From:	Dannryan5@aol.com
To:	HFS.Webmaster
Subject:	Coordinated Care Comments from Dee Ann Ryan
Date:	Friday, July 01, 2011 1:02:37 PM
Attachments:	Coordinated CAre Comments final.ZIP

Dear Director Hamos,

I am appreciative of the opportunity to comment on the Coordinated Care Program Key Policy Issues document. Although I assisted with the The Association of Community Mental Health Authorities of Illinois' (ACMHAI) submitted comments, as a member of the Human Services Commission, I want to expand upon some of the questions. present some models and offer my assistance in whatever capacity you see fit. I have volunteered to participate in the HSC Committee on Clusters and also hope to see a committee formed soon to make recommendations on workforce development as I see many opportunities with ACA and may challenges to our existing workforce availability and structure.
Thank you for taking on this difficult challenge in Medicaid and overall health reform in our state.

Dee Ann Ryan, Executive Director
Vermilion County Mental Health 708 Board
101 West North Street
Danville, Illinois 61832
217-443-3500/217-474-3500

From: Dannryan5@aol.com
To: HFS.Webmaster; Hamos, Julie
Cc: acmhai@shout.net; peter@ccmhb.org; slewis@mc708.org
Subject: Re: Coordinated Care Comments from Dee Ann Ryan
Date: Saturday, July 02, 2011 10:22:11 AM

I forgot to include this model with my care coordination comments in the event Illinois does decide to move toward managed care.

www.hscsn-net.org

The District of Columbia operates a specialty managed care plan called Health Services for Children with Special Needs (HSCSN), for children who receive Medicaid and SSI benefits. Medically complex foster children and children with CHIP coverage may also enroll in the plan. HSCSN has no carved-out services; physical health, behavioral health, care coordination, residential treatment and wrap-around services are all included in the managed care benefit package. The plan is capitated, but shares risk with the District of Columbia. A voluntary program, it currently enrolls more than 3,300 children in the District.

Dee Ann Ryan, Executive Director
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Danville, Illinois 61832
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In a message dated 7/1/2011 1:02:15 P.M. Central Daylight Time, Dannryan5@aol.com writes:

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>
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> **Vermilion County Mental Health 708 Board**
> **101 West North Street**
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ATTACHMENT #1 Care Coordination Comments

The National Health Law Program has developed a Medicaid managed care and children with special needs – An EPSDT checklist to insure compliance with federal regulations and in the spirit of the intent of the EPSDT program.

Outreach and the Provision of Information

1. Do guidelines and contracts set forth the specific responsibilities of plans, contracting providers, and the state agency for conducting outreach and for informing special needs children, adolescents, and their families?

2. Will each enrollee be provided information, in writing and face-to-face, about:

(a) the need for preventive care;
(b) EPSDT services;
(c) appointment scheduling and transportation assistance;
(d) managed care, gatekeepers, and accessing specialists.

3. Will plans be required to document when enrollees decline EPSDT services *and* to deem the rejection as specific to that particular service (so that outreach and informing for future EPSDT services continues)?

4. Will "high-risk" enrollees receive targeted outreach and informing regarding EPSDT (e.g., families of children with developmental disabilities, adolescents, children in foster care, pregnant adolescents)?

5. Will the state agency, health plans, and providers use written and other appropriate means to communicate with persons who are hearing or visually impaired?

6. Will the state agency, health plans, and providers use written and other appropriate means to communicate with children and families who speak a primary language other than English?

7. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees of transportation assistance – including the availability of medical/specially equipped van transport – and arranging for or providing non-emergency transportation coverage?

8. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees, if needed, of related transportation services, which include meals and lodging, and the cost of an attendant?

Screening Services

9. Do the managed care guidelines and contracts specify separate screening schedules for medical, vision, hearing, and dental screens and allocate responsibility for each of these screens?

10. Will medical screens minimally include:

(a) comprehensive physical health and developmental history;
(b) comprehensive mental health and developmental history;
(c) a comprehensive unclothed physical exam;
(d) immunizations as set by CDC;
(e) laboratory tests, *including lead blood tests*;

(f) health education, *including anticipatory guidance to the child and family.*

Of paramount importance for behavioral health care is the extent to which EPSDT screens include a mechanism for early detection of behavioral health problems. It has been found contractual language often does not specify that a behavioral health assessment be conducted within EPSDT screens. This might necessitate Medicaid officials to investigate whether managed care systems should include fiscal incentives or other strategies to encourage primary care practitioners to conduct EPSDT screens and, as needed, to make referrals for behavioral health services.

11. Are network providers required to provide health education to family members, including information on monitoring and improving specific health conditions?

12. Are plans/providers required to use mental health and developmental screening tools developed by child health experts in these fields?

13. Do the contracts provide that primary care providers will be trained in the use of mental health screening tools and identification of children needing referrals?

14. Are plans prohibited from requiring prior authorization for periodic and interperiodic screens?

15. Are plans/providers required to make referrals for necessary follow-up and treatment, assure timely receipt of services, and maintain accurate health records for all screening components?

Treatment and Provider Participation

16. Do the managed care contracts list *all* of the services included in 42 U.S.C. § 1396d(a), specify which services the plan is expected to provide, and describe the coordination process to ensure that all services listed in 1396d(a) are met, regardless of who provides them?

17. Are plans prohibited from placing caps on the number of services a child can receive (*e.g*., 2 psychology visits per month)?

18. If plans are permitted to place tentative limits on treatment services, are the plans required to have an accessible, easy to use prior authorization system to obtain additional medically necessary services without interrupting continuous care?

19. Does the contract specify the EPSDT definition of medical necessity (42 U.S.C. § 1396d(r)(5) (services to correct or ameliorate physical or mental conditions)?

20. Does the contract clearly explain that habilitative – and not just rehabilitative – services are covered under Medicaid EPSDT and also who has responsibility for these services?

21. Are plans required to determine medical necessity based on the individual needs of the child?

22. Is the plan required to provide family centered services and involve families of children with special needs in treatment decision making?

23. Does the plan's benefit package cover consumer-run services, family-to-family supports, and family monitoring of care?

24. Are providers encouraged to provide services in a manner that promotes hope, recovery, independence, and respect?

25. Do treatment services emphasize early intervention, use of alternatives to restricted/institutional care, use of self-help, and health counseling?

26. Are plans required to pay for out-of-network second opinions when services are denied to children with special needs?

27. Are plans required to provide written notice to families when services to their children are denied, delayed, terminated, or reduced (i.e. the plan takes an "adverse action")?

28. Are plans required to notify enrollees of the circumstances under which benefits will continue pending resolution of disputes regarding terminated or reduced services?

29. Do the plan's written notices explain the right to a fair hearing to challenge the adverse action?

30. Do contracts specify that the plan must provide "case management" services as defined by the Medicaid Act (to assist individuals in gaining access to needed medical, social, educational, and other services)?

31. Will the plan be required to have a specially designated case manager/case coordinator to assist children with special needs and their families?

32. Will enrollees be informed of the availability of family planning services, both in and outside of the plans?

33. Will plans and providers be required to report encounter data sufficient to complete the HCFA Form 416?

34. Do guidelines and/or contracts include specific incentives/sanctions to assure at least 80% EPSDT participation?

35. Are screening and referral rates publicly disclosed for each plan?

36. Are payment rates adequate to enlist enough providers for special needs children's services so that services are available to Medicaid eligibles at least to the extent services are available to the general population in the geographic area?

37. Does the contract require the plan to make available a pediatrician or adolescent specialist within stated travel standards for every child/family who requests one?

38. Are plans required to guarantee access to pediatric specialists, children's hospitals, school clinics, and other children's providers in their plan networks?

39. Are payment rates adequate to compensate gatekeepers to provide primary care and case management services to children with special needs?

40. Will plans and providers be required to coordinate with other services, e.g. WIC, Title V, Part B and Part H, school based services, Head Start?

41. Are plans required to honor treatment plans developed by, or cooperate with the development of treatment plans under, Part H, Part B, and Title V?

42. Are health plans required to monitor the development of children who are at risk of development disability or delay?

43. Is the plan required to maximize coordination of care and smooth transitions among care-givers and care sites?

44. Is the plan required to honor ongoing plans of care initiated prior to enrollment until the enrollee is evaluated by her or his primary care provider and a new plan of care is established?

45. Do quality of care and outcome measures look for discernable improvements in children's physical and psychological health, community-based living arrangements, and relationships?

46. Do consumer satisfaction surveys include measures of satisfaction with staff appropriateness and accessibility of care and services and consumer rights?

47. Are plans required to comply with the Americans with Disabilities Act/ Rehabilitation Act (e.g. facility access standards; treatment in the most integrated setting)?

48. Is each provider and service site wheelchair accessible?

Best Principles for Measuring Outcomes in Managed Care Medicaid Programs – The American Academy of Child and Adolescent Psychiatry

ELEMENTS OF SUCCESSFUL MANAGED CARE MEDICAID MENTAL HEALTH PROGRAMS

Successful managed Medicaid mental health programs provide services that are:

- Child- and family-focused, with the needs of children and families dictating service mix and system design;
- Embedded in a system of care within the child's community;
- Culturally competent;
- Responsive to the needs of high-risk children, including children with serious and persistent disorders;
- Based on children's and families' strengths, as well as needs;
- Coordinated with primary care;
- Provided in the least restrictive setting that can meet the child's needs; and
- Enforcing a no eject/no reject policy.

Successful outcomes measurement in these programs:

- Is practical, as well as evidence-based, using measures with demonstrated validity and reliability;
- Collects data regarding a child's functioning from multiple sources, including the child, family, school personnel, primary physician, psychiatrist, and other relevant agents;
- Obtains comparable data for children not in the program, to allow for evaluation of program-specific results;
- Includes patient and family (consumer) perspectives in the selected outcomes indicators; and
- Acknowledges the objectives of different stakeholders in the system.

ATTACMENT # 2 Care Coordination Comment-HFS

From Catalyst Center Website:

www.catalystctr.org

Care Coordination

Most Title V programs fund care coordination for Children and Youth with Special Health Care Needs (CYSHCN), but these services are often limited by the availability of block grant funds or state funding for this specific service. Several states have expanded the availability of care coordination services for CYSHCN by blending state Title V and Medicaid funding, or by blending Title V and Medicaid funding. Other states use Medicaid funding alone for care coordination.

In Michigan and Utah, state funds for CYSHCN are used to provide the state match to draw down federal Medicaid funds for care coordination for Medicaid-eligible CYSHCN. This means that states are able to expand the availability of care coordination services by preserving their block grant funds to pay for care coordination for children who are uninsured or privately insured. Michigan also uses these funds to provide case management services, including coverage for nurse home visits for children with more complex conditions.

In New Mexico, Title V employs 45 social workers throughout the state to provide care coordination for CYSHCN enrolled in either Title V or Medicaid. Care coordination is financed with a mix of Title V and Medicaid dollars.

Maine Medicaid uses Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding to operate its own three-tiered care coordination program:

- **Tier 1**: The state's Medicaid member services office provides standard referrals to services for all children.

- **Tier 2**: Nurses focus on hard-to-find services such as dental care for CYSHCN, private duty nursing and mental health care.

- **Tier 3**: Public health nurses work with families using the Bright Futures guidelines, a detailed standard of care to promote the health and well-being of children with a particular focus on child development and screening.

Oklahoma Medicaid also operates its own care management unit, using nurses and social workers to coordinate care for members. Other state Medicaid programs, such as Oregon's, purchase care coordination services from outside vendors.

The California and Vermont Medicaid programs fund the delivery of care coordination services in conjunction with primary care practices. In California, this is accomplished by paying enhanced rates for pediatric primary care, which includes funding for care coordination for CYSHCN. Vermont Medicaid, on the other hand, hires its own care coordinators who work with primary care practices to provide care coordination for adults or children with disabilities who are not connected with other care coordination services.

Texas Medicaid reimburses clinicians for face-to-face and non–face-to-face care coordination for CYSHCN served by the Medicaid program or the CSHCN Services Program. This new service is called Clinician Directed Care Coordination.

In New Hampshire, reimbursement for care coordination is covered by a private health plan. The Hood Center for Children and Families at Dartmouth Medical School, Anthem Blue Cross/Blue Shield, Title V and NH Family Voices have implemented a team approach to care, care coordination and family support for children with chronic health conditions. The Title V care coordinators partner with practice-based clinical providers. Anthem then provides reimbursement for care coordination services for those patients covered under a NH Anthem plan.

Highmark Caring Foundation's program, "Care Coordination for Children with Special Health Care Needs and Their Families," has provided care coordination services to over 5,000 children with special needs enrolled in CHIP in the 49 counties of Pennsylvania served by Highmark over the past two years. In addition, over 320 children and families have received in-home evaluations and on-going services from their Nurse Care Coordinators in the Caring Program. This special needs program and effort is solely funded by Highmark's Caring Foundation.

Also in Pennsylvania, Title V dollars support care coordination through the Pennsylvania Medical Home Program. When pediatric practices are trained, they can receive a small, short term stipend to support the cost of a care coordinator. Practices need to meet minimum practice criteria to be eligible for this funding. The Medical Home Program has trained 107 practices since inception in 2002 and is active in 37 counties. Pennsylvania has also developed some pay-for-performance (P4P) measures surrounding CYSHCN. Any pediatrician who serves children with complex care needs can receive extra funding for maintaining and updating a care plan twice a year. This is available to any pediatrician or family practice physician in Pennsylvania, not only those who are part of the medical home initiative.

Rhode Island ‘s CEDARR Program (Comprehensive Evaluation Diagnosis Assessment Referral, Re-evaluation) Family Centers is a Medicaid-sponsored program that provides care coordination/care management, along with a range of services such as nursing care, home-based therapeutic care or respite care. In addition, the RIte Care plans serve children who are low income (and their families) and provide in-plan care coordination by health plan staff. Also, the Pediatric Practice Enhancement Project (PPEP) employs parents in key primary and specialty sites to provide services including care coordination. There are 25 practices that are funded as PPEP sites through the Health Department‘s New Freedom Initiative (D-70) grant and through the Department of Human Services.

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Response to Coordinated Care Paper from HFS

Dee Ann Ryan, Executive Director
Vermilion County Mental Health 708 Board
Danville, Illinois
Illinois Human Services Commissioner

2.b. – Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients – for instance, children versus adults or disabled versus non-disabled

In order to be in compliance with federal Medicaid rules on EPSDT – Early, Periodic, Screening, Diagnosis and Treatment – special consideration for children must be utilized in the development of state Medicaid policies and practices.

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From: 2009 Kaiser Foundation Focus on Healthcare Reform –
CHILDREN AND HEALTH CARE REFORM: ASSURING COVERAGE THAT MEETS THEIR HEALTH CARE NEEDS
By Joan Alker, Karen Pollitz, Victoria Wachino, Jennifer Libster, and Julia Paradise

"Children are a distinct population with unique health care needs. Because children are growing and changing, the health care needed for children includes services to meet their developmental needs as well. For the same reason, health care for children also emphasizes preventive care and early intervention. Appropriate preventive care ensures that, to the maximum extent possible, disease is prevented in children, and children do not experience avoidable health complications. When illnesses or developmental disabilities are not detected and treated early, children may be unable to "catch up" on some developmental losses.

To confer the most benefit, many early detection and preventive services are best provided at specific points in a child's life. Professional guidelines developed by the American Academy of Pediatrics (AAP) establish a schedule for child preventive services, including immunizations and screenings. These guidelines are part of *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*, which was developed by the Health Resources and Services Administration, in conjunction with providers, consumer representatives, and other experts, to serve as a national standard for quality well-child care.

Medicaid's EPSDT benefit entitles all children in Medicaid to comprehensive screening, prevention, diagnosis, and treatment services through age 21. To foster early identification of children's physical, mental, and developmental conditions, EPSDT guarantees health screenings consistent with a periodicity schedule. If a screening or subsequent diagnosis identifies a health condition, Medicaid covers any follow-up treatment needed. This applies equally to medical, developmental, mental, acute, and chronic conditions. Covered services encompass long-term care services and support as well as the acute health services traditionally covered by commercial insurance policies. The EPSDT benefit package was designed to reflect professional pediatric standards of care.

Apart from its comprehensive benefit package, another aspect of EPSDT that distinguishes it from private insurance coverage is a broader definition of "medical necessity" that supports children's health and developmental needs and helps children with serious disabilities or diseases that may be improved, but not cured, to maximize their potential. The definition requires states to provide children with all services necessary to "correct or ameliorate defects and physical and mental illnesses and conditions…"

Medicaid's EPSDT benefit covers the full range of care children need, including both acute care and long-term services and supports. In addition, under EPSDT, little or no cost sharing is required and total cost-sharing in a year is limited to 5% of family income, providing important financial protection for low-income families. The American Academy of Pediatrics has recommended EPSDT as the model for the benefits package provided to children under health reform." I have also attached a document prepared by the National Health Law Program which could serve as a template for any Care Management model for children to insure compliance with EPSDT.

ATTACHMENT #1

2.f. – How can the Department most effectively work with other payers to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

For children It is necessary to recognize that there are multiple stakeholders involved in a managed care Medicaid contract. These include the child and family, treatment providers, managed care Medicaid contractors, the federal government, state Medicaid agencies, and the many child-serving agencies in the community (i.e. public and private child welfare, education, juvenile justice, health, substance abuse, and mental retardation/developmental disabilities organizations); as well as members of the community in which the program resides. Each of these stakeholders may desire different outcomes. For example, the state Medicaid office may emphasize control of overall costs; members of the community may want increases to children's access to services; child welfare agencies may want to decrease the number of out-of-home placements; and families might want a reduction or resolution of their child's symptoms and an increased ability to function in various social roles. Each of these perspectives is valid and should be represented in the community's outcomes model.

In addition, a system of mental health care should take into consideration the special characteristics and needs of children and adolescents with severe and persistent disorders. Although these youth frequently are high utilizers of care, it is well documented that they tend to receive fragmented, poorly coordinated care in overly restrictive settings.

Over the past few years, the state of Indiana decided to implement the CANS (Child Adolescent Needs and Strengths) as a common comprehensive assessment tool across child serving agencies for the purpose of improving the quality and cost effectiveness of behavioral health services for children and adolescents. Multiple factors were critical in making the decision to move from the current child/ adolescent assessment instrument used by Indiana DMHA. The most significant factors were:

1. Children and adolescents with serious emotional disturbance are commonly served by multiple systems including mental health, juvenile courts, public schools, and child protective services. Historically, these systems have developed separate jargon, missions, and services. This type of "silos" of services has resulted in communication barriers between the systems and fragmentation of services. An assessment instrument that can cross these barriers by creating a common assessment language while addressing the child and family status in a comprehensive manner was identified in Indiana as the first step toward improving service delivery for these youth and their families.

2. A major complaint of families and other stakeholders is that they have to answer the same questions over and over as they gain access to different organizations/agencies. Additionally, they feel confusion about what is best for the child and family when multiple professionals are involved and are not talking to each other. Demographic information and assessment data that can be access by any agency working with the child and family is expected to minimize the confusion and frustration of these families while also creating a bridge among the agencies.

3. Managed care programs (such as those implemented in Indiana) typically need a process to define what the child/family needs – what services in what amount and at what level of intensity (Level of Care Determination). DMHA needs to know whether or not children/adolescents are receiving the services they actually need and where gaps exist in the mental health service delivery system. Department of Child Services needs to know what type of placement is in the best interest of the child for safety and permanency planning. Department of Correction needs to know what community integration services are required to reduce recidivism. The CANS will enable each of these agencies/ organizations to have these needs met.

4. Finally, National Outcome Measures are being required by each state that receives mental health block grant funding from the federal Department of Health and Human Services, Substance Abuse and Mental Health Administration. For children and adolescents, these outcome measures include school participation, attendance, performance, juvenile justice involvement, building social supports, living arrangements, and level of functioning. For most states, including Indiana, obtaining data regarding these aspects of the youth's life is very difficult. The CANS will provide the data needed to

report on all these outcome measures.

Implementation of the Indiana CANS informs individualized care plans and level of care decisions regarding behavioral health needs and strengths. The CANS also provides a means for quality improvement through the aggregation of data into a centralized location for analysis. It is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of meeting the behavioral health needs of Indiana's youth through cost effective services.

Excerpted from: State of Indiana Family and Social Services Administration Division of Mental Health and Addiction-Business Case for Adoption and Implementation of the Child and Adolescent Needs and Strengths Assessment

The CANS is currently used in over 40 states with statewide utilization across child serving system, including child welfare, mental health, juvenile justice, education, and early interventions in 16 states and four Canadian provinces. In Illinois, the CANS has been used for 3 years in DCFS to support a system of coordinated behavioral healthcare for children and youth and to improve the responsiveness to the mental health needs of children and youth in state custody. CANS data is being used for geo-mapping and resource identification, quality assurance and continuous quality improvement. In Maryland, CANS is used across systems by family and systems navigators, care coordinators, and family support partners, all of whom are essential to a well designed care management system for children. In Massachusetts, CANS was introduced as part of statewide system reform as a result of an EPSDT class action suit-ROSIE D. This system change resulted in six new community based services including Wraparound which is proving to allow more children to remain in their homes and community and reducing costs of out of home care and hospitalizations.

RESPONSES TO FOLLOWING QUESTIONS COMBINED:

5.e. – Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

6.c. – Can entities limit the eligible population they serve, and how narrowly can they limit the population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

6.h. – If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

A demonstration project to enhance the existing program for Children with Special Healthcare Needs (CSHNS) in Illinois to include children with chronic/lifelong social/ emotional disorders such as SED, Autism and PDD with enrollment mandated to children identified through analysis of high utilization of medical, behavioral health and especially out of home care.

There needs to be special arrangement to provide coordinated care to children with SED and other social and emotional disorders who are cycling in and out of psychiatric hospitalization (high Utilizers) at enormous cost to our Medicaid system. (We have put in a request to HFS for a compilation of these costs for high utilizers but have not yet received it. These children need to be identified as Children with Special Healthcare Needs (CSHCN) and offered/or be mandated to participate in an ongoing care management program. In many states, children with severe emotional disturbance (SED) are considered eligible for care management through state Title V CSHCN (Children with Special Healthcare Needs) and Medicaid programs. In Illinois, the CSHCN care management does not include children with SED unless they have a co-existing specified physical disability even though children with SED most often have life long chronic conditions which require expensive medications and frequent hospitalizations. Illinois Medicaid children with SED do not receive integrated care even though they are likely involved with multiple systems and they only receive episodic care management when they experience a crisis. With care management services such as those already available in Illinois for CSHCN, a more holistic and continuous approach to their care might alleviate high cost crisis care, hospitalizations and out of home placements. There is an inherent conflict with the care management situation for children with SED in Illinois in that the "case management" must be provided by community mental health agency which is delivering the treatment. The resulting care management/treatment plan usually involves only the services that center can deliver and often not all that and independent care management entity might see as necessary. This adds to the disparity in treatment options and does not take into account medical or social needs the might require for continued emotional and physical health. Expanding the scope of CSHCN to include children with SED (would require an administrative rule change) would allow them to have the same benefits of care management and would reduce high costs of crisis driven care.

According to: Title V & XIX Interagency Agreements Issue Brief No. 1: CC/CM
http://www.mchlibrary.info/iaa/resources/ebrief_case_management.pdf

What is important is to know: what the service is, who is delivering the service, and how the service isfinanced, and what impact it is intended to have for the population served. (Rosenbaum et al., 2009) Especially now, when budgets are tight and new opportunities for maternal and child health (MCH)are being introduced under health reform, interagency agreements (IAAs) between state Title Vprograms and Medicaid can be a powerful tool in assuring coordination and mutual support in delivering services such as CC/CM.
Virtually every State has CC/CM for CSHCN supported by Title V dollars. In most states, CC/CM for CSHCN is funded by Medicaid. While sometimes strictly administrative in nature, CC/CM for CSHCN is more often covered as stand alone medical assistance case management. This area is ripe with opportunities for shared responsibilities and interagency collaboration. Title V-Title XIX IAAs in Connecticut, Florida, North Dakota, Oklahoma and Washington State reflect different approaches to collaboration. The ACA adds incentives to develop health homes for people with chronic conditions in Medicaid. A new Medicaid option will permit enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. For example, such an option might assist in providing patient-centered medical/health homes for women or children with chronic conditions. (Effective January 1, 2011)
(All CSHCN ,including children with SED, would fit this definition and the state would receive 90% FFP for two years.

Also, grants to states to promote Community Health Teams that support the patient-centered medical home are provided through ACA. Community-based interdisciplinary teams will provide support services to primary care providers. The team's roles would include: collaboration with providers; coordination of disease prevention and management; case management; and support for transitional health care needs from adolescence to adulthood

According to information in: http://www.chcs.org/usr_doc/CSHCN_Toolkit.pdf

Well-designed managed care programs offer more comprehensive health services than fee-for-service systems and can work with providers to create a medical home, to arrange for and coordinate specialty diagnostic examinations and care, and to act as an advocate on behalf of the child's needs. Managed care plans can make a major difference for all CSHCN by focusing attention and resources to improve their care. With the sophisticated data systems available to managed care plans, there are wonderful opportunities for identifying CSHCN (including children with SED) in the plan and offering physician incentives for providing care that corresponds with the medical home guidelines. Managed care plans can assist providers with enhanced care coordination aimed at preventing emergency room visits, hospitalizations, and days of work lost to parents.

Most health plans and PCCM programs have an infrastructure that can be used to identify service patterns and use, improve access to health care, strengthen care coordination, and monitor quality of care and health outcomes. Children with SED need this level of ongoing surveillance in order to monitor care in a horizontal timeline, an element which is missing with the current episodic, crisis driven care in multiple hospitals and with multiple providers.

Meg Comeau, the Director of the Catalyst Center, which is the MCHB funded national center dedicated to improving the health insurance and financing of care for children with special health care needs and disabilities, has offered to assist us in developing and determining financing models for these vulnerable children so they do not become an afterthought in Medicaid and Healthcare reform in Illinois. Attached are models from the Catalyst Center on Care Coordination from around the country.

Attachment #2

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