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

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This table is a non-exhaustive summary of state requirements for enhanced care coordination or intensive care coordination services as specified in state Medicaid managed care contracts, policies, or guidance for children with chronic and complex health and/or behavioral health needs.

ARIZONA'S CONTRACTOR CARE MANAGEMENT PROGRAM

Eligibility and Stratification for Enhanced Care Coordination	Select Enhanced Services *As required by the state Medicaid agency*	Care Coordinator Requirements	Care Planning, Communication, and Engagement
Eligible Members[1,2]: high-need/high-cost members; Includes children with special health care needs and Children's Rehabilitative Services qualifying conditions **Stratification Approach[2]:** medical, behavioral, and pharmacy claims; laboratory results; Health Risk Assessments; medical records	**Assessment:** comprehensive assessment consists of members' health status, physical and behavioral health history, medications, cognitive function, activities of daily living, and non-medical health factors **Care Plans:** care management service plan must include goals and self-management tools and focus on wellness and autonomy **Team-Based Communication & Family Assistance:** making and keeping medical and behavioral health appointments; understanding and complying with hospital discharge instructions; obtaining necessary services to ensure successful transition **Health Coaching & Skills Development:** provision of wellness, lifestyle, and prevention resources; interventions identified from tracking inappropriate emergency department utilization **Referrals/Provider Connections:** re-connecting with primary care providers; assistance with referrals **Care Transitions:** assist with barriers to transition to different levels of care	**Minimum Licensure or Credentials:** unspecified **Training or Expertise:** member self-management approaches; member advocacy; complex system navigation; strong communication with professionals and families; initial and ongoing training on identification and referral of quality of care and service concerns **Caseload Expectations:** the state does not prescribe caseload requirements for care management; however the MCOs are free to do so in order to best manage their care management programs	**Service/Care Plans:** developed within 30 days of completed assessment[2] **Member/Enrollee Engagement:** monthly care coordination and interdisciplinary care team meetings

Sources: [1] AMPM Policy 1021 [2] AHCCCS Complete Care Contract

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CALIFORNIA'S ENHANCED CARE MANAGEMENT (ECM)

Eligibility and Stratification for Enhanced Care Coordination	Select Enhanced Services *As required by the state Medicaid agency*	Care Coordinator Requirements	Care Planning, Communication, and Engagement
Eligible members for ECM[1]: child and youth population of focus per ECM policy guide, including high-need/ high-cost members; children enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond the CCS condition; those experiencing homelessness, individuals at risk for avoidable hospital or ED utilization, individuals with serious mental health and/ or SUD needs, individuals transitioning from incarceration, and children and youth in child welfare *Note: Members can be enrolled in ECM **or** in a 1915(c) waiver program, not in both at the same time.[1] **Stratification Approach[3]:** enrollment, claims, and other relevant data and available information regarding health care utilization, health needs (e.g., physical, behavioral, developmental, and oral), identified health risks and social drivers of health, and long-term services and supports needs	**Assessment:** comprehensive clinical and non-clinical assessment of health status and gaps in care **Care Plans:** care management plans must be individualized and person-centered and include performance goals, monitoring and follow-up associat-ed with the Member's physical and developmental health, mental health, sub-stance use disorder, oral health, palliative care, necessary community-based and social services, and housing **Team-Based Communication & Family Assistance:** centralized point of con-tact; provide family education to ensure understanding of treatment plans; assist family members to access support services; identification of and en-gagement with family and/or support networks **Health Coaching & Skills Development:** provide services to encourage and support healthy lifestyle choices and successfully monitor and manage health; strengthen skills to identify and access resources in preventing and managing chronic conditions Referrals/Provider Connections: coordination of and referral to social sup-port services and community resources; follow up to ensure services were rendered (i.e., "closed loop referrals") **Care Transitions:** targeted to reduce avoidable hospital admissions and read-missions; development of transition plans, including admission and discharge planning; communication supports, medication review and reconciliation, and monitoring service or treatment adherence	**Minimum Licensure or Credentials:** unspecified **Training or Expertise:** Managed Care Plans must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve **Caseload Expectations[1]:** the state does not provide required staffing ratios for the number of Members who can be served by each care manager	*Service/Care Plans:* Assessment and care plan upon successful engagement of the beneficiary and updated whenever needs change or it's clinically appropriate; Assessments from other programs (such as CCS or CCS Whole Child Model) may be utilized **Member/Enrollee Engagement:** must be primarily offered through in-person interactions[3]

Sources: [1] CALAIM Enhanced Care Management Policy Guide [2] ECM Requirements All Plan Letter (APL) 23-032 [3] Medi-Cal Managed Care Boilerplate Contract Exhibit A, Section 4.4

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DISTRICT OF COLUMBIA'S CARE MANAGEMENT AND CARE COORDINATION

Eligibility and Stratification for Enhanced Care Coordination	Select Enhanced Services *As required by the state Medicaid agency*	Care Coordinator Requirements	Care Planning, Communication, and Engagement
Eligible members for Level 3 Acuity and Specialty Cases: children and youth (0-21*) receiving SSI and/or those determined to have an SSI-related disability; specialty cases (e.g., involved in the child welfare or juvenile justice system; eligible for services under the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], also known as the Katie Beckett, program) *Note: Youth may remain covered up to 26 years if they were enrolled on their 21st birthday and remains in an CASSIP eligible program. **Stratification Approach:** MCO-developed stratification methodology approved by DHCF and categorized by acuity level (Level 1-Low; Level 2-Intermediate; Level 3-High); variables include predicting high cost, high utilization, clinical pathways, high social risk factors *Information presented here apply to high acuity populations stratified as "Level 3 Acuity" or "Specialty Cases"*	**Assessment[1,2]:** comprehensive assessment to determine medical, educational, social, or other services needed **Care Plans[1,2]:** multi-disciplinary and individualized; must specify short- and long-term goals and course of action required to manage medical, behavioral, social, educational complexities **Team-Based Communication & Family Assistance[2]:** educate on benefits, resources, and processes; identify and coordinate health education needs (e.g., classes, literature, referrals); make referrals to educational advocates and attend educational meetings **Health Coaching & Skills Development[1,2]:** educate on self-care strategies, illness prevention, health education and wellness activities; assist the provider and family to address overutilization and underutilization of services and noncompliance; provide resources to support primary, medical specialty, behavioral health care and social needs **Referrals/Provider Connections[1]:** follow-up with the referring source within 30 days, continue follow up activities until referral is closed; refer and link with other programs and services capable of addressing identified needs and achieve goals specified in the care plan **Care Transitions[1]:** assist in developing discharge plans; conduct home visits to support discharge plan understanding and treatment compliance; development of a transition plan between programs (e.g., from early intervention Part C to Part B), acuity/specialty care (e.g., acute care facilities, long-term care facilities, psychiatric residential treatment facilities, etc.), or levels of care (e.g., entering/exiting Child and Family Services Agency or Department of Youth Rehabilitation Services custody); formal guidelines for managing young adults with special health care needs aging out of CASSIP (e.g., minimum of 2 years before aging out) including recurring transition-related assessments to develop and monitor the transition plan	**Minimum Licensure or Credentials:** *Level 3 Acuity/Specialty Cases Primary Care Manager:* registered nurse, licensed independent clinical social worker / *TEFRA Primary Care Manager:* licensed independent clinical social worker **Primary Care Manager Training or Expertise:** *Level 3 Acuity/Specialty Cases Primary Care Manager (Level 3):* 5 years+ experience in related service systems (e.g., child protective services, juvenile diversion/delinquency programs, special education, psychiatric care, behavioral health care);provision of direct services and knowledge of and experience with relevant community resources; experience working with families in crisis who require intensive case management services / *TEFRA Care Manager:* trained in Coordination of Benefits, Third Party Liability and TEFRA eligibility requirements **Caseload Expectations:** For *Acuity Level 3/Specialty Cases,* no more than 60 CASSIP Enrollees assigned to a Care Manager; To maximize the caseload of 60, Specialty Care Managers may be assigned Level One (1), and Level Two (2) cases to reach the maximum caseload. At least one full-time Care Manager must be available to work only with the TEFRA population.	**Assessment and Service/ Care Plans:** comprehensive assessment within 60 days of enrollment; at least 3 care plans per year **Member/Enrollee Engagement:** at least 3 face-to-face visits per year

Sources: [1] Child and Adolescent Supplemental Security Income Program (CASSIP) [2] HSCSN Provider Manual [3] DC Medicaid Managed Care Quality Strategy

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MICHIGAN'S TARGETED CASE MANAGEMENT SERVICES FOR CMC			
Eligibility and Stratification for Enhanced Care Coordination	**Select Enhanced Services** *As required by the state Medicaid agency*	**Care Coordinator Requirements**	**Care Planning, Communication, and Engagement**
Eligible members for CMC TCM Services: children with medical complexities; must meet specified chronicity, complexity, and fragility criteria and experienced increased utilization **Stratification Approach**: medical records and utilization data review, following referral; intake/assessment to determine needs and goals, progress and outcomes, case complexity (i.e., medical, social, psychological, and financial), support systems and resource availability, self-management capabilities, risk factors, and preferences	**Assessment:** comprehensive assessment for medical, educational, social, and other service needs; 1st assessment must be in-person, subsequent assessments can be face-to-face (i.e., telehealth) **Care Plan:** individualized plan of care must include goals, document duration, scope, and amount of services, course of action and relevant providers and timelines for initiation/completion of actions to address medical, social, educational and any other identified needs, including non-medical health factors **Team-Based Communication & Family Assistance:** full integration of psychosocial and clinical care; 24/7 on-call coverage to respond to medical and care coordination needs **Health Coaching & Skills Development:** based on individual needs, the care team supports skill development, diagnosis-specific health management, and building independence for the child or youth **Care Transitions:** provision of comprehensive and intensive case management services and transitional care; ensure changes in needs or status are reflected in the individualized plan of care **Referrals/Provider Connections:** make referrals and establish effective working relationships with key health care and social service providers (e.g., primary care, specializes/subspecialists, private duty nurses, state and community-based organizations)	**CMC TCM Core Team and Qualifications:** Medicaid-enrolled, licensed pediatrician (Medical Director); non-physician practitioner (e.g., nurse practitioner, physician assistant, clinical nurse specialist); registered nurse; licensed master's prepared clinical social worker; program coordinator with bachelor's degree; and administrative staff/program assistant *Other providers (e.g., licensed pediatric behavioral health provider, dietician, respiratory therapist) may be recommended based on needs. **Desired Expertise of CMC TCM Core Team:** *Pediatrician:* medical/surgical experience; delivery of care to CMC or experiencing recurring hospitalizations and/or surgery; palliative care / *non-physician practitioner, registered nurse*, licensed independent clinical social worker: 2+ years professional pediatric experience **Caseload Expectations:** unspecified; however, a core team member must be available and accessible 24 hours per day, 7 days per week	**Service/Care Plans:** reviewed and updated quarterly **Member/Enrollee Engagement:** at least one in-person visit per year; monitoring should occur monthly, or more frequently based upon need

Sources: [1] Targeted Case Management (TCM) Services for children with medical complexity (CMC) [2] Comprehensive Health Care Program for the Michigan

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TEXAS' SERVICE COORDINATION

Eligibility and Stratification for Enhanced Care Coordination	Select Enhanced Services *As required by the state Medicaid agency*	Care Coordinator Requirements	Care Planning, Communication, and Engagement
Eligible members for Level 1 Services Coordination: Medically Dependent Children Program (MDCP) Members; members with complex needs, history of developmental or behavioral health issues; members with serious emotional disturbance or severe and persistent mental illness; or members at risk for institutionalization **Stratification Approach:** STAR Kids Screening and Assessment Instrument (SAI), telephonic screening, review of claims data, and communications with the Member, family, and providers *Information presented here* apply to highest need populations, stratified as "Level 1" for STAR Kids Service Coordination. Stratification criteria for Level 2 and Level 3 Service Coordination are detailed in the STAR Kids Contract.	**Assessment:** screening questions and modules that assess for medical, behavioral and functional services **Care Plan:** individualized service plan (ISP) includes recommended service needs to support Member's health and wellbeing; outlines covered and suggested services; establishes short and long-term goals and service preferences; and, for youth age 15 and older, must include goals and plans to transition to adulthood **Team-Based Communication & Family Assistance:** provide information about community organizations, such as public health, mental health and substance use services, disability programs, income and family support, nutritional assistance, housing programs, civic organizations, family support agencies and consumer groups or councils **Health Coaching & Skills Development:** provide health and wellness education to assist the member with self-management beginning at age 15 as a part of transition planning **Referrals/Provider Connections:** coordinate all covered services, non-capitated services, and non-covered services available; provide information to families around state and local programs and community organizations and, when applicable, options available through home and community- and facility-based programs **Care Transitions:** program education on long-term services and supports (LTSS) prior to the age of 10; begin planning for service and benefit changes at age 15; include transition-related goals in the ISP; develop continuity of care plan to transition Medicaid benefits without a break in service between STAR Kids and Texas' Medicaid Managed Care program for adults with disabilities, STAR+PLUS; discharge planning, transitional care, and other education programs regarding long-term care settings and options	**Service Coordinator Minimum Licensure or Creden-tials:** Level 1 Service Coordination: registered nurse, nurse practitioner, physician assistant, a licensed social worker; licensed professional counselor if the service needs are primarily for behavioral health Minimum licensure or credentials for Level 3 and Level 3 are detailed in the STAR Kids contract. **Training or Expertise:** All Service Coordinators must complete a minimum of 16 hours of service coordina-tion training every two years; All Services Coordinators working with members receiving LTSS must complete annual training; MCOs must administer the training; Transition Specialists must be trained on STAR+PLUS **Caseload Expectations:** Ratio must be clinically appro-priate; a named service coordinator must return a mem-ber's phone call or e-mail within two business days and attend at least 75 percent of face-to-face meetings.	**Service/Care Plans:** Initial SK-SAI within 15 or 30 business days of enrollment, depending on service coordination level. ISP must be completed within 90 days of initial SK-SAI and within 60 days of annual SK-SAI. ISP must be updated no less than annually and upon situations like a member request or change in condition. **Member/Enrollee Engagement:** at least one in-person visit per year for all members. The number of face-to-face service coordination visits and phone calls varies based on the member's service coordination level.

Sources: [1] STAR Kids Contract [2] STAR Kids Handbook

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WASHINGTON'S WRAPAROUND WITH INTENSIVE SERVICES (WISE) INTENSIVE CARE COORDINATION

Eligibility and Stratification for Enhanced Care Coordination	Select Enhanced Services *As required by the state Medicaid agency*	Care Coordinator Requirements	Care Planning, Communication, and Engagement
Eligible members[1,2]: individuals 20 years or younger, with complex behavioral health needs; must meet the Child Adolescent Needs and Strengths (CANS) algorithm* and have a mental health diagnosis; WISe is only available to Apple Health (Washington Medicaid) recipients. **Clinical judgement may be used if the youth does not meet the CANS algorithm or is under the age of 6* **Stratification Approach[2]:** screening process within 14 days following a referral; process includes information provided by the referral source, completion of the CANS Screen by a CANS-certified screener, and determining the youth meets qualifying medical necessity criteria	**Assessment[2]:** initial meeting(s) to establish rapport, build shared commit-ment, identification of strengths; obtain consent for services; initial discus-sions on the past, present, and future; discuss view of crises and develop a plan to stabilize dangerous or harmful situations; complete a strengths discovery, identify existing and natural supports; complete the full CANS within 30-45 days of enrollment **Care Plan[2]:** the cross-system care plan aligns needs and goals from multiple care plans into one plan; includes strengths-based solutions to address identi-fied needs; identifies barriers and potential crises; supports creating effective crisis prevention and response plans **Team-Based Communication & Family Assistance[1,2]:** focus on flexible and accessible supports by working at times (evenings, weekends) and locations that ensure meaningful participation of family members, youth, and natural supports; access to crisis response 24 hours a day, seven days a week **Health Coaching & Skills Development[2]:** intensive services and interventions to promote health and wellness and help build skills necessary for successful functioning in the home and community **Referrals/Provider Connections[2]:** coordination of other services (e.g., per-sonal care or respite hours, therapies [applied behavior analysis, speech, oc-cupational], medical or dental services); referral to, coordination of, and fol-low-up with providers for services and supports necessary to continue stabili-zation or prevent future crises, including coordination of services between the out-of-home provider and the youth's treatment team to facilitate a plan for rapid return home, when applicable **Care Transitions[1,2]:** creation of a formal transition plan, including identified post-transition strategies, services, and supports; for transition age youth, addition of a youth peer specialist to the child and family team and engage-ment in youth-led groups	**WISe Team:** Care Coordinator; Certified Peer Specialists (Family and Youth partners); Clinician/Mental Health Therapist **WISe Training and Coaching Framework:** *Orientation and onboarding:* 32 hours of live training + 14 hours of eLearning content for all new WISe staff; 36 hours of training + avg 6 hours of eLearning for Youth and Family Peers (not already certified) *Intermediate trainings:* 12-18 hours required training per role on the WISe team, annually *Coaching:* 8-16 hours of coaching calls annually **Caseload Expectations[1,2]:** maintain an average of 10 or fewer participants, with a maximum of 15 at any given time, for each Care Coordinator; must meet/exceed monthly caseload targets	**Care Plan Development[2]:** initial care plan completed during one or two meetings that take place within a 2-week period; monthly reviews; adjustments as suggested by the care team **Touch-Points[2]:** minimum of monthly but varies based on care team agreement and youth/family needs; must maintain WISe service intensity at a monthly average of 10.5 hours, but not less than 9 hours

Sources: [1] Washington Apple Health Integrated Managed Care Contract [2] WISe Service Delivery, Policy, Procedure, and Resource Manual