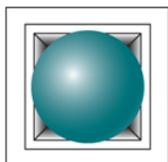


Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care

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ABOUT THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH

The National Alliance is a nonprofit organization whose mission is to achieve long-term, systemic improvements in comprehensive health care and insurance coverage for adolescents, with focused attention on those from low-income families and with special health care needs. Through policy analysis, technical assistance, quality improvement, and advocacy, The National Alliance works to promote effective transitions from pediatric to adult health care as part of its Got Transition program. In collaboration with others, The National Alliance also works to expand the availability of adolescent-centered care, access to mental and behavioral health services, and improvements in health insurance coverage for adolescents and young adults. For more information about The National Alliance, please visit [TheNationalAlliance.org](https://www.thenationalalliance.org).

ABOUT GOT TRANSITION®

Got Transition is a program of The National Alliance and is funded through a cooperative agreement from HRSA’s Maternal and Child Health Bureau. Its aim is to improve transition from pediatric to adult health care through the use of innovative strategies for health care professionals and youth, families, and caregivers. For more health care transition resources and information about Got Transition, please visit [GotTransition.org](https://www.gottransition.org).

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TABLE OF CONTENTS

Background, Report Organization, and Methods..... 4

Medicaid Managed Care Contract Language Options by Topic

- I. Definitions..... 6
- II. Member Services and Education..... 7
- III. Provider Networks..... 9
- IV. Covered Services 10
- V. Care Coordination 12
- VI. Quality and Evaluation..... 14

Conclusion 15

References..... 16

Appendix A. Useful Health Care Transition Resources..... 17

Appendices with 2018/2019 State Medicaid Managed Care Transition-Related Provisions by Topic

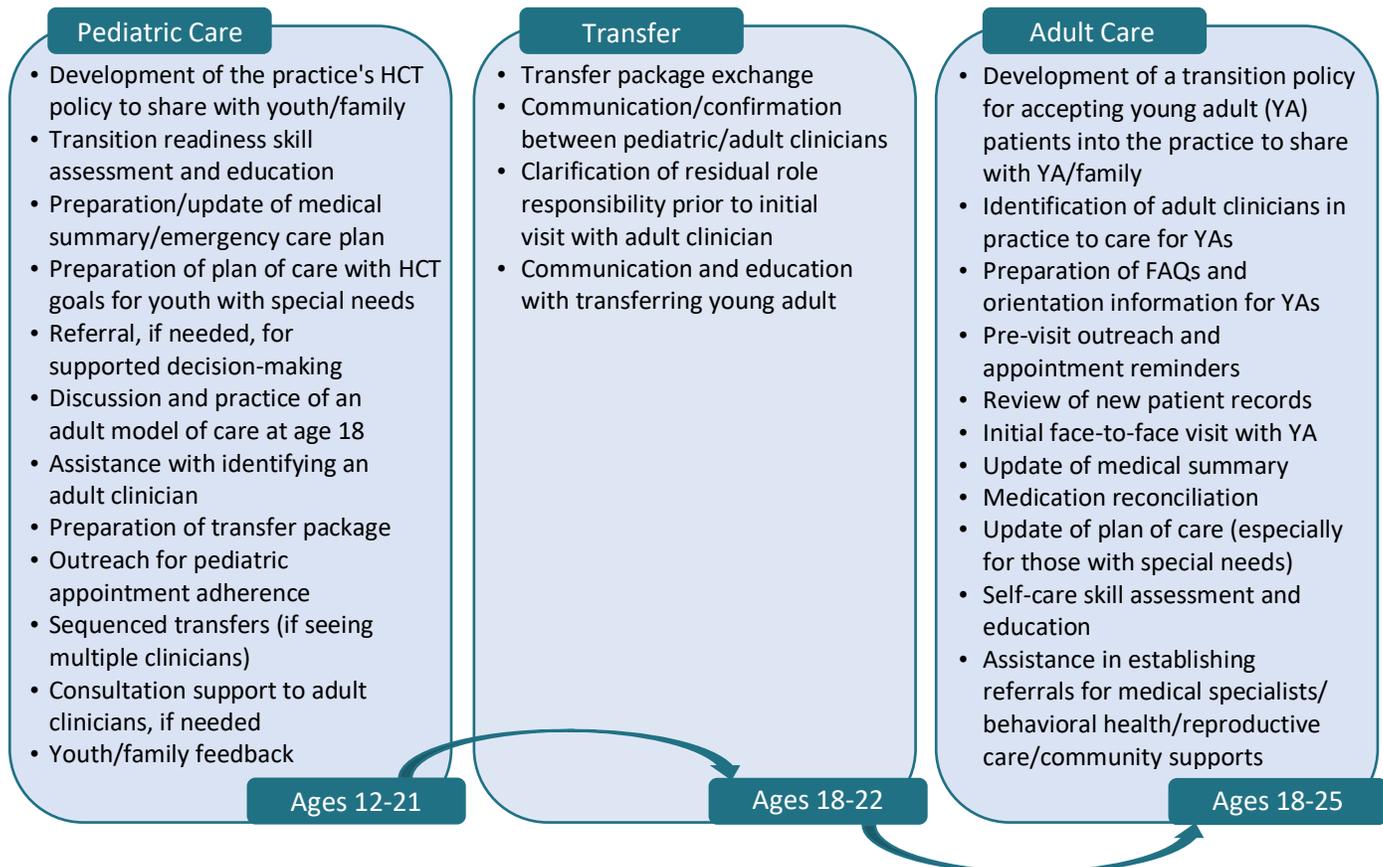
- B. Definitions 18
- C. Member Services and Education 19
- D. Provider Networks 20
- E. Covered Services..... 21
- F. Care Coordination..... 22
- G. Quality and Evaluation 27

BACKGROUND

Medicaid agencies and managed care organizations (MCOs) have extensive experience addressing transitions of care from inpatient to outpatient medical, behavioral, and long-term care settings. These transitions – like the transition from pediatric to adult health care – pose significant risks to care continuity, excess morbidity, and preventable hospitalizations. To date, however, national data reveal that few publicly-insured youth with and without special needs have received assistance from their health care providers to prepare for transition to adult care: only 17% of youth with special health care needs (YSHCN) and 15% of youth without special health care needs (non-YSHCN).¹

Recent professional recommendations from the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP) offer specific guidance for incorporating pediatric-to-adult health care transition (HCT) services into routine care in both pediatric and adult settings, beginning in early adolescence and continuing into young adulthood.² The evidence-driven quality improvement approach recommended is called the Six Core Elements of Health Care Transition.³ Figure 1 displays a set of services, based on the Six Core Elements, that constitute a structured HCT process. This pediatric-to-adult HCT approach includes a set of *transition planning services* that should begin in pediatric care typically starting between ages 12 and 14, followed by a set of *transfer services* typically occurring between ages 18 and 22, and finally a set of *integration into adult care services*, taking place following transfer and continuing through age 25.

Figure 1. Components of a Structured Pediatric-to-Adult HCT Process



Research shows that a structured pediatric-to-adult HCT process results in reductions in morbidity and mortality, improvements in adherence to and continuity of care, decreases in hospital use, and increases in ambulatory care visits among youth and young adults with special health care needs.^{4,5} Yet, studies of pediatric and adult health care providers reveal many barriers to implementing transition supports, including inadequate transition preparation of youth and families, disconnection between pediatric and adult systems of care, lack of payment incentives to offer transition services, absence of infrastructure supports for adult clinicians caring for young adults with special health care needs, and challenges engaging and retaining young adults in adult systems of care.²

REPORT ORGANIZATION AND METHODS

To assist state Medicaid agencies and MCOs in improving access to recommended pediatric-to-adult HCT services for their enrollees, this report offers specific options for managed care contract (MCC) language that can be incorporated into standard and specialty contracts. Suggestions are included on the following topics: definitions, member services and education, provider network, covered services, care coordination, and quality and evaluation. For each topic, we offer at least three options for consideration, each with examples of how the contract language could be specified. We also include a summary of related state MCC provisions, where they exist, and an appendix with the complete state-specific language. The state MCC examples were found from an analysis of standard Medicaid MCCs from 37 states that relied on statewide risk-based Medicaid managed care programs to serve children and adolescents in late 2018,⁶ as well as an analysis of 2019 specialty Medicaid MCCs from seven states with specialty Medicaid managed care programs that exclusively serve some or all children and youth with special health care needs populations.⁷ The MCC language options in this report were informed not only from our state Medicaid MCC analysis but also by the AAP/AAFP/ACP professional guidelines, evaluation studies on HCT, and extensive quality improvement experience working with pediatric and adult health care systems.

While the AAP/AAFP/ACP Clinical Report recommends that all youth and young adults receive transition supports from their health care providers, we recognize that states will likely want to tailor their MCC contract provisions on pediatric-to-adult HCT for specific populations. These may include transition-aged populations eligible for SSI, foster care, home and community-based or developmental disability waivers, and/or those eligible for other public program services such as special education, Title V, or juvenile justice programs. Alternatively, states may encourage MCOs to begin with youth who have selected chronic conditions (e.g., sickle cell disease, intellectual and developmental disability). Finally, states may want to begin with a focus on the transfer period, ensuring that the vulnerable handoff between pediatric and adult care is successfully accomplished.

States and MCOs are encouraged to visit [GotTransition.org](https://www.gottransition.org) for more practice and payment resources on HCT. In Appendix A we have included links to several of our most popular resources. For additional information or questions about this report, please contact Peggy McManus at MMcManus@TheNationalAlliance.org.

MEDICAID MCC LANGUAGE OPTIONS: I. DEFINITIONS

KEY POINTS

Including a definition of pediatric-to-adult HCT in the MCC sets the parameters for identification of transition-aged populations and scope of HCT services throughout the rest of the contract.

Options to Consider:

- 1) Include a stand-alone definition of pediatric-to-adult HCT and specify transition-aged populations of interest.
- 2) Expand an existing definition of transitional care to explicitly mention pediatric-to-adult HCT.
- 3) Expand other definitions that encompass transitional care, such as continuity of care, to explicitly mention pediatric-to-adult HCT.

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

No state included a stand-alone definition of pediatric-to-adult HCT in its standard or specialty MCC. In its standard MCC, Virginia mentioned transition-aged youth in its definition of a foster care program that offers services to young adults, ages 18-21, transitioning to adulthood and self-sufficiency. In specialty MCCs, four states (AZ, GA, TX, WI) briefly mentioned either HCT, aging into adulthood, or aging out of foster care. See Appendix B for existing contract language found in MCC definitions sections.

OPTIONS TO CONSIDER

1) Include a stand-alone definition of pediatric-to-adult HCT and specify transition-aged populations of interest.

Example: Contractors shall specify that pediatric-to-adult HCT encompasses transition planning, transfer of care from a child health care provider to an adult health care provider, and integration into adult care, starting at ages 12-14 and continuing into young adulthood. The goals of HCT are: a) to improve the ability of youth and young adults to manage their own health and effectively use health services; b) to ensure a planned process for HCT.²

2) Expand an existing definition of transitional care to explicitly mention pediatric-to-adult HCT.

Example: Contractors shall specify that comprehensive care consists of the planned coordination of transitions between health care providers and settings, *including pediatric-to-adult care*, to ensure continuity of care and reduce emergency department and inpatient admissions, re-admissions and lengths of stay. *Pediatric-to-adult HCT encompasses transition planning, transfer of care, and integration into adult care beginning in early adolescence and continuing into young adulthood, as called for by the 2018 AAP/AAFP/ACP Clinical Report on HCT.*²

3) Expand other definitions that encompass transitional care, such as continuity of care, to explicitly mention pediatric-to-adult HCT.

Example: Contractors shall specify that continuity of care is the uninterrupted, ongoing care of an enrollee as the enrollee transitions between different MCOs or between managed care and fee-for-service (FFS), whether due to eligibility or MCO enrollment changes, *or a shift from pediatric to adult care. Pediatric-to-adult HCT encompasses transition planning, transfer of care, and integration into adult care beginning in early adolescence and continuing into young adulthood, as called for in the 2018 AAP/AAFP/ACP Clinical Report on HCT.*²

MEDICAID MCC LANGUAGE OPTIONS: II. MEMBER SERVICES AND EDUCATION

KEY POINTS

Including member information, education, and services about HCT enables families, youth, and young adults to understand the changes that happen as youth move from pediatric to adult care. Participation by youth, young adults, and families in planning, implementing, and evaluating HCT member education is encouraged.

Options to Consider:

- 1) Include information and education about pediatric-to-adult HCT services and the MCO's HCT approach in member handbooks.
- 2) Include up-to-date information in provider directories about available adult providers for young adults with special health care needs.
- 3) Assist members experiencing access barriers related to transition to adult care, including difficulties finding adult care and lack of communication/exchange of updated medical information between pediatric and adult providers.

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

No state included HCT language within their standard MCC sections on member services and education in 2018. In specialty MCCs, one state (TX) required that MCOs maintain a member services department with transition specialists who assist with transition planning for adulthood. See Appendix C for the exact contract language found in Texas' member services and education description.

OPTIONS TO CONSIDER

- 1) **Include information and education about pediatric-to-adult HCT services and the MCO's HCT approach in member handbooks.**

Example: Contractors shall ensure that member handbooks and other informational resources include a clear statement about the MCO's services and approach for transition from pediatric to adult care to help families know what to expect. This includes what HCT services the MCO will offer to ensure a smooth transition, a clear explanation of the changes that happen at 18 when youth become legal adults, and, if needed, referrals for supported decision-making/guardianship. MCOs should also include member information about how to access their medical records.

- 2) **Include up-to-date information in provider directories about available adult providers for young adults with special health care needs.**

Example: Contractors shall ensure that provider directories include up-to-date information about available adult primary, specialty, behavioral, and reproductive health providers to care for young adults with special health care needs, including those with developmental disabilities, childhood-onset conditions, and mental/behavioral health conditions.

3) Assist members experiencing access barriers related to transition to adult care, including difficulties finding adult care and lack of communication/exchange of updated medical information between pediatric and adult providers.

Example: Contractors shall ensure that member services staff provide necessary assistance to young adults and others with special health care needs, including assisting members who experience difficulties obtaining timely access to adult primary and specialty medical care, behavioral health, and reproductive providers. Member services staff shall provide assistance to ensure exchange of current medical information between pediatric and adult systems of care.

MEDICAID MCC LANGUAGE OPTIONS:

III. PROVIDER NETWORKS

KEY POINTS

Developing and maintaining a sufficient number and geographic distribution of adult health care providers to address the needs of transition-aged youth and young adults with special health care needs is essential. Coordination and collaboration between pediatric and adult care providers/hospitals/systems are needed to ensure a safe and effective transition process.

Options to Consider:

- 1) Conduct regular surveys of adult provider networks to assess availability for special populations of transition-aged youth and young adults.
- 2) Describe mechanisms used to coordinate pediatric and adult providers to ensure a safe and effective transition to adult care.
- 3) Establish organized processes for transfer from pediatric to adult health care.

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

Two states (AZ, MI) included language on provider network capacity for transition-aged youth in their standard MCCs, and two states (AZ, DC) included such language in their specialty MCCs. Specific language can be found in DC's contract, which stated that the contractor shall ensure that there is an adequate network of general internists and adult specialists, and they shall assist enrollees in the transition from pediatric to adult care. See Appendix D for exact contract language found in provider network descriptions.

OPTIONS TO CONSIDER

1) Conduct regular surveys of adult provider networks to assess availability for special populations of transition-aged youth and young adults.

Example: Contractors shall regularly survey adult provider networks to assess availability for special populations of transition-aged youth and young adults, including those with medical complexity, intellectual and developmental disabilities, and chronic mental/behavioral health conditions. Efforts to expand adult provider capacity should be described, including, for example, new partnerships with medical school training programs, expanded infrastructure support (e.g., care coordination), pediatric consultation arrangements, and financial incentives.

2) Describe mechanisms used to coordinate pediatric and adult providers to ensure a safe and effective transition to adult care.

Example: Contractors shall describe methods used to coordinate pediatric and adult provider networks, including, for example, exchange of medical information, telehealth, and contractual arrangements.

3) Establish organized processes for transfer from pediatric to adult health care.

Example: Contractors shall establish a documented process for transfer from pediatric to adult care, including identification of transferring youth/young adults, documentation of new adult primary care provider, preparation and exchange of transfer package with a current plan of care and medical summary/emergency care plan, and offer of pediatric consultation assistance, as needed.

MEDICAID MCC LANGUAGE OPTIONS: IV. COVERED SERVICES

KEY POINTS

Although pediatric-to-adult transitional care is neither a mandatory nor an optional benefit under Medicaid, incorporating HCT services as part of EPSDT, medical home, behavioral health, and health home services is consistent with professional recommendations.²

Options to Consider:

- 1) Incorporate HCT into Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-visits.
- 2) Incorporate HCT into patient-centered medical home programs.
- 3) Incorporate HCT into behavioral health services.
- 4) Incorporate HCT into health home services.

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

Three states (AZ, MN, TN) included HCT language in their standard MCC sections on covered services; the seven specialty MCCs did not. Arizona's contract required the behavioral health service delivery system to facilitate transfer from the children's system to the adult system of health care. Arizona also included a requirement to use specific behavioral health practice tools, including a transition-to-adulthood practice tool.⁸ This tool addresses responsibilities of the child's behavioral health service provider, including coordinating transition planning with the adult provider and inviting the adult behavioral health services case manager to attend planning meetings for youth with serious mental illness. The practice tool states that transition planning can include assisting youth with transferring health care services from a pediatrician to an adult health care provider; obtaining personal and family medical history; methods for managing health care appointments, keeping medical records, following treatment recommendations, and taking medication; assuming responsibility for self-care; selecting a health plan and physician; and maintaining Medicaid coverage. See Appendix E for exact contract language found in covered services descriptions.

OPTIONS TO CONSIDER

1) Incorporate HCT into Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-visits.

Example: Contractors shall encourage primary care providers, as part of EPSDT well-visits, to conduct periodic transition readiness/self-care skills assessments and provide anticipatory guidance and health education to assist members gain needed self-care skills. A standardized transition readiness assessment tool* should be used along with sample questions and guidance from *Incorporating Health Care Transition Services into Preventive Care for Adolescents and Young Adults: A Toolkit for Clinicians*,⁹ which is intended for use in conjunction with AAP's Bright Futures.¹⁰

* There are many transition readiness assessments available. Visit GotTransition.org/6ce/leaving-ImplGuide-readiness-examples to find examples of transition readiness assessments.

2) Incorporate HCT into patient-centered medical home programs.

Example: Contractors shall incorporate into their patient-centered medical home (PCMH) programs, requirements for an organized process in both pediatric and adult medical home settings to facilitate transition preparation, transfer of care, and integration to adult care consistent with the 2018 AAP/AAFP/ACP Clinical Report.² Examples of how PCMH criteria can be cross-walked with transition resources is described in *Incorporating Pediatric-to-Adult Transition into NCQA Patient-Centered Home Recognition: 2019 Update*.¹¹

3) Incorporate HCT into behavioral health services.

Example: Contractors shall encourage behavioral health providers caring for transition-aged youth and young adults to establish a planned process for transition preparation, transfer of care, and integration into adult behavioral health consistent with the 2018 AAP/AAFP/ACP Clinical Report on HCT.² The contractor shall ensure that adult behavioral health services have processes in place to welcome and orient new young adults into their care and have available adult behavioral health clinicians interested in caring for young adults.[†]

4) Incorporate HCT into health home services.

Example: Contractors shall define comprehensive transitional care to consist of planned coordination of transitions between healthcare providers and settings, including pediatric-to-adult care, to ensure continuity of care and reduce emergency department use and inpatient admissions, readmissions, and lengths of stay. Pediatric-to-adult HCT services shall include but are not limited to the following: a) ensuring that a current medical summary and plan of care has been prepared, b) ensuring that an adult primary care provider has been identified, c) ensuring that initial and follow-up appointments with the adult provider are scheduled and kept, and d) facilitating linkages to other adult care providers (e.g., reproductive, behavioral, medical specialty).

[†] Visit [GotTransition.org/6ce/leaving-ImplGuide-readiness-examples](https://gottransition.org/6ce/leaving-ImplGuide-readiness-examples) for transition readiness sample tools, including a mental health transition readiness assessment. Visit [GotTransition.org/6ce/leaving-ImplGuide-planning-examples](https://gottransition.org/6ce/leaving-ImplGuide-planning-examples) for sample transition planning tools, including a sample mental health wellness plan. Visit [GotTransition.org/6ce/integrating-ImplGuide-orientation-adult-practice-examples](https://gottransition.org/6ce/integrating-ImplGuide-orientation-adult-practice-examples) for sample welcome & orientation materials.

MEDICAID MCC LANGUAGE OPTIONS: V. CARE COORDINATION

KEY POINTS

Incorporating HCT into care coordination activities is necessary to facilitate continuity of care as youth and young adults change providers and systems of care.

Options to Consider:

- 1) Define pediatric-to-adult HCT approach as part of care coordination programs.
- 2) Conduct transition readiness/self-care skill assessments and provide needed education and counseling.
- 3) Incorporate pediatric-to-adult transition planning as part of members' comprehensive care plans.
- 4) Initiate transfer planning 1-2 years prior to the date when members age out of pediatric medical, behavioral, and other child systems of health care.

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

Six states included care coordination provisions related to pediatric-to-adult HCT or transition to adulthood in their standard MCCs (LA, MI, NJ, NM, PA, VA), and five states included such language in their specialty MCCs (AZ, DC, FL, TX, WI). Arizona's specialty Children's Rehabilitative Services MCC required the contractor to develop a pediatric-to-adult transition plan for each member by age 20. The plan must be developed with members, families, and their providers and include strategies to address transition barriers. The plan should be age-appropriate and periodically updated to address the member's current needs and identification of an adult primary care provider. Planning should also include developmentally appropriate discussions related to work, education, recreation, and social needs. Texas' specialty STAR Kids MCC required that each MCO provide transition planning, with a transition specialist, starting at age 15, to prepare members for the service and benefit changes that will occur following age 21. Transition planning activities include development of a continuity of care plan with transition goals, self-management education, coordination with adult public program services, and assistance identifying adult health care providers. Other state MCC contracts included language that was more general. See Appendix F for exact contract language found in standard and specialty MCC descriptions of care coordination.

OPTIONS TO CONSIDER

1) Define pediatric-to-adult HCT approach as part of care coordination programs.

Example: Contractors shall develop an HCT policy/guide with input from youth and families that describes their approach to HCT and is shared with youth and families. This policy/guide should include information about the timing and content of HCT services offered (e.g., transition readiness assessment, transition plan, transfer assistance), information about privacy and consent changes that happen at age 18, and anticipated age of transfer. A process should be developed to educate staff, youth, and families about the transition policy/guide and the roles of care coordinators in the process.

2) Conduct transition readiness/self-care skills assessments and provide needed education and counseling.

Example: Contractors shall use a standardized tool at regular intervals for assessing the transition readiness/self-care skills of youth and conduct periodically starting at age 14.[‡] An educational process should be established to address transition readiness/self-care skill needs (e.g., via discussion, peer support, pamphlets, educational groups).

3) Incorporate pediatric-to-adult transition planning as part of members' comprehensive care plans.

Example: Contractors shall create and regularly update a plan of care, with input from the youth and family/caregiver, that incorporates results from the initial and subsequent transition readiness assessment, transition goals and prioritized actions. The plan of care should take into consideration the unique needs of the youth (e.g., preferred language and method of communication). The plan of care should also include a medical summary and emergency care plan, to be prepared by the youth's primary and/or specialty provider. To prepare for an adult approach to care at age 18, including legal changes in privacy and consent, contractors shall develop a process to assist youth and families in determining the need for decision-making support and filing appropriate paperwork, as needed. Transition specialists shall receive training on a structured transition process, including education on supported decision-making and guardianship.

4) Initiate transfer planning 1-2 years prior to the date when members age out of pediatric medical, behavioral, and other child systems of care.

Example: Contractors shall establish a documented process for transfer planning. This includes: a) assisting members identify adult health care providers and facilitating initial visits; b) helping members identify adult public programs services they are eligible for and facilitating applications; and c) creating a transfer package for each youth/young adult – with a current transition readiness/self-care skills assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents.

[‡] There are many standardized transition readiness/self-care skills assessments available. Got Transition's Six Core Elements of HCT™ 3.0 include transition readiness and self-care skills assessments. These tools, and accompanying implementation guides, are available for free at GotTransition.org/Implementation.

MEDICAID MCC LANGUAGE OPTIONS: VI. QUALITY AND EVALUATION

KEY POINTS

Adding HCT quality improvement and evaluation activities to existing performance assessment and improvement activities will help to ensure adoption of evidence-driven HCT processes and enhance the likelihood of gains in health, appropriate use of care, and satisfaction of care.

Options to Consider:

- 1) Measure implementation of HCT services.
- 2) Measure outcomes of a structured HCT approach.
- 3) Conduct a pediatric-to-adult HCT performance improvement project (PIP).

SUMMARY OF MANAGED CARE CONTRACT REVIEWS

Two states' standard MCCs included language related to transition-aged youth under their sections on quality assurance and evaluation (AZ, IL). Illinois, for example, required that MCOs implement a quality assurance program that describe its process for developing, implementing, and evaluating care plans for children transitioning to adulthood. Florida's specialty Children's Medical Services Health Plan, operated by WellCare, has a Youth Transitions to Adult Care performance improvement project. A variety of improvement strategies are called for, including a description of the quality improvement team, the processes and tools used to conduct gap analyses and prioritize with corresponding interventions, description of the process used to evaluate effectiveness and the use of results to guide the HCT intervention. In addition to the narrative description, the required key indicator is the percentage of young adults, ages 18-21, who transitioned from a pediatric provider to an adult care provider during the measurement period. See Appendix G for exact contract language found in quality and evaluation sections.

OPTIONS TO CONSIDER

1) Measure implementation of HCT services.

Example: Contractors shall assess the baseline level of HCT implementation in pediatric, family medicine, and adult care settings using Got Transition's Current Assessment of HCT. This assessment, which is aligned with the AAP/AAFP/ACP HCT Clinical Report,² should be repeated annually. The Six Core Elements of HCT tools, available for free at GotTransition.org, can be used and customized to guide contractors in their implementation of HCT practices.

2) Measure outcomes of structured HCT approach.

Example: Contractors shall establish pediatric-to-adult HCT performance measures for specific population groups (e.g., youth with sickle cell disease, youth on SSI), using objective quality indicators.⁵ Indicators could include:

1. Population Health Indicators
 - Patient-reported outcomes or self-care skills
 - Adherence to care/guidelines

⁵ Additional examples of pediatric-to-adult HCT quality indicators can be found in The National Alliance to Advance Adolescent Health's leadership roundtable report on value-based payment for HCT.¹²

2. Patient Experience Indicators
 - Percentage of youth and families who report feeling prepared to transition from pediatric to adult care, using Got Transition’s HCT Feedback Surveys for Youth and Parents/Caregivers
3. Utilization Indicators
 - Increase in adult ambulatory care visit rate among young adults
 - Reduction in length of time between the last pediatric and initial adult visit
 - Preventable emergency room utilization (excluding urgent care) during time between last pediatric visit and initial adult visit

3) Conduct a pediatric-to-adult HCT performance improvement project (PIP).

Example: The Contractor shall conduct a performance improvement project (PIP) that represents a partnership between pediatric and adult care practices or systems to pilot system interventions to establish a structured process for transition planning, transfer, and integration into adult care. The PIP requirements include:

- Conducting a baseline Current Assessment of HCT Activities in each participating pediatric and adult site, reporting on baseline score, and repeating annually to assess level of improvement. The customizable Current Assessment is available for free on Got Transition’s website at GotTransition.org.
- Forming an HCT quality improvement team, with senior leadership support and representation from youth/young adults/parents/caregivers. The team is responsible for establishing measurable aims for specific HCT system interventions aligned with the Six Core Elements of HCT™.
- Measuring HCT performance using valid quality indicators.
- Summarizing the status and results of the PIP in the annual quality report and making recommendations to state Medicaid officials based on lessons learned from the PIP.

CONCLUSION

State Medicaid agencies and their MCOs are in a unique position to expand the availability of pediatric-to-adult transition services. Using or adapting the MCC provisions offered in this report would go a long way to ensuring access to a structured transition process in both pediatric and adult settings, which research shows will positively impact health quality, experience, and utilization of care among youth and young adults with special health care needs.

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APPENDIX A: USEFUL HEALTH CARE TRANSITION RESOURCES

2020 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care (*click [here](#)*)

Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report (*click [here](#)*)

Incorporating Pediatric-To-Adult Transition into NCAQ Patient-Centered Medical Home Recognition: 2019 Update (*click [here](#)*)

Incorporating Health Care Transition Services into Preventive Care for Adolescents and Young Adults: A Toolkit for Clinicians (*click [here](#)*)

Transitioning Youth to an Adult Health Care Clinician (*click [here](#)*)

Transitioning to an Adult Approach to Health Care Without Changing Clinicians (*click [here](#)*)

Integrating Young Adults into Adult Health Care (*click [here](#)*)

APPENDIX B: DEFINITIONS IN STATE MEDICAID MCCS

STANDARD MANAGED CARE CONTRACT LANGUAGE

VIRGINIA'S MANAGED MEDICAL ASSISTANCE PROGRAM MODEL

"Fostering Futures" is Virginia's program implementing provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal Title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages 18 to 21. The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source.

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S CHILDREN'S REHABILITATIVE SERVICES PLAN

Title XIX Member: Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults \leq 106%), Adult Group above 106% Federal Poverty Level (Adults $>$ 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.

Young Adult Transitional Insurance (YATI): Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the 18th Department of Child Safety in Arizona on their birthday.

GEORGIA'S FAMILIES 360°

Transition of Care: The movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For FC Members, DJJ Members and [Adoption Assistance (AA)] Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360° program; transition from a CMO to the Georgia Families 360° CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

TEXAS' STAR KIDS

Transition Planning means the process of anticipating and preparing for changes in life circumstances and healthcare services to ease an adolescent's shift to adulthood.

Transition Specialist means an MCO employee or Subcontractor who works with adolescent and young adult Members and their support network to prepare the Member for a successful transition out of STAR Kids and into adulthood.

WISCONSIN'S FOSTER CARE MEDICAL HOME

Transitional Care: Processes to ensure continuity of care that include, but are not limited to, medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility or when a member is leaving out of home care or leaving the Foster Care Medical Home. Per 42 CFR § 438.208(b)(2), processes to coordinate services the HMO furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

APPENDIX C: MEMBER SERVICES AND EDUCATION IN STATE MEDICAID MCCs

STANDARD MANAGED CARE CONTRACT LANGUAGE

No HCT language was identified in standard managed care contracts.

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

TEXAS' STAR KIDS

The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. Each Member Services Department or another appropriate department must include Transition Specialists who are dedicated to assisting Members and Service Coordinators with transition planning for adulthood.

APPENDIX D: PROVIDER NETWORKS IN STATE MEDICAID MCCS

STANDARD MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S AHCCCS COMPLETE CARE

The Contractor's network of behavioral health providers shall include, at a minimum the following: Master's and doctoral level trained clinicians in the fields of social work, marriage and family therapy, counseling, psychology, and substance abuse counseling providers who deliver services to ... transition aged youth ages 18 through 20.

MICHIGAN'S STANDARD MANAGED CARE CONTRACT

Contractor must obtain a written attestation from PCPs willing to serve children with special health care needs (CSHCN) Enrollees that specifies the PCP/practice meets the following qualifications: Provides services appropriate for youth transitioning into adulthood.

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S CHILDREN'S REHABILITATIVE SERVICES PLAN

The Contractor's network shall include Master's level and doctoral trained clinicians in the fields of social work, counseling, and psychology that are trained in implementation of best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma related disorders, substance abuse, sexual disorders, and special age groups such as transition age youth and members aged birth to five years old.

DISTRICT OF COLUMBIA'S CHILD AND ADOLESCENT SUPPLEMENTAL SECURITY INCOME PROGRAM (CASSIP)

For Enrollees under the age of twenty-one (21), a PCP may be any of the following: pediatrician, family practice physician, general practice physician, internal medicine physician, OB/GYN, osteopath, nurse practitioner, or a subspecialty physician. Contractor shall ensure all CASSIP Enrollees over the age of twenty-one (21) receive primary care services from a general internist or adult specialist. Enrollees over the age of twenty-one (21) shall not receive these services from a pediatrician and may not use a pediatrician as his or her PCP. Some special needs children may be candidates for continuation with pediatric primary care beyond 21 depending on the clinical issues and determination by pediatrician to continue care. Contractor shall assist such Enrollees in the transition from pediatrician to general internist or adult specialist and shall ensure there is an adequate network of general internists and adult specialists available for Enrollees over the age of twenty-one (21).

APPENDIX E: COVERED SERVICES IN STATE MEDICAID MCCS

STANDARD MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S AHCCCS COMPLETE CARE

The Contractor's behavioral health service delivery system shall incorporate the following elements: Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning; and facilitating transfer from the children's system to the adult system of health care. Coordinate and provide access to chronic disease management support, including self-management support.

The following AHCCCS Behavioral Health Practice Tools shall be utilized: Transition to Adulthood.

MINNESOTA'S UCARE MINNESOTA

Case Management for Transitional Youth. Continued case management must be offered to a Child (or Child's legal representative) who is receiving children's case management and is turning eighteen (18) and his or her needs can be met within the children's service system. Before discontinuing case management for Children age seventeen (17) to twenty-one (21), the MCO must develop a transition plan that includes plans for health insurance, housing, education, employment and treatment.

Assertive Community Treatment for Youth provides intensive nonresidential rehabilitative mental health services by a multidisciplinary staff using a team approach consistent with assertive community treatment adapted for Children ages sixteen (16) to twenty-one (21), with a serious mental illness or co-occurring mental illness and substance abuse addiction that requires services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

Intensive nonresidential rehabilitative mental health services and supports must be provided by an eligible provider agency that meets the requirements and standards outlined in in Minnesota Statutes, §256B.0947, subds. 3a (c), 4 and 5. The services, supports and ancillary activities include the following, as needed by the individual Enrollee: [...] (k) Transition services as defined in Minnesota Statutes, §256B.0947*

*(k) "Transition services" means:

- 1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;
- 2) providing the client with knowledge and skills needed post transition;
- 3) establishing communication between sending and receiving entities;
- 4) supporting a client's request for service authorization and enrollment; and
- 5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

TENNESSEE'S TENNCARE STATEWIDE CONTRACT

The Contractor shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery system, through such activities as communicating treatment plans and exchange of information.

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

No HCT language was identified in standard managed care contracts.

APPENDIX F: CARE COORDINATION IN STATE MEDICAID MCCs

STANDARD MANAGED CARE CONTRACT LANGUAGE

LOUISIANA'S BAYOU HEALTH AETNA CONTRACT

Case Management: Continuity of care for identified Special Health Care Needs populations including managing transitions between pediatric and adult health care providers.

MICHIGAN'S STANDARD MANAGED CARE CONTRACT

Contractor must enter into an agreement with all Local Health Departments (LHDs) to coordinate care for CSHCS Enrollees in Contractor's service area; the agreement must address the following topics: Care planning for Enrollees transitioning into adulthood.

NEW JERSEY'S FAMILYCARE

Transfer of Pediatric Members to an Adult System of Care: The Contractor shall develop policies and procedures on assisting families of adolescent Members related to filing of appropriate paperwork for Social Security Income, Medicaid and if necessary, legal guardianship, at least six months prior to the Members' eighteenth (18th) birthdays. Members with intellectual or developmental disability diagnosis shall be referred to the Division of Developmental Disabilities upon their eighteenth (18th) birthday. For adolescent MLTSS Members who are approaching their twentieth (20th) birthday and currently reside in a pediatric facility, the Contractor shall develop policies and procedures to assist these Members and their families on options for community placement or transition to an adult facility at least six months prior to the Members' twenty-first (21st) birthday. The Department of Health licensing unit shall be consulted as appropriate.

NEW MEXICO'S CENTENNIAL CARE 2.0 CONTRACT

The CONTRACTOR shall conduct an additional assessment within seventy-five (75) Calendar days of transition to determine if the transition was successful and identify any remaining needs. 4.4.15.4 Transition scenarios include but are not limited to: [...] Transition for Member(s) turning twenty-one (21) years of age.

PENNSYLVANIA'S HEALTHCHOICES AGREEMENT

If a member with special health care needs (including but not limited to chronic illnesses or physical and developmental disabilities) who is 18 (eighteen) years of age or older uses a Pediatrician or Pediatric Specialist as a PCP, the PH-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

VIRGINIA'S MEDALLION 4.0 CONTRACT

The Contractor shall participate in mandatory case management collaboration. Additionally, the Contractor shall establish a process to notify youth in foster care who are approaching age eighteen (18) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor shall assist in care coordination during this transitional period.

Foster Care Transition Planning: The Contractor shall develop and maintain transition of care policies and procedures for enrollees who are transitioning out the child welfare system from Aid Category 76 to Aid Category 70, which shall include provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation. If the services are not covered by Medicaid, the Contractor shall inform the enrollee, or their authorized representative, of any community programs that may be able to meet their needs and make the necessary referrals, as needed. The Contractor shall start transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system or immediately upon notification that an enrollee has achieved permanency status.

Comprehensive System of Care - The Contractor shall develop a comprehensive system of care for the provision of services as medically necessary, to children ages 13-18 years in the Medallion 4.0 program. The Contractor must ensure that in the provision of services to this population any strategies and innovations implemented align with and advances the following goals:

- Supports an increase in oral health and vision health;
- Supports Increase in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);

- Prevents and/or reduces obesity, asthma, or other chronic conditions;
- Focuses on teens and adolescent health, including trauma-informed care, ACES and resilience;
- Focuses on children and youth with special health care needs (CYSHCN);
- Provides transition planning to help teens and young adults prepare for changes following their 18th birthday.

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S CHILDREN'S REHABILITATIVE SERVICES PLAN

Transition Activities: The Contractor shall develop a Pediatric to Adult Transition Plan for each Member by age twenty (20) years. The Transition Plan shall be developed with Members, families, and their providers. The Transition Plan shall include strategies to address barriers to transitioning from a pediatric- to an adult-oriented system of care. The Transition Plan should be age-appropriate and periodically updated to address the Member's current needs and identify an adult-care PCP, if the Member elects to transition to another health plan prior to transition out of the CRS program. In addition to health care, developmentally-appropriate discussions related to work, education, recreation, and social needs should be part of the planning for adulthood. All teens, including those with cognitive disabilities, should be included in planning for adulthood in a way that is meaningful to them. The CRS Contractor shall adhere to policies in the AMPM, Chapter 520, regarding Pediatric to Adult Transition Plans. Utilizing the Enrollment Transition Information (ETI) form, the CRS Contractor shall notify the Member's receiving AHCCCS Contractor once the CRS Member turns 21 years of age and chooses to leave the CRS program or the member is no longer eligible for the CRS program. CRS Members often require care over extended periods of time. Therefore, transitions from the children's to the adult system of care; from the CRS Contractor to another AHCCCS Contractor or a private health plan; between levels of inpatient and outpatient care; from physician to physician; from one carve out service program, such as behavioral health, to another; often are needed. Accordingly, the CRS Contractor shall implement specific policies and procedures to preserve the continuity of care during such transitions. The CRS Contractor must facilitate the development and implementation of a transition plan for members who no longer meet CRS eligibility or who make the decision to choose to transition to another AHCCCS Contractor or private health plan when they turn 21 years of age. The transition plan must be consistent with applicable evidence based practice guidelines, which combines the various elements of treatment plans with needed family support services and care coordination activities to provide a roadmap of the steps to be taken for each Member in achieving treatment and quality of life goals. The plan developed for each member must be completed in accordance with AHCCCS Policy, which includes developmentally-appropriate strategies to transition from a pediatric to an adult system of health care and a plan that addresses changing work, education, recreation and social needs.

DISTRICT OF COLUMBIA'S CHILD AND ADOLESCENT SUPPLEMENTAL SECURITY INCOME PROGRAM (CASSIP)

Transition for Enrollees Aging out of CASSIP: Contractor shall identify Enrollees two (2) years before they age out of CASSIP to allow sufficient time to develop a comprehensive Transition Plan to the adult Medicaid system. Contractor shall have protocols for this transition relating, but not limited to, the following:

- Department on Disability Services;
- DHCF, Long Term Care Administration;
- Certified Medicaid Providers;
- Community Social Service Agencies;
- Department of Behavioral Health;
- Department of Human Services, Adult Protective Services;

Contractor shall assist the Enrollee in identifying services, locating sources of support, and arranging for needed services to commence upon the Enrollee's disenrollment from CASSIP.

Case Management staff facilitates the transfer of medical information from one Provider to another and monitors the Care Coordination Plan; Case Management staff assists in planning for and arranging the services called for by a discharge plan after hospital treatment, or a stay at a PRTF or LTC facility; Case

Management staff assists in planning for termination when the Enrollee ages out of CASSIP or is disenrolled for any reason, including facilitating the communication of medical information to any new Providers the Enrollee might have.

FLORIDA'S CHILDREN'S MEDICAL SERVICES HEALTH PLAN

Ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to [Comprehensive Assessment and Review for Long-Term Care Services (CARES)] for Medicaid enrollees as follows:

- 1) Six months prior to an enrollee turning the age of 18 years for enrollees residing in a nursing facility; and
- 2) Six months prior to an enrollee turning the age of 21 years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program.

Work with enrollee, beginning at age 12 years old, and their family on the development and implementation of a transition plan that helps support the enrollee as they transition into adulthood. The transition plan must address, at a minimum, the educational and vocational supports, housing, income and guardianship. Case Managers must include, at a minimum, in the enrollee's annual plan of care process: Additionally, at a minimum,

- 1) Identification of specific milestones that would trigger need for or that will be addressed in transition plan.
- 2) Transition planning including the enrollee and his/her family, enrollee's providers and adult providers. Transition planning will include enrollee and family readiness assessments beginning at 14 years old.

Designate a Transitions Specialist within our care coordination team to help support complex transitions to adulthood, provide training, guidance and support to other care coordinators and help monitor effectiveness of transition planning.

TEXAS' STAR KIDS

Adult Transition Planning: The MCO must help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns 15 years old. The MCO must provide transition planning services as a team approach through the named Service Coordinator, if applicable, and with a Transition Specialist within the Member Services division. Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in the Members' support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process.

Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service
2. Prior to the age of 10, the MCO must inform the Member and the Member's [Legally Authorized Representative (LAR)] regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals
4. Coordination with [Department of Assistive and Rehabilitative Services (DARS)] to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.

6. Health and wellness education to assist the Member with self-management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult healthcare providers.

Individual Service Plan Description. Each STAR Kids MCO must create and regularly update a comprehensive Person-Centered Individual Service Plan (ISP) for each STAR Kids Member, unless the Member or Member's LAR declines the STAR Kids Screening and Assessment Process as described in Section 8.1.39. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences. The MCO must use the ISP to communicate and help align expectations between the Member, their LAR, the MCO and key service providers. The MCO must use the ISP to measure Member outcomes over time. The MCO must ensure that all ISPs must contain the following information:

1. A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process;
2. Covered Services currently received;
3. Covered Services not currently received, but that the Member might benefit from;
4. A description of non-covered services that could benefit the Member;
5. Member and family goals and service preferences;
6. Natural strengths and supports of the Member including helpful family members, community supports, or special capabilities of the Member;
7. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key service providers, the Member's Health Home, the MCO, and the Member's school, if applicable;
8. A plan for coordinating and integrating care between Providers and Covered and Non-Covered Services;
9. Short and long-term goals for the Member's health and well-being;
10. If applicable, services provided to the Member through [Youth Empowerment Services (YES), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Community Living Assistance and Supports Services (CLASS)], or third-party resources, and the sources or providers of those services;
11. Plans specifically related to transitioning to adulthood for Members age 15 and older; and
12. Any additional information to describe strategies to meet service objectives and Member goals.

The MCO must ensure that the ISP is informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO. To the extent possible and applicable, the MCO must ensure that the ISP accounts for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

Service Coordination Teams: Service Coordination teams are Member-centered support networks designed to enhance services provided by the Service Coordinator. Service Coordination team members must be individually selected based on the needs and preferences of the Member. The MCO will provide a Service Coordination team when the MCO or a Provider determines the Member could benefit from a multidisciplinary approach to Service Coordination or determines specific expertise is necessary to address needs identified in the Member's ISP. Service Coordination teams must be led by at least one Service Coordinator employed by the MCO, or appropriate Health Home employee, if the Member receives Service

Coordination through their Health Home. If a Member has a named Service Coordinator, the named Service Coordinator must lead the Service Coordination team. Service Coordination teams must have access to individuals with expertise or access to identified subject matter experts in the following areas:

25. School transition

Service Coordinators are responsible for helping to connect the Member to an extended service network to meet the Member's needs, which may include ...

12. Transition planning for aging out of STAR Kids

WISCONSIN'S FOSTER CARE MEDICAL HOME

The [Health Care Coordinator (HCC)] must periodically reassess the child 's level of service needs and, in collaboration with DMCPs or the child welfare agency, must recognize when more intensive care coordination may be needed. For example, needs may be greater during key periods in a child's life, such as entry into out-of-home care, change in health care status, discharge from inpatient hospitalization, after a change in placement, at reunification, at time of discharge from out-of-home care, or during transition to adolescence or adulthood.

Duties of Health Care Coordinators:

- e. Ensuring that health information is transferred to a new primary care provider when a child is transferred between agencies or foster homes, or discharged from foster care.

The HCC must engage in transitional health care planning prior to the child leaving the medical home. The transitional planning must be developed with input from the child, primary caregiver, legal guardian, health care providers, and the child welfare case manager as appropriate.

APPENDIX G: QUALITY AND EVALUATION IN STATE MEDICAID MCCS

STANDARD MANAGED CARE CONTRACT LANGUAGE

ARIZONA'S AHCCCS COMPLETE CARE

Children's System of Care: The Contractor shall contract with Centers of Excellence which implement evidence based practices and track outcomes for the following children with special healthcare needs:

Transition Aged Youth:

- a. First episode psychosis programs, and
- b. Transition to Independence (TIP) Model.

ILLINOIS' HEALTHCHOICE ILLINOIS MODEL

Require that Contractor have an ongoing, fully implemented QA program for health services that...describes its process for developing, implementing, and evaluating care plans for children transitioning to adulthood

SPECIALTY MANAGED CARE CONTRACT LANGUAGE

FLORIDA'S CHILDREN'S MEDICAL SERVICES HEALTH PLAN

Enhance and target transition planning for members transitioning into adulthood. Develop a specific performance improvement project (PIP) for improving the timeliness of key performance steps for efficient and effective member transition into adulthood.

Required Performance Measures: Percentage of youth reporting transition in place. Measure Steward: National Survey of Children's Health