Information Exchange.
[15] Provision is limited to Individualized Education Program (IEPs) and special education.
[16] Care plans are limited to members in CHOICES, the state's LTC program.
[17] WI limits assignment of a care manager to members on SSI and high-risk pregnant women.
[18] WI limits the development of care plans and reassessment activities to members on SSI and high-risk pregnant women.
[19] WI limits the use of provider teams to members on SSI and high-risk pregnant women.
[20] Medical homes are limited to high-risk pregnant women.

Appendix F-3. Network Adequacy/Access Standards

NETWORK ADEQUACY/ACCESS STANDARDS								
STATE	NETWORK DEVELOP -MENT PLAN	REQUIRE PEDIATRIC PROVIDERS [21]	REQUIRE PED. CENTERS OF EXCE-LLENCE[22]	HAVE SPECIALIST TO ENROLLEE RATIOS	MONITOR IF PROVIDER ACCEPTS NEW PATIENTS*	GEO-ACCESS - TRAVEL DIST-ANCE, TIME STANDAR -DS*	SET APPOINT -MENT WAIT TIMES	COVER TELE-HEALTH
AZ	G	S	S	N	N	G	G	N
CA	N	S	S	A	G	G	N	G
DC	N	S	S	G	G	G	G	N
DE	N	S	N	N	G	G	G	G
FL	G	S	S	G	G	G	G	S
GA	N	N	N	N	G	G	G	G
HI	G	G	N	G	G	G	G	G
IL	N	N	N	G	G	G	G	N
IN	N	S	S	N	G	G	N	G
IA	N	N	N	N	G	G	G	G
KS	G	N	N	N	G	G	G	N
KY	N	N	N	G	G	G	G	N
LA	N	S	N	G	G	G	G	G
MD	G	S	N	G	G	G	N	N
MA	N	G	N	N	G	G	G	N
MI	N	S	S	G	S	S[23]	N	N
MN	N	N	N	N	G	G	G	G
MO	N	G	S	N	G	G	G	G
MS	N	G	G	N	G	G	G	N
NE	G	G	N	N	G	G	G	N

[21] For this provision, "G" refers to pediatric providers for all children, and "S" refers to specifically to pediatric providers for CSHCN.

[22] For this provision, "G" refers to Children's Hospitals, "S" refers to more specialized children's facilities, and "N" is used when centers of excellence are not mentioned or are unrelated to pediatrics or ISHCN. The "A" category does Not Apply (NA).

[23] Exceptions to standard for CSHCN if appropriate PCP is beyond 30 miles/30 minutes.

NH	N	G	G	G[24]	G	G[25]	G	N
NJ	G	G	S	N	N	G	G	N
NM	G	G[26]	N	G	G	G	G	G
NY	G	G	S	N	G	G	A	G
OH	N	G[27]	N	N	G	G	N	G
PA	N	S	N	N	G	G	G	N
PR	N	N	N	G	G	G	G	N
RI	N	N	N	G	G	G	G	N
SC	N	G	S	N	G	G	G	N
TN	G	S[28]	N	G	G	G	G	N
TX	N	S	S	N	G	G	G	G
VA	S	S	N	G	G	G	G	G
WA	N	N	S[29]	G	G	S[30]	G	N
WI	N	N	N	N	G	G	G	N
TOTAL CATEGORIES								
Specific to CSHCN (S)	1	13	12	0	1	2	0	1
All Ages ISHCN (A)	0	NA	NA	1	0	0	1	0
A+S	1	13	12	1	1	2	1	1
General enrollee populat-ion (G)	10	11	2	15	31	32	28	14
Not in contract (N)	23	10	20	18	2	0	5	19

[24] The pediatric provider to enrollee ratio measure is limited to primary care.
[25] Does not distinguish pediatric PCPs or specialists.
[26] Limited to PCPs (pediatricians) and does not specify pediatric specialists.
[27] Pediatric PCPs required. Pediatric specialists not specified.
[28] Pediatric specificity in network composition was limited to psychiatry.
[29] Limited to a Center of Excellence for children with autism spectrum disorder.
[30] Allows special geo-access considerations for pediatric specialists.

Appendix F-4. Care Continuity and Relaxing Authorization and Network Requirements

CARE CONTINUITY AND RELAXING AUTHORIZATION						
STATE	REQUIRE CONTINUITY OF CARE FROM OUT-OF-NETWORK PROVIDERS DURING TRANSITION	ALLOW SPECIALISTS TO BE PCPs	ALLOWS/ REQUIRES WAIVER OR BYPASS OF PRIOR AUTHS*	EXPEDITED AUTHS POLICIES *	STANDARDS FOR TIMELY REFERRALS TO OUT-OF-NETWORK PROVIDERS*	PROVISIONS FOR ACCESS TO OUT-OF-STATE PROVIDERS
AZ	N	N	N	G	G	G
CA	A	S	S	G	G	N
DC	G	A	A	G	G	G
DE	S	G	N	G	N	G
FL	G	G	G	G	G	N
GA	G	G	G	G	G	N
HI	G	G	A	G	G	G
IL	G	S	A	G	G	G
IN	G	N	A	G	G	G
IA	G	N	N	G	G	N
KS	G	N	N	N	G	N
KY	G	S[31]	A	G	G	N
LA	G	N	N	G	G	G
MD	N	G	N	N	S	N
MA	N	S[32]	G	G	G	G
MI	S	G	S	G	N	N
MN	G	N	A	G	G	S[33]
MO	G	N	A	G	G	N
MS	A	S	N	G	G	N
NE	G	G	A	G	G	N
NH	G[34]	G	A	G	G	G

[31] Contract language does not specify CSHCN but does include children with disabilities.
[32] Contract language does not specify CSHCN but does include children with disabilities.
[33] Applies to children in residential mental health treatment.
[34] The provision was interpreted as requiring continuity with out-of-network providers but it does not explicitly refer to the out-of-network providers.

NJ	S	A	A[35]	G	G	G
NM	G	A	N	G	G	N
NY	G	A	A	S	A	A
OH	S	A	A	N	G	G
PA	N	A	A	G	A	N
PR	N	N	A	G	G	G[36]
RI	G	G	N	N	G	G
SC	G	N	G	G	G	N
TN	G	A	N	G	G	N
TX	G	A	A	G	G	G
VA	G	A	G	G	G	G
WA	N	S	N	G	N	G
WI	A[37]	A	G	G	G	N
TOTAL CATEGORIES						
Specific to CSHCN (S)	4	6	2	1	1	1
All Ages ISHCN (A)	3	10	15	0	2	1
A+S	7	16	17	1	3	2
General enrollee population (G)	21	9	6	29	28	16
Not in contract (N)	6	9	11	4	3	16

[35] Applies to enrollees with developmental disabilities receiving dental care.
[36] PR's provision is limited to emergency care (federal requirement) and pathology and clinical lab tests.
[37] Limited to SSI enrollees.

Appendix F-5. MCO Expertise, Reporting, and Monitoring

MCO EXPERTISE, REPORTING, AND MONITORING						
STATE	REQUIRE SPECIAL NEEDS EXPERIENCE ON MCO COMMITTEES, MEDICAL DIRECTOR ROLE*[38]	REQUIRED TO INFORM/ EDUCATE PROVIDERS ABOUT ACCESS PROVIS-IONS	SEPARATELY TRACK/REPORT FOR SPECIAL POPULATIONS E.G., APPEALS, UTILIZATION, ENCOUNTER DATA	REPORT ON NETWORK ADEQUACY FOR SPECIAL POPULAT-IONS	SEPARATELY SURVEY FAMILIES OF CSHCN ON ACCESS, SATISFACT-ION	SPECIFY STATE ENFORCE-MENT ACTIONS FOR BREACHING NETWORK STANDARDS
AZ	N	N	A	N	N	N
CA	N	N	S	N	N	N
DC	N	N	A	N	N	N
DE	N	N	A	N	N	N
FL	N	A	N	N	N	N
GA	N	G	A	G[39]	N	N
HI	N	N	A	N	N	N
IL	A	N	N	N	N	N
IN	N	N	S	S	N	N
IA	N	N	N	N	N	N
KS	N	N	N	A	N	N
KY	N	A[40]	A	S	N	G
LA	N	N	A	N	S	N
MD	N	A	S	N	N	N
MA	N	N	N	N	N	N
MI	N	N	S	N	N	N
MN	N	N	G	N	N	N
MO	N	A	A	N	N	N
MS	N	N	A	N	N	N
NE	N	N	A	N	N	N

[38] Federal rules require appropriate clinical expertise in treating the enrollee's condition or disease for professionals making grievance and appeal decisions, and similar language is common in the contracts. For this checklist table, we looked for requirements of MCO expertise in serving special health care needs populations.
[39] Requires geo-access reporting for pediatric PCPs but not specifically for CSHCN.
[40] Provision specifies only behavioral health and does not speak to particular needs of children.

NH	N	N	S[41]	N	N	G
NJ	A[42]	N	N	N	N	N
NM	N	A	A	A	S	N
NY	N	A	G	N	N	N
OH	A[43]	N	A	N	N	N
PA	A[44]	A	A	A	N	N
PR	N	G	A	N	A[45]	N
RI	N[46]	N	N	N	N	N
SC	N	N	A	N	N	G
TN	N	N	N	N	N	N
TX	N	A	A	N	N	N
VA	N	A	S	S	S	G
WA	N	N	N	N	N	N
WI	N	N	N	N	N	N
TOTAL CATEGORIES						
Specific to CSHCN (S)	0	0	6	3	3	0
All Ages ISHCN (A)	4	9	16	3	1	0
A+S	4	9	22	6	4	0
General enrollee populat-ion (G)	NA	2	2	1	NA	4
Not in contract (N)	30	23	10	27	30	30

[41] For children with chronic conditions, contract requires MCOs to report quality measures sets including all available CAHPS measures and sections, including supplements for children with chronic conditions and mobility impairment.
[42] Limited to medical necessity determination, P&T Committee and qualifications of medical director.
[43] Limited to the requirements for a Care Management Director.
[44] PA is unique in its requirement that the plan have a Unit headed by a Special Needs Coordinator who consults with the Medical Director.
[45] Requires survey findings for adults, children, behavioral health and chronic conditions.
[46] Contract has a disability competency provision for providers.

Appendix F-6. Provision Totals

PROVISION TOTALS					
STATES	SPECIFIC to CSHCN (S)	APPLIES TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (A)	REFERS TO CSHCN OR SCHN (S+A)	APPLIES TO GENERAL ENROLLEES (G)	NOT IN CONTRACT (N)
AZ	5	3	8	7	14
CA	9	4	13	5	11
DC	6	5	11	9	9
DE	3	2	5	11	13
FL	4	5	9	11	9
GA	0	2	2	16	11
HI	2	3	5	16	8
IL	4	4	8	9	12
IN	7	1	8	10	11
IA	2	2	4	10	15
KS	0	4	4	9	16
KY	7	6	13	8	8
LA	3	4	7	11	11
MD	9	2	11	6	12
MA	1	6	7	9	13
MI	14	0	14	5	10
MN	3	4	7	10	12
MO	1	10	11	8	10
MS	2	5	7	11	11
NE	1	6	7	11	11
NH	4	6	10	12	7
NJ	5	7	12	9	8
NM	2	4	6	16	7
NY	5	9	14	9	6
OH	1	9	10	7	12
PA	2	12	14	6	9
PR	0	4	4	13	12
RI	4	0	4	11	14

SC	3	4	7	12	10
TN	3	4	7	10	12
TX	4	8	12	9	8
VA	12	2	14	11	4
WA	4	5	9	6	14
WI	2	7	9	6	14

Appendix G. Identification Categories and Criteria for Identifying CSHCN

Type of CSHCN identifier	Description/Criteria	
Eligibility category	Children in foster care or adoption assistance Former foster care children Children registered with the Division of Developmental Disabilities Children eligible for SSI under Title XVI Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett) Children receiving Title V funding Children receiving MLTSS	
Service type	Children receiving behavioral health services Children who need or receive ST, OT and/or PT for a medical condition that has lasted or is expected to last at least 12 months Children who need or receive treatment or counseling for an emotional, developmental or behavioral problem that has lasted or is expected to last at least 12 months Children who receive private duty nursing Children who receive home health services Children who receive durable medical equipment/supplies Children who receive case management Technologically dependent for life or health sustaining functions Require complex medication regimen to improve health status Members receiving dialysis Members receiving chemotherapy Children receiving long term care	
Diagnosis	Asthma Autism spectrum disorder Bipolar disorder Bronchopulmonary dysplasia Cancer Cerebral palsy Chronic arthritis Chronic diabetes Cleft and craniofacial disorders Congenital heart disease COPD Cystic fibrosis Degenerative neurological disorders Developmental delays Hemophilia Hepatitis B or C HIV/AIDS	Hypertension Infectious diseases producing major sequelae Intellectual or developmental disability Lead poisoning Microcephaly Muscular dystrophy Obesity Post-traumatic stress disorder (PTSD) Pulmonary hypertension Recurrent major depression Schizophrenia Scoliosis Sickle cell anemia Spina bifida Traumatic injuries with vision and hearing impairments

Utilization	Children who are outliers for ER utilization Children being discharged from an acute care setting when LOS is greater than 10 days Children who have a hospital readmission within 30 days of discharge
Chronicity	Those who are at increased risk for a chronic physical, behavioral, developmental, or emotional condition who require services beyond that required by children generally Children who take medication for any behavioral/medical condition that lasted or is expected to last at least 12 months Members with at least two chronic conditions Members with at least one chronic condition and at risk for a second chronic condition Is in need of ongoing assessment or intervention to prevent serious deterioration of their health status Children who face physical, behavioral or environmental challenges daily that place at risk their health or ability to function
Situational	Children who meet the standard of limited English proficiency (DC) Children who are homeless (FL, MA) Children with functional limitations and/or dependency on devices (IN) Children who are Early Childhood Intervention program participants (TX) Farmworker children (TX) Children living with domestic violence (WA)

[1] The Medicaid managed care contracts as well as the literature use different terminology such as "children with special health care needs," "children and youth with special health care needs (CYSHCN)," or "children with complex medical needs." In this memo we use "CSHCN" for simplicity, and note differences where relevant.

[2] Who are Children with Special Health Care Needs? Data Resource Center for Child and Adolescent Health, 2014. http://www.cahmi.org/wp-content/uploads/2014/06/CSHCNS-whoarecshcn_revised_07b-pdf.pdf

[3] The Kaiser Commission on Medicaid and the Uninsured reported that, states have been expanding managed care programs to include beneficiaries with more complex needs. (Proposed Rule on Medicaid Managed Care: A Summary of Major Provisions, Kaiser Commission on Medicaid and the Uninsured, July 2015). http://kff.org/report-section/proposed-rule-on-medicaid-managed-care-issue-brief/

The Kaiser Commission also reported that a growing number of states is implementing mandatory enrollment in risk-based managed care for Medicaid beneficiaries with disabilities, and that budget actions indicate continued movement in this direction. (People with Disabilities and Medicaid Managed Care: Key Issues to Consider, Kaiser Commission on Medicaid and the Uninsured, February 2012). https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf

An Urban Institute study of 20 states found an increase in enrollment of SSI-related children in risk based managed care of 82% between 2001 and 2008. (Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future, Final Report to the Office of the Assistant, Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, July 2012).

[4] We focused on "standard" managed care plans serving CSHCN who are enrolled along with other Medicaid populations, rather than on specialty plans that serve only populations with special health care needs.

[5] The CSHCN identification contract provision was found in 21 out of 34 Medicaid managed care contracts and RFPs. While this provision was not found in 13 of the states' contracts, it may be included in other state documents, such as a Medicaid managed care manual or guidance memorandum, which were not included in the review.

[6] 42 C.F.R. § 438.208.

[7] We reviewed contracts for managed care plans serving the general Medicaid population that typically also serve a large portion of CSHCN; this study did not focus on contracts with specialty MCOs that in some states serve a relatively small portion of CSHCN with certain diagnoses or the most severe conditions.
[8] McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. Pediatrics. 1998; 102(1, pt 1):137–140.
[9] According to the 2009-2010 National Survey of CSHCN. (Who are Children with Special Health Care Needs?, Data Resource Center for Child and Adolescent Health, 2014. http://www.cahmi.org/wp-content/uploads/2014/06/CSHCNS-whoarecshcn_revised_07b-pdf.pdf)
[10] National Survey of Children with Special Health Care Needs (2009-2010), presented on State-at-a-Glance Coverage and Financing Charts, Catalyst Center. http://www.hdwg.org/catalyst/online-chartbook/comparestate
[11] See endnote #3.
[12] Improving Managed Care for Children with Special Needs: A Best Clinical and Administrative Practices Toolkit, Center for Health Care Strategies, Inc., 2004.
[13] Sources include: 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, Association of Maternal & Child Health Programs, March 2014; People with Disabilities and Medicaid Managed Care: Key Issues to Consider, Kaiser Commission on Medicaid and the Uninsured, February 2012; and interviews with experts and advocates of CSHCN. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf
[14] Kastner, T and the Committee on Children with Disabilities. Managed Care and Children with Special Health Care Needs, Pediatrics, December 2004, Vol. 114, Issue 6.
[15] 42 C.F.R. § 438, Managed Care http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4.pdf
[16] State Standards for Access to Care in Medicaid Managed Care, Department of Health and Human Services, Office of the Inspector General (September 2014), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf , and Access to Care: Provider Availability in Medicaid Managed Care, Department of Health and Human Services, Office of the Inspector General (December 2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf
[17] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31276 (June 1, 2015)
[18] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31271 (June 1, 2015)
[19] For example, Michigan, Rhode Island, and Texas are highlighted in: Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs, Association of Maternal and Child Health Programs (AMCHP), March 2014.
[20] We incorporated questions into surveys the research team was already conducting for another project, supported by the Robert Wood Johnson Foundation.
[21] While our goal for the Medicaid survey was to reach all of the states that contract with managed care organizations, we elected to survey a sample of Medicaid MCOs since there are over 250 nationwide. 30 gave us just over 10% representation, and helped us avoid duplicating surveys to multi-state plans.
[22] States suggested for further review included Michigan, Massachusetts, Colorado, Delaware, Maryland, Rhode Island, Kansas, Iowa, Washington, and New Hampshire. Suggestions on innovative MCOs included Texas STAR kids MCOs, Neighborhood Health in Rhode Island, Priority Partners at Johns Hopkins in Maryland, Maryland Physicians Care, Geisinger Health Plan, DC Special Health Care Needs Plan, and United Health Care.
[23] Indiana, Kentucky, Massachusetts, Michigan, and Virginia
[24] We did not review states without risk-based managed care, two states with only alternative risk-based models, or three states for which contracts were not available.
[25] Because our objective was to focus on standard MCO contracts serving CSHCN who are enrolled along with other Medicaid populations, we reviewed the standard contract rather than the specialty MCO contract for states that have both types of Medicaid managed care plans.
[26] We had assurances from state experts that the other state contracts were virtually identical.

[27] In cases where a contract referenced a policies and procedures manual for further guidance on MCO requirements relevant to CSHCN, we also reviewed relevant portions of the policy manual if publicly available and accessible.
[28] We reviewed one state's (Maryland) Medicaid regulations because it does not have a competitive procurement process and the regulations contain relevant managed care requirements.
[29] HMA obtained some contracts through the Freedom of Information Act.
[30] In 2014 the Association of Maternal and Child Health Programs (AMCHP) proposed national standards for systems of care for children and youth with special health care needs including access-related provisions such as: allowing specialists with a clinical relationships with CSHCN to serve as their 'PCP'; and bypassing prior authorization requirements for pediatric specialists included in the child's care plan whether or not the specialist is in the health plan network. (Standards for Systems of Care for Children and Youth with Special Health Care Needs, Association of Maternal and Child Health Programs (AMCHP), March 2014.)
[31] We did not include provisions related solely to long term services and supports or long-term care that would not apply to the vast majority of CSHCN.
[32] We included in this category individuals in specified diagnostic categories that are considered as having special health care needs.
[33] ISCHN may apply to all individual with special health care needs or to specific subgroups with special needs such as HIV/AIDS, MLTSS, children receiving behavioral health care, or high-risk pregnant women.
[34] 42 C.F.R. § 438.208(c).
[35] In California, plans have 120 days to complete an initial assessment for individuals who are not enrolled in the disabled eligibility group.
[36] Additional data sources specified for identifying CSHCN that appear less often (in just one out of the 34 Medicaid managed care contracts) are: lab results, discharge data and the utilization management process (pre-certifications, concurrent review and prior authorizations (MA)), DME and home health claims (NY), inpatient claims (NJ), and medical records (GA).
[37] 42 C.F.R. § 438.208(c)(3).
[38] Advocates and MCO representatives interviewed particularly emphasized the important role of parents/caregivers of CSHCN in care coordination and highlighted the value of parent participation in stakeholder collaboration and input on contract provisions. Some Medicaid and MCO interviewees described frequent meetings (as often as monthly or every two months) involving families to gather feedback and identify gaps in coverage or care. One MCO described holding member and provider focus groups when state contract provisions were updated, to assess the impact on families and providers.
[39] A Rhode Island MCO highlighted the value of a health information exchange platform, CurrentCare, developed by health care stakeholders in which patients can elect to participate, "almost like a statewide electronic medical record." The system is helpful in ensuring that emergency room clinicians have all of a child's most recent medical history and in minimizing overprescribing. It also allows providers to identify other providers who are treating that child if they need to make contact.
[40] MCO interviewees described initiatives they have implemented to facilitate cross-program coordination for CSHCN even though those activities are not required in their contracts. These include efforts to: identify all the care coordinators and entities involved in a child's care, and clearly identify a lead coordinator and each coordinator's roles; establish policies for frequent communication and sharing of medical records; use "social care managers" who support the member and clinical care manager by identifying and coordinating non-medical resources such as housing, financial assistance, food, clothing, or any other social needs. One MCO also has a parent advocate who can visit schools to ensure that a child's needs are being met, and a small team of clinicians who make home visits, in addition to the plan's in-house care managers whose outreach is primarily telephonic.
[41] Michigan's Title V program serving children and some adults with special health care needs.
[42] Michigan's "Children's Special Health Care Services" through the Department of Community Health is authorized by the Title V program for children with chronic health problems, who have one of the over 2,700 qualifying medical conditions. Children on CSHCS who also qualify for Medicaid may be eligible through the Temporary Assistance for Needy Families (TANF) program category are primarily for children 18 years old or younger, or full time students older than 18 who will graduate before the age of 20. Some children on CSHCS qualify for Medicaid under the Aid to Blind and Disabled (ABAD) program category of eligibility.

[43] 42 C.F.R. § 438.206(b)(1).
[44] Physical Health Managed Care Organization
[45] According to Michigan Medicaid and MCO interviewees, January 2016.
[46] 42 C.F.R. § 438.206(b)(4).
[47] According to interview with MCO representative, 2015.
[48] CMS requires that states consider the existing PCP relationship of new enrollees when they auto-assign them into MCOs: "The process must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries… An 'existing provider-beneficiary relationship' is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year." (42 C.F.R. § 438.50(f)(2)-(3))
[49] CMS' proposed Medicaid managed care rules if finalized would expand continuity and transition requirements. For example, the proposed rules would require states to have a continuity of care policy that ensures access to services consistent with the access that enrollees previously had and allows them to retain current providers for a time period. (Paradise, J and Musumeci, M. Proposed Rule on Medicaid Managed Care: A Summary of Major Provisions Jul 23, 2015. http://kff.org/report-section/proposed-rule-on-medicaid-managed-care-issue-brief/).
[50] The proposed rules also would give states flexibility to determine the types of enrollees to receive transition activities and to determine the time frames for retaining out-of-network providers. CMS proposes to require that "states include a transition of care policy standard in their MCO, PIHP, and PAHP contracts. We propose to provide flexibility for states to decide whether to apply the state developed policy consistently to their MCOs, PIHPs, and PAHPs, or whether to permit the health plans to have different policies, as long as the state's minimum standards are met. We believe this approach achieves an appropriate balance between assuring ongoing care for individuals who have significant needs while permitting states flexibility to determine how best to implement these transitions." Federal Register, Vol. 80, No. 104, Monday, June 1, 2015, Proposed Rules, page 31139.
[51] According to a Kentucky Medicaid official, the state does not require children in foster care children to have a PCP, because these children change residencies often, making it difficult to establish relationships with PCPs. Also, there is separate care coordination for this population, which may make coordination by a PCP less critical.
[52] 42 C.F.R. § 438.208(c)(4).
[53] If the out-of-network provider is unwilling to bill the MCO, the plan helps the enrollee find another provider.
[54] 42 C.F.R. § 438.210(d)(2).
[55] 42 C.F.R. § 438.406(a)(3)(ii).