



Serving Children and Youth with Special Health Care Needs in Medicaid Managed Care: Contract Language and the Contracting Process

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States have long used managed care delivery systems in their Medicaid programs to improve the quality of care provided to enrollees, improve health outcomes, and control health care costs. Many states have typically exempted Medicaid enrollees with chronic and complex health conditions from enrollment in managed care, but this trend is changing as states seek to control costs and improve care for this population. According to recent studies, over 40 states enroll at least some portion of eligible children and youth with special health care needs (CYSHCN) into Medicaid managed care^{1, 2}

Approximately 15 percent of all U.S. children ages birth to 18 years (over 11 million children) have a chronic and/or complex health care need (e.g., asthma, diabetes, spina bifida) requiring health care services and supports beyond what children require normally.³ A smaller but growing group of children have complex health care needs (approximately 3 million children), with estimates for children with the *highest levels of need* ranging from 0.4 – 0.7 percent of all U.S. children (approximately 320,000 – 560,000 children).⁴ Children with chronic and/or complex health care needs have unique physical and behavioral health needs that differ from other Medicaid enrollees. The needs of CYSHCN can include more frequent access to providers (particularly specialty providers), increased hospitalization or emergency room visits, and the need for multiple medications.⁵ These unique needs make clear that managed care plans have to specifically address certain aspects of CYSHCN care, such as identification and assessment of needs, access to providers, and coordination of care in order to ensure quality.

National researchers have studied the need for special language in Medicaid contracts regarding CYSHCN for many years. Sample pediatric purchasing specifications for Medicaid managed care arrangements were first described in the mid-1990s in recognition of the need to address the unique needs of children, particularly CYSHCN, in Medicaid managed care.⁶ State uptake and use of the specifications varied. Renewed interest in contracting language was heightened with the release of the *Standards for Systems of Care for Children and Youth with Special Health Care Needs (The National Standards)*⁷ in 2014. The National Standards were designed to “address the core components of the structure and process of an effective system of care for CYSHCN.”⁸ It includes specific system standards that address identification of the population, scope of benefits, a process for determining medical necessity, sufficient specialist provider networks, the establishment of a medical home model, and specific quality measures.⁹

A 2016 study by the Medicaid and CHIP Payment and Access Commission underscored the significance and role of Medicaid managed care contracts in ensuring access to care for CYSHCN, finding that a majority of states use general managed care contract provisions for all populations of beneficiaries and do not have requirements specific to CYSHCN.¹⁰ For example, network adequacy provisions and wait times for appointments typically applied to all enrollees, and there were not separate requirements for CYSHCN.¹¹

Federal Medicaid managed care regulations¹² released in April 2016 further emphasize the importance of access to care for all Medicaid populations, especially children and youth with special needs. Upon taking office, the Trump administration indicated that it will be reviewing the Medicaid managed care regulations, while states are moving forward with implementation to meet upcoming deadlines. By July 2018, state Medicaid managed care programs will be required to establish specific network adequacy standards (including time and distance standards) for certain provider types such as pediatric, specialty, and long-term service and support providers. As states work to meet the requirements of the new managed care rule, some states have already included specific standards and language in their contracts to ensure adequate access to and quality of care for CYSHCN (see Appendices A-D).

State Use of Managed Care to Serve CYSHCN

State Medicaid agencies have contracted with Managed Care Organizations (MCOs) in various forms over the past 40 years to deliver care to enrollees. In the 1970s, the federal government began regulating Medicaid managed care, and by the 1990s, some states began enrolling individuals with special health care needs into managed care.¹³ As a result of this history, there is longstanding recognition of the important role of the contracting process and contract management when partnering with managed care health plans. States use different strategies to manage contracts with Medicaid health plans, including collecting necessary data, changing administrative structure of Medicaid managed care divisions, and making changes to state procurement procedures.¹⁴ In recent years, many states have turned to value-based payment models as a strategy in their management of contracts with managed care plans to increase accountability and improve outcomes for enrollees.¹⁵ Value-based payment actions in states can range from incentivizing or penalizing performance on certain outcomes or process measures, creating risk-based or shared-savings models around certain quality or cost goals, or the implementation of bundled payments to treat certain conditions.¹⁶

The four states highlighted in this document have active and varied work in providing Medicaid services and supports to CYSHCN through managed care delivery systems. These states are also leading efforts in terms of planning and procurement for serving CYSHCN in Medicaid managed care. The states represent a variety of state models featuring different populations of CYSHCN enrolled, contracting models (procurement vs. regulatory), and types of managed care plans (standard vs. specialized for CYSHCN). Examples of each state's use of contract language specific to the care and services provided to CYSHCN can be found in Appendices A-D.

Texas has spent the past several years designing a specialty Medicaid managed care program, [STAR Kids](#), which exclusively serves children with complex health care needs.¹⁷ As of November 2016, Texas children who are enrolled in Supplemental Security Income (SSI) Medicaid or the Medically Dependent Children Program (MDCP) are enrolled in STAR Kids. The state contract with managed care plans for this program are specific to a population of children with special health care needs. It outlines specific requirements for providing care to children with complex needs, including detailed requirements for assessing needs and providing comprehensive care coordination to all enrollees.

Virginia currently enrolls CYSHCN and children receiving SSI Medicaid into [Medallion 3.0](#), its comprehensive Medicaid managed care program that serves the majority of its Medicaid enrollees. As of 2015, 70 percent of Virginia's Medicaid population was enrolled in managed care.¹⁸ While all Medicaid beneficiaries are served by the same managed care program, Virginia has taken steps to ensure that the specific needs of subpopulations, including CYSHCN, are addressed in its managed care contracts. Specific contract provisions include requirements for health plans to identify and assess children and youth with special health care needs, access to care and care coordination, and most notably, specific quality assurance and improvement provisions designed to measure the quality of care that CYSHCN receive in the Medallion 3.0 program. Virginia is in the process of transitioning some CYSHCN into a specialized managed care program, [Commonwealth Coordinated Care Plus](#).¹⁹ This specialized managed care program will serve children and adults with complex health care needs and include long-term services and supports.

Michigan's Medicaid managed care program's treatment of children with special health care needs is closely integrated with the state's Title V funded program for CYSHCN, [Children's Special Health Care Services \(CSHCS\)](#).²⁰ Individuals who are eligible for both CSHCS and Medicaid are mandatorily enrolled into a managed care program. Because of this mandatory enrollment, Michigan's managed care plans have specific language related to this CYSHCN population and required coordination between managed care plans and CSHCS. In the past several years, Michigan made the decision to move the CSHCS program from the state's public health agency to Medicaid, and it is now administered out of the same agency and division as the state's managed care program. This administrative change has allowed for even greater coordination between these programs and provided an opportunity for the CSHCS staff to be closely involved with the development of managed care contracts that impact CYSHCN.

Maryland mandatorily enrolls all CYSHCN into its Medicaid managed care program, [HealthChoice](#).²¹ HealthChoice is a comprehensive MCO that provides managed care services to 75 percent of Maryland's Medicaid population, including children and youth with special health care needs, foster care youth, individuals with physical and mental disabilities, and the homeless. HealthChoice provides a wide variety of services to these beneficiaries; however, certain services such as behavioral health and personal care services are delivered through a combination of a separate managed care program and fee-for-service. Under current law, Maryland does not use a procurement process to select managed care organizations to provide services to Medicaid beneficiaries, as is typical for many states. Instead, state regulations outline a defined set of standards and requirements for provision of services. A managed care organization that applies to participate in the Medicaid program and meets the standards is entitled to participate in the program.

State Strategies for Managing Contracts with Medicaid Managed Care Organizations

State monitoring and oversight of Medicaid managed care contract compliance is as important as specific contract language. State Medicaid managed care staff from the four states featured in this tool stressed the importance of contract management to ensure that contract provisions are fully carried out by managed care plans and with the intended results. The state staff from these four states shared the following strategies and lessons learned for contract management of managed care contracts for CYSHCN:

- **Monitor and support MCOs early on and throughout the process of transitioning CYSHCN into Medicaid managed care.** Texas is implementing its new managed care program for children with complex health care needs, STAR Kids, and is working to closely monitor health plan performance in the early months of the program and any challenges that plans are experiencing with meeting contract requirements.
- **Build in time to enable MCOs to increase capacity to serve CYSHCN and their families.** Texas incorporated specific and comprehensive care coordination requirements for CYSHCN in the STAR Kids program. Health plans have had to dramatically increase the number and capacity of care coordinators to meet these requirements.
- **Use a standard assessment tool designed for CYSHCN to evaluate services, needs, and establish a service plan.** To best serve the children in STAR Kids and their complex health care needs, the Texas Medicaid contract mandates that all health plans use a standard assessment tool that was designed for this population and contains questions the health plans need to evaluate services, needs, and establish a service plan. This tailored assessment tool is a contract management strategy that ensures all STAR Kids enrollees are being evaluated using the same information across all health plans.
- **Use quality incentive strategies to promote a focus on CYSHCN populations.** To encourage plans to focus on the care that CSYCHN populations receive within managed care, states can implement specific quality incentives and measures. When Virginia began serving children in foster care and adoption assistance through managed care in 2012, it created a pay-for-performance incentive program, which includes a measure on timeliness of health assessments performed for foster care youth enrolled in managed care.

- **Help managed care organizations set realistic and achievable goals.** Michigan makes a concerted effort to work with health plans to establish achievable goals for serving CYSHCN and their families. These goals include setting realistic timelines and expectations for contacting new enrollees for assessments and implementing strategies to meet these timelines, such as ensuring that the enrollee contact information provided to health plans is as current as possible.
- **Provide guidance and technical assistance to MCOs on relevant state processes.** Making sure that MCOs understand state policies and processes that impact the care provided to their enrollees can help them better coordinate care. The Michigan Medicaid program monitors work closely with contracted managed care plans to help them understand the prior authorization process for specialized services carved out of managed care. Medicaid Program Review staff work through actual cases to show managed care plans their prior authorization review processes. This strategy has helped to increase understanding and allows for plans to be more accurate in their referrals for specialized services for CYSHCN.
- **Get stakeholder input on managed care contract language.** Maryland was one of the first states to implement standards in its managed care program for CYSHCN. State Medicaid managed care contract monitors stressed the importance of using stakeholder input when developing standards for CYSHCN in managed care arrangements to ensure that the needs of CYSHCN are accurately represented and addressed in managed care standard language.
- **Use multiple tools to measure performance.** Maryland Medicaid relies on using multiple tools to measure plan performance for CYSHCN including: HEDIS measures, results of CAHPS Survey for special needs children, comments received via the state’s managed care hotline and the systems performance review process conducted by the state’s [External Quality Review Organization \(EQRO\)](#). An EQRO “provides analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care plan provides to Medicaid enrollees.”²²

As more states serve populations with special and complex health needs through managed care, there will be an increased interest in ensuring that these populations receive the care that they need. It is our hope that the tools in the Appendices provide interested states and stakeholders examples of how specific contract language provisions can be useful in providing high quality care that meets the needs of CYSHCN within a managed care environment.

The following tools provide examples of how four states (Texas, Virginia, Michigan, and Maryland) are incorporating specific provisions and requirements into their managed care contracts to better serve CYSHCN. The contract language is taken verbatim from Medicaid managed care contracts. For the purposes of this tool, we have organized the contract provisions by aligning them with several core domains from the [National Standards for Systems of Care for Children and Youth with Special Health Care Needs](#). These domains are: identification/assessment, access to care, medical homes/care coordination, and quality.

State Examples of Contract Language

All contract language listed is taken verbatim from indicated Medicaid contracts

Appendix A. Texas 5
[National Standard: Identification/Assessment](#)
[National Standard: Access to Care](#)
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Appendix B. Virginia 12
[National Standard: Identification/Assessment](#)
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Appendix C: Michigan 14
[National Standard: Access to Care](#)
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Appendix D. Maryland 18
[National Standard: Identification/Assessment](#)
[National Standard: Access to Care](#)
[National Standard: Medical Home/Care Coordination](#)
[National Standard: Quality Assurance and Improvement](#)

Appendix A. Texas

Source of sample contract language:

[STAR Kids Contract Terms - Texas Health and Human Services Commission – Version 1.3 – March 2017](#)

[STAR Kids Screening and Assessment Instrument](#)

National Standard: Identification/Assessment

“STAR Kids Screening and Assessment Process

The MCO must conduct an initial telephonic Member screening for all new Members. The telephonic screening must be used to help the MCO prioritize which Members require the most immediate attention. The MCO must also review claims data to prioritize Members who may need the most immediate assistance. For all Members who are new to the STAR Kids MCO on the Operational Start Date of the STAR Kids program, the STAR Kids MCO may take up to 15 Business Days for the initial telephonic Member screening unless notified by the Member, Legally Authorized Representative (LAR), or Member's PCP by phone or in writing of a more urgent need. Members who enroll in STAR Kids six months after the Operational Start Date or later must receive the initial telephonic Member screening within five business days from the day the Member is enrolled with the MCO.

The MCO must make at least three efforts to contact new Members telephonically. If an MCO is unable to reach a Member or a Member's LAR by telephone, the MCO must mail written correspondence to the Member and Member's LAR explaining the need to contact the MCO and requesting that the Member or Member's LAR contact the MCO as soon as possible.

In addition to the initial telephonic Member screening, all STAR Kids MCOs are responsible for conducting a comprehensive, holistic, and evidence-based service needs assessment for all Members. This process will be known as the “STAR Kids Screening and Assessment Process” and must help to inform or identify:

- 1. Service Coordination Level;*
- 2. Service preferences and goals for the Member and the Member's LAR;*
- 3. Natural strengths and supports such as Member abilities or helpful family members;*
- 4. Non-capitated services and community supports that the Member already receives or that would be beneficial to the Member;*
- 5. Members requiring immediate attention;*
- 6. Members who need LTSS;*
- 7. Members with behavioral health needs;*
- 8. Members who need physical, occupational, speech, or other specialized therapy services;*
- 9. Members who require Durable Medical Equipment and medical supplies;*
- 10. Members who currently receive and those who meet functional criteria to receive MDCP STAR Kids or Home and Community-Based Services (HCBS) Waiver services;*
- 11. Members who need Personal Care Services (PCS); and*
- 12. Members who need Nursing Services, including Home Health Skilled Nursing, Private Duty Nursing, and Nursing Services offered through a Prescribed Pediatric Extended Care Center.*

The MCO must attempt to schedule the STAR Kids SAI within 15 Business Days of a new Member's enrollment.”

National Standard: Access to Care

"The MCO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, 7 days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability.

- *The MCO must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the MCO's commercial lines of business or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.*
- *The MCO must provide coverage for Emergency Services to Members 24 hours a day and 7 days a week, without regard to prior authorization or the Emergency Service Provider's contractual relationship with the MCO.*
- *The MCO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area(s).*
- *If Medically Necessary Covered Services are not available through Network physicians or other Providers, the MCO must allow referral to an Out-of-Network physician or provider upon request of a Network Provider. The referral must occur within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed 5 business days after receipt of reasonably requested documentation.*
- *The MCO must provide access to PCPs and specialty care Providers with demonstrated experience serving children and adolescents with special healthcare needs, including behavioral health needs. Such Providers must be board-certified in their specialty.*
- *As described in RFP Section 8.1.38.2, the MCO is responsible for working with Members, their LAR, and their Providers to develop a seamless package of care in which primary care, community-based care, behavioral health, and specialty care needs are met through an Individual Service Plan (ISP) that is culturally competent and understandable to the Member.*

Wait times for appointments: Through its Provider Network composition and management, the MCO must ensure that the following standards are met. In all cases below, "day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

1. *Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;*
2. *Treatment for an Urgent Condition, including urgent specialty care, must be provided within 24 hours;*
3. *Routine primary care must be provided within 14 days;*
4. *Initial outpatient behavioral health visits must be provided within 14 days;*
5. *Initial outpatient behavioral health visits must be provided within seven days upon discharge from an inpatient psychiatric setting;*
6. *Community-Based Services for Members must be initiated within 7 days from the start date on the Individual Service Plan as outlined in Section 8.3.4.1 or the eligibility effective date for non-waiver LTSS unless the referring provider, Member or STAR Kids Handbook states otherwise;*
7. *Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;*
8. *PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than 30 days; and*
9. *Preventive health services for children, such as Texas Health Steps medical checkups, must be offered in accordance with the Texas Health Steps periodicity schedule. For a New Member birth through age 20, overdue or upcoming Texas Health Steps medical checkups, must be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members. The Texas Health Steps annual medical checkup for an existing member of the age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday."*

Network Adequacy

“The MCO’s Network must include all of the provider types described in this section in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the waiting times for appointments in RFP Section 8.1.3.1.

Time and Distance Standards

For each Provider type, the MCO must provide access to at least 90 percent of Members in each Service Area within the prescribed distance standard. This 90 percent benchmark does not apply to pharmacy providers (refer to the “Pharmacy Access” heading for applicable benchmarks). HHSC will consider requests for exceptions to the distance standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in HHSC’s exception request template.

- **PCP Access:** *At a minimum, the MCO must ensure that all adult Members have access to one age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member’s residence. Child Members must have access to two age-appropriate Network PCPs with an Open Panel within 30 miles of the Member’s residence. If the Member lives in a county with a minimum population of 800,000 individuals, the MCO must ensure the Member has access to at least one age-appropriate PCP in the Provider Network with an Open Panel within 20 miles of the Member’s residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice for STAR Kids Members.*
- **Outpatient Behavioral Health Service Provider Access:** *At a minimum, the MCO must ensure that all Members have access to an outpatient Behavioral Health Service Provider in the Network within 30 miles of the Member’s residence for Members in a county with more than 50,000 residents or within 75 miles of the Member’s residence for Members in a county with 50,000 or fewer residents. Outpatient Behavioral Health Service Providers must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; licensed professional counselors; licensed adolescent chemical dependency treatment facilities; licensed chemical dependency counselors (LCDCs) with experience treating children and adolescents; and entities employing Qualified Mental Health Professionals for Community Services (QMHPs-CS).*
- **Other Specialist Provider Access:** *At a minimum, the MCO must ensure that all Members have access to a Network specialist provider within 75 miles of the Member’s residence for common pediatric medical specialties for Members in a county with less than 800,000 residents, or within 30 miles for Members in a county with more than 800,000 residents. To the extent possible, Network specialty providers must be experienced with pediatrics. Common medical specialties must include general surgery, cardiology, orthopedics, urology, neurology, pulmonology, otolaryngology, and ophthalmology.*
- **Hospital Access:** *The MCO must ensure that all Members have access to an Acute Care Hospital with a staff or on-call pediatrician in the Provider Network within 30 miles of the Member’s residence. MCOs may request exceptions on a case-by-case basis. The MCO also must ensure that Members have access by transfer to an appropriate Network or Out-of-Network Hospital providing the needed level of care.*
- **Telemedicine:** *The MCO must contract with Providers with Telemedicine, Telehealth, and Telemonitoring capabilities to increase access to specialty and behavioral healthcare. The MCO must include information in its Provider Directory on Providers with Telemedicine, Telehealth, and Telemonitoring capabilities. Section 8.1.16, Behavioral Health (BH) Services and Network, provides additional information regarding Telemedicine, Telehealth, and Telemonitoring.”*

National Standard: Medical Homes

“The MCO must provide access to a Health Home to any Member the MCO determines would most benefit from a Health Home or for any Member who requests a Health Home. A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

Health Home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

- 1. Patient self-management education;*
- 2. Provider education;*
- 3. Patient-centered and family-centered care;*
- 4. Evidence-based models and minimum standards of care; and*
- 5. Patient and family support (including authorized representatives).*

Health Home Services may also include:

- 1. A mechanism to incentivize providers for provision of timely and quality care;*
- 2. Implementation of interventions that address the continuum of care;*
- 3. Mechanisms to modify or change interventions that are not proven effective;*
- 4. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;*
- 5. Comprehensive care coordination and health promotion;*
- 6. Palliative care options in the event of a life-limiting diagnosis;*
- 7. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;*
- 8. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;*
- 9. Referral to community and social support services, if relevant; and*
- 10. Use of health information technology to link services, as feasible and appropriate.”*

Care Coordination

“Service Coordination

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity.

Service coordination must be used to:

- 1. Provide a holistic evaluation of the Member's individual dynamics, needs, and preferences;*
- 2. Educate and help provide health-related information to the Member, the Member's LAR, and others in the Member's Support Network;*
- 3. Help identify the Member's physical, behavioral, functional, and psychosocial needs;*
- 4. Engage the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP);*
- 5. Connect the Member to Covered and non-covered services necessary to meet the Member's identified needs;*
- 6. Monitor to ensure the Member's access to covered services is timely and appropriate;*
- 7. Coordinate Covered and non-Covered Services; and*
- 8. Intervene on behalf of the Member, if approved by the Member.*

Through Service Coordination and other methods determined appropriate by the MCO, the MCO must implement a systematic process to coordinate non-capitated services and, if determined advantageous to the Member, enlist the involvement of community organizations providing non-covered services that are important to the health and wellbeing of Members.

The MCO also must also seek to establish relationships with state and local programs and community organizations, such as the following, to make referrals for Members who need community services:

- 1. Peer supports and Family Partners for Behavioral Health conditions;*
- 2. Community Resource Coordination Groups (CRCGs);*
- 3. Early Childhood Intervention (ECI) Program;*
- 4. Local school districts (Special Education);*
- 5. Health and Human Services Commission (HHSC) Medical Transportation Program (MTP);*
- 6. Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;*
- 7. Department of State Health (DSHS) services, including community mental health programs, the Title V Maternal and Child Health, Case Management for Children and Pregnant Women, Children with Special Health Care Needs (CSHCN) Programs, and Youth Empowerment Services (YES) HCBS Waiver;*
- 8. Supplemental Nutrition Assistance Program (SNAP), the Women, Infants, and Children's (WIC) Program, and Head Start;*
- 9. Department of Aging and Disability Services (DADS) HCBS Waivers, including Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCBS); and*
- 10. Civic and religious organizations and consumer and advocacy groups, such as Easter Seals.*

Individual Service Plan (ISP)

Each STAR Kids MCO must create and regularly update a comprehensive Person-centered ISP for each STAR Kids Member. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences. The ISP must be used to communicate and help align expectations between the Member, their LAR, the MCO, and key service providers. The ISP may also be used by the MCO and HHSC to measure Member outcomes over time.

All ISPs must account for the following information:

- 1. A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process;*
- 2. Covered Services currently received;*
- 3. Covered Services not currently received, but that the Member might benefit from;*
- 4. A description of non-covered services that could benefit the Member;*
- 5. Member and family goals and service preferences;*
- 6. Natural strengths and supports of the Member including helpful family members, community supports, or special capabilities of the Member;*
- 7. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key service providers, the Member's Health Home, the MCO, and the Member's school (if applicable);*
- 8. A plan for coordinating and integrating care between Providers and Covered and Non-Covered Services;*
- 9. Short and long-term goals for the Member's health and well-being;*
- 10. If applicable, services provided to the Member through YES, TxHmL, DBMD, HCS, CLASS, or third-party resources, and the sources or providers of those services;*
- 11. Plans specifically related to transitioning to adulthood for Members age 15 and older; and*
- 12. Any additional information to describe strategies to meet service objectives and Member goals.*

The ISP must be informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO. To the extent possible and applicable, the ISP must also account for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

Service Coordination Teams

Service Coordination Teams are Member-centered support networks designed to enhance services provided by the Service Coordinator. Service Coordination Team members must be individually selected based on the needs and preferences of the Member. The MCO will provide a Service Coordination Team when the MCO or a Provider determines the Member could benefit from a multidisciplinary approach to Service Coordination or determines specific expertise is necessary to address needs identified in the Member's Individual Service Plan (ISP).

Service Coordination Teams must be led by at least one Service Coordinator employed by the MCO, or appropriate Health Home employee if the Member receives Service Coordination through their Health Home. If a Member has a named Service Coordinator, the named Service Coordinator must lead the Service Coordination Team.

Service Coordination Teams must have access to individuals with expertise or access to identified subject matter experts in the following areas:

- 1. Behavioral health,*
- 2. Co-occurring behavioral health conditions and IDD,*
- 3. Medically complex conditions,*
- 4. Substance abuse,*
- 5. Local resources (e.g., basic needs like housing, food, utility assistance)—MCOs are encouraged to use certified Community Health Workers to support individuals in local*

areas,

6. Pediatrics,
7. Long Term Services and Supports (LTSS), including HCBS Waiver programs,
8. Durable Medical Equipment (DME),
9. End of life/advanced illness,
10. Curative treatment or palliative care,
11. Acute care,
12. Preventive care,
13. Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS),
14. Pharmacology,
15. Nutrition,
16. Consumer Directed Services,
17. Texas Promoting Independence strategies such as diversion and relocation,
18. Person-Centered Planning,
19. Family Partners,
20. Peer Supports,
21. Positive behavior support,
22. Assistive Technology including augmentative communication and seating and positioning,
23. Supported employment,
24. Permanency planning, and
25. School transition”

Appendix B. Virginia

Source of sample contract language:

[Medallion 3.0 Managed Care Contract – July 1, 2016](#)

National Standard: Identification/Assessment

Identification

The Contractor must develop and maintain a system of assessment procedures for identifying members with special health care needs (children and adults), including people with disabilities, or chronic or complex medical and behavioral health conditions, and Children and Youth with Special Health Care Needs.

Assessment

The Contractor must take all reasonable steps to assure that the following newly eligible/enrolled populations receive an assessment: Children and Youth with Special Health Care Needs (CYSHCN), including Early Intervention, Health and Acute Care Program children, and Adoption Assistance children.

The Contractor shall take steps to assure that newly eligible/enrolled members requiring assessment as defined in 7.7.A, are assessed within sixty (60) calendar days of initial enrollment. A monthly report of new members, noting who received a successful assessment must be submitted to the Department as specified in the Managed Care Technical Manual. A successful assessment is considered a contact with the member, by the health plan, which results in a fully completed health assessment that meets the requirements of this Section. A fully completed assessment must assess health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs and have all applicable questions completely answered.”

National Standard: Access to Care

Specialists as PCPs

Members enrolled under the HAP program criteria, with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children for whom the PCP is a specialist receive EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor’s credentialing policies and procedures.

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. “Hand to hand” service includes transporting the member from a person at the pickup 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.””

National Standard: Care Coordination

“Case Management

The Contractor is responsible for establishing policy and procedures, which facilitate provider contact with medical management staff to explore alternative resources and services for members with special health care needs. Case managers serving children and youth 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.”

National Standard: Quality Assurance and Improvement

“The Contractor shall assess the quality of care of CYSHCN in the following areas:

- 1. **Program Development** – Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.*
- 2. **Enrollment Procedures** – Identify and collect data on children and youth 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.*
- 3. **Provider Networks** – Assure the availability of providers who are experienced in serving children and youth with special needs and provide a “medical home” that is accessible, comprehensive, coordinated, and compassionate.*
- 4. **Care Coordination** – Provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.*
- 5. **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.*
- 6. **Assurance of Expertise for Child Abuse and Neglect and Domestic Violence** - The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse and neglect and domestic violence. The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community. The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.”*

Appendix C. Michigan

Source of sample contract language:

[Michigan Medicaid Sample Health Plan Contract, 2016](#)

National Standard: Access to Care

“Network Requirements

1. Contractor must maintain a network of qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service area, including counties contiguous to Contractor’s service area, for the provision of all covered services.
2. Contractor’s provider network must be sufficient to serve the maximum number of Enrollees specified under this Contract including CSHCS Enrollees and persons with special health care needs and submit documentation to MDHHS to that effect.
3. Contractor must ensure contracted PCPs have a system to provide or arrange for coverage of services 24 hours per day, 7 days per week when medically necessary.
4. Contractor must consider anticipated enrollment and expected utilization of services with respect to the specific Medicaid populations (e.g., disabled, CSHCS, duals).
5. Contractor must ensure Enrollees have an ongoing source of primary care appropriate to the Enrollees needs and covered services are administered or arranged for by a formally designated PCP.
6. Contractor must ensure contracted providers offer an appropriate range of preventive care, primary care, and specialty services to meet the needs of all Enrollees including CSHCS Enrollees and persons with special health care needs and submit documentation to MDHHS to that effect.
7. Contractor must maintain a PCP-to-Enrollee ratio of at least one full-time (minimum of 20 hours per week per practice location) PCP per 750 members, except when this standard cannot be met because a geographic area (rural county) does not have sufficient PCPs to meet this standard; MDHHS has the sole authority to determine whether an exception will be granted.
8. Contractor must provide access to specialists, including specialists in contiguous counties to the Contractor’s service area, if those specialists are more accessible or appropriate for the Enrollee.
9. Contractor must maintain a network of pediatric subspecialists, children’s hospitals, pediatric regional centers, and ancillary providers to provide care for CSHCS Enrollees.
10. Contractor must consider the geographic location of providers and Enrollees, including distance, travel time and available means of transportation and whether the provider location provides access for Enrollees with physical or developmental disabilities.
11. Contractor must ensure PCP services, and hospital services are available within 30 miles or 30 minutes travel time from the Enrollee’s home unless MDHHS grants an exception.

PCP Selection and Requirements

Contractor must provide all Enrollees the opportunity to select their PCP at the time of enrollment.

Contractor must allow CSHCS Enrollees to remain with their established PCP at the time of enrollment with the Contractor not limited to in network providers; upon consultation with the family and care team, CSHCS enrollees may be transitioned to an in-network PCP. CSHCS Enrollees who do not choose a PCP must be assigned a CSHCS-attested PCP.

CSHCS PCP Requirements:

1. Contractors must assign CSHCS Enrollees to CSHCS-attested PCP practices that provide family-centered care.
2. Contractors must obtain a written attestation from PCPs willing to serve CSHCS Enrollees that specifies the PCP/practice meets the following qualifications:
 - a. Is willing to accept new CSHCS Enrollees with potentially complex health conditions.
 - b. Regularly serves children or youth with complex chronic health conditions.
 - c. Has a mechanism to identify children/youth with chronic health conditions.
 - d. Provides expanded appointments when children have complex needs and require more time.
 - e. Has experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
 - f. Has a designated professional responsible for care coordination for children who see multiple professionals.
 - g. Provides services appropriate for youth transitioning into adulthood.
3. Contractors must maintain a roster of providers who meet the criteria listed above and able to serve CSHCS Enrollees.
4. Contractor must take the availability of handicap accessible public transportation into consideration when making PCP assignments.
5. Contractor must allow a CSHCS Enrollee to choose a non-network PCP if:
 - a. The CSHCS Enrollee has an established relationship with the PCP at the time of enrollment with the Contractor.
 - b. Upon consultation with the family, the selected PCP is the most appropriate for the CSHCS Enrollee.”

Care Coordination

“Care Management Requirements

For CSHCS Enrollees:

1. Contractor must assess the need for a care manager and a family-centered care plan developed in conjunction with the family and care team
2. Contractors must collaborate with the family and established primary and specialty care providers to assure access to the most appropriate provider for the Enrollee.
3. Contractor must have separate, specific PA procedures for CSHCS Enrollees.
 - a. 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.
 - b. Upon expiration of the prior authorization, the Contractor may utilize the Contractor’s prior authorization procedures and network ancillary services.
4. 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.

For Persons with Special Health Care Needs:

Contractor is required to do the following for members identified by MDHHS as persons with special health care needs:

1. Conduct an assessment in order to identify any special conditions that require ongoing case management services for the Enrollee.
2. Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.
3. For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the Enrollee

Local Health Departments and CSHCS Coordination

Contractor must enter into an agreement with all Local Health Departments (LHDs) to coordinate care for CSHCS Enrollees in Contractor's service area; the agreement must address the following topics:

- a. Data sharing
- b. Communication on development of Care Coordination Plans
- c. Reporting requirements
- d. Quality assurance coordination
- e. Grievance and appeal resolution
- f. Dispute resolution and
- g. Care planning for Enrollees transitioning into adulthood

Contractor must utilize an electronic data system by which providers and other entities can send and receive client-level information for the purpose of care management and coordination (VIII-C).

Contractor must assess the need for a care manager and family-centered care plan, and if established, updated annually.

Contractor may share Enrollee information with Local Health Departments to facilitate coordination of care without specific agreements.”

Quality Assurance and Improvement

“Data Analysis to Support Population Health Management

Contractor must utilize information such as claims data, pharmacy data, and laboratory results, supplemented by UM data, health risk assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:

1. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.
2. Persons with high prevalence Chronic Conditions, such as diabetes, obesity and cardiovascular disease.
3. Enrollees in need of Complex Care Management, including high risk Enrollees with dual behavioral health and medical health diagnoses who are high utilizers of services.
4. Women with a high-risk pregnancy.
5. Children eligible for the Children's Special Health Care Services (CSHCS) program.
6. People with Special Health Care Needs (PSHCN).
7. Other populations with unique needs as identified by MDHHS such as foster children or homeless members

Grievance and Appeal Process for Enrollees

Contractor's internal grievance and appeal procedure must include the following components:

1. Allow Enrollees 90 days from the date of the adverse action notice within which to file an appeal under the Contractor's internal grievance and appeal procedure.
2. Give Enrollees assistance in completing forms and taking other procedural steps. Contractor must provide interpreter services and TTY/TDD toll-free numbers.
3. Acknowledge receipt of each grievance and appeal
4. Ensure that the individuals who make decisions on grievances and appeals are individuals who are not:
 - a. involved in any previous level of review or decision-making, and
 - b. health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease when the grievance or appeal involves a clinical issue.

In reviewing appeals for CSHCS Enrollees, the Contractor should utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate or limit pediatric subspecialist provider services."

Appendix D. Maryland

Source of sample contract language: [Maryland State Code 10.09.62](#)

National Standard: Identification and Assessment

Definition of CYSHCN

"Child with a special health care need" means an individual younger than 21 years old, regardless of marital status, suffering from a moderate to severe chronic health condition:

- a. With significant potential or actual impact on health and ability to function;*
- b. Which requires special health care services; and*
- c. Which is expected to last longer than 6 months."*

Assessment

- 1. The Department or its agent shall attempt to complete the health service needs information at the time of enrollment.*
- 2. The Department shall transmit any information obtained from health service needs information to the recipient's MCO within 5 business days.*
- 3. Upon its receipt and review of the health service needs information, an MCO shall take appropriate action to ensure that a new enrollee, who needs special or immediate health care services, as identified by the health service needs information, receives them in a timely manner."*

National Standard: Access to Care

Providers

- 1. An MCO shall demonstrate that its pediatric and adult primary care providers (PCPs) and specialists are clinically qualified based upon generally accepted community standards to provide or arrange for the provision of appropriate health care services to individuals who are members of a special needs population. The MCO shall submit to the Department referral protocols that demonstrate the conditions under which PCPs will make the arrangements for referrals to specialty care networks.*
- 2. Clinical qualifications are to be determined through the MCO's credentialing and recredentialing processes, including a review of the provider's medical education, special training, and work history and experience.*
- 3. Specialty and subspecialty providers shall:*
 - a. Have experience in treating individuals within a special needs population;*
 - b. Have experience in interdisciplinary medical management; and*
 - c. Understand the relationship between somatic and behavioral health care issues and interventions."*

Network Adequacy

"An MCO shall demonstrate that its therapies provider network is adequate by demonstrating its:

1. Providers' pediatric specialties;
2. Collaboration with schools that provide IEP or IFSP services to its enrollees, where available; and
3. Provision of family-focused services and development of family-focused plans of care.”

“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, subject to the following provisions:

1. If the MCO denies the request for an out-of-network provider referral, the child's parent or guardian may initiate the complaint and appeal process set forth at COMAR 10.09.72;
2. If at any time the MCO decides to terminate or reduce services provided by the approved out-of-network provider, the child's parent or guardian may initiate the complaint and appeal process set forth at COMAR 10.09.72;
3. The MCO shall continue to cover the services of the out-of-network provider during the course of the appeal until such time as the Office of Administrative Hearings issues its decision.”

National Standard: Medical Home/Care Coordination

“The MCO shall demonstrate the use of a primary care system of care delivery which includes a comprehensive plan of care for an enrollee who is a member of a special needs population and which uses a coordinated and continuous case management approach, involving the enrollee and, as appropriate, the enrollee's family, guardian, or caregiver, in all aspects of care, including primary, acute, tertiary, and home care.

To meet the commitment outlined in §C(4) of this regulation, an MCO shall:

- a. Provide case management services to adult and pediatric enrollees as appropriate;
- b. Have the capacity to perform home visits as part of the ongoing case management program and have the ability to respond to urgent care needs while in the enrollee's home;
- c. Ensure that, if warranted, a case manager is assigned to an enrollee at the time of the initial health screen by the MCO;
- d. Ensure that the PCP, who may also be the specialist, shall be the admitting or referring provider for all hospital admissions;
- e. Ensure that it will:
 - i. Collaborate with inpatient facilities in facilitating preadmission and discharge planning, and
 - ii. Communicate all post-discharge home and community arrangements to the enrollee, the PCP, and, as appropriate, the enrollee's family, guardian, and caregiver;
- f. Document the plan of care and treatment modalities provided to enrollees in special populations, assuring that the plan of care:
 - i. Is updated annually, and
 - ii. Involves the enrollee and, as appropriate, the enrollee's family, guardian, and caregiver in care decisions; and
- g. Be familiar with community-based resources available for the special populations.”

“An MCO shall establish protocols for effecting medically necessary service referrals to specialty care providers for children with special health care needs.

The service referrals referenced in this regulation shall:

1. *Include services intended to improve or preserve the continuing health and quality of life for children with special health care needs, regardless of the ability of the services to effect permanent cure; and*
2. *Be made when the child is:*
 - a. *Identified as being at risk of a developmental delay by the developmental screen required by EPSDT;*
 - b. *Experiencing a delay of 25 percent or more in any developmental area as measured by appropriate diagnostic instruments and procedures;*
 - c. *Manifesting atypical development or behavior; or*
 - d. *Diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.”*

National Standard: Quality Assurance and Improvement

“The Department shall maintain a record of the complaints received through the Department’s enrollee and provider hotlines which involve the denial of care for children and review these complaint logs as part of its quality assurance system.”

“An MCO shall establish a consumer advisory board to facilitate the receipt of input from enrollees.

The consumer advisory board membership shall:

1. *Consist of enrollees and enrollees’ family members, guardians, or caregivers; and*
2. *Be comprised of no less than one third representation from the MCO’s special needs populations, or their representatives and the MCO’s special needs coordinator.*
3. *The consumer advisory board shall meet at least 6 times a year.*
4. *Pursuant to Regulation .15E(2) of this chapter, the consumer advisory board shall annually report its activities and recommendations to the Secretary.”*

ENDNOTES

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- ¹¹ *Ibid.*
- ¹² 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 (81 FR 27497). <https://www.federalregister.gov/documents/2017/01/03/2016-31650/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>
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About AMCHP: The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.



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