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IDENTIFICATION AND ASSESSMENT OF  
CHILDREN AND YOUTH WITH SPECIAL HEALTH  
CARE NEEDS IN MEDICAID MANAGED CARE:  
APPROACHES FROM THREE STATES

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— **FEBRUARY 2014** —

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## IDENTIFICATION AND ASSESSMENT OF CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS IN MEDICAID MANAGED CARE: APPROACHES FROM THREE STATES

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## EXECUTIVE SUMMARY

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Children and youth with special health care needs (CYSHCN) have been historically exempted from Medicaid managed care because of concerns about access to care and appropriate providers for this high-need population. With greater state experience with Medicaid managed care, including advancements in improving access and quality of care for CYSHCN, along with state budgetary pressures, more states have started enrolling CYSHCN into Medicaid managed care. In 2009 – 2010, about 3.8 million CYSHCN had public health insurance coverage.<sup>1</sup> In 2010, thirty-two states reported mandatory enrollment of at least some CYSHCN into Medicaid managed care (in at least one program and/or geographic area) and twenty reported enrolling CYSHCN into managed care on a voluntary basis.<sup>2,3</sup>

States administer their Medicaid managed care programs within general federal rules.<sup>4</sup> Federal Medicaid managed care regulations require states to implement mechanisms to identify *individuals* with special health care needs to managed care entities, including managed care organizations (MCO). MCOs must implement mechanisms to assess enrollees with special health care needs to identify any ongoing conditions that require treatment or monitoring.<sup>5,6</sup> Relatively little has been known about state approaches for identifying and assessing CYSHCN.

This report, prepared with support from the Lucile Packard Foundation for Children’s Health, describes the approaches taken in three states—California, Michigan, and Massachusetts—to identify and assess CYSHCN in Medicaid managed care. The states’ approaches to identifying and assessing CYSHCN were similar in that they relied heavily on health plans for these functions and that contracts articulated health plans’ responsibilities while providing some flexibility to the plans. There was general agreement among informants in the states that the processes for identifying and assessing CYSHCN worked adequately, but that families may experience challenges in accessing care in a managed care delivery system. There was some variation among states in whether contracts identified CYSHCN as a specific subpopulation of the Medicaid population or tailored requirements for identification and assessment, and also some variation in monitoring approaches.

Although this study was limited to three states and was focused on identification and assessment of CYSHCN, it surfaced some promising state practices that could help enable strong identification and assessment processes, as well as facilitate the implementation of Medicaid managed care in ways that address the special needs of this population. The promising practices include:

- **Incorporating provisions that specifically address CYSHCN and their needs into health plan contracts.** California’s and Michigan’s contracts include provisions that explicitly delineate health plan requirements with respect to CYSHCN. Identifying CYSHCN as a specific subpopulation in managed care plan contracts and articulating specific health plan contract requirements for their care could help to assure health plan focus on meeting the needs of this population.
- **Tailoring state monitoring activities to address CYSHCN as a specific subpopulation.** Michigan is taking some steps to monitor care for Children’s Special Health Care Services (CSHCS)/Title V enrollees as a specific subpopulation of Medicaid enrollees. The state’s grievance and appeals process requires health plans to use appropriate pediatric providers to review grievances and appeals and that grievances and appeals filed by CSHCS enrollees and their families be tracked separately from those filed by others.
- **Partnering with stakeholders in the implementation of Medicaid managed care for CYSHCN.** State Medicaid agencies have a clear oversight relationship with Medicaid managed care plans,

but some states also have worked with health plans as partners in developing and implementing components of their managed care programs. Massachusetts requires plans to use a specific core set of questions as part of enrollee assessments, including for CYSHCN. The state developed these questions together with Medicaid health plans. Michigan, as part of its preparation for the transition of Title V program enrollees to Medicaid managed care, worked with health plans to review and make needed changes to contracts to ensure contracts explicitly addressed the care needs of this population. Michigan also obtained input from families of CYSHCN by holding focus groups prior to the transition to Medicaid managed care to identify issues and areas of concern, and to recommend steps that would help smooth the transition for CYSHCN and their families.

As states move more CYSHCN into Medicaid managed care, it is important to have policies and practices in place to assure attention to their needs, as well as compliance with federal requirements. The three states studied each had some promising practices in place that other states may want to examine as they seek to assure good care for this vulnerable population.

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## INTRODUCTION

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States use managed care delivery systems in Medicaid, to both achieve cost savings and improve enrollees' care. Increasingly, states have begun mandating enrollment for Medicaid covered individuals who were previously exempt or excluded from managed care, such as children and youth with special health care needs (CYSHCN). In 2009 – 2010, about 3.8 million CYSHCN had public health insurance coverage.<sup>7</sup> In 2010, thirty-two states reported mandatorily enrolling at least some CYSHCN into Medicaid managed care (in at least one program and/or geographic area) and twenty reported enrolling CYSHCN into managed care on a voluntary basis.<sup>8,9</sup> In the 1990's, the enrollment of CYSHCN in Medicaid managed care was uncommon. Medicaid enrollees in managed care were more likely to be pregnant women or other enrollees without disabilities. However, during this time, there was much interest by researchers and states in gaining a greater understanding of how states and health plans would identify CYSHCN and how the plans would ensure the population's care needs would be met.<sup>10</sup>

The federal Medicaid managed care regulations provide the general framework and rules for state Medicaid programs and the health plans operating in those programs. The regulations do not explicitly mention CYSHCN, describing instead requirements related to the identification and assessment of the broader population of *individuals* with special health care needs in Medicaid managed care. Specifically, the regulations require states to implement mechanisms to identify individuals with special health care needs to managed care entities, including managed care organizations (MCO). They also require that MCOs implement mechanisms to assess enrollees with special health care needs to identify any ongoing conditions that require treatment or monitoring.<sup>11, 12</sup> While it has been and remains generally understood that state MCO contracts address these regulatory requirements, relatively little has been documented recently about specific state policies or how those policies are operationalized.

Given the continued and likely increased reliance on Medicaid managed care for CYSHCN, it is important to understand how states and Medicaid health plans can effectively identify and assess the care needs of this population to ensure their needs are being met. To contribute to understanding states' approaches for identifying and assessing CYSHCN in Medicaid managed care, the National Academy for State Health Policy (NASHP), with the support of the Lucile Packard Foundation for Children's Health, conducted an exploratory study of the approaches in three states: California, Massachusetts and Michigan. This report summarizes how these states identify and assess CYSHCN in Medicaid managed care. It also highlights some promising practices for implementing Medicaid managed care that were identified by this work. Other states could consider these practices when implementing or expanding Medicaid managed care programs for CSYHCN.

### METHODOLOGY

NASHP utilized a multi-pronged approach of research and information gathering, beginning with a review of literature and reports, and interviews with national experts in the fields of CYSHCN and Medicaid managed care. These early steps helped surface key issues related to the identification and assessment of CYSHCN in Medicaid managed care, and identify states with experience that could be informative to others. NASHP was also interested in the experiences of states that recently transitioned CYSHCN into enrollment in Medicaid managed care, as well as states with a longer history of doing so. With input from national experts, NASHP identified states and conducted telephone interviews with senior-level state officials from Medicaid managed care and state Title V CYSHCN programs, as well as with representatives of organizations that assist families of CYSHCN in each state. State Medicaid managed care staff provided

NASHP with referrals for one managed care health plan in each state. NASHP then conducted interviews with and/or received written responses to an interview protocol from these entities, which included: L.A. Care Health Plan in California, Neighborhood Health Plan in Massachusetts and UnitedHealthcare Community Plan in Michigan. A complete list of interviewees is provided in Appendix A, and a list of acronyms used in this report is in Appendix B.

NASHP also reviewed documents, which included: state Medicaid managed care contracts in each state; federal Medicaid managed care regulations; where available, state Medicaid quality improvement strategy documents; and other materials from states (e.g., policy guidance sent to counties) pertinent to CYSHCN and Medicaid or Title V programs.



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## IDENTIFYING, ASSESSING, AND MEETING THE NEEDS OF CYSHCN IN MEDICAID MANAGED CARE IN THREE STATES

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**A**cross the states studied, the identification and assessment of CYSHCN occurs, with some exceptions, in similar ways, with Medicaid health plans playing a key role. Health plan responsibilities are delineated in their contracts with the states, but states have taken somewhat different approaches to laying out some of the requirements. The state profiles that follow provide an overview of their requirements for identifying and assessing CYSHCN and the approaches they have taken to monitor CYSHCN experiences in Medicaid managed care. This report also identifies some promising practices from the three states that may be useful for other states serving CYSHCN in Medicaid managed care.

### **CALIFORNIA**

The California Department of Health Care Services (DHCS) oversees the state's Medicaid program, or "Medi-Cal," as well as the state's Title V program for CYSHCN, known as California Children's Services (CCS). DHCS administers CCS in partnership with county health departments. To be eligible for CCS, a child's health condition must meet the qualifying definition of an eligible health condition, which is defined in state regulations.<sup>13</sup> Additionally, these children must be in families with total income of less than \$40,000 per year, or where out-of-pocket medical expenses exceed 20 percent of the family's adjusted gross income.<sup>14</sup> CYSHCN in California who are dually eligible for Medi-Cal and CCS receive specialty care services through CCS on a fee-for-service basis and primary and preventive care services through a Medi-Cal managed care health plan. For these children, enrollment in Medi-Cal managed care for the receipt of primary care services has been mandatory since May 2012, but services related to their CCS qualifying condition remain carved out of managed care. In 2010, the state received approval of its "Bridge to Reform" Section 1115 Medicaid demonstration waiver. This waiver created CCS county level pilots, providing health plans an opportunity to carve-in specialty services provided to children receiving CCS. Thus far, implementation of the CCS pilot has occurred in one county.<sup>15</sup>

### **Requirements for Identification and Assessment**

California operates three Medi-Cal managed care models. The Two-Plan model, in which beneficiaries select between a local initiative health plan or a commercial health plan; the Geographic Managed Care model (GMC), in which beneficiaries choose one plan among several available commercial plans; and the County Organized Health System (COHS) model, in which all beneficiaries must enroll in a single non-profit plan, created by the County Board of Supervisors.<sup>16</sup> Different counties have implemented different models of managed care.<sup>17</sup>

The contracts for health plans in each of these models distinguish between a general population of children and youth with special health care needs (CYSHCN) and the specific population of children who are eligible to participate in the CCS program, describing separate albeit similar requirements for the two populations.<sup>18</sup> With respect to CYSHCN generally, contractors under the Two-Plan model of Medi-Cal managed care are to implement and maintain "a program for CYSHCN" that must include standardized procedures for identifying CYSHCN upon enrollment and periodically thereafter.<sup>19</sup> Although the Two-Plan Model boilerplate contract reviewed for this analysis does not explicitly address provider training for the identification of CYSHCN, when asked about training requirements, Medi-Cal officials stated provider training is required of Two-Plan Model health plans.<sup>20</sup> Contractors under the GMC and COHS models must, in addition to having standardized procedures, train providers on the identification of CYSHCN.

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Health plans in each of California’s three managed care models have an affirmative obligation to identify and refer CCS-eligible children to the local CCS program, and must have written policies and procedures for doing so.<sup>21</sup> Depending on the county, either the county CCS programs or the state’s Children’s Medical Services Branch within DHCS determine program eligibility.<sup>22</sup> These requirements are articulated in a section of the state managed care health plan contract specifically pertaining to CCS-eligible children.<sup>23</sup> The state also takes steps to identify CCS children. For example, to help ensure that health plans are aware of which of their members are enrolled in CCS, the state Medicaid program sends the health plans monthly eligibility files that identify those children.<sup>24</sup> The state has also in the past placed some CCS staff within children’s hospitals to help with identifying children who are CCS-eligible.

Health plans providing services to Medi-Cal managed care enrollees in each of the three models of managed care in California are to ensure that both CYSHCN and children who may be CCS-eligible receive an assessment of their care needs. The assessment requirements for CYSHCN generally are the same across the managed care models—contractors are required to have methods for ensuring that the population receives a comprehensive assessment of health and related needs.<sup>25</sup> For children who may be CCS-eligible, Two-Plan model, GMC, and COHS contractors must ensure that providers conduct baseline health assessments that provide sufficient information to establish that a member may be eligible for CCS.<sup>26</sup> According to a senior health plan representative, the provider assessments are not standardized.

Health plans and contractors in each of the three models of Medi-Cal managed care are required to conduct an Initial Health Assessment (IHA)—including a physical exam and a health education behavioral assessment—of all enrollees to assess current acute, chronic, and preventive services needs, as well as to identify enrollees with health care needs that require coordination with other community resources and agencies.<sup>27</sup> Conducting the IHA for individuals under age 21 is a component of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).<sup>28</sup> Two-Plan model and GMC health plans are subject to the same time frames for conducting the IHAs. For enrollees up to 18 months old, health plans must provide the IHA within 60 calendar days of enrollment or within the periodicity schedule recommended by the American Academy of Pediatrics (AAP) for children younger than 2 years. For enrollees older than 18 months at the time of enrollment, health plans are to conduct the IHA within 120 calendar days of enrollment.<sup>29</sup> COHS contractors are also required to ensure the provision of the IHA, but are required to do so within 120 days of enrollment for each new member.<sup>30</sup>

### **Monitoring**

Health plan “programs” for CYSHCN must include methods for monitoring access to appropriate pediatric providers, such as specialists, and for monitoring quality of care provided to CYSHCN. Health plans are contractually required to submit a full provider network report on an annual basis and a quarterly report that describes network changes.<sup>31</sup> The Department of Health Care Services’ (DHCS) Audit and Investigation Division monitors health plan networks as well as access and availability of covered services through medical performance audits.<sup>32</sup> DHCS conducts quarterly reviews of health plans’ call center and grievance and appeal reports, and the state continually monitors calls to the DHCS Office of the Ombudsman and State Fair Hearing requests.<sup>33</sup>

Other Medi-Cal managed care monitoring requirements that focus on quality and access to care are described in both the managed care contracts as well as the state’s Quality Strategy Report. The Report describes the state’s overall Medi-Cal managed care quality strategy, which states are required by the Centers for Medicare and Medicaid Services to develop and implement.<sup>34</sup> Monitoring activities specifically pertaining to health plans’ identification and assessment of CYSHCN or CCS-eligible children are not explicitly articulated.

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Health plans must collect and report HEDIS measures and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The survey is administered to evaluate enrollee (both adult and children) satisfaction with the care they received. Health plans must also participate in other quality measurement and improvement activities.<sup>35</sup> California’s Quality Strategy does not speak to the use of the CAHPS Children with Chronic Conditions Supplemental Items, which states may use to assess care provided to Medicaid-enrolled children with chronic conditions.<sup>36</sup> The state also reviews data from plans’ HEDIS compliance audits, which are conducted annually by an external quality review organization.<sup>37</sup> In California, health plan accreditation is not required.

### **Family Experience**

Representatives from Family Voices of California (FVCA), a statewide collaborative of locally-based parent-run centers working to ensure quality health care for CYSHCN, noted families’ experience with Medi-Cal managed care can be difficult to generalize because of the variation in delivery systems and available health plans. They noted in general, families do not raise identification and assessment of CYSHCN as a concern. Families are more likely to identify other challenges that could impede access to services, such as families’ lack of understanding of managed care, language and cultural barriers to services, and occasional delays in getting referrals to care. FVCA works to reduce barriers to care and helps families navigate available systems of care to ensure that their children are getting the health care services they need. FVCA conducts trainings for families on their health plans and how to use them and developed the publication “Health Care Connections,” which provides families tools for navigating Medi-Cal managed care.<sup>38</sup>

### **MICHIGAN**

The Michigan Department of Community Health (MDCH) oversees the state’s Medicaid and Title V program. MDCH also oversees the state’s specialty program for children with special health care needs, Children’s Special Health Care Services (CSHCS), which is part of Title V. Children under age 21 with a qualifying medical condition are eligible for CSHCS, which covers approximately 2,600 medical diagnoses that require care by a medical or surgical specialist, and are handicapping in nature.<sup>39</sup> Because eligibility for CSHCS is based on specific diagnoses, the program does not serve children with special health care needs who do not have a CSHCS qualifying diagnosis. A MDCH medical consultant reviews each case to determine CSHCS eligibility. If a Medicaid enrolled child is determined eligible for CSHCS on the basis of a medical report submitted to CSHCS, the child is enrolled in the program without having to complete a separate CSHCS application, easing the enrollment process.<sup>40</sup> There is no upper income eligibility limit for CSHCS, but enrollees must pay an income-based fee to participate in the program. For CSHCS enrollees who also are enrolled in Medicaid, the CSHCS fee is waived, as are managed care copayments.<sup>41</sup> Those dually enrolled in CSHCS and Medicaid but who lose Medicaid coverage, can continue to receive specialty care through CSHCS.

Prior to October 1, 2012, children enrolled in both CSHCS and Medicaid were excluded from enrollment in a Medicaid Health Plan (MHP). Effective October 1, 2012, the state began mandatory enrollment of these dually eligible individuals into MHPs. To accommodate the transition of this population from fee-for-service to managed care, the state added contract provisions developed with input from MHPs specifically to address the needs of CSHCS enrollees. These included requirements to provide continuity of care with the primary care provider (PCP) and specialists with whom they have an established relationship at the time of enrollment in the MHP; and honoring prior authorizations in place at the time of enrollment (including but not limited to durable medical equipment, medical supplies and therapies).<sup>42</sup>

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CSHCS enrollees in MHPs can also receive assistance from local health departments with accessing and coordinating community-based resources. Local health departments can assist enrollees in navigating community resources through schools, mental health providers, and other public health programs. Local health departments also assist families with accessing respite services. MHPs and local health departments have all executed care coordination agreements to assure service coordination and continuity of care.<sup>43</sup>

### **Requirements for Identification and Assessment**

The Medicaid managed care contracts for MHPs address CSHCS enrollees as a specific subpopulation enrolled in MHPs and include provisions designed to meet the needs of the population. The contract requires that MHPs “maintain a roster of primary care providers that may appropriately serve CSHCS enrollees.” The contract recommends that MHPs consider several criteria in this determination:

- The PCP should regularly serve children/youth with complex chronic health conditions;
- The PCP practice should have a mechanism to identify children/youth with chronic health conditions;
- The PCP should have experience coordinating care for children/youth who see multiple professionals;
- The PCP should indicate a willingness to accept new patients with chronic health conditions; and
- The PCP should, whenever possible, be appropriate for children/youth transitioning to adulthood.

PCPs that are qualified and willing to serve CSHCS enrollees must attest to MHPs that they meet the qualifications stated in the preceding list.<sup>44</sup> When MHPs identify a child as potentially eligible for the CSHCS program, they refer the child to MDCH for a determination of eligibility.<sup>45</sup> MHPs must provide a completed Medical Eligibility Referral Form within 30 days of admission or the MHP’s receipt of notification of an eligible condition; if information is unavailable within the 30-day timeframe, the form must be completed within 10 days once it becomes available.<sup>46</sup>

The Michigan MHP contracts are less explicit with respect to health plan responsibilities for assessing the care needs of CYSHCN who are not enrolled in CSHCS. MHPs are required to conduct an assessment of CYSHCN enrollees to determine whether they require case management services. The contract does not specify the use of a specific screening tool or timeframes for completing the screening.<sup>47</sup> The state also requires that MHPs be accredited. Most MHPs are accredited by the National Committee for Quality Assurance (NCQA), which considers MHP assessment processes as part of the accreditation review.<sup>48,49</sup> The NCQA health plan accreditation process includes an assessment of health plan complex care management processes and whether they include the initial assessment and ongoing management of members, including children and adolescents.<sup>50</sup>

In addition to the contract provisions on identifying and referring potentially eligible CYSHCN to the CSHCS program described above, the Michigan MHP contracts also identify CYSHCN specifically in contract sections related to disenrollment, out-of-network providers and prior authorizations, grievances and appeals, and enrollee education. As noted earlier, amending MHP contracts and identifying needed contract changes in preparation for the transition of CSHCS enrollees into Medicaid managed care, occurred with the input of health plans. The state regards health plans as partners in the delivery of care to Medicaid enrollees, rather than just entities they regulate. In the state’s view, partnering with

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health plans is critical to ensuring the success of the Medicaid managed care program.<sup>51</sup> The state also conducted trainings for MHPs to help them understand their role in the CSHCS eligibility determination process.<sup>52</sup>

### **Monitoring**

One way that Michigan monitors the experience of CSHCS enrollees in Medicaid managed care is by operating a special grievance and appeals process for this population. The contract states that for appeals filed by CSHCS enrollees, appropriate pediatric subspecialists should review decisions to deny, suspend, terminate, or limit pediatric subspecialist provider services.<sup>53</sup> The general process for filing grievances and appeals for CSHCS and the associated timeframes and notice requirements are the same as for other MHP enrollees. The state also requires that MHPs be able to track all grievances and appeals filed by CSHCS families separately from those filed by the general population.<sup>54, 55</sup>

Other monitoring efforts pertinent to CYSHCN in Michigan's Medicaid managed care program are focused on MHP readiness to serve the CSHCS population and whether this population is experiencing any barriers to obtaining care. To assess the extent to which plans are enrolling and transitioning the CSHCS population into managed care, the state's Medicaid Managed Care Plan Division assessed data from the fiscal year 2013 compliance review focus study. The state assessed MHP processes for enrolling and transitioning the CSHCS population into the health plan in the categories of: Access to Care, IT Systems, Member Rights, Family Centered Medical Home, and Quality Care.<sup>56</sup> The state also offered performance bonuses to health plans that demonstrated that the processes and procedures were in place for transitioning CSHCS beneficiaries into the state's Medicaid managed care delivery system.<sup>57</sup> Upon completion of the assessment, all 12 health plans serving CSHCS enrollees received a portion of the \$1.2 million performance bonus pool.<sup>58</sup> The state is developing plans for its fiscal year 2014 focus study, from which they hope to have a better understanding of plan performance. MHPs will be asked to report on several quality measures such as well-child visits, immunizations and blood-lead testing.<sup>59</sup>

### **Family experience**

In Michigan, identification and assessment of CYSHCN is not an area of concern for families of CYSHCN according to informants interviewed for this report. Access to care and ability to navigate a managed care delivery system are more likely to be areas of concern for families.<sup>60</sup> For example, the variability in health plans' experience in caring for the population of CSHCS, differences in plan formularies, and some of the MHP requirements for gaining access to specialists can be challenging to families.<sup>61</sup> According to one informant, in some cases, families are unaware who their PCP is.

Just as the health plans were involved in planning and preparing for the move to Medicaid managed care, so too were families. Prior to implementing Medicaid managed care in October 2012, the state conducted focus groups of families of CYSHCN to identify their viewpoints, concerns, and recommendations for the transition. A consultant who serves as the co-chair of the state's CSHCS stakeholder group that meets to identify challenges and solutions for CYSHCN in Michigan's Medicaid managed care program conducted the focus groups. The consultant, who has worked on behalf of families of CYSHCN in Michigan for several years, remarked that Michigan, through the CSHCS program, has a long history of family engagement to ensure that the program was meeting their needs. She felt the state and the family community had an important role to play in supporting health plans to adopt new processes and procedures, such as family involvement and engagement, as the MHPs gain experience caring for and working with the CYSHCN population.

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## MASSACHUSETTS

In Massachusetts, the Executive Office of Health and Human Services oversees the state’s Medicaid program, “MassHealth,” in addition to the state Title V program. The vast majority of Massachusetts’ Medicaid covered individuals, including CYSHCN, are mandatorily enrolled in Medicaid managed care. CYSHCN who receive foster care services through the state’s Department of Children and Families (DCF) or Department of Youth Services (DYS) may choose to opt out of MassHealth managed care enrollment. MassHealth and DCF also cosponsor a pilot program, Special Kids Special Care (SKSC) to enroll certain CYSHCN in foster care into Neighborhood Health Plan (NHP), a health plan that contracts with MassHealth. A child who has been placed in the custody of DCF and is living in a foster home at the time of enrollment may be eligible to participate in the pilot. To be medically eligible for SKSC, the child must, over a prolonged period of time and on a regular basis, need complex medical management and direct administration of skilled-nursing care, skilled assessment or monitoring related to an unstable medical condition.<sup>62</sup>

### Requirements for Identification and Assessment

Within some general, state-defined parameters, health plan approaches for identifying enrollees and CYSHCN vary. Health plans participating in the MassHealth managed care program are required to maintain procedures for conducting a Health Risk Assessment (HRA) for all new enrollees within 60 days of enrollment. The HRA helps identify whether the enrollee has special health care needs and would benefit from receiving care management services, and identifies the enrollee’s care needs, including behavioral health services.<sup>63</sup> Enrollees with special health care needs are defined in the health plan contract as including two subpopulations, CYSHCN and adults with complex or chronic medical conditions requiring specialized health care services.<sup>64</sup> For the purposes of the contract, Massachusetts has adopted the federal definition of CYSHCN—children who have, or are at increased risk for, chronic physical, developmental, behavioral, emotional conditions and who also require health and related services of a type and amount beyond that required by children generally.<sup>65</sup>

The health plan HRA must incorporate the Health Needs Assessment Core Questions developed by the state Medicaid agency; some plans supplement the core question set with their own assessment. The development of the Health Needs Assessment Core Questions occurred over time with the involvement of health plans to create a state standard that also afforded health plan flexibility. The state anticipates the Health Needs Assessment will continue to evolve with ongoing input from the health plans.<sup>66</sup>

Health plans also use other methods for identifying CYSHCN. For example, one health plan in Massachusetts conducts comprehensive clinical rounds where CYSHCN may be identified through the discussion of children’s use of routine case management services. The health plan also runs monthly reports based on claims and utilization, which staff in the health plans’ clinical services groups use to identify and reach out to CYSHCN. Inpatient case managers at Boston Children’s Hospital also help identify children who may have special health care needs at the time they are admitted to the hospital.

### Monitoring

MassHealth requires that health plans have “structures” for quality management/quality improvement. These include: performance measurement and improvement activities; assessment of the quality and appropriateness of care; and assessment of physical and behavioral health services provided to enrollees with special health care needs, particularly as they relate to case management services.<sup>67</sup> As part of case management services, health plans are required to maintain ongoing management and assessment of enrollee health needs, ensure timely access and coordinate access to medically necessary services, and



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ensure that enrollee primary care providers have expertise in treating the enrollee’s medical condition.<sup>68</sup> Health plans must also be able to provide data on CYSHCN participating in case management programs, and report HEDIS measures and participate in external quality review activities. Like Michigan, Massachusetts’ Medicaid health plans are required to be accredited, but in Massachusetts plans must obtain accreditation from the National Committee for Quality Assurance. The plans must achieve accreditation by the end of the second contract year.<sup>69</sup>

The MassHealth Care Quality Strategy reiterates health plan responsibilities for identifying enrollees with special health care needs. The Quality Strategy also addresses access to care for enrollees with special health care needs by reinforcing the contractual requirement that health plans have “a mechanism in place to assess enrollees identified as having special health care needs.” However, the Quality Strategy does not speak to how to monitor that requirement.<sup>70</sup> The state convenes a quality improvement committee focusing on behavioral health and includes on the committee health plan quality directors, representatives of the Behavioral Health Advisory Council, and officials from Medicaid.<sup>71</sup>

### **Family Experience**

Informants in Massachusetts did not identify any major concerns about identification or assessment of CYSHCN. Some interviewees noted that any issues raised are more likely to be related to enrollees’ ability to access services.<sup>72</sup> For example, some challenges that families of CYSHCN have reported facing include difficulty with access to some services, accessing pediatric providers and specialists, wait times, and providers that do not accept MassHealth or are not in the managed care network.<sup>73</sup> One organization that assists families of CYSHCN noted that sometimes families seek assistance in understanding what Medicaid coverage they might qualify for, if they are not already enrolled, or in understanding how to obtain needed services in a managed care delivery system.<sup>74</sup> This organization is creating tools for families to better understand how they might be eligible for Medicaid based on clinical criteria.

## DISCUSSION & PROMISING PRACTICES

California, Michigan, and Massachusetts have taken some similar approaches to identifying and assessing CYSHCN in Medicaid managed care, with health plans bearing much of the responsibility for these functions. Table 1 summarizes some the key features of the states' approaches.

**Table 1: Summary of Selected Features of Medicaid Managed Care for CYSHCN in Three States**

	<i>California</i>	<i>Massachusetts</i>	<i>Michigan</i>
<i>Overview of State Contract</i>	<ul style="list-style-type: none"> <li>- Contracts for all three managed care models identify and differentiate between CYSHCN and CCS-eligible children.</li> <li>- Plans must maintain “a program” for CYSHCN and provide a written description to the state.</li> </ul>	<ul style="list-style-type: none"> <li>- Includes provisions addressing enrollees with special health care needs, defined as CYSHCN, as well as adults with complex or chronic medical conditions requiring specialized health care services.</li> </ul>	<ul style="list-style-type: none"> <li>- Addresses CSHCS enrollees as a specific subpopulation.</li> <li>- Identifies CYSHCN in sections on disenrollment, out of network providers, prior authorizations, grievances and appeals, and enrollee education.</li> </ul>
<i>Identification and Assessment Contract Requirements</i>	<ul style="list-style-type: none"> <li>- Plans must provide an Initial Health Assessment (IHA), including a physical exam and health education behavioral assessment.</li> <li>- Care needs of CYSHCN and CCS-eligible children must be assessed.</li> <li>- Health plans must ensure baseline health assessments are conducted to determine CCS eligibility.</li> </ul>	<ul style="list-style-type: none"> <li>- Health plans must maintain procedures for the conduct of a Health Risk Assessment (HRA).</li> <li>- HRAs must incorporate the state developed-Health Needs Assessment Core Questions, but can be supplemented by the plan.</li> </ul>	<ul style="list-style-type: none"> <li>- Health plans must maintain a roster of primary care providers for CSHCS enrollees that have a mechanism to identify children/youth with chronic health conditions.</li> <li>- Contracts are not explicit about health plan responsibilities for assessment of CYSHCN who are not enrolled in CSHCS.</li> </ul>
<i>Monitoring and Quality Improvement</i>	<ul style="list-style-type: none"> <li>- State's contracts and Quality Strategy Report describe monitoring requirements.</li> <li>- Health plans' CYSHCN programs are required to describe monitoring and quality activities.</li> <li>- Health plan accreditation is not required.</li> </ul>	<ul style="list-style-type: none"> <li>- Health plans must report data on CYSHCN participating in case management programs.</li> <li>- Health plans must be accredited by the National Committee for Quality Assurance, and must achieve accreditation by the end of the second contract year.</li> </ul>	<ul style="list-style-type: none"> <li>- Grievance and appeals process requires:               <ul style="list-style-type: none"> <li>o Appropriate pediatric subspecialists review appeals filed by CSHCS enrollees.</li> <li>o Health plans track CSHCS grievances and appeals separately.</li> </ul> </li> <li>- Performance bonus given to plans demonstrating preparedness for transitioning CSHCS enrollees into managed care.</li> <li>- Medicaid Health Plans must be accredited.</li> </ul>
<i>Examples of Collaboration between Medicaid, Health Plans, Title V and Families</i>	<ul style="list-style-type: none"> <li>- The state sends health plans monthly eligibility files identifying the CCS-eligible population in their membership.</li> <li>- Medicaid and Title V administered by the same department, facilitating collaboration between the programs, including work on the health needs assessment.</li> </ul>	<ul style="list-style-type: none"> <li>- The state worked with health plans over a period of time to develop the Health Needs Assessment Core Questions.</li> <li>- The state includes health plans' Quality Directors on its quality improvement committee focused on behavioral health.</li> </ul>	<ul style="list-style-type: none"> <li>- In preparing for the transition of CSHCS enrollees to Medicaid health plans, the state:               <ul style="list-style-type: none"> <li>o worked with plans to add contract provisions;</li> <li>o trained plans on the CSHCS eligibility determination process; and</li> <li>o held focus groups of families.</li> </ul> </li> </ul>



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Informants in the three states agreed that in general, the processes and policies in place for the identification and assessment of CYSHCN are working adequately. Informants from organizations that assist families of CYSHCN report that the families they are in contact with have not raised identification or assessment as an issue. One health plan informant said it was the responsibility of health plans to know and understand their membership's care needs and that the state appropriately has little role in identifying CYSHCN.

However, according to informants, families sometimes reported challenges other than identification and assessment. Some families experience challenges in accessing services. In California, for example, the variation across the state in Medi-Cal managed care delivery systems combined with the inexperience of some families with managed care created challenges to their ability to obtain needed care. One informant questioned whether recent transitions of adults with special health care needs into Medi-Cal managed care have resulted in greater focus on that population than on CYSHCN.

This examination of states' Medicaid managed care programs, although limited to three states, nevertheless surfaced some promising practices for implementing Medicaid managed care for CYSHCN that other states may want to consider. The promising practices could help to enable strong identification and assessment processes that stakeholders support, as well as facilitate the implementation of Medicaid managed care in ways that address the special needs of this population. The promising practices described below could be implemented by other states—whether newly implementing Medicaid managed care for the CYSHCN population, or making changes to or expanding an established program.

- **Incorporating provisions that specifically address CYSHCN and their needs into health plan contracts.** California's and Michigan's contracts include provisions that explicitly delineate health plan requirements with respect to CYSHCN. The contracts require health plans to refer children who may be eligible for states' Title V programs for an eligibility determination and to provide needed medical information for making the determination. Identifying CYSHCN as a specific subpopulation in managed care plan contracts can help to make explicit the state's expectation with regard to this vulnerable population. It also could help to elevate the profile and needs of this population to the health plans that are responsible for providing them services, but that might have limited experience doing so.

In California, contracts used in each of the models of managed care distinguish between a general population of CYSHCN and the specific population of children who are eligible to participate in the Title V/CCS-program. The contracts include a set of provisions describing contractor obligations for identifying and assessing and providing services for CYSHCN generally, and a separate, but similar, set of requirements for the CCS-eligible population. In California, specifically identifying both the CYSHCN *and* the CCS-eligible population in the health plan contracts recognizes that not all CYSHCN are CCS-eligible, but that they nonetheless have care needs that warrant an intentional health plan focus.

- **Tailoring state monitoring activities to address CYSHCN as a specific subpopulation.** Analysis of data from health plan's HEDIS compliance audits and the states' external quality review processes, which are federally required for states' Medicaid managed care programs, are key ways that California, Michigan, and Massachusetts are monitoring care provided to CYSHCN in Medicaid managed care. However, Michigan is also taking steps to monitor care for Title V enrollees as a specific subpopulation of Medicaid enrollees. The state's grievance and appeals process requires health plans to use appropriate pediatric providers to review grievances and

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appeals, and also requires that grievances and appeals filed by CSHCS enrollees and their families be tracked separately from those filed by others. The state's process could help not only to inform how Michigan health plans perform in providing care to CSHCS enrollees, but also to identify particular aspects of the Medicaid managed care delivery system that might be challenging for their families.

In California, health plan "programs" for CYSHCN are to include strategies for monitoring access and quality of care provided to CYSHCN. This requirement suggests recognition by the state of the importance of focused monitoring of the care and services provided to CYSHCN; however it does not prescribe how such monitoring is to occur. Assessing health plan performance over time and against the procedures and expectations set forth in their "programs" for CYSHCN will determine how well they are working for CYSHCN.

- **Partnering with stakeholders in the implementation of Medicaid managed care for CYSHCN.** State Medicaid agencies have a clear oversight relationship with Medicaid managed care plans, but some states also have worked with health plans as partners to develop and implement components of their managed care programs. For example, Massachusetts requires plans to use a specific core set of questions as part of the assessment of enrollee care needs, including for CYSHCN. To develop the minimum core set of assessment questions, the state worked with health plans. In Michigan, the state worked extensively with health plans to review and make needed changes to ensure contracts addressed the care needs of the CSHCS/Title V population as it transitioned to Medicaid managed care.

Michigan identified issues and areas of concern, and recommended steps that would help smooth the transition for CYSHCN and their families with input from families of CYSHCN obtained through focus groups prior to the transition to Medicaid managed care. Michigan continues to seek the input of families of CYSHCN by having family representatives on the CYSHCN Stakeholder Group. An informant in Michigan suggested the state could leverage its experience and knowledge of effectively engaging families of CYSHCN to assist health plans in doing the same. Health plans in Michigan are expected to engage families to provide them an opportunity to share input on health plan policies and procedures. Since the plans may have only limited experience in doing so, they could gain useful strategies and insights from the state. Informants in Massachusetts and Michigan felt that a culture of partnership was important to ensuring a smooth transition by CYSHCN to Medicaid managed care.

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## CONCLUSION

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The three states described in this report—California, Michigan, and Massachusetts—are at different stages of implementing Medicaid managed care for CYSHCN. In these three states, and as can be expected in others, health plans play a major role in identifying and assessing children who are likely to have special health care needs. These children include those who may be eligible for services through the state’s Title V program, as well as those who are not, but nonetheless have special health care needs. The processes and policies for identifying and assessing CYSHCN in California, Michigan, and Massachusetts are reported to be working adequately, although it was beyond the scope of this report to formally evaluate their effectiveness. The focus of this work was limited to understanding how states identify and assess CYSHCN generally; identifying and assessing CYSHCN’s need in specific care areas, such as behavioral health and dental care, are not addressed. However, given the critical importance of these services for CYSHCN, future work to understand how states identify and assess behavioral health and dental care needs is warranted.

During the course of this work, some promising practices for implementing Medicaid managed care for CYSHCN emerged from the states studied. These practices reflect the states’ commitment to developing and implementing Medicaid managed care programs that address the needs of CYSHCN. States moving to or expanding Medicaid managed care for CYSHCN, could consider these promising practices when developing their programs.

APPENDICES

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## APPENDIX A. INTERVIEWEE LIST

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### California

- **Dr. Trudi Carter**, Chief Medical Officer, L.A. Care Health Plan
- **Juno Duenas**, Executive Director, Support for Families of Children with Disabilities
- **Pip Marks**, Manager, Family Voices of California
- **Jane Ogle**, Deputy Director, Health Care Delivery Systems, California Department of Health Care Services
- **Louis Rico**, Chief, Systems of Care Division, Children’s Medical Services Branch, California Department of Health Care Services
- **Margaret Tatar**, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services

### Michigan

- **Lonnie Barnett**, Director, Children’s Special Health Care Services Division, Bureau of Family, Maternal and Child Health, Michigan Department of Community Health
- **Bev Crider**, Co-Chair, Children’s Special Health Care Services Parent Stakeholder Group
- **Carol Jorgensen**, Compliance Officer, UnitedHealthcare Community Plan
- **Dr. Nina Mattarella**, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health
- **Kathleen Stiffler**, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health

### Massachusetts

- **Ron Benham**, Director, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health
- **Priscilla Meriot**, Executive Director, Neighborhood Health Plan
- **Kathy Messenger**, Senior Budget Planner, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health
- **Barbara Popper**, Health Care Projects, Federation for Children with Special Needs
- **Rich Robison**, Executive Director, Federation for Children with Special Needs
- **Pam Siren**, Vice President, Quality & Compliance, Neighborhood Health Plan
- **Claudia VanDusen**, former Director, Managed Care Program, MassHealth, Massachusetts Executive Office of Health and Human Services

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## APPENDIX B. ACRONYMS

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General list of acronyms used in the paper:

<b>Acronym</b>	<b>Term</b>
<b>CAHPS</b>	Consumer Assessment of Healthcare Providers and Systems
<b>CYSHCN</b>	Children and Youth with Special Health Care Needs
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis, and Treatment
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set
<b>MCO</b>	Managed Care Organization
<b>NCQA</b>	National Committee for Quality Assurance
<b>NASHP</b>	National Academy for State Health Policy
<b>PCP</b>	Primary Care Provider

California-specific acronyms used in the paper:

<b>Acronym</b>	<b>Term</b>
<b>CCS</b>	California Children's Services
<b>COHS</b>	County Organized Health System
<b>DHCS</b>	Department of Health Care Services
<b>FCVA</b>	Family Voices of California
<b>GMC</b>	Geographic Managed Care
<b>IHA</b>	Initial Health Assessment

Michigan-specific acronyms used in the paper:

<b>Acronym</b>	<b>Term</b>
<b>CSHCS</b>	Children's Special Health Care Services
<b>MDCH</b>	Michigan Department of Community Health
<b>MHP</b>	Medicaid Health Plan

Massachusetts-specific acronyms used in the paper:

<b>Acronym</b>	<b>Term</b>
<b>DCF</b>	Department of Children and Families
<b>DYS</b>	Department of Youth Services
<b>HRA</b>	Health Risk Assessment
<b>NHP</b>	Neighborhood Health Plan
<b>SKSC</b>	Special Kids Special Care

## ENDNOTES

- 1 National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [1/29/13] from [www.childhealthdata.org](http://www.childhealthdata.org). 2009 – 10 data are the most current data available from NS-CSHCN.
- 2 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Managed Care: Key Data, Trends, and Issues* (Washington. D.C., February 2012).
- 3 Gifford, K, Smith, V, Snipes, D and Paradise, J. “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey”, Kaiser Commission on Medicaid and the Uninsured, *The Henry J. Kaiser Family Foundation*, September 2011.
- 4 42 CFR 438
- 5 42 CFR 438.208(c)(1)
- 6 42 CFR 438.208(c)(2)
- 7 National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [1/29/13] from [www.childhealthdata.org](http://www.childhealthdata.org). 2009 – 10 data are the most current data available from NS-CSHCN.
- 8 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Managed Care: Key Data, Trends, and Issues* (Washington. D.C., February 2012).
- 9 Gifford, K, Smith, V, Snipes, D and Paradise, J. “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey”, Kaiser Commission on Medicaid and the Uninsured, *The Henry J. Kaiser Family Foundation*, September 2011.
- 10 Many publications addressed strategies and options for identifying CSYHCN. For example, “Approaches to Identifying Children and Adults with Special Health Care Needs, A Resource Manual for State Medicaid Agencies and Managed Care Organizations” *The Children and Adolescent Health Measurement Initiative*, 2002; “Optional Purchasing Specifications: Medicaid Managed Care For Children with Special Health Care Needs” *George Washington University Center for Health Services Research and Policy*, August 2000; Oehlmann, M. “Improving Managed Care for Children with Special Needs” *Center for Healthcare Strategies Inc.*, 2004; Kaye, N, Curtis, D, Booth M. “Certain Children With Special Health Care Needs: An Assessment of State Activities and Their Relationship to HCFA’s Interim Criteria” *National Academy for State Health Policy*, June 2000; Bethell, C, Blumberg S. “Identifying Children with Special Health Care Needs: Development and Evaluation of a Short Screening Instrument” *Ambulatory Pediatrics*, 2002; 2 (1); McManus, M, Fox, H. “Improving State Medicaid Contracts and Plan Practices for Children with Special Needs” *The Future of Children*, 1998; 8 (2).
- 11 42 CFR 438.208(c)(1)
- 12 42 CFR 438.208(c)(2)
- 13 For full description, refer to the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, CCS, Chapter 4, Medical Eligibility, Sections 41800-41872.
- 14 California Department of Health Care Services, *Information About California Children’s Services* (DHCS 4480 (01/08), <http://www.dhcs.ca.gov/formsandpubs/forms/Forms/childmedsvcfoms/dhcs4480.pdf>).
- 15 Interview with Louis Rico, Chief, Systems of Care Division, Children’s Medical Services Branch, California Department of Health Care Services and Jane Ogle, Deputy Director, Health Care Delivery Systems, California Department of Health Care Services, June 19, 2013.
- 16 California Department of Health Care Services, *Medi-Cal Managed Care Program Fact Sheet* Retrieved from: <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf>.
- 17 Ibid. Fourteen counties use a COHS model, 14 counties use a Two-Plan model, and two counties use a GMC model. See <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf>.
- 18 Boilerplate versions of California’s Medi-Cal Managed Care contracts for the Two-Plan Model, County Organized Health Systems, and Geographic Managed Care were accessed on September 16, 2013 at <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.
- 19 Boilerplate versions of California’s Medi-Cal Managed Care contracts for the Two-Plan Model, Exhibit A, Attachment 11, Section 8.

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- 20 Interview with Margaret Tatar, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services September 30, 2013.
- 21 For the Two-Plan model, see Two-Plan Model Boilerplate Contract, Exhibit A, Attachment 11, Section 9A. For the GMC model, see CMS Model Boilerplate Contract Exhibit A, Attachment 11, Section 9A. For the COHS model, see COHS Boilerplate Contract Exhibit A, Attachment 11, Section 8A.
- 22 In California, eligibility determinations for CCS are made at the county level. In counties with populations greater than 200,000 (independent counties), county staff perform all case management activities for eligible children residing in their county. This includes determining all phases of program eligibility. For counties with populations under 200,000 (dependent counties), the Children's Medical Services Branch (within DHCS) provides medical case management and eligibility determinations through its regional offices located in Sacramento, San Francisco and Los Angeles. <http://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx>.
- 23 For the Two-Plan model, see Two-Plan Model Boilerplate Contract, Exhibit A, Attachment 11, Section 9. For the GMC Model, see CMS Model Boilerplate Contract Exhibit A, Attachment 11, Section 9.
- 24 Interviews with Margaret Tatar, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services September 30, 2013 and Louis Rico, Chief, Systems of Care Division, Children's Medical Services Branch, California Department of Health Care Services, June, 19, 2013.
- 25 For the Two-Plan model, see Two-Plan Model Boilerplate Contract, Exhibit A, Attachment 11, Section 8C. For the GMC model, see CMS Model Boilerplate Contract Exhibit A, Attachment 11, Section 8C. For the COHS model, see COHS Boilerplate Contract Exhibit A, Attachment 11, Section 7C.
- 26 For Two-Plan Model, see Two-Plan Model Boilerplate Contract, Exhibit A, Attachment 11 Section 9A.1; for GMC, see GMC Boilerplate Contract Exhibit A, Attachment 11 Sections 9A.1; and for COHS, see COHS Boilerplate Contract Exhibit A, Attachment 11 Section 8A.1. <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.
- 27 For Two-Plan Model, see Two-Plan Model Boilerplate Contract, Exhibit A, and Attachment 10 Section 3; for GMC, see GMC Boilerplate Contract Exhibit A, Attachment 10 Sections 3; and for COHS, see COHS Boilerplate Contract Exhibit A, Attachment 10 Section 3.
- 28 For Two-Plan Model, see Two-Plan Model Boilerplate Contract, Exhibit A, Attachment 10 Section 5A, and for GMC, see GMC Boilerplate Contract Exhibit A, Attachment 10 Sections 5A.
- 29 Ibid.
- 30 The Boilerplate COHS contract does not specify whether the timeframe is in calendar or business days. See COHS Boilerplate Contract Exhibit A, Attachment 10 Section 3A.
- 31 Ibid.
- 32 Personal communication with Louis Rico, on December 9, 2013.
- 33 Ibid.
- 34 Department of Health Care Services, Medi-Cal Managed Care Quality Strategy Report, Annual Update, June 2013.
- 35 Department of Health Care Services, Medi-Cal Managed Care Quality Strategy Report, Annual Update, June 2013.
- 36 Guidance for Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Child Survey, Technical Assistance Brief Number 3, December 2012. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSBrief.pdf>.
- 37 HEDIS compliance audits are conducted to ensure the validity of the HEDIS data collection and reporting process. Interview with Margaret Tatar, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services, September 30, 2013.
- 38 Interview with Juno Duenas, Executive Director, Support for Families of Children with Disabilities, Pip Marks, Manager, Family Voices of California, July 24, 2013.
- 39 Diagnoses alone does not guarantee medical eligibility to CSHCS, as an individual must also meet the evaluation criteria regarding the level of severity, chronicity, and the need for annual medical care and treatment by a physician subspecialist as described in the CSHCS Chapter of the Medicaid Provider Manual.



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- 40 Michigan Department of Community Health, Medical Services Administration Bulletin Number 12-26, Issued August 31, 2012.
- 41 Michigan Department of Community Health, *Information For Families About Children's Special Health Care Services*. Retrieved from: [http://www.michigan.gov/mdch/0,4612,7-132-2942\\_4911\\_35698-15087--,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_35698-15087--,00.html). Persons 21 and older with cystic fibrosis or certain hereditary blood coagulation disorders may also qualify for CSHCS.
- 42 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, retrieved from [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf) on September 4, 2013, Section 1.022.S(1).
- 43 Email correspondence with Lonnie Barnett, Director, Children's Special Health Care Services Division, Bureau of Family, Maternal and Child Health, Michigan Department of Community Health, December 10, 2013.
- 44 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, Section 1.022.S (5).
- 45 Interview with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health and Dr. Nina Mattarella, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health Michigan Medicaid, June 27, 2013.
- 46 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, retrieved from [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf) on September 4, 2013.
- 47 Ibid Section 1.022.F.
- 48 Ibid. Section 1.022.K.
- 49 Interview with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health and Dr. Nina Mattarella, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health Michigan Medicaid, June 27, 2013.
- 50 2013 NCQA Health Plan Accreditation Requirements, accessed on October 28, 2013, <http://www.ncqa.org/Portals/0/Programs/Accreditation/2013%20NCQA%20HP%20Requirements%20and%20HEDIS%20Measures-2.pdf>.
- 51 Interview with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health and Dr. Nina Mattarella, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health Michigan Medicaid, June 27, 2013.
- 52 Interview with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health and Dr. Nina Mattarella, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health Michigan Medicaid, June 27, 2013.
- 53 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, Section 1.022.I.2.d.ii, retrieved from [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf) on September 4, 2013.
- 54 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, Section 1.022.I.2.d.ii, retrieved from [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf) on September 4, 2013. Section 1.022 P(1)(e).
- 55 Interview with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health and Dr. Nina Mattarella, Physician, Office of Medical Affairs, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health Michigan Medicaid, June 27, 2013.
- 56 Comprehensive Health Care Program for the Michigan Department of Community Health, Contract No. 071BXXXXX, Appendix 5, retrieved from [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf) on September 4, 2013.
- 57 Michigan Contract, Appendix 5; Email correspondence with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health December 10, 2013.
- 58 Email correspondence with Kathleen Stiffer, Director, Managed Care Plan Division, Bureau of Medicaid Operations and Quality Assurance, Michigan Department of Community Health December 10, 2013.
- 59 Ibid.
- 60 Interview with Bev Crider, Co-Chair, CSHCS Parent Stakeholder Group, October 24, 2013.
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61 Ibid.

62 Massachusetts Executive Office of Health and Human Services, *Additional Insurance and Assistance Programs, Special Kids/ Special Care Pilot Program* Retrieved from <http://www.mass.gov/eohhs/consumer/insurance/more-programs/special-kidsspecial-care-pilot-prog.html>.

63 First Amended and Restated MassHealth Managed Care Organization Contract, Sections 2.4 G and 2.14 G, obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

64 The First Amended and Restated MassHealth Managed Care Organization Contract, Section 1, obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

65 Ibid.

66 Interview with Claudia VanDusen, former Director, Managed Care Program, MassHealth, Massachusetts Executive Office of Health and Human Services August 13, 2013.

67 First Amended and Restated MassHealth Managed Care Organization Contract, Section 2.13 C.1.f. and 2.14.C.6, obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

68 First Amended and Restated MassHealth Managed Care Organization Contract, Section 2.14.C.6 obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

69 First Amended and Restated MassHealth Managed Care Organization Contract, Section 2.13.H obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

70 MassHealth Care Quality Strategy, Update Fall 2008, Section IV.B1.c.

71 Interview with Claudia VanDusen, former Director, Managed Care Program, MassHealth, Massachusetts Executive Office of Health and Human Services August 13, 2013; First Amended and Restated MassHealth Managed Care Organization Contract, Section 2.13.C.5 obtained from Jon Seiff, Custodian of Records, Privacy Office, Massachusetts Executive Office of Health and Human Services August 27, 2013.

72 Interview with Ron Benham, Director, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health, Kathy Messenger, Senior Budget Planner, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health, August 1, 2013.

73 Ibid.

74 Interview with Rich Robison, Executive Director, Federation for Children with Special Needs, Barbara Popper, Health Care Projects, Federation for Children with Special Needs, July 25, 2013.