



Implementing Medical Homes for Children and Youth with Special Health Care Needs (CYSHCN) within Medicaid Managed Care

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Introduction

The medical home is a model of primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”¹ This model emphasizes partnerships between primary care providers and families, and personalized care plans to support patients’ access to quality health care. Medical homes are particularly beneficial for children and youth with special health care needs (CYSHCN) due to their complex care coordination needs. Promotion of medical homes for CYSHCN by states within Medicaid managed care delivery systems can be an effective strategy for increasing access to this important model of care.

Children and youth with special health care needs (CYSHCN) are those who “have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”² CYSHCN account for nearly 20 percent (13.8 million) of children under the age of 17.³ In comparison to other racial and ethnic groups, special health care needs are most prevalent among children who are black and American Indian or Alaskan Native, with prevalence rates of 25 percent and 24 percent, respectively. Children who are black represent 18 percent of CYSHCN, while accounting for 12 percent of all children.⁴ Black children with special health care needs, as well as those who are Hispanic, are more likely to have unmet health care needs and to receive lower quality primary care than CYSHCN who are white.⁵

Receiving care through a medical home offers multiple benefits for children, including CYSHCN and their families in terms of the patient experience and quality of care. For CYSHCN, this includes improved care coordination, fewer unmet specialty care needs, and less time spent by the family arranging or providing care for their child.⁶ While these benefits are well-recognized, many CYSHCN do not have access to a medical home. CYSHCN are less likely to receive care in a medical home than children without special health care needs (42.1 percent and 49.2 percent, respectively).⁷ Additionally, this rate has decreased since 2005 when 47.1 percent of CYSHCN had access to a medical home.⁸

Implementing Medical Homes for CYSHCN through Medicaid Managed Care

As of 2017, about 47 percent of CYSHCN were either completely or partially covered by Medicaid and CHIP.⁹ Medicaid plays a critical role in increasing access to services that CYSHCN may require.¹⁰ As of 2017, 47 state Medicaid programs have provided services through managed care organizations (MCOs) for at least some CYSHCN¹¹ who are enrolled in Medicaid and CHIP. These CYSHCN are significantly more likely to be black or Hispanic (57 percent) than white (35 percent).¹² Given that children who are black and Hispanic are more likely to have unmet special health care needs and are more likely to be enrolled in public health insurance, Medicaid programs have a unique opportunity to improve service delivery for these children by supporting medical home implementation.

One strategy that states can pursue in an effort to improve quality care for CYSHCN is to structure their Medicaid managed care contract language to support the delivery of health care services that meet medical home model standards. This includes offering incentives for MCOs to work with providers who have implemented the medical home model, adding reporting requirements for MCOs and providers on medical home-related measures, and delivering training for providers on the medical home model. The National Committee for Quality Assurance (NCQA) developed the Patient-Centered Medical Home (PCMH) Standards and Guidelines to assess and recognize providers that have implemented a medical home approach. As of June 2020, 21 states and the District of Columbia use the PCMH standards to guide their medical home initiatives, including incentivizing or requiring NCQA PCMH recognition.¹³ Several PCMH standards are designed to address racial disparities including assessing diversity among patients, evaluating cultural needs, and providing culturally competent education for providers.¹⁴ States can promote these standards and others to support comprehensive medical home care, which may help to lessen racial disparities in access to quality care among CYSHCN.

States may also facilitate partnerships between agencies that serve CYSHCN. For example, states can leverage Title V CYSHCN programs to support medical home implementation. One of the Title V Maternal and Child Health Services Block Grant National Performance Measure state Title V programs may choose is improving access to medical home for children, including CYSHCN.¹⁵ State Title V programs that have identified this measure as a priority area

Collaborating with state Title V programs

States and MCOs can encourage medical home implementation for CYSHCN by collaborating with state Title V programs to facilitate training, develop tools and resources, and improve data collection. As of June 2020, 44 state Title V programs have developed specific plans to improve access to medical homes as part of their Title V program efforts.¹⁸ Medicaid programs that are implementing strategies to increase medical homes through managed care can leverage these existing opportunities to support their efforts. Medicaid agencies can consider encouraging or requiring their MCOs to work with Title V programs to:

- Identify system gaps and needs based on National Performance Measure medical home data
- Align performance measures and data collection processes to support care coordination
- Promote training on medical homes for providers and families
- Improve referral networks for providers

will have developed strategies to address this need. These strategies may include partnering with families to gather insight on medical home-related needs, offering education to providers on care coordination, and supporting the use of care plans.¹⁶ States can prioritize collaboration between state Medicaid managed care and Title V agencies to align efforts to increase access to medical homes for CYSHCN.¹⁷

State Examples of Medical Home Implementation in Medicaid Managed Care

States have implemented a range of strategies to support medical home implementation for CYSHCN through their Medicaid managed care programs. These strategies include developing partnerships to connect children to medical homes, incorporating the medical home model in managed care contract language, and incentivizing providers to use a medical home approach. The following examples highlight five states' approaches.

WISCONSIN

Develop Partnerships to Connect Children to Medical Homes

In 2014, **Wisconsin's Department of Health Services and Department of Children and Families** partnered to develop Care4Kids, a specialized Medicaid managed care program that provides services through medical homes for all children and youth in foster care in six southeastern counties.¹⁹

The managed care contract for this specialized program requires the prepaid inpatient health plan (PIHP) to ensure that:

- 1) During medical home enrollment, each child is assigned a health care coordinator who oversees a care coordination team
- 2) Within 60 days of medical home enrollment, each child has an individualized health care plan
- 3) The contractor must coordinate with state agencies (Department of Health Services, Department of Children and Families, and the Division of Milwaukee County Child Protective Services) to develop performance measures that assess quality related to integrated and comprehensive health service delivery; timely access; high quality and flexibility of care; transitional planning and cross-system coordination; well-being outcomes; and psychotropic medication management.²⁰ These measures align with elements of the medical home model, including the key principles that primary care should be accessible, comprehensive, continuous, and coordinated.

In 2016, the Wisconsin Title V program supported Care4Kids in their efforts to coordinate across medical home initiatives in the state.²¹ The 2015 state plan developed by the Title V agency identified opportunities for collaboration, including promoting tools and resources to Care4Kids clinicians and supporting Care4Kids in providing mental health or developmental screening for children in foster care.

COLORADO

Need a description

Colorado's Title V program has prioritized the implementation of medical home by partnering with the **Colorado Department of Health Care Policy and Financing (DHCPF)**, the state Medicaid agency. Through its Accountable Care Collaborative (ACC) program, DHCPF contracts with Regional Accountable Entities (RAE), which serve as local managed care organizations in the state. The managed care contract requires the RAEs to support access to medical homes, including training and resources based on existing needs.²² The state Title V program has also developed strategies to support medical home implementation for CYSHCN within the ACC program by collaborating with RAEs and local public health agencies to develop data sharing agreements. These agreements allow for the development of interagency shared care plans, a best practice for serving CYSHCN, and a core component of the medical home model.²³ The Title V program also "provides ongoing content expertise and support to the Medicaid ACC Program, to maximize access to a medical home approach."²⁴

ARIZONA

Include the Medical Home Model in Medicaid Managed Care Contract Language

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System, sets specific requirements for its MCOs to serve the unique needs of CYSHCN who are enrolled in its Medicaid managed care plans. The contract between the Medicaid agency and the MCOs outlines the definition of a medical home, requires that the MCOs develop a process for identifying providers that have implemented this approach, and encourages the MCOs to connect CYSHCN to such providers "with the goal of obtaining maximized health outcomes."²⁵ One of the ten services that the American Academy of Pediatrics recommends for medical home implementation is "provision of care coordination services in which the family, physician, and other service providers work to implement a specific care plan as an organized team."²⁶ Arizona's contract adheres to this principle by specifying that services for these children should be provided by a team of providers "covering the entire continuum of care."²⁷ To ensure that providers meet these goals, the MCOs must develop a process for sharing medical records between themselves and service providers, and a comprehensive service plan that "contains the clinical, medical, and administrative information necessary to monitor coordinator treatment plan implementation."²⁸

NEW YORK

Incentivize Providers to Use a Medical Home Approach

New York's Medicaid agency incentivizes providers to use a medical home approach by paying MCOs increased reimbursements above the capitation rate, the fixed amount they pay their MCOs for each enrollee, "for the sole purpose of the Contractor making enhanced payments" to providers that meet medical home standards.²⁹ To be eligible for the Patient Centered Medical Home (PCMH) Incentive Payment Program, providers must meet the state's PCMH requirements outlined by NCQA.³⁰ These standards include specific criteria, grouped within six concept areas: team-based care and practice organization; knowing and

managing your patients; patient-centered access and continuity; care management and support; care coordination and care transitions; and performance measurement and quality improvement.³¹ Several criteria that New York requires providers to meet may help to address racial disparities in care, including “targeting population health management on disparities in care” and “educating practice staff in cultural competence.”³²

When the program began in 2010, less than 300,000 people who were enrolled in New York’s managed care plans were receiving services through a PCMH-recognized provider. By 2014, that number grew to over one million. New York has identified its PCMH Incentive Payment Program as the “primary driver of the exponential growth” of PCMH-recognized providers.³³ As of 2018, 48 percent of those enrolled in the PCMH through Medicaid managed care were children under the age of 21.³⁴ A 2013 study indicated that the state’s PCMH model was associated with several pediatric health care quality improvements relative to non-PCMH providers, including childhood and adolescent immunization status, nutrition and physical activity counseling, and weight assessments.³⁵

TEXAS

Need a description

The **Texas Health and Human Services Commission (HHSC)** is required through state law to ensure that its MCOs promote and incentivize a medical home approach.³⁶ To meet this state requirement, HHSC specifies in its contracts with MCOs that they must encourage providers to use a medical home model for CYSHCN. Texas provides services through a specialized managed care program, STAR Kids, to serve children and youth who are enrolled in the Medicaid aid category for Aged, Blind, or Disabled individuals and those enrolled in federal home and community-based 1915(c) waiver programs. The STAR Kids Medicaid managed care contracts require the MCOs to “actively promote” medical homes and offer training for providers on the medical home model. The MCOs must also “develop provider incentive programs for designated providers who meet the requirements for patient-centered medical homes.”³⁷ Texas operates a second managed care program for CYSHCN who are enrolled in foster care or are receiving adoption assistance through the STAR Health managed care program. The STAR Health Medicaid managed care contract requires the MCO to provide medical home services to members. The MCO must “promote, monitor, document, and make best efforts to ensure” primary care and specialty care providers comply with the medical home model.³⁸

Conclusion

Providing services through a medical home model presents benefits for children, including CYSHCN, and their families.³⁹ One strategy that states seeking to improve care for CYSHCN can pursue is to design their managed care programs to support medical home implementation. This can be achieved through contract language that requires MCOs to encourage or incentivize providers to meet medical home standards. States may also consider requiring MCOs to report on performance measures related to medical homes to monitor the quality of care provided. Finally, states may leverage Title V programs to support access to medical homes through collaboration.

Delivering comprehensive care for CYSHCN requires a multi-faceted approach that can meet their unique needs. One way that state Medicaid programs can support this is by promoting the implementation of medical homes through managed care.

Resources

- [Medicaid Managed Care: Challenge and Opportunities for Pediatric Medical Home Implementation and Children and Youth with Special Health Care Needs](#)
- [Serving Children and Youth with Special Health Care Needs in Medicaid Managed Care: Targeted Contract Language](#)
- [State Strategies to Advance Medical Homes for Children and Youth with Special Health Care Needs](#)
- [State Strategies to Leverage Medicaid and Title V Programs to Improve Care for Children with Special Health Care Needs in Medicaid Managed Care](#)
- [National Standards for Systems of Care for Children and Youth with Special Health Care Needs](#)
- [State Medicaid Managed Care \(MMC\) Program Design for Children and Youth with Special Health Care Needs \(CYSHCN\)](#)

Endnotes

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