MED Policy Brief
August 2025

MEDICAID EVIDENCE-BASED DECISIONS PROJECT, IN COLLABORATION WITH THE OREGON CHILD INTEGRATED DATASET PROJECT

Building an Integrated System of Care for Children and Youth With Special Health Care Needs

Children and youth with special health care needs often receive services from many different care providers and settings, including specialty health care, education systems, and other state agencies such as child welfare. Medicaid and the Children's Health Insurance Program play a significant role in the care of children with special needs.

This policy brief highlights Medicaid-related tools and models that states use to build pediatric systems of care. It also leverages the linked, cross-agency and cross-program information in the Oregon Child Integrated Dataset to profile the distinct needs and experiences of this group of children in 1 state.

BACKGROUND

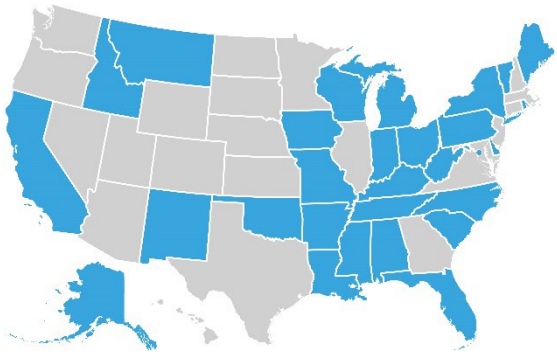
Children and youth with special health care needs (CYSHCN) make up around 20%–25% of the pediatric population[1] and are defined by the US Health Resources and Services Administration (HRSA) as those who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."[2] This broad definition includes conditions such as asthma, cerebral palsy, cystic fibrosis, autism spectrum disorder, developmental delays, and learning disorders.[3] It also

encompasses a subset of *children with medical complexity*, who have multiple chronic medical conditions, experience functional limitations, and often require supportive medical technologies.[4]

In 2023, at least 50% of CYSHCN were covered by Medicaid or the Children's Health Insurance Program (CHIP) in 12 states, and at least 41% in 28 states and the District of Columbia (**Figure 1**).[1] That share may be even higher among children with medical complexity,[5] who make up a significant portion of total pediatric Medicaid spending.[6] Many children with serious health conditions may be eligible for Medicaid coverage through pathways outside of family income thresholds, such as specialized Medicaid waiver programs for home- and community-based services.[7] Additionally, Medicaid's benefit package, anchored by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions, is often more generous than private insurance plans, particularly for services such as private-duty nursing that CYSHCN often need.[7,8] Families may have secondary Medicaid coverage to fill gaps left by private insurance.[1,7,8]

FIGURE 1

States where at least 41% of CYSHCN are covered by Medicaid or CHIP

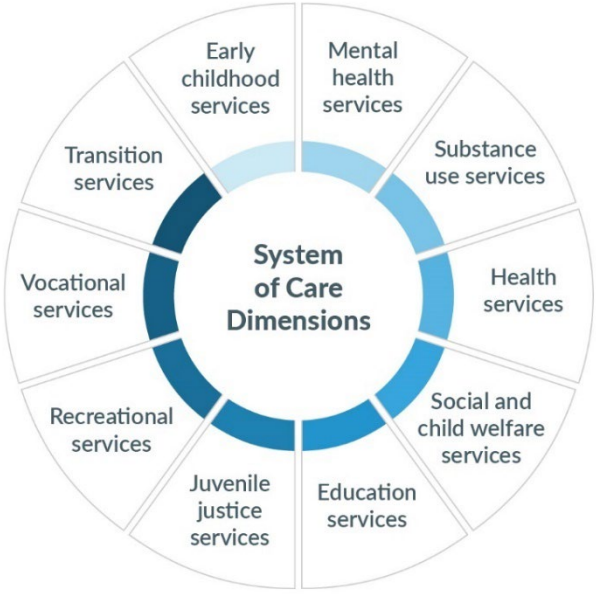


Source. Kaiser Family Foundation analysis of data from the 2023 National Survey of Children's Health.

This policy brief synthesizes key findings from the MED Report *Building an Integrated System of Care for Children and Youth With Special Health Care Needs (CYSHCN)*. State agencies within the MED collaborative have access to the full research report. The brief provides state Medicaid agencies with key insights, tools, and examples for more effectively leveraging the Medicaid program to build an integrated system of care for children with special needs. The report included a policy and literature review on building systems of care for children with special health care needs and the specific role of Medicaid, along with key informant interviews with subject matter experts and state agency staff from Medicaid, Title V, early childhood, and additional child-focused programs. It also leveraged a collaboration with the Oregon Child Integrated Dataset (OCID) project[9] to create a profile analysis of Oregon children enrolled in Medicaid or CHIP who have special health care needs.

FIGURE 2

System of Care Dimensions



Adapted from Stroul, Blau, and Larson (2021).

A "System" or "Systems" of Care

Children with special needs often require health services from multiple providers (e.g., both specialists and primary care) across various care settings (e.g., inpatient, outpatient, home-based, school-based, residential, or institutional environments).[10]

Additionally, data consistently show these health needs may be occurring alongside significant social and economic challenges affecting both the children and their household members (including contact with additional state services and systems, such as child welfare; **Figure 2**).[9,11]

The concept of a "system of care" or services for children (originally designed for mental and behavioral health) points to 3 key components of a system[12]:

- A **philosophy** of core values (e.g., community-based) and principles (e.g., mental health integration)
- **Infrastructure** and processes to meet those aspirations (e.g., financing, interagency partnerships)
- **Comprehensive services and supports** to deliver care (e.g., specialty providers, school-based care)

This broader system includes many different overlapping service dimensions aimed at addressing the needs of children and adolescents. These services may be funded, administered, delivered, and regulated by many different sectors and federal, state, and local agencies with different entry and enrollment criteria.[10,13] For example, in **Figure 3,** a hypothetical child with complex medical needs may receive services from primary care clinicians, medical specialists, developmental providers, and school-based staff members in settings ranging from hospitals and classrooms to pop-up care clinics. These services can be paid by many different funding sources, including private insurance and Medicaid, the latter of which can offer waiver services not typically covered by private plans. Consequently, service and program administration may fall under 3 or more different state agencies.

FIGURE 3

Care mapping for a child with complex medical needs

Source. Center MED report, "Building an Integrated System of Care for Children and Youth With Special Health Care Needs."

Research consistently shows that families of CYSHCN find this broader system of care and services to be fragmented, confusing, and many times, inadequate, with associated health and economic burden for caregivers.[3,8,13-15] Sector leaders and subject matter experts have highlighted potential models for a more integrated system of care that increases family perspective, integrates data, ensures predictable cross-sector care pathways, offers single entry points with multiprogram eligibility opportunities, and builds mechanisms to interpret and curate relational data across systems to troubleshoot problems.[2,13,16]

THE OREGON CHILD INTEGRATED DATASET

Background

The Oregon Child Integrated Dataset (OCID) is a resource for Oregon state policymakers and community leaders to ground their decisions in the best available data to improve the well-being of all Oregon's children and families.[17] Housed within the Center for Evidence-based Policy, OCID serves as an objective, nonpartisan data resource for answering questions, generating ideas, and advancing collective accountability for the well-being of Oregon's children.

OCID contains linked, cross-agency and cross-program information for children born in Oregon and their birth parents beginning in 2001, as well as data for children who receive services from a range of programs and services regardless of their place of birth. It includes data elements provided by 5 state agencies in the areas of education, early learning, health, housing, and safety with the goal of providing a powerful Oregon-specific, cross-program view across childhood, from birth through high school. See the OCID website for the exact services and data elements within OCID.[17]

LEARN MORE

For detailed analysis tables and a full description of the methodology used to create this analysis, including definitions for children with complex and noncomplex chronic health conditions, see **Appendix**. Readers may also be interested in OCID's related *Series on Complex Medical and Social Needs in Early Childhood* released in September 2024.[9] More information on the OCID project, OCID research and policy work, and the Child Well-being Dashboard can be found on the OCID website.[17]

OCID is guided by a governance committee that includes Oregon state legislators from both chambers and parties, a representative from the Governor's office, and directors of state agencies contributing data to OCID or its designees.

Since 2019, OCID has produced a series of analyses, policy briefs, and interactive online data visualizations on topics concerning the well-being of Oregon children, including those focused on school mobility and graduation, chronic absenteeism, early childhood medical and social complexity, and behavioral health.[17] OCID also maintains a Child Well-being Dashboard, which allows users to investigate a selection of health, educational, and social service indicators on child well-being using geographic, demographic, and cross-program attributes.[17]

CYSHCN in Oregon

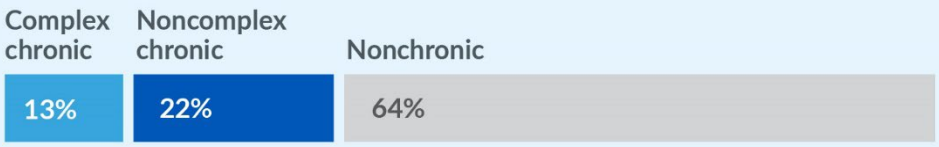
For the purposes of this MED report, the Governance Committee of the OCID project supported the use of OCID data to create a profile analysis of Oregon children and youth enrolled in Medicaid or CHIP who had special health care needs in 2021. Special health care needs were defined as having complex or noncomplex chronic health conditions using the Pediatric Medical Complexity Algorithm, a claims-based algorithm that identifies diagnoses specific to chronic conditions using ICD-10 codes in

administrative claims.[18,19] More information on OCID's application of this algorithm can be found in the Appendix. Our findings provided key insights into the social and environmental circumstances of these children in the realms of public program participation, agency contacts, educational experiences, housing stability, health status, and health care, highlighting the importance of agency integration and collaboration during child development.

Medicaid has a large role in CYSHCN care in Oregon—more than one-third of children enrolled in Oregon Medicaid or CHIP had at least 1 chronic health condition

FIGURE 4

Percent of children in Oregon with chronic health conditions



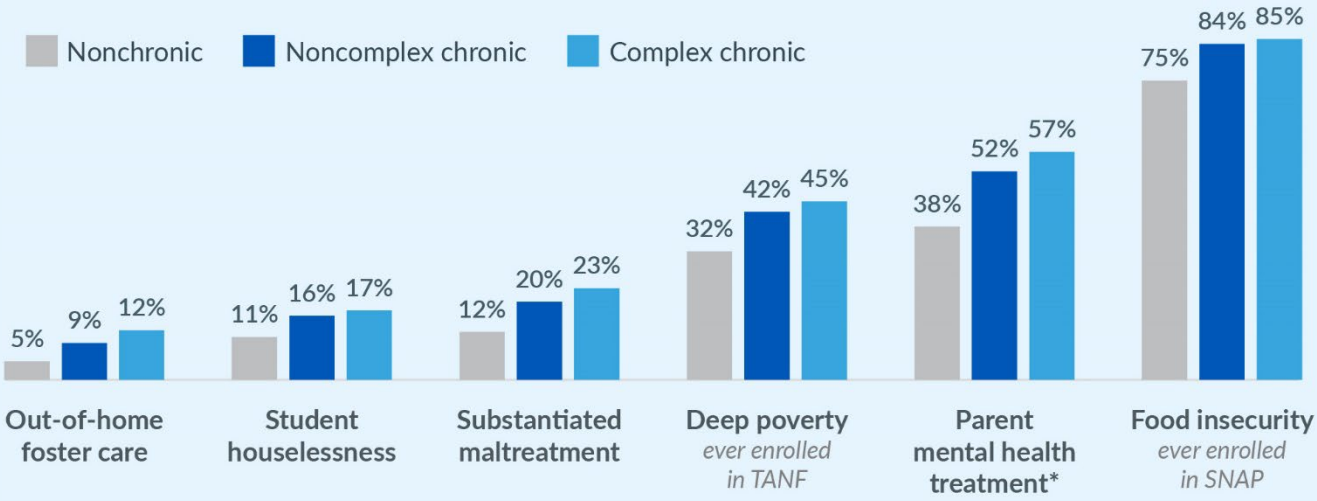
Note. Nonchronic includes children with no known chronic health conditions.
Source. OCID analysis of Oregon Medicaid or CHIP enrollees aged 0 to 21 years, 2021. See Appendix for detailed analysis tables and definitions.

Children with special health care needs had more challenging social and environmental circumstances and experiences at both the individual and family level

More children with chronic conditions were involved with child welfare, experienced houselessness, accessed economic support programs, and had a parent who received mental health services.

FIGURE 5

Prevalence of social and environmental experiences for children with chronic health conditions



**Parent-level experiences are those that occurred in the parent during the life of the child and are only calculated for youth born in Oregon.*
Source. OCID analysis of Oregon Medicaid or CHIP enrollees aged 0 to 21 years, 2021. See Appendix for detailed analysis tables and definitions.

Children and youth with special health care needs had higher health care utilization

More children and youth with chronic conditions attended recent well-child visits, but they also experienced higher rates of emergency department visits and inpatient hospital stays.

TABLE 1

Percent of children with chronic health conditions who accessed health care services in 2021

	Well-child visit (3–6 yrs)	>1 ED visit	>1 inpatient visit
Nonchronic	53.1%	12.1%	0.7%
Noncomplex chronic	64.5	18.5	1.3
Complex chronic	67.0	25.8	3.8

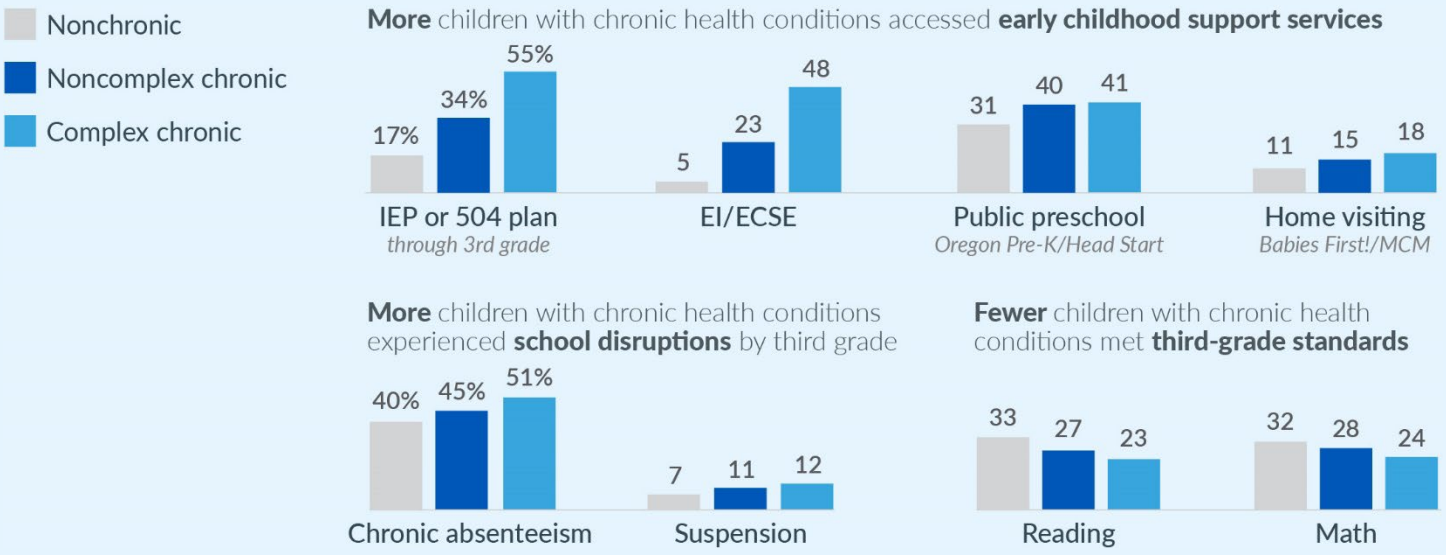
*Source. OCID analysis of Oregon Medicaid or CHIP enrollees aged 0 to 21 years, 2021. See **Appendix** for detailed analysis tables and definitions.*
Abbreviation. ED: emergency department.

Integrated data can help demonstrate how measures of well-being and education vary for children with complex health needs and conditions

Linked administrative data sources enable the types of cross-system connections envisioned in many early childhood efforts, allowing for identification of child-level needs, tracking utilization of key support programs, and integration of health systems data with broader well-being goals, such as educational outcomes. **Figure 6,** drawn from the OCID *Series on Complex Medical and Social Needs in Early Childhood*,[9] depicts the numerous programs accessed by children with medical needs during early childhood and links them to subsequent early educational experiences and outcomes. For example, a much larger proportion of children enrolled in Medicaid or CHIP with chronic health conditions accessed early childhood support services and experienced educational disruptions, while a smaller proportion met third-grade reading and math standards.

FIGURE 6

Early childhood program involvement and education outcomes for children with chronic health conditions



Source. OCID analysis of children in 2017–2018 and 2018–2019 third-grade classes enrolled in Medicaid or CHIP between ages 0 to 5.[9]
Abbreviations. ECSE: Early Childhood Special Education; EI: Early Intervention; IEP: Individualized Education Program; MCM: Maternity Case Management.

Identifying the many programmatic touchpoints that CYSHCN may have during early childhood can shed light on the potential opportunities for coordination among programs, as well as integration between the health system and additional critical social and educational services.

FINANCING AN INTEGRATED SYSTEM OF CARE

States receive federal funding from multiple agencies, including, for example, Medicaid, the Individuals with Disabilities Education Act (IDEA), and the Title V Maternal and Child Health Services (MCH) block grant (see **Sidebar**); this funding can be leveraged or even blended to deliver CYSHCN services.[10] Historically, targeted federal grants from HRSA,[22] the Substance Abuse and Mental Health Services Administration,[23] and other federal agencies have focused on establishing systems of care for children with special health needs by creating sustainable systemic infrastructure and services. However, the ongoing reorganization of the US Department of Health and Human Services has introduced uncertainty around whether some of these financing opportunities will continue.[24]

In a 2022 commentary on financing a system of services for children with special health care needs, experts recommended extending Medicaid's more generous benefit package to more CYSHCN, providing adequate funding for long-term services and supports, primary care, and care integration and coordination, and developing financing models that support cross-sector coordination.[15] They called for collaboration across public and private insurers and among the many federal and state programs often serving the same children.[15]

Title V MCH Block Grant

The HRSA-administered Title V Maternal and Child Health (MCH) Services Block Grant program is a federal-state partnership, with states and localities contributing at least a $3 match for every $4 of federal Title V funds.[20] State-designated MCH agencies must spend at least 30% of federal funds on primary and preventive care for children, and another 30% to support a program focused on CYSHCN services.[20] Under the law, Title V agencies and the Medicaid program must have an interagency agreement to increase partnership and coordination.[21] Title V CYSHCN programs historically funded direct care services, but as Medicaid has expanded, these programs have also adopted care-enabling and system-building roles including care coordination, delivery system infrastructure development, and evaluation—in some cases, with direct funding ties and collaboration with the Medicaid program.[20,21]

Medicaid Levers

Our review of the literature and discussion with subject matter experts identified a wide assortment of funding authorities, care models, and benefits that Medicaid programs may consider using to build and influence critical elements of the care system for children with special needs (**Figure 7**). These levers connect to many of the strategic aims that experts have called for to achieve a high-functioning system of care for children with special needs, such as:

- Building focal organizational and coordination structures that work across systems[13,16,25]
- Addressing health care workforce concerns[2,13,26]
- Lowering financial burden for CYSHCN families[15]
- Supporting the role of the education system for CYSHCN care[10,13]
- Ensuring access to core and specialty health care services[13]
- Improving the breadth of covered services[7,15]

While **Figure 7** may help state Medicaid programs consider options for supporting CYSHCN, changes in federal funding and programmatic priorities may influence the approval of proposed state benefits and waivers and the continuation or renewal of federal grants and innovation programs.[24,27]

FIGURE 7

Medicaid levers

LEVERAGING EPSDT BENEFIT STANDARDS

Agencies may strategically use the EPSDT benefit, which is often more expansive than private coverage,[7,8,15] to:

- Create specialty care access obligations
- Link pediatric care systems together
- Set standards for state Medicaid MCOs
- Extend EPSDT to CHIP population

Medicaid and Title V agencies are statutorily required to collaborate around EPSDT.[21]

TAILORED CYSHCN PLANS AND BENEFITS

States can create Medicaid managed care plans or provider networks specifically for children with special health care needs and disabilities (e.g., California,[28-30] Florida[31-33]), or those involved in the foster care system.[34] State agencies may also develop MCO contract standards specific to children with high needs (e.g., pediatric specialty network adequacy) and design coverage to better capture and reimburse key services like early intervention programs.[35]

HEALTH HOMES AND COORDINATION

Agencies may look for mechanisms to increase CYSHCN care coordination and integration:

- Enhanced or targeted case management benefit[36]
- Title V agency-led care coordination for children in Medicaid MCOs[21,37]
- Creating health homes for chronically ill children under Section 2703 authority[25,38]
- Creating health homes for medically complex children under ACE Kids Act authority[25,38]

SCHOOL-BASED SERVICES

The education system plays an important role in delivering services for children with special needs, but financing resources may vary widely across schools.[13] Since 2014, states have had the option to receive Medicaid reimbursement for school-based services delivered to Medicaid-eligible children regardless of whether they met criteria for an individualized education plan.[39] As of 2023, 25 states had pursued this expanded eligibility.[40]

PAYING FAMILY CAREGIVERS

To address both a shortage of home-based nursing services and economic burdens for families who sacrifice employment to care for CYSHCN, states can allow family members to be paid through Medicaid as trained and certified nursing aides.[41,42]

TELEHEALTH

Expanded telehealth service coverage since the COVID-19 pandemic can be a particularly important benefit for CYSHCN who may need access to a small number of pediatric specialists who may not practice nearby.[43-45]

EXPANDING MEDICAID PATHWAYS

States can expand Medicaid eligibility to more CYSHCN families with high clinical need who may not meet standard eligibility (subject to recent federal legislative changes):

- Katie Beckett/TEFRA option[46-48]
- Family Opportunity Act option[25,46,48]
- State-specific pathways for children meeting SSI disability criteria (e.g., Masschusettes[49], Pennsylvania[47,50])
- Section 1915(c) HCBS waivers[51-54]
- Section 1115 waivers[55]
- Medically needy Medicaid eligibility[46,48]

WHOLE-CHILD MEDICAID MODELS

States may design more holistic care models through Medicaid that link different service areas together for CYSHCN, for example:

- The federal Integrated Care for Kids model, where states like North Carolina have explicitly connected medical and social needs across different sectors including health, education, and juvenile justice[56,57] (CMS may make changes to this program)[27]
- New York's former First 1,000 Days initiative, which aimed to use Medicaid across sectors for early childhood development[58]

Abbreviations. ACE Kids Act: Advancing Care for Exceptional Kids Act; CHIP: Children's Health Insurance Program; COVID-19: coronavirus disease 2019; CMS: Centers for Medicare & Medicaid Services; CYSHCN: children and youth with special health care needs; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; HCBS: home and community-based services; MCO: managed care organization; TEFRA: Tax Equity and Fiscal Responsibility Act; SSI: Social Security Insurance.

How States Build Integrated Systems of Care

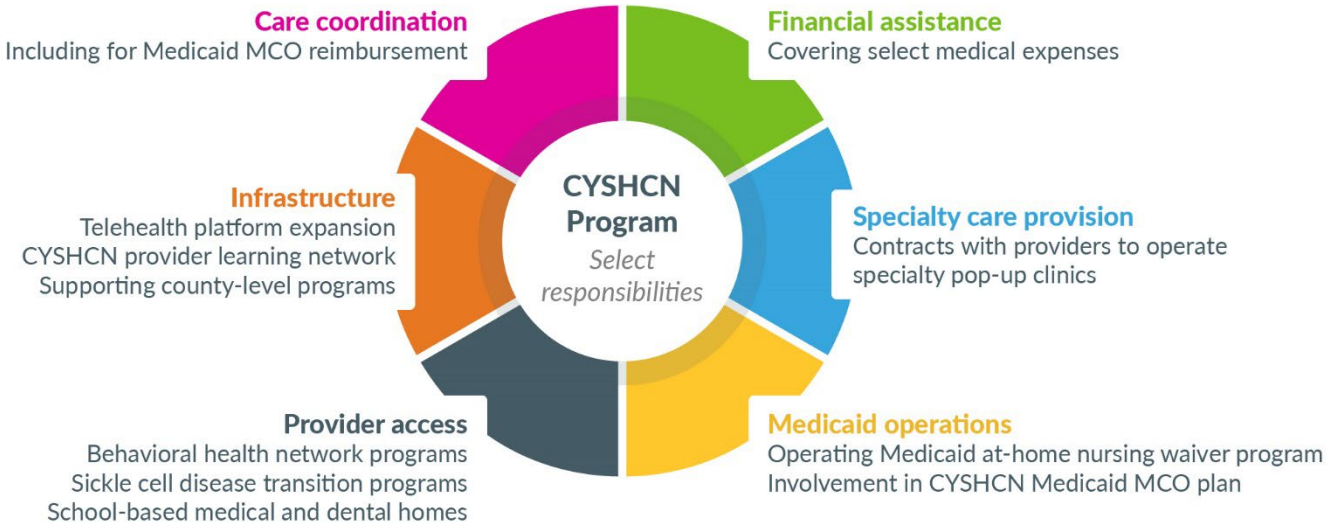
In our research, we identified many examples of ways that states are integrating different programs, funding sources, and service areas to care for children with special needs—with consistent and creative linkages to the state's Medicaid program.

Title V CYSHCN Program Roles

State Title V CYSHCN programs consistently sit within the state's health or public health department, often separate from the Medicaid agency, and they can play strategic roles that encompass both broader population health and system infrastructure development, as well as direct service provision for CYSHCN.[20,21] These activities can interface with patients and many of the health care providers and institutions that CYSHCN may come into contact with, and Title V CYSHCN programs may even have direct Medicaid-related roles such as administering CYSHCN care coordination programs as subcontractors to Medicaid managed care organizations (MCOs),[37] involvement with the state's CYSHCN-specific Medicaid MCO plan,[32,33] administering the state's at-home nursing waiver program,[37] and providing direct specialty services to Medicaid-enrolled children.[59]

FIGURE 8

Title V CYSHCN program roles



Source. Center MED report, "Building an Integrated System of Care for Children and Youth With Special Health Care Needs (CYSHCN)."
Abbreviations. CYSHCN: children and youth with special health care needs; MCO: managed care organization.

Building Out Behavioral Health Integration

Our research consistently identified behavioral health care as a critical area of unmet need both for CYSHCN and children generally, particularly for children with acute needs and those with other underlying health conditions requiring higher-intensity services. We identified state efforts including:

- Developing Medicaid pediatric health homes programs to better integrate physical and behavioral health care[38]
- Targeting Medicaid case management models to identify high-need children for behavioral health coordination[36]
- Using specialized Medicaid managed care entities for pediatric behavioral health[60]
- Using federal grants to create and support behavioral health provider networks and consultation hubs (including within school-based health centers) and build behavioral health specialty teleconsultation platforms[61]
- Piloting a high-fidelity wraparound model through federal grant funding and building it into a statewide pediatric Medicaid benefit within a Section 2703 health home program[62,63]

System and Provider Models

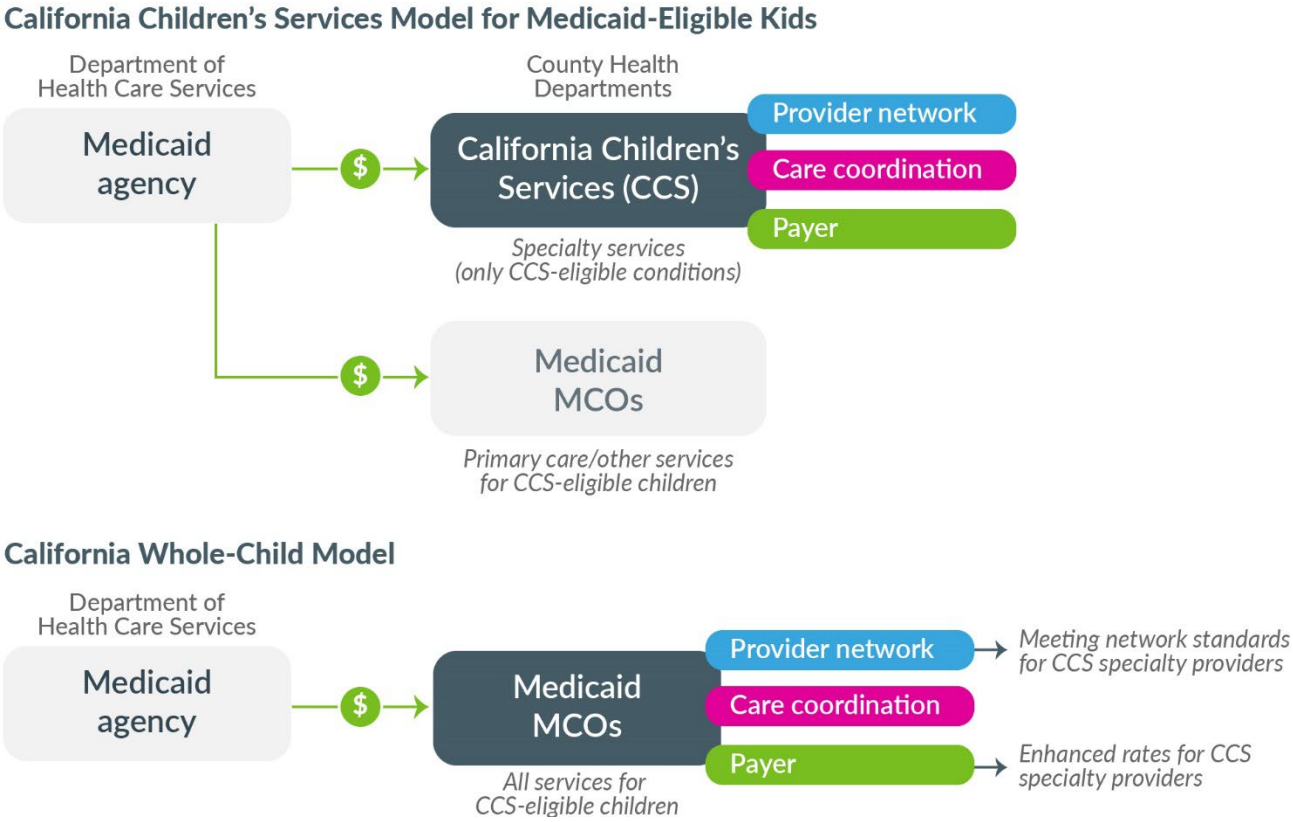
In our research, several states stood out with Medicaid-linked programs specifically designed to offer care services to CYSHCN, ranging from population-specific Medicaid plans to full system-level structures. These models and their various components may serve as examples for how states can create more streamlined systems using many of the Medicaid tools mentioned throughout the brief.

Under each state model, we provide a schematic figure to help illustrate the financial and structural connections between the state Medicaid agency and the delivery systems that provide treatment services to children with special health care needs.

California Children's Services (CCS) is statewide provider network and coverage program delivering specialty treatment to all low-income CYSHCN who meet medical and financial criteria—currently nearly 200,000 children, with around 90% eligible for Medicaid.[29,30,64] Jointly administered by the state's Department of Health Care Services (overseeing Medicaid) and county programs, CCS provides specialized care management services and has a robust network of specialty providers paid at ~40% higher rates than Medicaid.[29,30,65] The agency recently integrated the CCS program directly into Medicaid MCOs for certain regions through its CCS Whole Child Model, requiring MCOs to maintain CCS provider network standards and payment rates and manage *all* care for those children.[30]

FIGURE 9

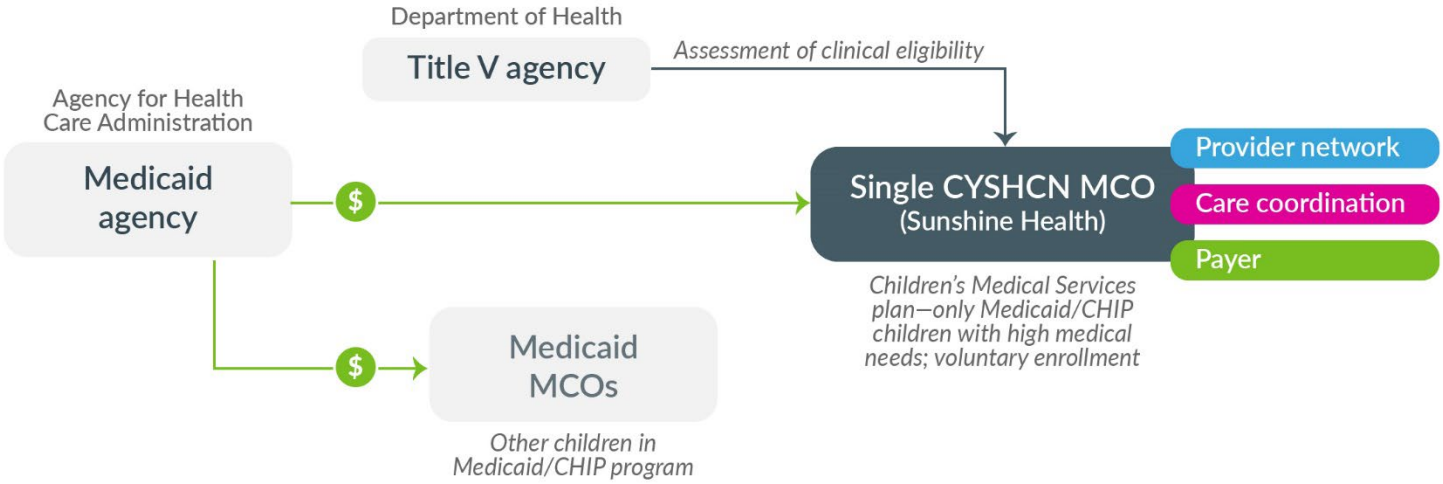
California models



Information sources. California Children's Services program overview *(2025);* Okumura, et al. *(2022).*
Abbreviation. MCO: managed care organization.

Florida Children's Medical Services Managed Care Plan is a CYSHCN-specific MCO plan for Medicaid and CHIP-eligible children who meet clinical eligibility criteria.[31] More than 100,000 children are enrolled in the plan, which is managed by a single MCO vendor (Sunshine Health) that assigns a specialized care manager to each child and must maintain a robust provider network.[31,66] Previously, the state's Title V program within the Department of Health (separate from the Medicaid agency) directly administered and managed the Children's Medical Services plan and MCO vendor while receiving Medicaid and CHIP funding from the Medicaid agency.[33,67] However, state legislation passed in June 2025 transferred the administration of the Children's Medical Services MCO plan to the Medicaid agency, while the Department of Health remains responsible for assessing the clinical eligibility of children for the plan.[32,67-69] Other relevant CYSHCN programs also sit under the Title V agency (e.g., early intervention, medical foster care).[70]

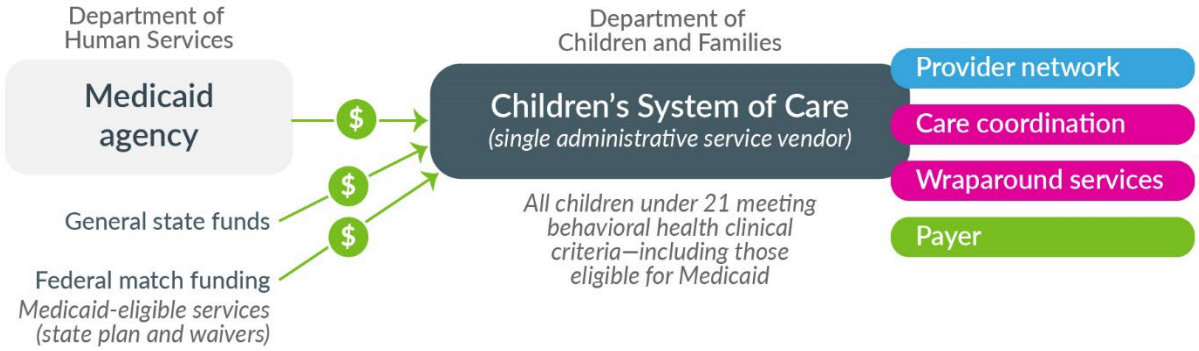
FIGURE 10
Florida model



Information sources. Florida State House of Representatives *(2025);* Florida Department of Health *(2025);* McCarthy and Waugh *(2022).*
Abbreviations. CHIP: Children's Health Insurance Program; CYSHCN: children and youth with special health care needs; MCO: managed care organization.

New Jersey Children's System of Care serves as the state's public child behavioral health system, delivering services to residents under 21 of all income levels with mental health, substance use, and intellectual and developmental disability needs.[71,72] Conceived around the System of Care model and sitting within the Department of Children and Families, the system served around 70,000 children in 2022 (~65% enrolled in Medicaid) with services including mobile response and stabilization, care management and wraparound services, and in- and out-of-home treatment, with a single assessment for entry.[72,73] The system receives sub-allocated Medicaid funds, directly manages its provider network, and pays claims through the state's Medicaid fiscal agent for all services and children, while also receiving federal match funding for services to Medicaid-eligible children covered under the Medicaid state plan and Section 1115 waiver.[72,73]

FIGURE 11
New Jersey model



Information sources: New Jersey Children's System of Care overview *(2023);* Center for Health Care Strategies and Casey Family Programs *(2025).*

Ohio Partners for Kids, a Medicaid accountable care organization (ACO) based out of Nationwide Children's Hospital in Columbus, is responsible for organizing, delivering, and paying for health care services for most children with Medicaid in the central and western regions of the state—more than 470,000 total.[74] The ACO receives most of its capitation funding from Medicaid MCOs and is financially at risk for providing care.[74] It contracts with a provider network, including providers within the larger Nationwide health system, who receive enhanced reimbursement above standard Medicaid rates.[74,75] The ACO has a robust care coordination effort both inside and outside of specialty hospitals that may work with other sectors involved in a child's care (e.g., school).[74,76] It also plays a regional consultative role to build school health center and behavioral health service capacity.[74]

FIGURE 12

Ohio model

Adapted from Partners for Kids overview (2024).
Abbreviations. ACO: accountable care organization; MCO: managed care organization.

Interagency Relationships and Collaboration

Our research consistently identified challenges and opportunities for coordinating Medicaid agency efforts alongside other agencies serving the same children. While experts aspire to single points of entry for multi-program enrollment and cross-agency data sharing, families often encounter more frustrating realities such as trying to enroll in Medicaid waiver services operated by agencies outside of the state's Medicaid program. Examples of efforts to improve collaboration and alignment included:

- Creating mechanisms for more direct collaboration and feedback between Medicaid and Title V CYSHCN programs (e.g., serving on Medicaid advisory committees, reviewing MCO contracts)
- Consolidating Medicaid 1915(c) waivers for CYSHCN under the direction of the Medicaid agency[77]
- Participating in cross-agency collaborative bodies such as Children's Cabinets[78]
- Pursuing data and eligibility integration projects (e.g., creating early intervention e-referrals directly connected to health care provider electronic health records,[79] multi-program eligibility screening platforms[80])
- Coordinating operations for jointly delivered services (e.g., medical foster care programs[81])

STATE CONSIDERATIONS

State Medicaid officials may want to consider some of the following principles and approaches as they look for ways to apply the findings from this brief and create a more effective and integrated system of care for children with special needs. Importantly, they will also need to navigate a rapidly evolving federal funding landscape that may alter some of the grants and spending authorities outlined within this brief.

- **Exploring ways to use different Medicaid levers.** State Medicaid tools for improving the system of care for CYSHCN range from cross-system coordination and integration structures, to addressing workforce shortages and family financial burden, to increasing access to key services and improving the breadth of coverage for high-need children.
- **Bringing the pieces together.** States have found innovative ways to link different care models, benefits, and funding streams and authorities to improve the system of care. For example, New Jersey's Children's System of Care has created a service array for acute behavioral health needs aligned with the state's Medicaid coverage authorities to allow for more seamless financing, and California has integrated an existing specialty provider system for CYSHCN with its Medicaid managed care plans.
- **Connecting Medicaid and Title V.** State Medicaid agencies may consider collaborating on higher-level systems projects that Title V CYSHCN programs are well situated to focus on (e.g., improving pediatric specialty provider telehealth infrastructure, soliciting Title V subject matter expert perspective around Medicaid issues, requiring Medicaid MCOs to contract with Title V agencies for CYSHCN care coordination, and involving Title V agencies in the administration of Medicaid CYSHCN-specific plans or benefits).
- **Improving integration of data across programs.** Medicaid and other state agencies are often interacting separately with the same children who have special needs, and the Oregon OCID dataset is an example of how states might connect and analyze data across child-serving programs. This integration could help support more holistic decisions about care pathways and treatment planning, and remove hurdles around program eligibility, enrollment, and screening processes to help ensure children with complex needs do not fall through the cracks of a multifaceted system.

CONCLUSION

This report provides a high-level overview of the systems and sectors involved in CYSHCN care, and it gives state Medicaid agencies examples for using program models, funding sources, and interagency collaboration to build different types of systems and care structures. The information provides a foundation for ideas as Medicaid programs and their state agency partners consider ways to bring different elements and entities together within local contexts.

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No authors have conflicts of interest to disclose. All authors have completed and submitted the Oregon Health & Science University form for Disclosure of Potential Conflicts of Interest.

Visualizations

Designed by the Center's Morgan Reeder.

About the Center for Evidence-based Policy

The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

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