Recommendations for How Illinois’s Medicaid Managed Care System Can Positively Impact Care for Children with Special Healthcare Needs

Kathryn Cordiano

Culminating Experience – Northwestern University Masters of Public Health

This paper is submitted in partial fulfillment of requirements for the Master in Public Health Degree
ABSTRACT

Introduction: Illinois aims to introduce 29,000 Children with Special Healthcare Needs (CSHCN) into its Medicaid Managed Care (MMC) program starting in 2018. In theory, the care coordination and quality-based incentives in MMC could improve care and reduce healthcare costs for this population. However, other states have experienced issues bringing such complex patients into a system that aims to be streamlined and cost-effective. Due to the large medical costs and complexities of CSHCN, improving care for this population in MMC could lead to a significant number of pediatric health improvements and cost savings across Medicaid. This paper aims to draw on experiences from previous implementations and provide recommendations for states considering this transition, specifically around what requirements to include in insurer contracts and how to ensure insurers are meeting their obligations.

Methods: Five areas of focus were selected: reduction of racial and income disparities, ability to monitor and ensure network adequacy, ease of transition into and between managed care providers, adequacy of provider payments, and protection of EPSDT benefits. In each area, a literature review was conducted to identify best practices among states who previously went through this transition. These strategies were separated into recommendations for insurer contracts and recommendations for implementation, and apply to all states who are still looking to integrate CSHCN into MMC. These recommendations were then compared to the Illinois model contract with insurers, to create suggestions specific to Illinois.

Results: Contract and implementation recommendations for all states, as well as specific suggestions for Illinois, were provided for each focus area. In each focus area, Illinois had already integrated at least one of the review’s recommendations, but was also missing at least one.
**Conclusion:** Across all focus areas, there were three principal recommendations for states looking to introduce CSHCN to MMC. States would ideally provide CSHCN-specific exceptions in MMC contracts when necessary, attempt to align insurer and state goals through incentive updates, and employ comprehensive monitoring systems to oversee insurer behaviors. These recommendations can be used as a platform for discussion between organizations within the Child Health Policy Collaborative to help shape future research and strategies of the collaborative.
INTRODUCTION

Illinois first launched its mandatory Medicaid Managed Care (MMC) program in 2011, requiring 50% of Medicaid recipients to enroll in managed care in order to reduce waste in the state’s $15 billion program and improve the health of the enrollee population. Over the years, the state has expanded the list of eligible populations and added services. Managed care has led to cost reductions and an overall increase in care compared to the previous fee-for-service (FFS) model. However, participant confusion, along with a lack of Managed Care Organizations (MCOs) and eligible providers in numerous counties, has caused the state to rethink the program’s current structure. In February 2017, Governor Rauner announced an overhaul of the Medicaid program, which included expanding MMC to every county in Illinois, cutting the number of MCOs from 12 to 6, creating a new standard contract for all insurers, and increasing the overall percentage of Medicaid recipients covered by managed care from 65% to 80%. As part of the expansion, several special child populations will be moved into managed care, including 29,000 children with special health care needs (CSHCN). The purpose of this paper is to create recommendations for how Illinois, or any other state considering this change, can approach the introduction of this population into MMC by examining the structure of care for CSHCN in states that have already made this shift and uncovering best practices.

The Maternal and Child Health Bureau broadly defines CSHCN as “those who have or are at increased risk for a chronic, physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required for children generally.” Under this definition, 19.4% of children in the United States have special health care needs. Within this population, 30% reported two or more functional difficulties and 71% live below 400% of the Federal Poverty Level. Through avenues such as income or eligibility for an increased
level of care, 48% of these children are enrolled in Medicaid or CHIP, making up about 26% of the pediatric population in these programs.\textsuperscript{8}

CSHCN outcomes are particularly important when it comes to the success of programs that are meant to improve population health and create a more efficient, cost-effective healthcare system. Although they make up only 19.4% of children in the country, CSHCN account for over 50% of children who are in less than very good or excellent health, as measured by the 2016 National Survey of Children’s Health. Therefore, health and preventive care improvements for this group could lead to a large decrease in morbidity.\textsuperscript{8} In addition, their health expenditures are 3 times higher than typical children, with CSHCN making up 15.6% of the pediatric population but 42.1% of medical costs in 2000.\textsuperscript{8} These disproportionate medical costs burden not only federal and state insurance organizations, but also the families of these children. Parents of CSHCN are almost twice as likely as parents of non-CSHCN to experience problems paying medical bills.\textsuperscript{8} Therefore, improvements in care for this population could lead to a significant number of pediatric health improvements and cost savings across Medicaid, even though CSHCN make up a small percentage of the overall Medicaid population.

Illinois’ switch from fee-for-service to managed care, along with the recent Medicaid expansion, is meant to improve health outcomes and decrease costs by changing the structure and incentive system around health insurance. Managed care focuses on coordinating care between an individual’s different providers, which both improves care by treating the “whole person” instead of focusing on a single medical issue and also streamlines processes by minimizing duplicative procedures and other unnecessary services. The program also aims to reward quality over pure numbers of services, which encourages providers and insurers to take steps to obtain the highest health benefit per dollar spent. For patients without special health needs, managed care have been shown to provide these expected benefits. In a pilot program at Lurie Children’s Hospital, children
who were enrolled in Medicaid Managed Care used more therapy and checkup visits overall, but spent 50% fewer days in the hospital, 22% less time in the emergency room, and the overall cost of care was reduced by 18%.6

The focus on care coordination and quality-based incentives make a compelling case for how managed care can benefit CSHCN, who frequently have to navigate a complex network of providers and use a large number of services. However, introducing patients this complex into a streamlined program can cause unforeseen issues. CSHCN patients introduce new situations that Managed Care Organizations previously did not have to address and highlight gaps in coordination that negatively affect the health of complex patients. For example, since MMC programs have limited networks, they will not include all the doctors these children were previously able to see in their FFS program. CSHCN then may need special authorizations to access a specialist outside of their network or a certain distance away from their homes, which can be difficult to navigate and delay access to care or necessitate an unwelcome switch in provider.11 In addition, MCOs may have difficulty coordinating care for complex diagnoses. For CSHCN, adequate care coordination typically means organizing several different specialists for each patient, which requires additional resources and community-level knowledge that a MMC program may not have or know to provide.11

Illinois experienced these issues when it first started mandatory Medicaid managed care to almost 40,000 adults with disabilities. The program had trouble recruiting leading academic medical centers, so patients could not see physicians with whom they had spent years building relationships and struggled to find specialists who performed the specific services they needed. In addition, MCOs in some areas did not have enough providers to meet expected travel requirements, which caused network adequacy issues in multiple counties.12

Given the potential benefits and previous difficulties, it is important for Illinois to take extra steps to ensure a successful introduction of the CSHCN population into MMC. One step towards this
goal would be to look at current practices in states who have already experienced this implementation, and learn from their achievements and missteps. Most states are already using MMC to try to improve care and reduce costs around CSHCN. As of 2017, Medicaid programs in 47 states and Washington D.C. have moved at least some CSHCN from fee-for-service to managed care and 34 states enroll a proportion of this population in MCOs specifically (Table 1). Each state seems to take a slightly different approach in their care for CSHCN, which means there are a lot of different strategies to compare and learn from. Although most states do not conduct their own surveys on CSHCN experience and do not collect extensive CSHCN-specific outcome data, there are studies that compare different states policies and interview members of MCOs, Medicaid, and parents of CSHCN. Through these sources, this paper will provide insights into best practices that Illinois and other states can follow when introducing special child populations into MMC programs, specifically MCOs. The implications for creating efficient and effective managed care system for this population can lead to significant pediatric outcome improvements and expense reductions within state Medicaid systems.

**METHODS**

In order to evaluate the potential impact of Medicaid Managed Care on CSHCN and create recommendations for Illinois and other states who are thinking about this transition, five focus areas were chosen and a review of the literature was conducted to find expert recommendations and previous strategies around these areas from states who already went through this process. These findings were then synthesized into managed care contract and implementation recommendations for each of the five areas. In addition, the recommendations were compared to Illinois’ published model contract with MCOs to create Illinois-specific next steps to achieve these goals.
Focus Area Selection

The Illinois Child Health Policy Collaborative, a partnership initiated by Ann & Robert H. Lurie Children’s Hospital of Chicago which consists of several advocacy organizations throughout the state, chose 5 focus areas to evaluate the impact of MMC on the care of CSHCN. The collaboration decided to look at: reduction of racial and income disparities, ability to monitor and ensure network adequacy, ease of transition into and between managed care providers, adequacy of provider payments, and protection of EPSDT benefits. Although these areas do not cover every topic required to make the move to managed care successful, they were determined important features in ensuring equal and adequate care among the CSHCN population.

Reduction of racial and income disparities was chosen as a focus area because, for many states, Medicaid is seen as part of the solution to reduce these differences in key health metrics such as access to care, health outcomes, and non-emergency use of emergency rooms.\textsuperscript{27} By providing services to lower-income patients, Medicaid reduces income-related disparities in healthcare utilization within the general population.\textsuperscript{28-29} In addition, studies have shown that Medicaid overall, along with MMC specifically, decreases racial disparities in healthcare when compared to private insurance.\textsuperscript{30-33} However, even with this reduction, racial and income disparities still exist both between private and Medicaid enrollees and among Medicaid patients.\textsuperscript{34} Researchers have specifically found these inequities in pediatric specialty care metrics, such as utilization of mental health services\textsuperscript{35} and access to care coordination.\textsuperscript{36} By taking steps to minimize these differences, Illinois can help make specialist services accessible to all children who need them.

States’ ability to monitor and ensure network adequacy is a particularly important area because, with the introduction of managed care, states contract out their previous responsibilities of directly paying providers and monitoring enrollee networks. Although this change in roles is meant to improve care coordination for participants, the details of the process can cause potential
problems for pediatric specialty services. The risk of capitation payments is that MCOs have an incentive to contain costs through smaller provider networks, which could constrict access to care. In addition, MCOs may have limited experience creating networks for CSHCN, which could lead to difficulties in implementation. Although states are required to develop and implement network adequacy standards for different types of providers by 2018, CSHCN require access to a wide range of specific pediatric specialists and may require higher levels of care than are typically available in a managed care network.

The collaborative chose to look at the ease of transition into and between managed care providers because of widespread concerns that children in active treatment will be forced to change specialty providers when they are most vulnerable. Switching providers can lead to negative outcomes for these children, since they often have complicated diagnoses and need providers that are familiar with all aspects of their condition, such as prior and current treatment plans. This level of complication means that CSHCN may need a longer transition period than most patients when switching to a new provider, and will likely have fewer options of new providers to contract with since many of their providers will be specialists. By making the transition as easy as possible, states and MCOs can protect the current level of care these children receive.

Adequacy of provider payments is a significant issue because the incentive structure of managed care is one of the program’s most attractive elements: insurers and providers can potentially be compensated for each patient enrolled and receive bonuses for meeting quality and budget goals. However, Illinois has struggled with the implementation of this new cost structure. Administrative issues, along with significant differences between each MCO’s provider requirements and reimbursement rates, led to a lack of managed care providers. Ultimately, providers’ confusion around the managed care system forced some insurers to pull out and counties such as Champaign to switch back to fee-for-service. This instability and lack of clarity is particularly harmful to CSHCN,
who rely on a complex network of providers and have a low tolerance for instability when it comes to insurance and access to care.

Protection of EPSDT benefits is an area of focus because of the importance of the program and the potential risk to these benefits in managed care. EPSDT benefits were started by Medicaid in 1967 with the goal of providing comprehensive prevention, diagnostic, and treatment services for children and adolescents under 21. The program entitles children to age-appropriate screening, vision, dental, hearing, diagnostic, and treatment services to ensure children’s health problems are properly addressed as early as possible. However, the switch to managed care can create a conflict between an insurance plan’s included benefits and the habilitative services guaranteed through EPSDT. If a managed care plan includes a set number of speech therapy services but a child needs more, who is responsible for covering the extra sessions? Since CSHCN require more specialized services than the average child, this situation could come up frequently and any confusion around the answer could delay access to care. By providing clear answers around what EPSDT services are provided by which party and abiding by these rules in practice, the state can eliminate any confusion with the insurer and CSHCN can more easily access any needed services.

Contract Review

A review was conducted of the Medicaid Managed Care model contract between the Illinois Department of Healthcare and Family Services and the RFP awardees, as an indication of the 2018 final contract that all MCOs would be required to sign. The contract was originally published on February 27, 2017 and went through two revisions: one in April before RFP Award Notices and one in September after MCOs were notified of RFP results. The goal of this evaluation was to understand the requirements Illinois already planned to place on all insurers, and which provisions would be removed for both parties to reach an agreement. The September version of this contract was
specifically reviewed for any language surrounding the 5 focus areas determined by the Illinois Child Health Policy Collaborative through the full reading of articles, whose relevance was determined through an evaluation of the table of contents and key-word searches throughout the document. A review of the articles used for each focus area is detailed in Table 2.

**Review of Other States’ Strategies and Experiences**

A literature search was performed to look for evaluations of both contract and implementation strategies employed by other states as they moved CSHCN, general pediatric populations, or adults with special healthcare needs into Medicaid Managed Care. Each of the 5 focus area required a different literature review, due to the significant differences between each topic, but the same overall methodology was employed for each one. As part of the search, we first looked through journal articles and academic reports using key words and phrases specific to each focus area, to obtain cross-state analyses of policy surrounding pediatric or adult specialty services in MMC. We limited the results to studies from 2014 or later, due to the introduction of the Affordable Care Act and its subsequent changes to Medicaid and health policy overall. In addition, we conducted searches for newspaper articles and state-sponsored documents that evaluated strategies to improve care for CSHCN or general pediatric specialty services on the local and individual state level. The results went as far back as 2010, depending on the context and the state being examined.

Once all the literature was collected, each document received an initial screening to confirm it fell into the desired focus area. Studies that did not fall into the specified topic were discarded. The remaining sources were separated into types: academic study or report, state-sponsored document, or newspaper article. Each document was then read carefully and summarized based on questions that pertained to each source. Table 3 shows the types of sources and the questions
used for each type of source. The article summaries were then combined into one master document for each focus metric, organized by recommendation.\textsuperscript{45,46} The arguments, supporting points, and comments for each article were synthesized into a summary for each recommendation, to help evaluate the successes and failures of similar transitions that led to these strategies and best practices. The summaries were then separated into two categories: contract recommendation and implementation recommendation. Contract recommendations consisted of suggested language or requirements that states should add into managed care contracts with insurers. Implementation recommendations included strategies and best practices for how states should enforce the contract and keep insurers motivated to provide adequate care to complex patients such as CSHCN.

These recommendations were proposed for all states who are looking to transition CSHCN into managed care. The recommendations were then compared to the current Illinois contract to determine next steps that Illinois could take to help ensure quality care for the CSHCN population as they move to MMC. A review of which studies were ultimately used to inform recommendations and next steps for each area is detailed in Table 4.

RESULTS & POLICY ANALYSIS

After reviewing the Illinois model MMC contract and the literature around strategies from previous state implementations, we came up with general contract and implementation recommendations in each of the five focus areas. These recommendations are intended for all MMC programs looking to expand coverage to CSHCN populations. We then compared these recommendations to Illinois’s model contract, and found that the state had already implemented at least one recommendation in every area. However, in each area there was also some room for improvement.
Reduction of Racial and Income Disparities

Contract Recommendations:

In order to reduce these disparities, states can require MCOs to gather standardized data around the race, income, and language preference of patients and report this information to the state to show where and how these disparities exist. Although the Affordable Care Act requires federal collection of race, ethnicity, and language information for public insurance enrollees, this data is often incomplete for managed care plans. Given this limitation, states could improve upon this information through stricter requirements around the percentage of patients with information in CAHPS or HEDIS, or by mandating supplemental reporting from insurers.

MMC contracts optimally would include language that directs MCOs to provide Integrated Case Management (ICM), a program providing care coordination and individualized health plans, to children with chronic conditions. A study in Virginia found that both standardized and patient-centered ICM plans essentially eliminated racial disparities in healthcare utilization between African American and White patients with chronic conditions. In addition, patient-centered plans reduced racial differences in Emergency Department use and inpatient admission rates.

Implementation Recommendations:

Some states who successfully integrated CSHCN into MMC created goals for reducing disparities in the Medicaid population as part of their quality initiatives and incentivized MCOs who can show they are meeting these objectives. Michigan passed a public act requiring the Department of Community Health to develop a structure to address racial health disparities and monitor statewide progress. In addition, California provides incentives to MCOs who are able to improve health equity among their patient populations. This step can help ensure MCO and patient objectives are properly aligned.
By conducting regular audits of state Medicaid non-emergency medical transportation (NEMT) program, states can provide patients with transportation to doctor’s appointments and preventive care when these enrollees otherwise could not afford the trip. Travel assistance is especially important for pediatric specialty care because networks tend to have few specialized pediatric providers, so patients have to travel farther for these appointments. NEMT allows low-income families to reliably access specialized services significantly outside the realm of walkability or public transportation. Massachusetts and Connecticut uncovered cases of fraud and abuse by drivers, while New Jersey and North Carolina both found gaps in oversight. In addition, either states or MCOs would ideally explore innovative ways to improve patient access to NEMT, such as Transportation Network Companies, which several states have used to provide more flexible travel options to enrollees.

Suggestions for Illinois:

1. Update current contract to require MCOs gather data around enrollee race and ethnicity, and maintain reporting on patient language preferences. Maintain current provisions saying contractors have to report HEDIS results to Illinois, providing the state with data around where possible racial and income disparities exist.
   a. If the state mandates comprehensive data within the contract, MCOs will either need to focus on obtaining complete HEDIS information or supplement the results with additional reporting.
   b. Illinois’s contract does focus on obtaining data on language preferences, but does not focus on race data collection within the enrollee population.

2. Either use race and ethnicity information to create disparity reduction goals, or require that MCOs create these goals within their current quality initiatives. Provide incentives to MCOs that can show they are improving health equity within their enrollee populations.
3. Maintain current MCO contract requirement to provide ICM programs to patients with chronic conditions. If possible, require that ICMs use a patient-centered plan to further reduce health disparities among this population.

4. Monitor effectiveness of NEMT programs to reduce fraud and inefficiencies, especially in rural areas where specialty care providers are more spread out. Look into implementation of transportation based network companies or other ways the program could provide more flexibility to patients that better suits their travel needs.

**Ability to monitor and ensure network adequacy**

Contract Recommendations:

States can specifically require that MCOs have in-network pediatric providers and specialists to ensure these insurers are recruiting the providers CSHCN need. Michigan’s MCOs must maintain networks that include pediatric subspecialists, children’s hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCN. Delaware’s contract says MCOs must have agreements with pediatric subspecialists for CSHCN if certain types of specialists are not included in the network.\(^{11,15}\) CSHCN in these two states experience lower level of frustration in getting healthcare services, with 71% saying they were never frustrated over the past year, as opposed to 61.5% of CSHCN in MMC generally.\(^{16}\)

States should explicitly allow for geo-access and out-of-network exceptions for CSHCN. These children might benefit from seeing specialized providers who are not in their MCO’s network or within what the state considers a reasonable distance from their homes, so the normal geo-access rules that are meant to protect enrollees might hinder their ability to access necessary treatment.
Authorization policies for CSHCN can be relaxed so these children can directly access specialists when needed. Relaxation of these policies include providing standing referrals for pediatric specialists and different medical necessity criteria than normal clinical standards. New York, Michigan, and California’s contracts have at least one of these two policies for CSHCN, as recognition that their timelines and access needs are different than the general enrollee population.\textsuperscript{11}

Implementation Recommendations:

Relaxed authorization requirements can also occur through implementation, such as in Michigan and Virginia. These two states do not require prior authorizations for specialists for any enrollees, finding that enrollees visit specialists only when recommended by a Primary Care Provider and do not tend to overuse this benefit. This implementation method improves access to care for all enrollees, and eliminates the need for contract provisions specific to CSHCN.\textsuperscript{11}

States should closely monitor the implementation of adequate networks through external quality reviews, which federal law requires states to conduct every 3 years to see whether MCOs are complying with state access standards.\textsuperscript{11} Specifically, states can conduct direct tests such as calling providers and making “secret shopper” calls, which Health and Human Services has determined is the best way to measure MCO compliance. Only 8 states currently use direct tests, and 3 of them uncovered 75% of the violations found across all states from 2008-2013. Illinois, along with 2/3 of states who conducted reviews in this time period, has found no violations.\textsuperscript{18} In addition, calling providers directly allows states to uncover important access barriers their enrollees face, and correct these issues for the future. Connecticut’s secret shopper survey found that only 26% of calls to pediatricians, dentists, dermatologists, neurologists, and orthopedists resulted in timely appointments for newly enrolled children.\textsuperscript{19} Another state found that some providers requested and
reviewed enrollees’ medical records prior to making appointments, which increased patients’ wait times for seeing a doctor.\textsuperscript{18}

Suggestions for Illinois:

1. Illinois’s contract already states that individuals with special healthcare needs (ISHCN) need access to a specialist that is appropriate for his or her condition and can have a specialist as a primary care provider. However, Illinois should specify access to pediatric providers as a requirement to help differentiate the rights of CSHCN from adults with chronic conditions and explicitly protect both populations’ access to care.

2. Keep clauses in the MMC contract that permit enrollees to “travel beyond the distance standards” when selecting a provider and guarantee appropriate specialists for ISHCN when one is not in network.\textsuperscript{17} Illinois can also expand these clauses with explicit language that makes it easy for CSHCN to take advantage of these exceptions.

3. Add language back into the contract that requires a “suite of prior authorized services…for each High Needs Children tier” to help ensure CSHCN have access to the providers they need. This idea was originally included in the model care contract, but it was removed with the latest revision.\textsuperscript{13,17} If the addition of these clauses is not realistic, consider removing authorization requirements for specialists across all enrollees.

4. Include direct tests of compliance in every external quality review, to ensure Illinois uses a thorough method to verify MCO compliance, measure network adequacy, and identify any prominent barriers its enrollees face in accessing care.

\textbf{Ease of transition into and between managed care providers}
Contract Recommendations:

States with successful CSHCN integration outcomes mandated that MCOs implement a comprehensive assessment to identify children who need specialty care when they are first enrolled in that MCO’s plan. They also provided outreach to families of identified children to educate them about the services, plan procedures, or general aspects of managed care if they are transferred over from a fee-for-service program. Maryland, Michigan, and Virginia currently require MCOs reach out to the families of these children to help them transition into the program and answer any questions they may have about their health services.11

Requiring that MCOs “seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries” helps children who require pediatric specialty care transition into managed care or between managed care plans.11 States can create specific procedures and time periods around this requirement that provide children with adequate time and provider availability to facilitate a smooth transition.11 For example, Michigan’s contract explicitly states that MCOs must honor prior access authorizations until their care teams agree to switch to a new provider, while California requires MCOs to cover services provided by previous providers for up to one year after enrollment.11 In addition, Rhode Island mandates that MCOs have to offer provider agreements to specialists that enrollees have a previous relationship with.11

Implementation Recommendations:

States can provide better communication and increased transparency around MCO policies and procedures, and improve availability of MCO representatives for questions from new enrollees and their providers. In the initial rollout of MMC in Illinois from 2011-2015, there was confusion among both providers and participants on how to best enroll and find care. 45% of doctors
encountered delays when credentialing with an MCO. In addition, 72% of providers and participants had trouble finding or navigating their MCO’s drug manual, 90% did not understand medications could require a prior authorization, 49% did not feel they had timely access to a staff contact at their MCO to ask questions, and 45% indicated their issues were not adequately addressed when they did reach a MCO to voice a concern. Since CSHCN have a wide range of healthcare requirements and a heightened need for timely access to care, a lack of clarity around the required procedures could lead to large problems with the transition of this population.

Suggestions for Illinois:

1. Keep provisions in the MMC contract that specify a health-risk screening for all enrollees who enter the program, the creation of risk-stratification based on screening results, and the placement of all children who require pediatric specialty care into the highest risk group that also receives a health-risk assessment. In addition, maintain clauses that require the MCOs to provide outreach to high-risk groups and education to all new enrollees.

2. Illinois’s contract already goes above federal requirements and specifies that each MCO will have an interdisciplinary Transition-of-Care team to design, implement, and monitor the transition into MMC and between MCOs. The contract specifies a 90-day transition period for enrollees to continue to see previous out-of-network providers where the MCO honors prior authorizations and pays for covered services. If an enrollee’s treatment goes beyond 90 days, non-network providers can be offered agreements on a case-by-case basis to continue care. However, the contract could create different transition and continuity of care criteria for CSHCN to account for the complexity of their medical situations through the following revisions:

   a. Require MCOs to allow longer transition period for ongoing treatment, ideally until the child’s family and transition of care team agree to transition to another provider.
b. Make MCOs offer provider agreements to specialists that CSHCN have a long-standing relationship with, so these children can continue to see providers they trust who specialize in their specific conditions and are aware of their care and treatment history.

3. Take steps to make provider and participant enrollment into MCOs as easy as possible and provide clear information and communication around MCO practices and policies. Some concrete steps could include:
   a. A common credentialing system across MCOs to ease burden of contracting for physicians
   b. A state-created or MCO-created drug manual that details which drugs are covered through the Medicaid drug manual and preferred drug list
   c. Increased availability of MCO representatives to field questions
   d. Clear time expectations and guidelines for approval of prior authorizations

**Adequacy of provider payments**

Contract Recommendations:

States could minimize confusion around provider payments by requiring all MCOs to use a standardized value-based payment (VBP) model. Creating a broad model with set rules around eligibility requirements, payment methods, and quality measures would provide consistency and reduce the administrative burden on providers. This model then also allows states to effectively advocate for providers to join managed care, since they are able to provide a clear picture of the experience. Minnesota currently requires its MCOs in Medicaid Managed Care to participate in a shared savings/risk payment model with all participating Accountable Care Organizations. Starting with VBP requirements that have a small impact on provider and insurer payments would make the transition away from fee-for-service as easy as possible. States can increase the amount and complexity of the VBP models over time as stakeholders become accustomed to the
new payment model. Arizona and South Carolina initially mandated that only 5% of insurer payments fit the VBP model, and gradually increased the requirement to 20% over 2 years. New York’s first goal around VBP models only included a fee-for-service model with a shared savings component. The state then expanded savings opportunities and added a risk-sharing component, with the goal of moving to a quality-based capitation program.  

Implementation Recommendations:

By withholding a certain percentage of capitation payments contingent on MCOs meeting state-defined VBP benchmarks, states can incentivize compliance. Pennsylvania currently withholds 2% of capitation payments if insurers do not meet the minimum percentage of VBP-approved provider payments.  

Suggestions for Illinois:

1. Maintain current focus around creating a consistent managed care experience for providers, such as having a limited number of contractors and keeping all insurers on the same contract. In addition, keep clauses that mandate the maximum amount of time an insurer can take to pay their providers. These steps reduce the administrative burden on providers and reduces confusion around the changes that come with managed care.  

a. Create a universal set of provider reimbursement rates that insurers should use. In the model contract, insurers are allowed to set different provider payment rates for the same covered services, which can create confusion among providers and dis-incentivize them from participating in the program.
2. Preserve requirement that insurers provide quarterly report of progress towards including value-based incentives into provider payments, which includes description of models used and breakdown of shared savings versus shared risk models.

   a. Mandate that a minimum percentage of payments to providers that need to fit into an approved value-based model. This requirement can increase annually, and meeting the stated goal can be tied to a certain percentage of the insurer’s capitation payment.  

**Protection of EPSDT benefits**

**Contract Recommendations:**

Contracts should follow guidance issued by The Centers for Medicare and Medicaid Services (CMS) in January 2017, which requires them to: 1) explicitly state which EPSDT services insurers will provide so the state can adequately cover any gaps, 2) specify whether the insurer or the state needs to inform patients about EPSDT benefits, and 3) ensure states have access to the necessary insurer data to meet EPSDT reporting requirements.

**Implementation Recommendations:**

States can EPSDT requirements are part of the areas monitored by quality improvement team that looks over MMC programs. CMS specifies state quality improvement teams should look out for failure by the insurer to provide EPSDT benefits such as screens, immunizations, or other preventive services.

**Suggestions for Illinois:**

1. Maintain section 2.1.1 of the current contract, which adheres to all aspects of the new CMS guidance. Illinois’s model contract states the insurer is responsible for informing eligible families of
the services available to them.\textsuperscript{17} The contract also references the Handbook for Providers of Healthy Kids Services, which provides a comprehensive list of services the insurer is responsible for covering and report data the insurer has to provide to the state.\textsuperscript{23}

2. Ensure Illinois’s external quality review process monitors EPSDT benefits, which was identified by CMS as a possible area of fraud and abuse by contractors.
   a. If insurer does not meet standards in Handbook for Providers of Healthy Kids Services, enforce contracted right to withhold up to 2\% of insurer’s capitation payments.
   b. If any abuse related to the EPSDT benefits is found, report the information to the Health Care Financing Administration so the group can impose a sanction.\textsuperscript{24}

CONCLUSION

Illinois’ decision to introduce a medically complex group such as CSHCN into the same MMC program as the rest of the population could have large implications on the state’s overall medical costs and health outcomes. If the state is able to successfully integrate these groups into one managed care contract, then we could potentially see improvements in streamlining of processes, coordination of care, and quality of medical services across all of Medicaid. The realization of this goal can lead to significant healthcare savings and increased medical value for every dollar the state puts into this system, especially in the CSHCN population who makes up 50\% of children with health conditions and 42\% of pediatric medical expenses. Therefore, any steps taken to improve this Medicaid overhaul and expansion could have a large positive effect on public health within the state. Since multiple states have already gone through this process, Illinois should not have to start from the beginning when it comes to implementing this policy change. Illinois can learn from the mistakes and achievements of other states and employ already-established best practices, to avoid some of the missteps that the state otherwise may have experienced.
Through the evaluation of the contract and existing literature, we found three overarching recommendations for states looking to introduce CSHCN to MMC, which apply across the different focus areas. First, MMC contracts should acknowledge that CSHCN require a different level of care than the rest of the managed care population. If this special population remains in the same contract, ideally there would be exceptions to some rules and additional regulations on others so insurers can provide the needed care. Second, states should attempt to change the Medicaid incentive structure through requirements such as VBP payment models, goals to reduce disparities, and integrated care management, so that insurer and state goals are properly aligned. This recommendation is not CSHCN-specific, but improves MCO motivation to provide the benefits that make managed care appealing these medically complex patients, such as coordination of care and quality-based provider payments. Third, states can employ a comprehensive monitoring system that allows them to oversee insurer behaviors and ensure insurers are meeting their contracted obligations. A complete system includes requiring external quality review organizations to conduct direct tests of network adequacy and looking for gaps in access such as failures in NEMT and EPSDT programs. This monitoring system should also provide recommendations for how to improve aspects of the MMC program if it notices shortcomings in certain areas.

After creating state recommendations and comparing them to Illinois’s current model contract, we found that Illinois has already included many of our recommendations in each focus area. For example, the Illinois contract includes: ICM programs for patients with chronic conditions, separate geo-access regulations for individuals with special healthcare needs, a transition process that identifies and provides outreach to complex patients, consistent processes for provider payments, and requirements that insurers provide EPSDT benefits and report results to the state. However, within each area there are additional steps the state can take to lessen the burden on children who require pediatric services. Most of these actions are implementation-focused, such as
revisions to current monitoring programs, meaning the state could carry them out without explicitly listing them in MCO contracts. Therefore, it will be important to see how the state interacts with MCOs in the first year of the MMC expansion, to see if the state has already considered these strategies. In addition, as the managed care program grows and the state is forced to contract out these processes, these implementation recommendations could be important to include in those future agreements.

There are a few limitations to the review and recommendations. First, the contract and strategy review centered around only five topics. Although these areas were chosen because of their importance to pediatric specialty services and common problems around managed care implementation, choosing focus topics inherently means other potential issues are excluded. For example, this analysis failed to discuss the relationship between primary and secondary pediatric care, and how any problems with primary care access limits the secondary care options available.

Another limitation is that, although a thorough review was conducted on both the Illinois model contract and the available literature in these focus areas, it is possible that contract articles or cross-state studies were missed in the process. This literature review is currently being evaluated by other members of Lurie Children’s Hospital and the Child Health Policy Collaborative, in order to get additional feedback on the content and reduce the chance that any important materials were excluded from review.

In addition, this review focuses on a very specific sub-population of pediatric specialty care. There are several different categories of care requirements that children can fall into, with CSHCN being one of the most specialized and medically complex. Almost all children will require some sort of pediatric specialty care in their lifetime, and so these recommendations could end up affecting more than just CSHCN. However, the review conducted was not broad enough to encompass all children’s specialty care experiences in the determined focus areas. Further research is required to
determine if additional recommendations are necessary to account for other child populations who access specialty care.

The next steps for our Medicaid Managed Care review is to finalize these recommendations based on feedback from external readers and summarize them into a policy brief. Afterwards, the review and any summary or supplemental materials will be sent to member organizations of the Child Health Policy Collaborative. This document can then be used as a platform for discussion between the organizations to reach alignment on this theme and surrounding subjects, and help shape future research and strategies within the collaborative.
REFERENCES

1. Venteicher W. Illinois Medicaid shifts 1.4 million to managed care. Chicago Tribune [Internet].
   2015Jan3

   Integrated Care Program: Findings from the Baseline through Year Two. Illinois Department of Public
   Health; 2014 May.

3. Kennedy K. Illinois Issues: Has The Managed Care Option Helped Medicaid Patients? [Internet].
   Illinois Public Media. College of Media at the University of Illinois; 2017 [cited 2018Apr8].

4. Fairgrieve A. Illinois Issues RFP to Rebid Medicaid Managed Care Programs, Expand Statewide
   [Internet]. Health Management Associates. 2017 [cited 2017Nov8].

5. Honsberger K, VanLandeghem K. State Medicaid Managed Care Enrollment and Design for Children

6. Kennedy K. Illinois Issues: Has The Managed Care Option Helped Medicaid Patients? [Internet]. NPR

   Resources and Services Administration, Maternal and Child Health Bureau. U.S. Department of
   Health and Human Services; 2004 [cited 2017Dec10].

8. 2016 National Survey of Children's Health [Internet]. Data Resource Center for Child and Adolescent

9. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of
   Medicaid and the Children’s Health Insurance Program (CHIP). Catalyst Center & National Academy
   for State Health Policy; 2017 Sep.

10. PUBLIC AID (305 ILCS 5/) Illinois Public Aid Code Legislative Reference Bureau;


42. Ganiuza A, Davis R. Made possible through suppDisruptive Innovation in Medicaid Non-Emergency Transportation. Center For Health Care Strategies. 2017Feb


Table 1: Current Status of CSHCN care in state public insurance systems, as of 8/24/2017

<table>
<thead>
<tr>
<th>CSHCN Enrolled in MMC</th>
<th>Type of Plan</th>
<th>Managed Care Model</th>
<th>Type of Enrollment</th>
<th>Number of States*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Fee for Service</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3 (across 3 states)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Standard</td>
<td>Primary Care Case Management</td>
<td>Mandatory</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Voluntary</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managed Care Organization</td>
<td>Mandatory</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Voluntary</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other**</td>
<td>Mandatory</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Specialized</td>
<td>Managed Care Organization</td>
<td>Mandatory</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Voluntary</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unknown</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepaid Inpatient Health Plan</td>
<td>Voluntary</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>52 (across 47 states + DC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Includes D.C.; some states have more than 1 program included

** Includes Coordinated Care Organizations, MCO + Managed Long Term Services & Supports

Table 2: Articles of the State of Illinois Model Contract between the Department of Healthcare and Family Services and Health Plans examined for each focus area

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Contract Articles Reviewed</th>
</tr>
</thead>
</table>

| Reduction of racial and income disparities | 1.1, 2.7, 3.2, 9.1 |
| Ability to monitor and ensure network adequacy | 1.1, 2.8, 5.7, 5.8, 5.9, 5.11, 5.12, 5.13, 5.14, 5.15, 5.19, 5.20, 5.21, 5.40, Attachment II, Attachment XI, |
| Ease of transition into and between managed care providers | 1.1, 4.1, 4.3, 4.6, 4.10, 4.14, 4.15, 5.13, Attachment XXII |
| Adequacy of provider payments | 1.1, 5.24, 5.29, 5.31, 5.32, 5.39, 7.1, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, 7.9, 7.10, 7.11, 7.12, 7.18, Attachment XI, Attachment XX, |
| Protection of EPSDT benefits | 1.1, Attachment XI, Appendix I, |

Table 3: Questions used to summarize the pertinent information in each source from the literature review.

<table>
<thead>
<tr>
<th>Journal Article or Report</th>
<th>State-Sponsored Document</th>
<th>Newspaper Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title, Author, Year</td>
<td>Title, Year</td>
<td>Title, Author, Year</td>
</tr>
<tr>
<td>Journal or Organization</td>
<td>State/Publishing Organization</td>
<td>Newspaper</td>
</tr>
<tr>
<td>Purpose of Study</td>
<td>Purpose of Study/Review</td>
<td>State/Counties Referenced</td>
</tr>
<tr>
<td>Type of Study</td>
<td>Setting and Time Period</td>
<td>Time Period</td>
</tr>
<tr>
<td>Setting and Time Period</td>
<td>Main Findings</td>
<td>Main Argument</td>
</tr>
<tr>
<td>Main Findings</td>
<td>Recommendations (optional)</td>
<td>Supporting Facts Used</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Supporting Evidence Used</td>
<td>Additional Notes/Comments</td>
</tr>
<tr>
<td>Supporting Points</td>
<td>Additional Notes/Comments</td>
<td></td>
</tr>
<tr>
<td>Additional Notes/Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Studies, newspaper articles, and state-sponsored documents used as part of Existing Strategy Review process to create contract and implementation recommendations, along with next steps for Illinois.
<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Literature Articles Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of racial and income disparities</td>
<td>A Path toward Value Based Payment: Annual Update. New York State Department of Health; 2016 Jun.</td>
</tr>
<tr>
<td></td>
<td>Medicaid Managed Care: Key Data, Trends, and Issues. Kaiser Family Foundation. 2012.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Ability to monitor and ensure network adequacy</th>
<th>7. Ganuza A, Davis R. Made possible through Disruptive Innovation in Medicaid Non-Emergency Transportation. Center For Health Care Strategies. 2017Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Reference</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>