CHCS
Center for
Health Care Strategies, Inc.

Strategies to Improve Care Management for Children with Special Health Care Needs

CCS Technical Workgroup

February 9, 2010

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CHCS Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

- Our Priorities
  - Advancing Health Care Quality and Cost Effectiveness
  - Reducing Racial and Ethnic Disparities
  - Integrating Care for People with Complex and Special Needs
- Our Approach
  - Direct technical assistance on design and implementation issues to Medicaid/CHIP stakeholders
  - Funded largely by national and regional health care philanthropies

Managing Care in Medicaid

Goals:

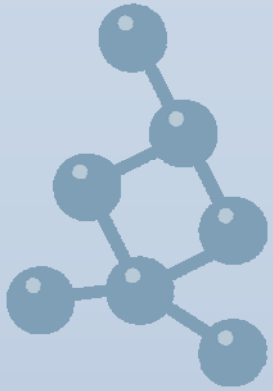
- Improve or maintain health status
- Create accountable medical homes
- Integrate care for those with complex conditions

New State Purchasing Strategies for Medicaid

Based on interviews with Medicaid officials in 12 states, we identified 3 key themes:

1. Growing momentum to move beyond FFS to more coordinated approaches (e.g., EPCCM, medical home, managed care).
2. Increasing interest in alternative financing mechanisms (e.g., shared risk/savings, P4P, capitation, etc.).
3. Emerging efforts to develop/test appropriate performance measurement and monitoring strategies.

Common Elements: Emerging Models of Care



- Identifying and stratifying target populations
- Targeting tailored interventions
- Connecting patients/families with providers
- Integrating/coordinating services (e.g., physical & mental health)
- Using performance measures for accountability
- Structuring financing to support integration of care/care management

Elements of Medical Home

- A participant is linked with a physician, non-physician medical practitioner, clinic, or other safety net provider who will serve as their medical home.
- The medical home acts as a team to:
    1. Assess the participant's health care needs
    2. Coordinate and plan the participant's care
    3. Provide quality primary care services and preventive screenings
    4. Authorize referrals to specialists, and
    5. Provide linkages to other care and equipment providers
- The team has a whole person orientation: *"Success depends on their ability to focus on the needs of a patient or family one case at a time."*
- The medical home integrates HIT to support quality and safety and accountability.

Typical Medical Home Enhancements

- Beneficiaries are offered:
  - Toll-free health advice, 24/7;
  - In person health education and counseling;
  - Linkages to community-based services (housing, behavioral health, etc.);
  - Integrated care management for those identified as having complex medical and social needs.
- Providers serving complex populations are offered:
  - Practice support as needed;
  - Care managers to call for help with referrals, problem-solving;
  - Training and education on Patient-Centered Medical Home;
  - Technical assistance on quality improvement, evidence-based medicine, HIT resources.

Medical Home – Literature on CSHCNs

- Review of 30 published studies[1] (6 randomized control trials) on medical home for CSHCNs. Examples include:
  - RCT of high-risk infants: intervention group had fewer ICU admits and fewer days in ICU for those admitted.
  - RCT of children with asthma: intervention group, fewer ED visits.
  - PACC study: Nurse Practitioner made home visits to children with severe needs, resulting in fewer hospitalizations.

- "Preponderance of evidence supported a positive relationship between the medical home and desired outcomes, such as better health status, timeliness of care, family centeredness, and improved family functioning." [1]

[1] **Homer, Charles, et a. A Review of the Evidence for the Medical Home for Children with Special Health Care Needs. Pediatrics. 2008; 122; e922-e937.**

Medical Home – Resources

- Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool
  - Covered services and cost-sharing
  - Pediatric provider network capacity
  - Plan features (care coordination; staff expertise; appropriate vendors)
  - Quality Management (access; authorization for services; satisfaction surveys and QI projects specific to CSHCNs)
- National Center of Medical Home Initiatives for Children with Special Needs
  - AAP/MCHB cooperative agreement
  - Training program: "Every Child Deserves a Medical Home"

Models that Support Medical Home

- Enhanced Primary Care Case Management (OK)
- Administrative Services Organization (IL)
- Accountable Care Organization (NC)
- Specialty Managed Care Organization (WA DC)
- Combinations/variations that include managed care organizations, carved out case management (PA, WA)

Model Option 1: State-operated "EPCCM"

- Oklahoma's Sooner Care Choice:
  - Builds on, supports, and strengthens the existing primary care provider network
  - Provides supports to beneficiaries and providers (nurse advice; education)
  - CSHCNs are included in program (on a voluntary basis)
  - Provides care management to high risk beneficiaries, including children receiving in-home private duty nursing services
  - P4P model rewards providers

Model Option 2: Single Private Vendor "ASO"

- State of Illinois:
  - Single contractor provides all operations
  - Vendor forms and operates provider network
  - Vendor provides supports for beneficiaries and providers including care management for children with asthma and with high ED use (CSHCNs excluded from program)
  - Care coordination through subcontracted arrangement for high risk population
  - Is relatively quick to implement & can be contracted at risk

Model Option 3: Local Public / Private Partnership "ACO"

- Community Care of North Carolina:
  - Gradually developed local public/private entities in 14 geographic locations
  - Local entities responsible for network, provider and beneficiary supports
  - Local determination of QI efforts
  - State funds are split between providers and regional partnerships
  - CSHCNs included in program as voluntary population; unique requirements for providers

Model Option 4: Specialty Managed Care Organization (Washington DC)

- Washington DC's Health Services for Children with Special Needs
  - A care management network coordinating health, social, and education services for the pediatric SSI-eligible population.
  - Includes traditional Medicaid benefits plus individualized care management; 24-hour access to care coordination; outreach services; respite care; medically necessary home modifications; and mental, behavioral, and developmental wraparound services.
  - A not-for-profit, started as a demonstration project under 1115 waiver in 1995; now 80% enrolled.

Alternative Models in PA & Seattle

- Pennsylvania EPCCM:
  - State staff provide care management/coordination for complex special needs children enrolled in PCCM program.
- Seattle Children's Hospital
  - Complex care management for children at high risk of hospitalization
  - CCM program provides additional resources to the PCP (medical home): Shared care plan; case management; transition planning; expert consultation; CCM Clinic

Questions/Discussion

- How might these options work for children eligible for the CCS program?

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