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Enhanced Care Coordination Services in Medicaid Managed Care for Children with Chronic and Complex Needs

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Care coordination[1] is a core component of a well-functioning system of care and an important strategy to improve health outcomes and quality of life, decrease health care costs, and improve the quality of care for children with chronic and complex needs (CCCN). Families of CCCN often experience fragmented systems, inadequate health coverage, increased caregiver burden and higher out-of-pocket expenses than their peers and lack availability of services and specialists. As such, care coordination has become central to the provision of services that address multi-faceted and interrelated physical, behavioral, and social health needs.

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Integrated and coordinated systems remain a focus of state and federal efforts to advance pediatric value-based care and payment approaches that support whole-person care delivery for CCCN. As part of these efforts, several states have implemented enhanced care coordination services and alternative payment models for special populations, including CCCN enrolled in Medicaid. State Medicaid and Children's Health Insurance Programs play an essential role in the coverage, structure, and delivery of care for CCCN, and over 40 percent of CCCN use public health insurance for health coverage. Since 2017, enrollment of CCCN in Medicaid managed care (MMC) plans has increased, and more states are leveraging MMC to provide comprehensive services to CCCN.

This brief examines state approaches to the provision of enhanced care coordination for CCCN in five states (Arizona, California, Michigan, Texas, and Washington) and Washington, DC. Information regarding each state's program can be found in Appendix A. NASHP analyzed state MMC contracts and program policies in four areas of enhanced care coordination services for CCCN: 1) service provision, 2) eligibility and risk stratification, 3) care coordinator requirements, and 4) care plan management and beneficiary engagement. Additional details are available in this chart.

Key Takeaways

- States are providing enhanced care coordination services to children with complex medical, behavioral, and social needs who have the highest risk for increased health care utilization and care costs.
- States are using risk stratification approaches to establish tiered models of care coordination.
- Enhanced care coordination models in Medicaid managed care include guidance and expectations for the education, credentials, experiences, and training for care coordinators.
- States are defining the scope, intensity, and frequency of key care coordination services, such as screenings, assessments, and care plan development, for high-risk populations.

Enhanced Care Coordination Service Provision

Many state Medicaid programs are leveraging standards for high-quality care coordination with the goal of improving systems of care and informing managed care contracts for those serving CCCN. They are also establishing specialty MMC programs for CCCN (DC and Texas), tiered care coordination models (Arizona, California, and Texas), and programs for targeted services or populations, such as behavioral health (Washington) and children with medical complexities (Michigan). States are enhancing care coordination services in the following ways:

Screening and Identification

A foundation for high-quality care coordination programs is establishing a systematic process to identify children in need of services. States are enhancing screening and stratification approaches to identify those in need of care coordination generally and those who would benefit from enhanced services. These approaches include identification of health and social risk factors, needs-based assessments, and utilization-based screening tools. All states require managed care organizations (MCOs) to establish dedicated referral and eligibility pathways for those with the highest needs.



California offers Enhanced Care Management (ECM) benefits to eligible child and youth populations of focus. Managed care plans are to prioritize community-based referrals and may also proactively use health care utilization data, needs-based assessments, and identified health risks and social drivers of health to identify children who may benefit from ECM and meet criteria. To streamline access, managed care plans are required to establish streamlined authorization arrangements with providers for children and youth who automatically qualify for ECM.

Assessment and Care Plans

Individualized care plans can provide a roadmap for services and supports, serve as a mechanism to address identified child and family needs or priorities, and support communication among the care team. States are setting standards and developing protocols around the frequency of assessments and care plan reviews and establishing intentional and frequent communication with the beneficiary and their family or care team. States are focusing on whole-person care, inclusive of medical, community, and social supports, that identifies goals and action steps to support improved health outcomes.



Following referral, eligibility determination, and informed consent, children enrolled in **Michigan's** Coverage of Children with Medical Complexity Targeted Case Management (CMC TCM) program experience an in-person comprehensive assessment, which focuses on the beneficiaries' medical, educational, social, and related service needs and informs the individualized care plan. The care plan must specify goals that address the identified needs, including non-medical drivers of health, and a course of action to respond to those needs. The plan must also clearly describe the scope and amount of services needed, necessary service providers, and time frames for initiating and/or completing the identified actions.

Team-Based Communication and Family Assistance

Building trust among the family allows a care coordinator to address the full range of social, behavioral, environmental, and health care needs of CCCN and their families and connect families to community resources. All states require a centralized point of contact for care coordination, which supports communication across providers and service agencies and organizations and reduces the burden on the family. Some states are also supporting closed-loop referral systems and establishing access to care coordinators outside traditional business hours.



The **Washington** Health Care Authority provides detailed guidance around the team-based approach expected through the Wraparound with Intensive Services (WISe) model. The state emphasizes participation of family members and natural supports (e.g., friends, neighbors, community), 24/7 availability for crisis intervention and stabilization services, and connection among the family and WISe team members and partners. Care coordinators build relationships with the families to support identification of needed resources for the youth and family and leverage connections with the MCO to ensure appropriate services are received and support family voice and choice.

Health Coaching and Skills Development

Enhanced care coordination services include a focus on family and child empowerment through education, coaching, and other support activities. These activities assist families to leverage strengths, build self-efficacy skills, achieve their goals, and support peer-to-peer connections. States also include a focus on whole-family approaches, including supporting referrals and services for caregivers and other family members as risk is identified and establishing value-added services that support the child and family.



Within **Washington, DC's** Child and Adolescent Supplemental Security Income Program (CASSIP), a core responsibility of the care manager is to coordinate caregiver education needs, such as classes, literature, and referrals, and educate families on all available benefits, including value-added benefits established by the MCO. For example, a "Summer Benefit Program" provides up to $1,500 for a child to participate in a summer program that promotes socialization, recreation, self-care, fitness, vocational or other skills, and/or education about their condition.

Qualified and Supported Care Coordination Workforce

Ensuring an adequately trained and supported care coordination workforce is essential to the provision of enhanced care coordination services. It can also help ensure that care coordinator experience aligns with the needs of the individual being served. States are defining specific roles associated with the provision of care coordination for CCCN, such as the responsibilities of the care coordinator, family, and providers in the coordination of care and the inclusion of those with lived experience (e.g., peer navigators, peer supports). Many states specify the primary care coordinator has advanced training across a broad range of issues, such as cultural and linguistic competency and implicit bias, or professional experience with complex health and social systems, which can support cross-sector partnership in care.



Arizona requires that individuals providing contractor care management services have expertise in navigating complex systems, child and family advocacy, and self-management approaches, as well as experience in communicating with both families and health care professionals. In some cases, the state specifies required trainings based on populations served. For example, for CCCN generally, the care manager must participate in family-centered cultural competency trainings. For those serving children with complex behavioral health needs, they must have training on covered behavioral health services, accessing and referring to available services, including those not covered under Medicaid state-specific trainings (e.g., Arizona Vision-12 Principles for Children Behavioral Health Service Delivery) and national frameworks (e.g., 10 Principles of Wraparound).

Care Transitions

Planning for needs during care transitions — transferring care between medical providers, moving between service delivery systems or from pediatric to adult care, or promoting independence in the transition to adulthood — is common among states' enhanced care coordination models. States are ensuring support for families in preparing for planned transitions and establishing plans to support continuity throughout and following the transition, including community integration and post-transition monitoring.



Texas's MMC program for CCCN age 20 and younger, STAR Kids, requires MCOs to educate families of members as early as 10-years-old about continuity of long-term services and supports through Texas's 1915(c) waiver programs that cover adults. MCOs must begin transition planning for service and benefit changes beginning at age 15. Texas requires transition-related goals to be included in member's individual service plan and the development of a continuity of care plan to ensure a member's transition from STAR Kids to STAR+PLUS, which is Texas's MMC program for adults with disabilities, occurs without a break in service. Additionally, the state requires each MCO to employ a transition specialist dedicated to working with STAR Kids members, families, and service coordinators to prepare for a successful transition out of STAR Kids and into adulthood.

Table 1: Key Variations on Eligibility Determination and Stratification Approaches

Data used to determine eligibility	AZ	CA	DC	MI	TX	WA
Medical claims or service utilization data	●	●	●	●	●	○
Evidence-based or validated screening tool	○	○	○	○	●	●
Medical records	●	●	●	●	●	●
Social needs or risk factors	○	●	●	●	●	●
Referrals	P, F, M	C, P, F, M	C, P, F, M	P	C, P, F, M	C, P, F, M

(**P** = Provider, **F** = Family or Self, **M** = MCO)

Eligibility and Stratification for Enhanced Care Coordination

Most states use risk stratification activities to identify and predict Medicaid beneficiaries that may qualify for enhanced care coordination services. Eligibility for enhanced care coordination varies by state and includes a variety of criteria and methods (see Table 1).

State Medicaid programs are establishing tiered models of care coordination to provide care coordination services to beneficiaries with varying needs. All states establish a base, or standard, set of care coordination services for all served through managed care and require a stratification, screening, and/or assessment process to assign children enrolled in the plan into a tiered eligibility category. States use "levels" or "risk categories" to distinguish between the level of intensity of care coordination services, enhancing care coordination for those that have significant health needs, social risk factors, increased utilization, or diagnosed medical and/or behavioral conditions. All six states have multi-faceted approaches to coordinating care and services for CCCN through managed care:

- **California and Arizona** have a tiered care coordination model included in managed care contracts for general Medicaid populations.
- The **DC** and **Texas** have a tiered care coordination model in managed care contracts for specialty programs for CCCN populations.
- **Michigan** and **Washington** serve high risk, subpopulations of CCCN through standalone or "carve-out" programs within the state's managed care service delivery structure.



STATE SPOTLIGHT

California's care management continuum includes Basic Population Health Management (BPHM) for all members, Complex Care Management (CCM) for medium- and rising-risk members, and Enhanced Care Management (ECM) for those with the highest medical, behavioral, developmental, and social complexity. ECM delivers seven required core service components: outreach and engagement, comprehensive assessment and care management planning, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports, and coordination of and referral to community and social support services.

States use a variety of data to determine eligibility for enhanced care coordination services. These include utilization or claims data, access and need for health or social services, diagnosis or defined qualifying conditions, or targeted population groups (e.g., recipients of home- and community-based services). **Arizona and DC** require the MCO to define the approach and obtain approval from the state. The remaining states define eligibility through their managed care contracts or established policy or programmatic guidance.

- All states use service utilization or medical claims data to some extent in eligibility determinations. Four states **(Arizona, California, Michigan, and Texas)** determine eligibility based on specific medical diagnoses or conditions defined by established state programs.
- Most states have a pathway for referrals for enhanced services; however, **Michigan** and **Washington** use provider and community referrals as the primary entry-point for consideration or assessment.
- Some states define the screening criteria to be used, such as the Child Adolescent Needs and Strengths (CANS) screener in **Washington** and the state-developed STAR Kids Screening and Assessment Instrument (SK-SAI) in **Texas.**



STATE SPOTLIGHT

Texas STAR Kids provides three levels of service coordination. Children and youth with more complex needs receive more service coordination (i.e., Level 1 Service Coordination) than those whose needs are less complex (i.e., Level 3 Service Coordination). Medical, behavioral, and functional service needs are assessed using the STAR Kids Screening and Assessment Instrument at least once per year. Claims data and family or provider communications may also be used to determine the service coordination level.

Care Coordinator Requirements

States are requiring advanced education, training, credentials, and other expectations for care coordinators that provide enhanced care coordination services. This can also include establishing caseload minimums and availability expectations (see Table 2). This can ensure child and family needs are met and improve coordination across complex systems of care experienced by CCCN.

Table 2: Care Coordinator Requirements for Enhanced Care Coordination

	State Medicaid Requirements	Case Load and Availability Expectations
Arizona	Experiential	Caseload requirements are set by MCOs.
California	Training (for LTSS needs)	Unspecified
Washington, DC	Licensure, experiential, training	Varies by acuity of need. For highest acuity population (i.e., Acuity Level Three) no more than 60 enrollees per one case manager are allowed.
Michigan	Licensure, experiential	Core team member is available at all times.
Texas	Licensure, experiential, training	Ratio must be clinically appropriate; service coordinator must attend at least 75 percent of face-to-face meetings and return phone calls/emails within two business days.
Washington	Credentialing, training	Average 10 enrollees per one case manager. Maximum of 15 enrollees at any time.

States are defining professional requirements for care coordinators that provide or oversee enhanced care coordination services. This includes minimum licensure requirements (e.g., registered nurse, licensed social worker) or specialized certifications or training (e.g., person-centered planning, certified behavioral health provider).

- Of the states that include specific requirements around licensure **(DC, Michigan, and Texas)**, registered nurses and licensed independent clinical social workers are the most common.
- **Arizona** and **California** allow the MCO to determine requirements for care coordinators.

State guidelines support multi-disciplinary and improved patient- or family-centered care coordination experience. States describe experiences that would be valuable for the coordinator to meet the needs of the population, such as experience with child and family advocacy, complex system navigation, and strong communication with professionals and families. Others specify training and experience in person-centered planning, service delivery within related service systems (e.g., child protective services, special education) and experience working with families in crisis.

- **Washington, DC**, specifies that the primary care manager has responsibility to oversee the multi-disciplinary care coordination team, and **California** specifies the ECM lead care manager works alongside a caregiver, often in person, to coordinate across a child's care team.
- The two states serving targeted subpopulations of CCCN, **Michigan's** CMC TCM program and **Washington's** WISe program, operate under a team-based service model, and the state provides expectations around the core team members and their roles.
- **Washington** requires staff to complete an introductory training through the WISe Workforce Collaborative, consisting of six online video modules and a two-day in-person training



STATE SPOTLIGHT

Michigan's Coverage of Children with Medical Complexity Targeted Case Management services are provided by a core case management team, which must include a pediatrician, a non-physician practitioner, a registered nurse, a licensed clinical social worker, a program coordinator, and administrative staff. A licensed pediatric behavioral health provider is recommended, and additional team members may be added to consult regarding specific health concerns (e.g., dietician, respiratory therapist, etc.). The program also includes a variety of qualifications and experiential requirements for core team members.

Some states define case load ratios or availability requirements for care coordinators in enhanced care coordination programs. Typically, states specify case load ratios to ensure care coordinators can adequately serve CCCN and their families.

- In **Washington, DC**, the highest acuity level may not exceed 60 assigned cases per CASSIP care manager.
- **Washington state** directs that WISe care coordinators should maintain an average caseload of 10 or fewer participants but are not allowed to exceed 15 at any given time.
- **Michigan** requires a core team member to be available and accessible 24/7.



STATE SPOTLIGHT

In addition to caseload maximums, the **Washington, DC**, requires specialty cases be assigned a designated specialty case manager. This includes children and youth involved in the child welfare or juvenile justice system and those eligible for services under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), also known as the Katie Beckett program. Additionally, CASSIP requires that at least one full-time care manager be available to work only with the TEFRA/Katie Beckett population.

Care Planning, Communication, and Engagement

States ensure continuous and ongoing assessment and care planning processes. This is a foundation of state approaches and helps ensure the needs, preferences, and priorities of the child and family are adequately addressed. As such, states are setting expectations for MCOs around the timing of initial assessments and development of care plans, the frequency of contact or communication, and the cadence for re-assessments and/or care plan updates (see Table 3).

Table 3: Expectations for Beneficiary/Family Engagement and Care Plan Development

	Engagement and Communication with Beneficiaries and Families	Development and Updates of Assessments and Care Plans
Arizona	Monthly care coordination and inter-disciplinary care team meetings	Care plan must be developed within 30 days of assessment
California	Engagement must be primarily through in-person interactions.	Assessment and care plan upon successful engagement of the beneficiary and updated whenever needs change or is clinically appropriate; assessments from other programs (such as CCS or CCS Whole Child Model) may be used.
Washington, DC	At least three face-to-face visits per year	Assessment within 60 days of enrollment; at least three care plans each year
Michigan	At least one in-person visit each year; monitoring activities monthly or more often as needed	Initial assessments and annual updates must be completed in-person; quarterly reviews/ updates can be done via tele-health.
Texas	At least one in-person visit per year for all members; number of face-to-face service coordination visits and phone calls vary based on service coordination level.	Initial individualized service plan within 90 days of STAR Kids-Screening and Assessment Instrument completion (60 days for reassessments); must be updated annually.
Washington	At least monthly, varies based on Child and Family Team (CFT) agree-ment and youth/family needs	Pre-enrollment screener: 14 days from referral. Full CANS assessment: 30-–45 days from enrollment. Initial care plan completed over one to two meetings within a two-week period after assessment. Monthly reviews and adjustments as suggested by the team.

Many states include specifications for the timing and completion of assessments and development of the care plan for enhanced care coordination. Most states require the completion of a comprehensive assessment, within a specified time frame following referral or enrollment, to inform the individualized care plan. States require care plans to be updated at specified times, ranging from monthly to annually. Other reasons noted to update the care plan include new diagnoses, significant health changes, during care transitions, or upon request. Many states also encourage coordination or integration of care plans that may be developed through other programs or service systems.

- The **Washington, DC,** requires beneficiaries to be assessed for enhanced care management services within 60 days of referral to CASSIP and care plans to be updated three times per year.
- **California's** ECM program encourages leveraging existing assessments and care plans developed by other programs, such as the California Children's Services program.



STATE SPOTLIGHT

Arizona's care management program requires a comprehensive assessment of the beneficiary, including health status, physical and behavioral health history, medications, cognitive function, activities of daily living, and non-medical health factors, followed by development of a care plan within 30 days of the assessment. Monthly care coordination and interdisciplinary team meetings are also required.

States outline the expected minimum frequency of interactions between the care coordinator and the child and their family. States also distinguish between in-person, face-to-face, and telephonic visits, with the majority preferring in-person for assessments and initial care plan development and quarterly face-to-face assessments/reviews, with monthly interactions being acceptable as a phone call.

- All states emphasize beneficiary and family engagement in enhanced care coordination, with four of the six states requiring a monthly touchpoint for high-need beneficiaries (**Arizona, Michigan, Texas,** and **Washington**).
- In the **Texas** STAR Kids program, the frequency of MCO outreach for enhanced care coordination throughout the year is tier-based. Texas requires that service coordinators conduct at least four face-to-face visits and monthly phone calls with beneficiaries and their families for their highest level of need (i.e., service coordination Level 1).



STATE SPOTLIGHT

Washington's WISe program requires an initial cross-system care plan to be completed during one to two meetings that take place within a two-week period. Monthly reviews are required, with adjustments made as suggested by the care coordination team. The state requires a six-step process for working with youth and families, including specifying the timing for the pre-enrollment screener (14 days from referral) and completing the full CANS assessment (30–45 days from enrollment).

Quality and Value-Based Care Strategies

State Medicaid programs continue to align quality measures with care coordination efforts, improved outcomes, and reduced health care spending. Several states are establishing and implementing quality measurement and improvement activities in their state Medicaid and public health programs. Additionally, **California's** ECM program services have been associated with reduced care utilization and depressive symptoms among adult Medicaid beneficiaries participating in the program.

States are exploring opportunities to establish pediatric value-based care payment (VBP) approaches, focusing on integrated care, enhanced care delivery systems, and enhancements to care coordination services. Two (California and Washington, DC) embed VBP strategies in their managed care contract or state-issued guidance documents related to the provision of enhanced care coordination services.

- The **California** Department of Health Care Services (DHCS) has used a symmetrical, two-sided risk corridor for the ECM benefit since it was implemented in 2022. This VBP arrangement shares the risk with the MCO and uses actual ECM expenditures and associated revenues (i.e., costs funded within the capitation rate). Under this arrangement, the MCOs assume full risk of gains or losses within 5 percent of the gross medical expense center-point calculation (e.g., from 95 to 105 percent). DHCS uses data reported quarterly to monitor implementation and select quality measures to evaluate outcomes of members that received ECM services. DHCS continues to strengthen its monitoring approach with added emphasis on cost-effectiveness, access for children and youth, delivery intensity, provider network capacity, and improvements in avoidable utilization and preventive care. DHCS also publishes a quarterly report regarding the utilization of the ECM benefit.

- **Washington, DC,** links financial incentives to improvement in health outcomes through alternative payment methodologies or VBP arrangements. DC's VBP framework aligns provider payment with quality and health outcomes. Under the framework, MCOs are required to implement alternative payment arrangements using qualified payment methodologies, such as fee-for-service bonus arrangements, shared savings, capitation, or other value-based models. The VBP arrangements support enhanced care coordination and population health management to improve quality and help reduce avoidable emergency department visits and hospitalizations. DC reports that all risk-based managed care plans are operating VBP programs and that there are continued efforts to achieve alignment across MCOs to increase provider efficiencies and support positive health outcomes for enrollees. Care coordination services are cited as a key approach to reducing emergency department visit utilization for non-emergent visits, preventable hospital admissions, and the rate of readmissions.

Conclusion

States are considering various approaches to creating enhanced care delivery models and solutions with the goal of improving quality of care, measure cost savings and return on investment, and support whole-person care delivery for CCCN. Enhanced care coordination may allow states to deliver a wide range of support services that address the social, behavioral, environmental, and health needs of CCCN and their families, ensure CCCN and their families are partners in care, and receive the resources, services, and care planning needed. As states continue to design, implement, and evaluate the impact of enhanced care coordination services on health outcomes, successful transitions to adult care, and improved care experiences, they can leverage national standards and quality measures to create and sustain their efforts. NASHP is committed to supporting states in understanding the benefits and impact of enhanced care coordination and elevating innovations that expand access to high-quality family-centered care coordination to meet the needs of CCCN.

Endnote

1. *The term "care coordination" is defined in various ways across the state programs in this analysis. For the purposes of this brief, NASHP uses the definition outlined in the National Care Coordination Standards when discussing this array of services generally and the state-specific definition when applicable.*

Appendix A

Among the six state MMC programs reviewed in this analysis, one pertained only to behavioral health care, one to children with medical complexities, and the remaining four applied to general health care needs (physical and behavioral). Two of the state programs reviewed were MMC programs specifically for children with CCCN (Washington, DC, and Texas), two were standalone or "carve-out" programs for children with Medicaid coverage (Michigan and Washington), and two were integrated into managed care contracts (Arizona and California).

State Programs & CCCN Served



The **Arizona** Health Care Cost Containment System (AHCCCS) Contractor Care Management program coordinates care and supports access to services for members with multiple or complex conditions and who require intensive physical, and/or behavioral health support services. This includes children with special health care needs and Children's Rehabilitative Services qualifying conditions.



California Medicaid (Medi-Cal) offers an Enhanced Care Management (ECM) benefit, providing comprehensive care management or coordination of all health and health-related care) for members with complex needs. This includes multiple child and youth populations of focus listed in the ECM Policy Guide, which includes those enrolled in California Children's Services (CCS) with additional needs beyond their CCS-eligible condition(s).



Washington, DC's Child and Adolescent Supplemental Security Income Program (CASSIP) specialty care plan provides care management and care coordination services to children and youth that have special health care needs and that receive Supplemental Security Insurance (SSI) benefits. This includes children and youth with an SSI-related disability, involved in the child welfare or juvenile justice system, or TEFRA/Katie Beckett eligible populations.

continued



Michigan's Coverage of Children with Medical Complexity Targeted Case Management program provides intensive care coordination to children with medical complexity that also meet specified chronicity, complexity, and fragility and increased utilization criteria. This includes those determined dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid, enrolled in the CSHCS program only, or eligible for Medicaid or the Children's Health Insurance Program.



The **Texas** STAR Kids managed care program provides varying levels of service coordination to children and youth under the age of 21 that receive SSI, SSI-related Medicaid, and/or 1915(c) waiver services. The highest level of service coordination is provided to children enrolled in select 1915(c) waiver programs or to children with complex needs, a history of developmental or behavioral health issues, severe emotional disturbance or serious and persistent mental illness, or at risk for institutionalization.



The **Washington** State Health Care Authority offers Wraparound with Intensive Services (WISe), a range of intensive care coordination, behavioral health services and supports to children with complex behavioral health needs. This includes children age 20 and younger that meet specified criteria (i.e., behavioral or emotional needs, and either defined risk factors or serious functional impairments).