



USING MANAGED CARE CONTRACTS TO PROMOTE CHILD HEALTH:

A Report on the 2004 State Advanced Leadership Workshops on
Fiscally Sound Medicaid and SCHIP
Managed Care Contracts for
State Title V Maternal and Child Health Agencies
And Local Health Departments



U.S. Department of Health and Human Services,
Health Resources and Services Administration,
Maternal and Child Health Bureau



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Report on the 2004 Advanced Leadership Workshops on Fiscally Sound Medicaid and SCHIP Managed Care Contracts for State Title V Maternal and Child Health Agencies and Local Health Departments

I. Introduction

Since 2000, the Center for Health Services Research and Policy at The George Washington University (GWU), has undertaken a series of projects based on the Medicaid managed care contracts studies and the managed care purchasing specifications. Specifically, GWU researchers developed Medicaid Pediatric Purchasing Specifications and Children with Special Health Care Needs Purchasing Specifications with funding from the Health Resources and Services Administration (HRSA) and the Commonwealth Fund, among others. These purchasing specifications offer suggested model contract language options for States to use in drafting managed care agreements.

In 2001, GWU worked with HRSA's Maternal and Child Health Bureau (MCHB) to host a workshop in Little Rock, Arkansas, for teams of State and local officials from six States. The team members represented Medicaid, State Children's Health Insurance Programs (SCHIP), Title V, and local public health agencies. This successful team approach became the model for a series of State-specific "leadership" workshops, designed to address similar issues as the Little Rock workshops with the advantage of being able to provide tailored technical assistance.

In 2004, five States responded to the offer for technical assistance related to child health and used the workshops as an opportunity to focus on particular challenges. HRSA'S MCHB and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC), John Snow, Inc. co-sponsored this workshop series. For each workshop, Jeff Levi of GWU and Kay Johnson of Johnson Group Consulting provided faculty support. James Resnick of HRSA'S MCHB attended each workshop. A leadership group – including a minimum of leaders from Medicaid, SCHIP, Title V and local public health – was assembled in each State to plan, convene, and attend the workshop.

Each workshop involved collaboration among Federal sponsors, private-sector faculty, and State leaders. The role of HRSA'S MCHB and MCTAC in co-sponsoring the workshops was to: identify the faculty to conduct the workshop, pay for the honorarium and travel expenses of the faculty, and coordinate with Maternal and Child Health leaders and faculty to customize the workshop to a State's particular Medicaid/SCHIP concerns. State-level co-sponsors were responsible for arranging and paying for the following activities: 1) promoting the workshop, including the development, printing, and mailing of the promotional materials, 2) sending invitations to the target audience, 3) securing meeting space, audiovisual equipment, and the food, if desired, 4) registering attendees, and 5) identifying issues and developing the agenda for a workshop.

This paper describes the substantive results of these "Advanced Leadership Workshops." We set out to offer strategies, tools, and techniques to negotiate fiscally sound managed care contracts that ensure the delivery of quality maternal and child health services and to provide practical

knowledge and experiential learning about pediatric managed care contracts. The workshop content included this and more. Several key themes and some promising new ideas emerged. Most important, perhaps, is how the workshops created an opportunity for dialogue about maternal and child health issues and challenges. The paper concludes with some “lessons learned” about the process of engaging States in this technical assistance activity.

Finally, we note that much of what emerged from these workshops is reflected in the briefing materials prepared with each State during the planning process for their workshop. (See appendices.) These briefing materials were developed to reflect each State’s issues of concern and each workshop’s agenda. Readers are encouraged to read and refer to these materials.

II. Key Content Areas for the Workshops

While each workshop was customized to meet the needs of the individual States, in fact, some standardized subject areas were covered by the workshops on issues ranging from Medicaid, SCHIP, managed care contracting, and their relationship to maternal and child health programs. Each of the trainings was a mixture of didactic presentations by the facilitators, discussions led by the facilitators, and group problem solving. The pages that follow in this section contain the standardized information that was transmitted at the workshops. See the Appendices for the background information specific to each of the States visited.

Medicaid and SCHIP Policies to Improve Child and Family Health

- Medicaid is a leading purchaser of pediatric care. It is a source of coverage for one out of every five U.S. children, including more than one-third of births. Seen in another light, the program covers 60 percent of poor children younger than 18 and nearly half of births to low income women.
- Children need coverage and benefits tailored to their unique needs and designed to foster their health, growth, and development. Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) package of benefits and services are specifically designed to fit with pediatric clinical standards and children’s health needs.
- With Medicaid, poor children's access to health care is similar to that of non-poor, privately insured children.
- Millions of uninsured children are eligible for, but not enrolled in, publicly financed health coverage through Medicaid or SCHIP. Effective outreach and enrollment can make a difference in coverage levels.
- Children are half of all Medicaid enrollees, but represent only 16 percent of the total program spending primarily because they use less expensive, primary and preventive services. The average per capita Medicaid cost for a child is approximately \$1,150, compared to more than \$10,000 per elderly enrollee.
- In more than half of the States, Medicaid has been used to expand health coverage beyond traditional groups. Under current Federal law, Medicaid can be used to cover millions more children and their parents.
- SCHIP offers no individual legal entitlement to a federally defined benefit. In the 35 States that maintain separately administered SCHIP programs, child health benefits vary. States are

obligated to use their funds to purchase coverage known as “child health assistance,” making separately administered SCHIP plans a form of premium support, with broad discretion given to contracting health plans.

Managed Care and Children

An increasing number of children receive health coverage and services through Medicaid or SCHIP managed care arrangements.

- Overall, more than half of all Medicaid beneficiaries are enrolled in some form of managed care in all States and the District of Columbia, except Alaska and Wyoming.
- Children are the group in Medicaid most likely to be required to enroll in managed care. Children are more likely than beneficiary groups such as the elderly, pregnant women, adults with disabilities to be included in mandatory managed care enrollment rules under Medicaid.
- In 1998, more than half (55 percent) of Medicaid beneficiaries enrolled in managed care were children under age 21. Many SCHIP eligible children are enrolled -- on a voluntary or mandatory basis -- in managed care arrangements.
- Children in Medicaid SCHIP plans are entitled to the same benefits and protections as children in regular Medicaid plans.
- Among 26 States using separate, non-Medicaid SCHIP and comprehensive managed care in 2000, 11 States integrate the SCHIP managed care contract with the Medicaid contract.¹

The promise of managed care is that it can reduce costs to purchasers while improving health outcomes for the insured individual. Managed care organizations (MCOs) seek to fulfill this promise through three basic mechanisms: organizing provider relationships, limiting what will be covered, and controlling enrollee access to services. Controls on access to service generally are aimed at high-cost and unnecessary services (e.g., some elective surgery, and emergency department use for routine care).² In theory, MCOs also will seek to ensure necessary care, which can help enrollees remain healthy and reduce long-term costs. In practice, MCOs' limits on care are more frequent than promotions for utilization of health services, primarily because they have greater incentives to reduce short-term than long-term costs. For children, such emphasis on short-term results is a disadvantage.

¹ Rosenbaum S and Markus AR. *Policy Brief #2 "State Benefit Design Choices under SCHIP: Implications for pediatric health care.* Washington, DC: The George Washington University, 2002.

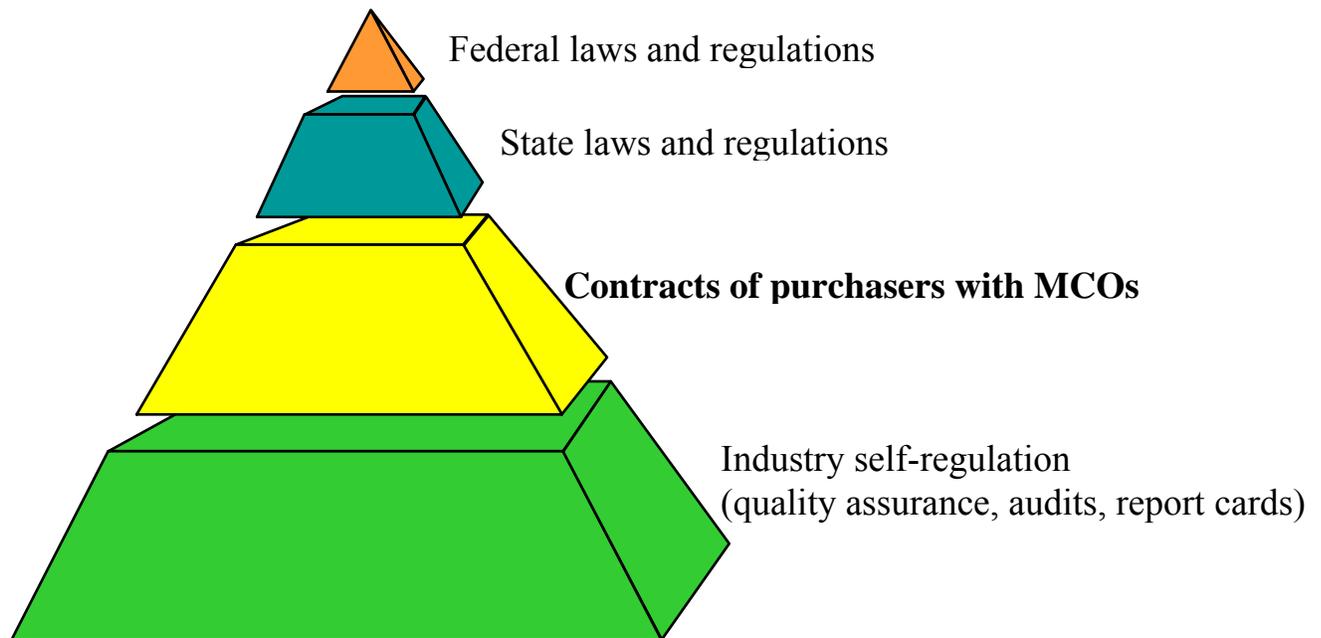
² Rosenbaum S, et al. *Negotiating the New Health System: A nationwide study of Medicaid Managed Care Contracts.* (First Edition) Washington, DC: The George Washington University, 1997.

Improving Child Health Access and Outcomes through Effective Managed Care Contracting

Managed care arrangements are defined in contracts between the purchaser and the MCO, as well as between the managed care organization and its network providers. The contract between the MCO and the purchaser – in this case the State Medicaid or SCHIP Agency – sets the boundaries on what services will be delivered, when, and how. As use of managed care has increased, contracts have become an increasingly important part of the legal and regulatory framework under which children and families receive health care. (See Figure A).

Solid managed care contracts are based on negotiation and an agreement that reflects “a meeting of the minds.” Success depends on clearly defining the terms of the contract, specifying the performance objectives and measures, and using multiple enforcement tools with varying levels of severity. When State governments are the purchasers, contracts also should specify the nature of the agreements and interactions expected between MCOs and various public programs (e.g., local health departments, WIC Supplemental Food Program sites).

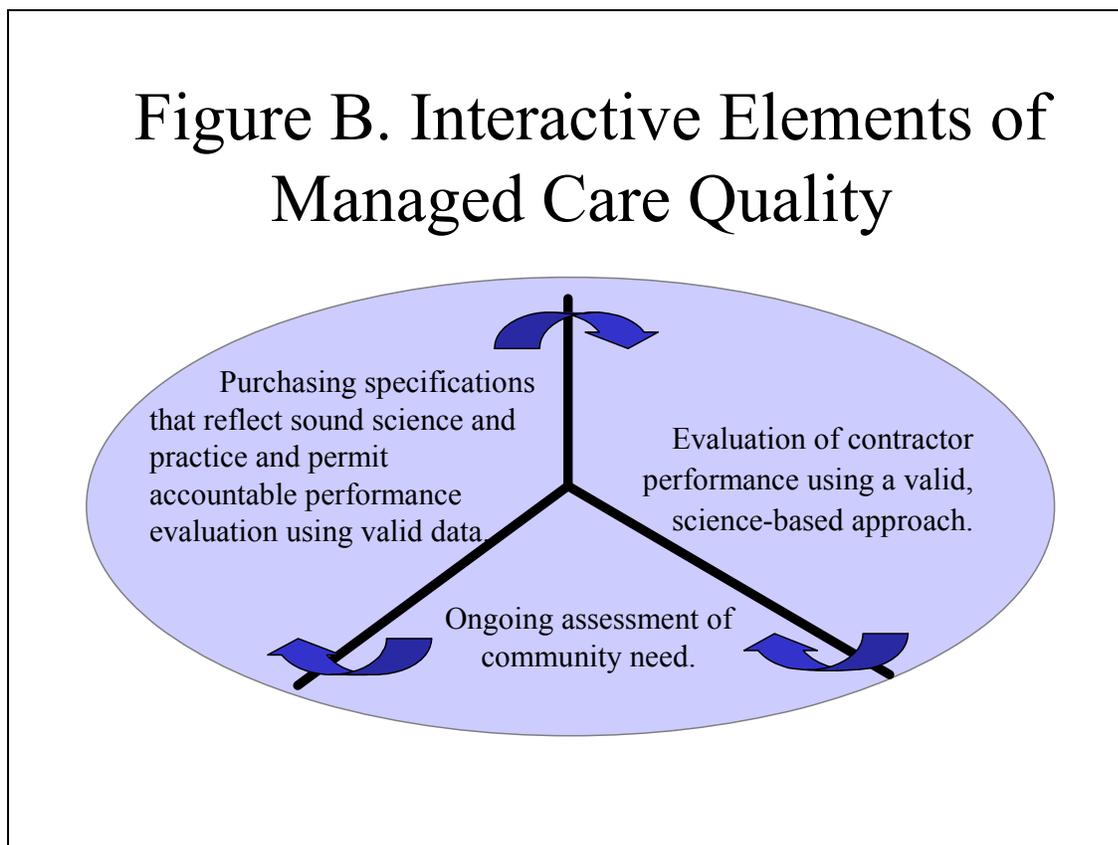
Figure A. Role of Managed Care Contracts in a Regulatory System



Source: *Negotiating the New Health System*, Rosenbaum et al. 1997

Managed care contracts are a particularly useful tool for States to use in efforts to improve health care quality. (See Figure B.) State Medicaid or SCHIP Agencies cannot overcome certain systemic barriers to effective pediatric preventive care, such as constraints on access to care, inadequate provider training and practice, or deficits in parental knowledge and parenting skills. States can, however, set out expectations for quality and, in turn, monitor quality, pay for performance, or penalize those who do not perform.

Managed care contracts represent a unified policy Statement by the State and are the principal means to create legally binding agreements with managed care organizations (MCOs). Contracts, and the negotiations around contracts, are the means for working out some very specific challenges in the delivery system. Furthermore, if a benefit, quality standard, or other expectation is not in the contract, MCOs and their providers cannot be expected to meet the State's expectations. Contracts are also useful for policy makers, as a means to express priorities. If the State's contract development process is inclusive, it creates inter- and intra-departmental communication about the inter-relationship of categorical and entitlement programs. Such processes force categorical programs to think about adapting their programs to an evolving health care delivery and financing system. Finally, well-expressed contracts set the framework for communication with beneficiaries (covered persons), including what should be contained in enrollment materials, how people can engage in grievance processes, and what protections exist for those involuntarily disenrolled.



Managed Care Contracts and Child Health

A series of analyses of States' Medicaid managed care contracts by GWU researchers³ found that such contracts express a vision of health care and the health care system, not merely health coverage. As State Medicaid Agencies become more sophisticated health care purchasers, contracts have become larger and more complex. Increasingly, States include detailed specifications that emphasize the structure and process of care. Contracts are generally comprehensive and specific in the areas of networks, access, service delivery, quality improvement, data collection and reporting, consumer protections, and provider payments. At the same time, States continue to make fairly limited use of provisions regarding resolution of conflicting treatment decisions in the case of contractors and agencies responsible for the same member.

Detailed analysis of contract provisions on pediatric care found that State Medicaid managed care contracts generally have:

- Merged coverage and care into comprehensive specifications that give attention to pediatric care delivery -- not just coverage.
- Increased specificity regarding services for special populations, such as children with special health care needs.
- Attempted to close the gap between Federal requirements and State contracts.
- Not often met the challenge of incorporating the broad EPSDT benefits into contracts, despite greater attention to child health.
- Specified the inclusion of "pediatric providers" in the managed care network.⁴

Table 1. Pediatric Purchasing Specifications: Table of Contents

<i>Part I Items and Services Covered</i>	
101-	Medicaid Items and Services
101-A.	Coverage Determination Standards and Procedures
101-B.	Delivery of Covered Items and Services
102-	EPSDT
103-	Prescription Drugs
104-	Family Planning Services and Supplies
105-	Medicaid Items and Services Not Covered
106-	Dental Services
107-	STD Services
108-	HIV Services
109-	TB Services
110-	Childhood Lead Poisoning Services
111-	Diabetes Services
<i>Part 2 Enrollment and Disenrollment</i>	
<i>Part 3 Information for New and Potential Enrolled Children</i>	
<i>Part 4 Provider Selection and Assignment</i>	
<i>Part 5 Provider Network</i>	
<i>Part 6 Access Standards</i>	
<i>Part 7 Relationships with Other State and Local Agencies</i>	
<i>Part 8 Quality Measurement and Improvement</i>	
<i>Part 9 Data Collection and Reporting</i>	
<i>Part 10 Enrolled Child Safeguards</i>	
<i>Part 11 Vaccines for Children Program</i>	
<i>Part 12 Remedies for Noncompliance</i>	
<i>Part 13 Other Applicable Federal and State Requirements</i>	
<i>Part 14 Definitions</i>	

³ Rosenbaum S, et al. *Negotiating the New Health System: A nationwide study of Medicaid Managed Care Contracts*. First Edition, 1997; Second Edition, 1998; Third Edition, 1999; Fourth Edition, 2001. Washington, DC: The George Washington University.

⁴ Rosenbaum S, Sonosky CA, Shaw K, et al. *Negotiating the New Health System: A nationwide study of Medicaid Managed Care Contracts*. Third Edition, Vol. 1, 1999. Washington, DC: The George Washington University.

Pediatric Purchasing Specifications

GWU has prepared purchasing specifications to assist State agencies, private purchasers, and others interested in improving managed care contract provisions. The Medicaid Pediatric Purchasing Specifications include numerous provisions addressing a wide range of issues for Medicaid-eligible children and adolescents.

The purchasing specifications are based on an understanding of existing contract provisions (such as those in the Medicaid managed care contract database), as well as review by Federal and State government agencies, issue content experts, and consumer advocates.

The GWU Pediatric Purchasing Specifications are not official government policies and do not define a right and a wrong way to set up contracts. They do provide advice on how to construct contract provisions so that they accurately and precisely reflect the intentions and expectations of those who purchase managed care coverage. They give options and alternatives based on legal or clinical guidelines -- they do not indicate a single "correct" course of action. The Purchasing Specifications are designed for "plug and play" to address key issues in the context of a larger purchasing process in a specific State context. Thus, they can assist Medicaid and SCHIP agencies operating in different health systems and under different State policies.

Purchasing specifications might be used as a checklist for comparing contract language, as a source for examples of legally accurate provisions, or as a way to explore specific contract issues in greater depth. The following examples illustrate how purchasing specifications might be used by different agencies.

State Maternal and Child Health (MCH) Programs may wish to use the Pediatric Purchasing Specifications to:

- Raise maternal and child health issues with the State Medicaid agency;
- Integrate appropriate public health surveillance activities -- such as immunization registries or birth defects surveillance -- with managed care efforts;
- Clarify the role of Programs for Children with Special Health Care Needs (CSHCN) in financing extra items and services for Medicaid beneficiaries under age 21;
- Ensure that quality standards appropriate to children's unique developmental, physical, and mental health needs are reflected in the contract;
- Ensure reimbursement for Medicaid-covered services provided through local health or early intervention agencies (under Part C of IDEA); and
- Define linkage and referral mechanisms between outreach and home visiting programs for families with young children.

State Medicaid Agencies may choose to use pediatric specifications to:

- Maximize the value of purchasing Medicaid or SCHIP coverage for children;
- Better define standards and expectations of MCOs, particularly under the EPSDT benefit for children and services for children with special health care needs;

- Better define services that go into determination of a capitation rate for Medicaid or SCHIP, particularly the EPSDT benefit for children and services for children with special health care needs;
- Better define performance expectations of MCOs, beyond typical measures such as immunization or prenatal care rates;
- Define the outreach, informing, and support services required under EPSDT, clarifying and specifying the expected role of MCOs;
- Better integrate Medicaid or SCHIP managed care with other publicly supported services such as early intervention for infants and toddlers, school-based health services, home visiting, or mental health services;
- Assist in reducing overall State spending by avoiding unnecessary public health expenditures for children enrolled in Medicaid or SCHIP (e.g., immunization, lead poisoning, transportation, or case management); and
- Focus on selected outcomes to improve health and reduce costs in areas such as obstetrical risk management, early childhood developmental screening, or preventive services to adolescents.

Having clear and specific contracts is key to optimal service for children and families enrolled in managed care plans. The Pediatric Purchasing Specifications are a tool to assist with improving contract language. Each player in the health care system has a role to play. Suggestions for using the pediatric purchasing specifications to improve contract provisions related to pediatric care are shown in Table 2.

III. Leadership Workshops on Managed Care and Child Health

What did States choose to discuss?

The design of the Leadership Workshop project offered States considerable flexibility in defining the topics they wished to discuss. For example, the project brochure suggested topics such as:

- How to promote the highest quality of health care through the managed care contracting process.
- How to use the pediatric purchasing specifications as a tool to improve managed care contracts and ensure the inclusion of Title V services and comprehensive child-focused benefits— i.e., Early Periodic Screening and Diagnostic Treatment (EPSDT).
- What key terms and elements to look for when negotiating a fiscally sound managed care contract.
- How to evaluate contract provisions using practical checklists.

How to foster contractual relationships with managed care organizations and provider groups and Medicaid/SCHIP agencies.

- How to negotiate provider network specifications to ensure adequate access to primary care pediatric providers and to increase provider participation in the Vaccines for Children (VFC) program.
- How purchasing specifications can be used to tailor contracts to ensure quality health care for children with special health care needs.

Table 2. A Contract Review Tool for Purchasing Child Health Services in Medicaid Managed Care

Does your State's Medicaid managed care contract:

1. Specify pediatric services covered, including items necessary to prevent, correct, or ameliorate a condition, disability, illness, or injury or to promote growth and developmental, or to maintain functioning.
2. Specify coverage of recommended childhood immunizations without prior authorization.
3. Specify coverage of items and services for an enrolled child under an *Individualized Family Services Plan* (IFSP) or an *Individualized Education Program* (IEP) developed by an agency under the *Individuals with Disabilities Education Act* (IDEA)
4. Specify coverage of dental services.
5. Reference "*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*" or other applicable medical and dental association guidelines.
6. Prohibit prior authorization with respect to comprehensive well-child (EPSDT) screens based on a State's periodic visit schedule, as well as interperiodic visits not on the schedule.
7. Prohibit denial of coverage for newborns due to a "pre-existing condition" according to the *Newborns' and Mothers' Health Protection Act of 1996*.
8. Require that plans offer the family or caregiver of a child with special health care needs the option of designating as the child's primary care provider a *pediatric specialist* participating in the provider network as described in enrollee information materials.
9. Require that safety net providers be included in provider networks.
10. Require timely access to pediatric services, including an initial assessment of an enrolled child conducted by a primary care provider using the standards of Bright Futures.
11. Specify elements for Memorandum of Understanding (MOU) defining relationships between the contractor and public health departments, Title V agency, SCHIP agency, child welfare agency, State and local education agencies, developmental disabilities agency, and mental health and substance abuse agency.
12. Specify use of quality measures or studies appropriate for children.
13. Specify that the contractor shall collect and report to the purchaser on underutilization of services by enrolled children.
14. Require that contractor ensure each provider furnishing covered immunizations participate in the Vaccines for Children Program.
15. Specify remedies for noncompliance or nonperformance, such as withholding payments, suspension of enrollment, or money penalties.

Source: George Washington University Center for Health Services Research and Policy. Pediatric Purchasing Specifications Module © 2001

The five States which held workshops selected an array of issues and topics that reflect some of the current challenges and unmet needs in maternal and child health. (Note that Pennsylvania held two workshops, the first and last in the series.) The issue “briefing sheets” contained in appendices 1-5 describe these issues in some detail. Table 3 summarizes the issues. Three checks show States that gave priority to an issue (i.e., made it a focal point of their agenda, briefing papers, and discussions). When an issue was identified as a subtopic in the briefing sheets, two checks are shown. Those discussed but not identified as a priority by the planning group have one check.

Children’s mental health, particularly early childhood mental health, was a topic of discussion in every workshop. Mental health was one of the three priority issues in some States, and a lesser point of discussion in others. In Connecticut, the discussion of early childhood mental health was linked to planning under the MCHB State Early Childhood Comprehensive System grant. In Wisconsin, the topic of managed care purchasing for children in out-of-home placement necessitated discussion of mental health services across children and adolescents. Leadership Workshop participants in each State expressed concerns about the provider supply, screening, referrals, and mechanisms to “carve-out” or “carve-in” this population.

Another topic identified in all five States was children with special health care needs. In some States, these discussions focused more specifically on children with mental health needs, in out-of-home placement, and with developmental delays, but also addressed general concerns about linkages between Title V Maternal and Child Health Agencies and managed care providers. In Connecticut, Ohio, Pennsylvania, and Wisconsin, participants described initiatives to ensure that each child with special health care needs has a medical home. Some had concerns that too little had been done to engage the MCOs and their providers in efforts to ensure medical homes for children.

As a result of projects funded by the Commonwealth Fund, the MCHB State Early Childhood Comprehensive System grants, and other initiatives, many States are looking at opportunities to finance services that promote child development with Medicaid and SCHIP. In their Leadership Workshops, Connecticut and Ohio gave particular attention to these issues. Screening and referral mechanisms, provider training, and finance mechanisms were discussed.

Table 3: Workshop Topic Areas

State	Special Populations			Administrative Issues		Other topics
	Mental health and early childhood mental health	Early childhood development services	Children with special health care needs	Collaboration of health, welfare, Medicaid, and MCO activities	Performance monitoring	
CT	✓✓✓	✓✓✓	✓✓✓	✓	✓	Medical home
KS	✓	✓	✓		✓✓✓	Pay for performance
OH	✓✓✓	✓✓✓	✓✓	✓	✓✓	Home visiting
PA (1)	✓✓	✓✓	✓✓	✓✓✓		Dental care
PA (2)	✓	✓✓	✓✓✓	✓		Case management
WI	✓✓	✓✓	✓✓✓	✓✓	✓✓✓	Foster care

Administrative issues also were on States' agendas, particularly those related to collaboration among Title V, child welfare, and Medicaid agencies. Representatives for local public health attended each meeting and expressed concerns about relationships with MCOs. While GWU research suggests that States have made considerable progress in defining such relationships in managed care contracts, local public health leaders from Pennsylvania and other States identified ongoing issues of concern.

What did States' leaders hope to do?

Several strategies related to improving Medicaid and SCHIP managed care contracts and practices emerged from the discussions at these five State Leadership Workshops. First and foremost, participants expressed enthusiasm for meeting as an interagency and public-private sector group. This enabled these State and local leaders to discuss cross-cutting issues, debate alternatives, and identify possible action steps requiring collaboration. In four out of five of the States, some or all of the participating leaders reconvened to further advance their discussions and strategies. While the workshop process was not formally evaluated, the enthusiasm of participants and the initial action steps taken since the workshops indicate that these were useful discussions.

Specific and actionable strategies include:

Reviewing and monitoring the system of care

- Review the State's Medicaid and/or SCHIP managed care contracts using the GWU purchasing specifications and other tools.
- Develop a system or finance map to show the relationships among agencies and the flow of funds for specific priorities such as early childhood mental health or child development.
- Identify gaps in provider networks between Medicaid and SCHIP have been widely reported. States could use geo-mapping or similar approaches to identify specific areas in need of improvement.
- Revise care coordination or case management strategies, after identifying duplication of effort, overlapping service areas, and targeting funding opportunities.

MCO practices

- Determine the best use for and the best practices of MCO special units for children with special health care needs, pregnant women, EPSDT, and so forth.
- Make greater use, through contracts, of performance monitoring, quality studies, child health indicators, and similar quality improvement mechanisms.
- Require, through contracts, relationships between MCOs and local public health and other child serving agencies.
- Adopt pay-for-performance strategies to maximize existing dollars and health provider capacity.

Special populations

- Consider special issues related to adolescent health, including confidentiality, individual cards, and services in transition to adult years.

- Clarify contract language and service strategies with regard to child Medicaid beneficiaries in out-of-home placement, including those identified through the Child Abuse Prevention and Treatment Act (CAPTA).
- Clarify periodic and interperiodic screening under EPSDT, particularly related to children at risk for mental and behavioral health problems, developmental delays, and other special health care needs.
- Clarify the definition of child development services (e.g., screening versus diagnostic assessment) under Medicaid’s child health component, EPSDT.
- Adopt contract language to encourage MCOs and their providers to adopt a medical home approach, building on best practices from the demonstration projects.
- Improve care coordination for CSHCN, particularly for those children who have care plans in multiple systems of care (e.g., health, child welfare, special education, early intervention).
- Refine the approach to serving children with or at risk for mental health problems, including revised billing codes, service definitions, and referral mechanisms.

Financing mechanisms

- Use Title V block grant funding as “glue” to hold together various services, case management, and care coordination approaches, as well as to fill gaps.
- Enhance capitation fees for medical home providers of children with special health care needs and/or adopt Medicaid managed care payment adjustments based on pediatric patient acuity.

IV. Concluding thoughts about the technical assistance process through leadership workshops

We believe these workshops had an impact in creating dialogue and a stronger working relationship between Title V programs and their counterparts in State-financed health care delivery programs. The availability of the TA provided through MCTAC served as a critical catalyst for dialogue in each of the States – dialogue that clearly would not have happened without external facilitation. The measure of success, in part, is that MCH leaders in four out of five states used their workshops as a springboard to continued action and policy development.

While all the relationships among the public and private players in maternal and child health programs were improved as a result of the workshop, these five States began with varying “baselines” in terms of the level of the MCH-Medicaid-SCHIP collaborations. While each workshop identified a “follow up” agenda, some States could have benefited from further “nurturing” of the collaborative relationship than a 1 or 1.5-day workshop format would permit.

Based on our experience with the five States we visited for technical assistance, we have identified several elements of the process that are potential predictors of success for this kind of technical assistance effort. We suggest they become the basis for determining either “eligibility” for technical assistance workshops of this kind and/or the level of effort that might be a requirement for such an intervention to be most successful. These elements are:

- States must express interest (i.e., volunteer) for a technical assistance workshop.

- A State must have its own “catalyzer” who has the authority and/or credibility to bring the relevant players to the table. External facilitation is necessary, but not sufficient, as a catalyst. The catalyzer can be from within one of the government programs or can be a leader from one of the community organizations working with State government on MCH issues.
- A State must meet a “threshold” test of being able to organize a planning committee for the workshop that is reflective of all of the key constituencies concerned with financing maternal and child health services in the State. This is both a test of the seriousness of the players and a measure of the State’s ability to follow up on the recommendations or conclusions of the workshop without further external facilitation.
- From beginning to end, the workshop must be designed around finding “common ground” among the participants. If any participants perceive the workshops as attempts to hold a particular player accountable, the motivation for the workshop will be questioned and frank and full participation will be limited. The more successful workshops avoided this pitfall, and thus more creative avenues for follow up could be identified.
- To maximize benefit, the workshops must be tailored to the needs of the individual State. While the Little Rock experiment in 2001 was successful in creating a common baseline of information for the participating States, focusing on key issues that were on the agendas of some if not all of the players in a State increased interest and active participation by a broader range of participants. As Table 3 (above) shows, there was great overlap among the States regarding the content of the workshops. However, the particular motivating factors that caused States to request workshops ranged from pay-for-performance in Kansas to child welfare issues in Wisconsin.
- To maximize participation by higher-level officials, workshops must be held in State. This not only solves barriers created by restrictions on out-of-State travel, it also increases the likelihood that higher-level officials will participate in at least part of the workshop. In almost every State, we had senior officials (e.g., Governor’s office, legislature, program directors) participating. Their presence (often for the entire workshop) conveyed seriousness of purpose to those who would be responsible for follow up.

Appendix 1

Materials for Pennsylvania Leadership Workshop



This document was prepared for a Leadership Workshop on Managed Care and Child Health to be held on March 18, 2004 in Harrisburg, Pennsylvania. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss approaches to ensure that health plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting; and Jeff Levi, Center for Health Services Research and Policy under contract with HRSA.

1. Assuring Continuity in Benefits and Coverage for Children with Publicly Subsidized Health Coverage

The 120,000 children served under the Pennsylvania SCHIP program and the more than 900,000 children enrolled in eligible for Medicaid are often thought of as discrete populations. Yet, we know that low-income working families frequently change income and employment status in ways that affect their eligibility for publicly subsidized health coverage. For States with separate SCHIP programs, ensuring linkages with Medicaid eligibility, providers, and MCOs is important to assure access to needed health services.

Bridges between Medicaid and SCHIP Eligibility

- **Specify coordination and patient information transfer procedures contractors must follow.** What are the MCO obligations when a child enrolls or disenrolls from Medicaid or SCHIP? For example, are notices to the eligibility agency or prompt, efficient record transfers required?
- **Clarify definitions under SCHIP eligibility to aid SCHIP and Medicaid enrollment.** A study of non-Medicaid SCHIP programs found that more than a dozen States (including Pennsylvania) had ambiguous or unclear language to define a family, attribute income, set income adjustments for size of family, and specify income standards and methodologies under SCHIP.¹ The Pennsylvania Renewal Workgroup is discussing such definitions.

Assuring Continuity of Care between Medicaid and SCHIP

- **Offer parallel benefit categories.** For example, a GWU study of non-Medicaid SCHIP programs found that several States (including Pennsylvania) did not define case management services or services for children with special health needs.²
- **Require that a course of treatment be continued/completed during transitions.** For children under a course of treatment at the time of Medicaid or SCHIP enrollment or disenrollment, require that the contractor continue to furnish needed services until that course of treatment is completed or until the child is enrolled in a successor MCO.
- **Offer presumptive eligibility for children.** Building on the policy precedent set for pregnant women, States have this option under Federal law. Presumptive eligibility can improve child health coverage levels and be of benefit to community health clinics, WIC nutrition sites, and other public providers. Implementation of the proposed pilot program is the first step toward success.

¹ Rosenbaum, S., Markus, A. *Policy Brief #4: State Eligibility Rules under Separate State SCHIP Programs—Implications for Children's Access to Health Care*. September 2002.

² Rosenbaum, S., Shaw, K., and Sonosky, C. *SCHIP Policy Brief #3: Managed Care Purchasing Under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts*. December 2001.

Appropriate Provider Networks for Children with Publicly Subsidized Coverage

- **Monitor involvement of “traditional” providers in MCO networks:** A “traditional” provider has experience serving a substantial number of uninsured low-income children, including: 1) Federally qualified health centers (FQHCs), 2) rural health clinics, 3) city or county health departments operating clinics, 4) other maternal and child health clinics receiving funds under Title V, 5) providers funded under the Ryan White Comprehensive AIDS Research and Education Act, and 6) family planning clinics receiving funds under Title X. A GWU study found, for example, that several States (including Pennsylvania) did not define relationships with FQHCs under their SCHIP managed care contracts.³
- **Give access to out-of-network providers in certain circumstances:** For example, prohibit contractors’ restrictions on children’s access to emergency services, public health services, or health care at school-based health centers. Another option is to require that contractors give access to out-of-network providers for children in migratory or seasonal agricultural worker families, in homeless families, and/or in foster care. Special attention should be given to MCO contracts under SCHIP.

2. Services for Special Needs Children in Medicaid/SCHIP Managed Care

Children with special health needs, including those with mental/behavioral health needs

Children with special health care needs (CSHCN) are defined in as “children under 21 who have or are at risk for a chronic physical, developmental, or behavioral, or emotional condition, and require health and related services of a type or amount beyond that which is required by children generally.”⁴ Such children may have a variety of conditions, but all have a need for specialized health care services, care plans, and care coordination.

Benefits and Services for CSHCN

- **Clarify how services will be provided.** States may contract for the full range of services to which children beneficiaries are entitled under Medicaid. Additionally, the State “carves out” services under contracts for behavioral health. Measuring and enforcing the adequacy of provider networks is an ongoing role of the State’s management of these contracts. Alternatively, States may contract with MCOs for the provision of some services and “carve out” others. Carved-out services, in turn, may be covered on a fee-for-service basis or through a risk contract with another MCO, or both. Clarity is key.
- **Elect to cover care coordination services.** States may choose to place care coordination under MCO contracts or to provide them on a fee-for-service basis through other State or local agencies or private organizations. While Federal Medicaid law does not define “care coordination,” either administrative or targeted case management may be used.
- **Use care plans.** Such plans assist families, providers, plans, and purchasers. States may require contractors to ensure that a primary care provider develop and maintain a care plan for CSHCN.
- **Require linkage to IFSP or IEP under special education.** Contractors should understand and comply with their obligations under an Individualized Family Service Plan (an IFSP under IDEA Part C Early Intervention) or Individual Education Program (an IEP under IDEA Part B Special

³ Rosenbaum, S., Shaw, K., and Sonosky, C. *SCHIP Policy Brief #3: Managed Care Purchasing Under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts*. December, 2001.

⁴ McPherson et al. A New Definition of Children with Special Health Care Needs. *Pediatrics*. 1998;102:137-140.

Education) requirements for enrolled children. Defining the related roles and responsibilities of an MCO in Medicaid/SCHIP contracts facilitates cooperation.

- **Give attention to mental/behavioral health needs**, because Medicaid populations generally have a higher prevalence of children with serious emotional disturbance than privately insured populations. Medicaid managed care contracts may include prevention and early intervention through EPSDT, as well as long-term treatment. For children, a family-focused/family-centered approach is the standard of care. The leadership of the Department of Public Welfare understands the importance of these issues and may help focus attention on the mental health needs among children and their families. The State determines how to finance this care.

Provider Networks for CSHCN

- **Require Contractors to give families and caregivers of enrolled children the option of choosing the child's primary care provider for their medical home**, either (1) a primary care practitioner, or (2) a physician who is trained as a specialist in pediatrics, including pediatric medical subspecialists, pediatric surgical specialists, and child psychiatrists and psychologists. Regardless of the providers' credentials, the medical home assists in early identification of special needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.
- **Require Contractors to provide information about their networks to newly enrolled CSHCN** through an enrollee handbook, a provider directory, and other means.
- **Require memoranda of understanding (MOU) between contracting MCOs and State agencies other than the purchaser that have responsibility for CSHCN.** These include State: Title V CSHCN agencies, substance abuse and mental health agencies, educational agencies, child welfare agencies and/or developmental disabilities agencies.
- **Define (and reflect in the contract) the benefit and payment relationships between contractor and the CSHCN program division.** Some State Title V CSHCN Programs pay for or provide medical care directly to children with special health care needs; others furnish care coordination and referrals but do not pay for or provide medical care.

3. Strengthening Relationships to Improve Efficiency and Effectiveness

The efficiency and effectiveness of Medicaid/SCHIP managed care in Pennsylvania depends on well-functioning State agency coordination and strong State-to-local relationships. While the State has delayed further expansion of mandatory managed care enrollment, the mandatory HealthChoices program and the voluntary managed care program continue. Moreover, the behavioral health program may yet be modified. The impact of Medicaid managed care policies is particularly important in the case of children's health care. Children comprise more than half of Medicaid managed care consumers in HealthChoices, (PA Office of Medical Assistance, 2003) a similar percentage of those enrolled in voluntary arrangements, and all, of course, 100 percent of those enrolled in SCHIP managed care. The Renewal Workgroup, Interagency Outreach Committee, Medical Assistance Advisory Committee, Cultural Diversity Committee, and others are working to improve collaboration. Other entities (such as Healthy Start, the Perinatal Partnership, and the Partnership for Children) provide opportunities to link to local resources.

Relationships between Medicaid and the State Department of Health

The Pennsylvania Department of Public Welfare (DPW), Department of Health (DOH), and Department of Insurance (DOI) have solid, ongoing professional relationships that reflect their shared interest in fiscal

accountability and good health for Pennsylvanians. As the health care system continues to evolve, however, new mechanisms and operational approaches are needed to strengthen the system.

- **Share information from Medicaid/SCHIP managed care performance measurement and data reporting.** While certain summary data from MCOs are available, increasing the level of information shared could improve State health planning, services, and access. For example, a variety of public health databases (immunization, sexually transmitted diseases, children with special needs, birth defects) need information from MCOs to be accurate, timely, and complete.
- **Develop an ongoing forum for discussion of public health and Medicaid managed care issues.** Either within an existing body or a new workgroup, Pennsylvania could benefit from ongoing discussion of Medicaid/SCHIP managed care issues that have an impact on public health programs and services. Topics for discussion might include: patient education and utilization, provider education and cultural competence, and enhancement of provider networks. Entities (including but not limited to Healthy Start, the Perinatal Partnership, and the Partnership for Children) already exist and provide opportunities to link to community resources and public health providers.
- **Work collaboratively to collect and utilize consumer and community input.** Public health agencies are in regular contact with many Medicaid beneficiaries. Increased collaboration in assessment of consumer satisfaction, cultural competency, and unmet needs could benefit DPW, MCOs, and public health.

Relationships between Medicaid-Contracting MCOs and Local Health Agencies

Enrollment of large numbers of low-income children in MCOs and primary care case managers (PCCMs) has important implications for State and local public health agencies.⁵ Well-functioning local relationships are essential to protecting the public's health.

- **Require communicable disease reporting by contractors.** PCCM arrangements present an opportunity for public health agencies to improve reporting of notifiable conditions. Low-income individuals are at greater risk than the general population to have communicable diseases (e.g., STDs, HIV/AIDS, and TB) and to be affected by other public health problems (e.g., lead poisoning).
- **Assess the criteria for successful implementation of memoranda of understanding (MOUs) between providers and public health agencies.** The function of an MOU is to clarify roles and responsibilities in meeting the health needs of Medicaid enrollees and the community as a whole.⁶ Effectively implemented MOUs help providers and payers.

⁵ Rosenbaum S, et al. *Negotiating the New Health System: A nationwide study of Medicaid Managed Care Contracts*. (3rd Edition) Washington, DC: The George Washington University, March 2000).

⁶References and more information at:

http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/MOU/MOU_Specs.html#2;

<http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/MOU/>.

This document was prepared as follow-up to a Leadership Workshop on Managed Care and Child Health held on March 18, 2004 in Harrisburg, Pennsylvania. The more than 35 senior policy makers and professionals attending the workshop discussed approaches to assure that children enrolled in Medicaid and SCHIP health plans receive the highest quality care. These documents have not been endorsed by Federal or State officials. The workshop was based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB).

Post-workshop Summary

1. Assuring Continuity in Benefits and Coverage for Children with Publicly Subsidized Health Coverage: Discussion Topics

Bridges between Medicaid and SCHIP Eligibility

- Specify coordination and patient information transfer procedures contractors must follow.
- Clarify definitions under SCHIP eligibility to aid SCHIP and Medicaid enrollment.

Assuring Continuity of Care between Medicaid and SCHIP

- Offer parallel benefit categories.
- Require that a course of treatment be continued during transitions between Medicaid or SCHIP enrollment or disenrollment.
- Offer presumptive eligibility for children.

Appropriate Provider Networks for Children with Publicly Subsidized Coverage

- Augment the number of available children's dental and mental health providers.
- Monitor involvement of "traditional" providers in MCO networks.
- Give access to out-of-network providers in certain circumstances.

Possible actions or solutions discussed (and entity accepting responsibility for continuing the dialogue or taking next steps)

1. **Encourage local collaboration.** (managed care organizations) In some regions of the State MCOs meet with providers and MCH local agencies to discuss challenges and design local solutions. This approach could be used voluntarily in other regions.
2. **Identify gaps in provider networks.** (Department of Insurance - DOI) Gaps in provider networks between Medicaid and SCHIP have been widely reported. DOI and DPW reported that such data are collected; however, this information is not applied across programs. The State could use geo-mapping (e.g. Colorado) or similar approaches to identify specific areas in need of improvement.
3. **Require that SCHIP providers participate in Medicaid.** A number of States have adopted such rules to reduce potential for discrimination against one group of publicly insured children.
4. **Develop standardized documents/card for eligibility verification.** (Cabinet on Children, Youth, and Families) Working across agencies, the Children's Cabinet representatives could develop a more uniform document or card and require that it be the standard, acceptable means of verifying SCHIP or Medicaid eligibility.

5. **Use presumptive eligibility for children or a similar State-designed method of assuring payment based on presumed eligibility.** (Department of Public Welfare and Title V) Pennsylvania could adopt presumptive eligibility for children. Alternatively, the State might devise a mechanism to assure payment for visits made by children when Medicaid or SCHIP eligibility determinations are being finalized and/or children are in transitions between programs.
6. **Improve methods and timeliness for electronic eligibility verifications.** (Department of Public Welfare) Such methods are important for verifying both eligibility and for plan enrollment.
7. **Strengthen and monitor mechanisms to ensure continuity of coverage and continuation of treatments.** (Department of Public Welfare and Title V) An issue for providers and MCOs.
8. **Adopt parallel benefit packages.** (Pennsylvania Perinatal Partnership) Other States (e.g., Connecticut, Kansas, and Wisconsin) have aimed to develop parallel benefit packages for their Medicaid and separate SCHIP plans. Pennsylvania could increase the similarity in covered benefits for these two programs.

2. Services for CSHCN in Medicaid/SCHIP Managed Care: Discussion Topics

Benefits and Services for CSHCN

- Clarify how services will be provided.
- Cover care coordination services.
- Use care plans.
- Require linkage to IFSP or IEP under special education.
- Give attention to mental/behavioral health needs.

Provider Networks for CSHCN

- Require contractors to assist families of CSHCN in choosing the child's primary care provider for their medical home.
- Take steps to improve the supply of providers for CSHCN.
- Require memoranda of understanding (MOU) between contracting MCOs and State agencies other than the purchaser that have responsibility for CSHCN.

Possible actions or solutions discussed (and entity accepting responsibility for continuing the dialogue or taking next steps)

Generally, more quality improvement activities and replication of best practices was called for in this area. The discussion particularly focused on the following recommendations.

1. **Better use the Medicaid case management benefit that exists** for all children under EPSDT in Pennsylvania, with particular attention to case management for CSHCN. (Department of Public Welfare and Title V)
2. **Create demonstration projects on enhanced case management and wraparound services** based on examples such as HIV waiver program and mental health system of care approaches. (Department of Public Welfare, Title V, and Perinatal Partnership)

3. **Determine the best use for and the best practices of MCO special needs units.** What can they do well and what is needed in addition to what such units can provide? (MCOs)
4. **Consider a case management carve out.**
5. **Replicate the medical home project across the State, building on best practices from the 19 Pennsylvania American Academy of Pediatrics (AAP) demonstration projects.** Funding needed to support replication. (AAP)
6. **Consider Medicaid managed care payment adjustment according to patient acuity.** DPW is investigating use of software to make such adjustments. The State should consider experience of other States with regard to CSHCN in managed care. (Department of Public Welfare and AAP)
7. **Monitor network capacity for CSHCN.** (Department of Insurance)
8. **Consider special issues related to adolescent health,** including confidentiality, individual cards, and services in transition to adult years. (Title V)
9. **Conduct MCO focus studies related to services for CSHCN.** (MCOs and Title V)
10. **Use Title V CSHCN funding as “glue” to hold together various services, case management, and care coordination approaches, as well as to fill gaps.** (Title V)

3. Strengthening Relationships to Improve Efficiency and Effectiveness: Discussion Topics

The efficiency and effectiveness of Medicaid/SCHIP managed care in Pennsylvania depends on well-functioning State agency coordination and strong State-to-local relationships. While the State has delayed further expansion of mandatory managed care enrollment, the mandatory HealthChoices program and the voluntary managed care program continue. Moreover, the behavioral health program may be modified. These managed care policies are particularly important in the case of children. Children comprise more than half of Medicaid managed care consumers in HealthChoices, a similar percentage of those enrolled in voluntary arrangements, and all of those enrolled in SCHIP managed care.

Relationships between Medicaid and the State Department of Health

- Share information from Medicaid/SCHIP managed care performance measurement and data reporting.
- Develop an ongoing forum for discussion of public health and Medicaid managed care issues.
- Work collaboratively to collect and utilize consumer and community input.

Relationships between Medicaid-Contracting MCOs and Local Health Agencies

- Require communicable disease reporting by contractors.
- Assess the criteria for successful implementation of memoranda of understanding (MOUs) between providers and public health agencies.

Possible actions or solutions discussed (and entity accepting responsibility for continuing the dialogue or taking next steps)

1. The Title V agency should work with the Departments of Insurance and Public Welfare to advance approaches and mechanisms for data sharing and engage in existing forums for discussing Medicaid and SCHIP managed care issues. Title V also should continue to identify issues of concern such as neonatal follow up, provider availability, and local public health financing for services delivered. (Title V)

2. Regional planning and discussion groups should engage all key stakeholders. Currently, some do not include SCHIP plans and others do not include Title V. Medicaid could help foster such involvement. (MCOs, Title V, and Perinatal Partnership)
3. While MOUs between public health agencies and MCOs exist in some areas of the State, more could be done to strengthen enforcement of MOU provisions, as well as to set up MOUs across Pennsylvania. (Department of Public Welfare, Title V, and Perinatal Partnership)
4. Another meeting should be convened to discuss mental/behavioral health issues, including prevention, early intervention, and treatment. (Department of Public Welfare, Title V, and Perinatal Partnership)
5. Providers, plans, and public agencies should investigate opportunities to adopt an electronic medical record system for children. (Pennsylvania AAP and MCOs)

Appendix 2

Materials for Connecticut Leadership Workshop



This document was prepared for a Leadership Workshop on Managed Care and Child Health to be held on June 2, 2004 in Hartford, Connecticut. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss approaches to ensure that health plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting; and Jeff Levi, Center for Health Services Research and Policy under contract with HRSA.

I. Services for Special Needs Children in Medicaid/SCHIP Managed Care

Children with special health care needs (CSHCN) are defined as children under 21 who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, and require health and related services of a type or amount beyond that which is required by children generally.⁷ Such children may have a variety of conditions, but all have a need for specialized health care services, care plans, and care coordination. CSHCN account for an estimated 76 percent of total Medicaid expenditures for children, even though they represent less than 25-30 percent of the population.⁸ While Husky A and B -- Medicaid and State Children's Health Insurance Program -- offer generous child health benefits, opportunities exist to maximize existing financing and services, contract mechanisms can help the State in purchasing services for CSHCN.

Financing Services for CSHCN

- **Maximize Medicaid and Title V financing.** Data indicate that 80 percent of CSHCN in Connecticut are eligible for Medicaid benefits. These data also reveal that Title V Maternal and Child Health Block Grant funds have been used to pay for Medicaid-covered services to Medicaid-eligible children. With this knowledge, Connecticut is poised to redesign its approach to financing services for CSHCN. Working together, Medicaid and Public Health can better ensure that eligible children are enrolled in Husky plans and that managed care organizations (MCOs) are prepared to identify and deliver covered services to enrollees who are CSHCN. Remedying this problem will make Title V funding available for additional CSHCN who are uninsured or underinsured and not eligible for Medicaid.
- **Set appropriate, risk-adjusted rates.** In a letter to State Medicaid Directors dated October 5, 1998, HCFA (now the Center for Medicare and Medicaid Services-CMS) suggested that "States should consider ... developing rates of payment to MCOs, prior to enrollment of persons with special health care needs that assure adequate payment... (and) providing appropriate financial incentives to providers and MCOs to encourage appropriate delivery of care to persons with special health care needs. Such approaches also must recognize that serving individuals with special health care needs takes more time and resources than with healthier patients..."⁹ In Connecticut, the Department of Public Health, the Papanicou Center at the University Connecticut, and others have discussed strategies for revising billing codes and setting enhanced capitation rates.
- **Assure continued access to a full range of Medicaid/EPSDT benefits.** Connecticut has done a good job of contracting for a broad range of services to which children are entitled under Husky A

⁷ McPherson et al. A New Definition of Children with Special Health Care Needs. *Pediatrics*. 1998;102:137-140.

⁸ Oehlmann ML. *Improving Managed Care for Children with Special Needs: A Best Clinical and Administrative Practices Toolkit*. Princeton, NJ: Center for Health Care Strategies, 2004.

⁹ GWU Purchasing Specifications. <http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/>

and B. In recent months, however, the State has considered options for reducing benefits through a Federal waiver option. For CSHCN, this is a particular burden.

Providers and Networks for CSHCN

- **Apply the “medical home” project model within managed care plans.** This model was developed by the Title V agency and is ready for replication, with documentation, CPT codes, and procedures already tested. The success of the pilot projects to refine the medical home model in Connecticut and other States has been documented. In the Connecticut approach, CSHCN are identified using a screening tool and severity index. Providers, serving as the child’s medical home, “flag” the child’s chart, and a nurse manager is assigned to provide care coordination and case management. Care coordination is the “lynchpin” of this effort.

Currently, mechanisms to pay for pediatric medical home case management under Medicaid managed care are not fully developed. Such mechanisms need to be articulated in the managed care contract, and plans may need operational advice. While Federal law does not define “care coordination,” administrative or targeted case management may be used. Defining the appropriate billing codes and setting the reimbursement rates (and strategy) under Medicaid is the next step. Given the relatively high percentage of Connecticut’s CSHCN enrolled in Husky A and B managed care plans, any new mechanisms should be articulated in managed care contracts between the State and Medicaid MCOs.

- **Require contractors to give families and caregivers of enrolled children the option of choosing the child’s primary care provider for their medical home,** either (1) a primary care practitioner, or (2) a physician who is trained as a specialist in pediatrics, including pediatric medical subspecialists, pediatric surgical specialists, and child psychiatrists and psychologists. Regardless of the providers’ credentials, the medical home assists in early identification of special needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.
- **Give families better information about provider choices.** As suggested in the GWU purchasing specifications for CSHCN, State contract language might require MCOs to offer information about: a) the pediatric professionals participating in Contractor’s provider network who are willing to serve as primary care providers for children with special health care needs; and b) pediatric specialists not participating in Contractor’s provider network to whom enrolled children with special health care needs are referred.

Selected Connecticut Initiatives and Research Projects on CSHCN

- A Medicaid Managed Care Model Demonstration project is designed to test the ability of Connecticut to monitor the quality of the new children's behavioral health system and of the services that will be provided to children and families under Connecticut Community KidCare. (Mark Schaefer, Ph.D.)
- Connecticut was one State in the Medical Home Learning Collaborative for Children with Special Health Care Needs (a 15-month project ending in January 2004) to implement the Medical Home Model to improve care for children with special health care needs. Care coordination, parent involvement, and coding/reimbursement were some of the hot topics. Over 30 clinical practice sites from twelve States, along with their State Title V Agencies, participated in this project. (National Initiative for Child Health Quality NICHQ) The goal of the Best Clinical and Administrative Practices Workgroup on Improving Managed Care for Children with Special Needs was to develop and pilot strategies to improve the quality of care for children with special needs enrolled in Medicaid and SCHIP. Connecticut was represented on the workgroup, consisting of key Medicaid health plans leaders. Plans focused on creating a "Medical Home," cultural competency, risk adjustment, and consumer relations (Center for Health Care Strategies)

II. Promoting Early Childhood Development in Medicaid Managed Care

Currently, promoting early childhood social-emotional development is a focus of attention in Connecticut. Medicaid managed care offers specific opportunities. Medicaid managed care contracts typically include prevention and early intervention through EPSDT, as well as treatment. States can work with MCOs to improve care, using their power as purchasers to ensure that important services are properly provided.

Benefits and Services to Promote Early Childhood Development

- **Use the GWU purchasing specifications on child development to develop contract language that clearly communicates policies on developmental services to managed care plans.** While Medicaid has over 30 benefit categories, no category is labeled "child development services." The GWU purchasing specifications identify a range of covered services linked to child development.
- **Improve and clarify the description of developmental assessment under EPSDT.** For example, a State may distinguish a routine developmental screening conducted as part of an EPSDT screen from a developmental exam or diagnostic assessment conducted by a medical social worker, public health nurse, or developmental pediatrician. States also could encourage or mandate use of professionally recommended objective screening tools appropriate for young children.
- **Clarify State Medicaid guidance on screening, assessment, and treatment related to early childhood mental health development.** The State might clarify benefits covered, better define developmental screening and assessment, put protocols into place for developmental services, and define a set of providers qualified to receive reimbursement. Such guidance might distinguish treatment services for children with diagnoses from those to promote healthy mental development. This is particularly important where Medicaid mental health services are "carved out."
- **Encourage pediatric provider sites to promote healthy development.** State Medicaid agencies could reimburse primary pediatric practitioners for providing preventive mental health care and development services (see Bright Futures). Medicaid might also pay for developmental services provided by social workers and child psychologists co-located in pediatric practices.
- **Develop protocols and guidelines for more effective screening and referral of mothers and young children.** Families affected by depression, domestic violence, substance abuse, and related conditions can benefit from early interventions carried out by physicians, psychologists, and psychiatrists. States might clarify coverage of parent-child (or family) services for young children.

Financing Services to Promote Early Childhood Development

- **Clarify rules on Medicaid payment for services delivered through other public programs,** such as the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention, children's mental health, child welfare, and Head Start. Many State Medicaid contracts require MCOs to sign memoranda of understanding with public agencies.
- **Clarify and adopt billing codes appropriate to early childhood development.** Some States have found that billing codes tailored to young children's conditions (e.g., using DC:0-3)¹⁰ helped to reduce unnecessary spending, minimize fraud, and maximize early intervention.
- **Consider the potential impact for children of a behavioral health carve out.** If behavioral health services were carved-out of HUSKY A by amendment to the 1915(b) waiver, it could lead to different definitions of EPSDT 'medical necessity' for children in mandatory versus optional groups. Coverage of transportation assistance, case management, and certain "wrap-around" support services might be different (reduced) for the optional group. Children at-risk, but without a diagnosis, may be affected.

¹⁰ Zero to Three. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)* (1994) and *DC:0-3 Casebook*. Washington, DC: Zero to Three Publications, 1997.

Appendix 3

Materials for Wisconsin Leadership Workshop



This document was prepared for a Leadership Workshop on Managed Care and Child Health held on September 8, 2004 in Milwaukee, Wisconsin. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss approaches to ensure that plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting; and Jeff Levi, Center for Health Services Research and Policy under contract with HRSA.

Health Services and Supports for Children in Out-of-Home Placement in Milwaukee County and in Wisconsin

Children with special health care needs (CSHCN) are defined as children under 21 who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, and require health and related services of a type or amount beyond that which is required by children generally.¹ These children may have a variety of conditions, but all have a need for specialized health care services, care plans, and care coordination.

The target population for this Request for Proposal (RFP) is the Medicaid eligible children in out-of-home care living in Milwaukee County, who are under the child welfare/child protection system in the County. Virtually all children in out-of-home placement have one or more special health needs. An estimated 80 percent of children in foster care have at least one chronic medical conditions and an estimated 30-70 percent have severe emotional problems.² Among school-aged children involved in child welfare systems, one national survey found that 27 percent had high levels of behavioral and emotional problems, compared to 7 percent of their peers who live at home in their parents care.³ Children in foster care tend to have complex medical needs and often do not have adequate medical records, making ongoing care management problematic. Moreover, while a significant number of these children experience emotional trauma as a result of being removed from the home, most do not receive timely mental health screening, assessment, and treatment.^{4 5}

Benefits and Services

- Special components of routine health care services specific to children in foster care might include:
 - a. Health Information gathering at the time of removal (performed by child welfare staff with medical/health care manager consultation as indicated).
 - b. EPSDT screening within five days of removal from the home and periodically thereafter, including developmental and mental health screening.
 - c. Comprehensive Health Assessment (enhanced EPSDT screen) within six weeks of enrollment.
 - d. Specialist evaluation of developmental and mental health status as necessary.

¹ McPherson et al. A New Definition of Children with Special Health Care Needs. *Pediatrics*. 1998;102:137-140.

² Mauery DR, Collins J, McCarthy J, McCullough C, and Pires S. Contracting for Coordination of Behavioral Health Services in Privatized Child Welfare and Medicaid Managed Care Princeton, NJ: Center for Health Care Strategies, June 2003.

³ Vandivere S, Gallagher M, and Moore KA. Changes in children's well-being and family environments. *Snapshots of America's Families III*. Washington, DC: Urban Institute. 2000; No. 18.

⁴ Rosenbaum, S., Sonosky, C., Shaw, K., and Mauery, D.R. Policy Brief #5: *Behavioral Health and Managed Care Contracting Under SCHIP*. September 2002.

⁵ McCarthy J and McCullough C. *Promising Approaches for Behavioral Health Services to Children and Adolescents and their Families in Managed Care Systems: A view from the child welfare system*. Washington, DC: Georgetown University. March 2003.

- e. Health Care Manager assigned.
 - f. Comprehensive Health Care Plan completed and updated every six months.
 - g. Medically necessary treatment for medical, behavioral, developmental, or related conditions.
 - h. Transitional planning provided to ensure continuity of care at permanency/discharge encounters.
- Through managed care contracts, some States have demonstrated success in improving health care and health for children in out-of-home placement. A study of nine States using behavioral health managed care plans in the child welfare system⁶ found consensus on the following positive effects:
 - a. Improved access to appropriate mental health services
 - b. More completed initial screens and behavioral health assessment
 - c. Primary care physicians for medical care/physical health
 - d. Flexible, more individualized services developed under capitation
 - e. More cross-system communication for better planning, fiscal management, and training.
 * The same study found that managed care in these nine State reform projects did not improve early identification rates or cultural competence in the service system for African-American children.

Case Management and Care Coordination Services

States may choose to place care coordination under MCO contracts or to provide them on a fee-for-service basis through other State or local agencies or private organizations. While Federal Medicaid law does not define “care coordination,” either the category of “administrative case management” or “targeted case management” may be in fee-for-service systems and it may be incorporated into managed care contracts.

- Case Management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes. Examples could include: helping families to understand their child’s insurance benefits, helping families to identify and use community based services and other public programs, coordinating care, or finding alternative funds to pay for non-health, uncovered services.⁷
- Care Coordination is a process that links children and their families to services and resources in a coordinated effort to maximize the potential of children and provide them with optimal health care. The focus of care coordination in this context is on the physical and mental health care needs of the child.⁸ For example, care coordination can help to ensure appropriate and timely service delivery and to communicate service specific information to the case worker, foster family, birth family, and health providers.

Levels of care coordination might include:

1. *Level I* - Short-term technical assistance that typically involves information sharing, referral, and/or brief follow-up calls;
2. *Level II* - Significant but not necessarily long-term assistance in planning and coordinating multiple services; and
3. *Level III* - Intensive case management (kids at risk of institutionalization, family experiencing severe social and environmental risk factors and is at risk for disintegration).⁹

⁶ Schulzinger R, McCarthy J, Meyers J, Irvine M and Vincent P. Health Care Reform Tracking Project: *Tracking state health care reforms as they affect children and adolescent with emotional disorders and their families – Special Analysis on Child Welfare Managed Care Reform Initiatives*. Washington, DC: Georgetown University Child Development Center, 1999.

⁷ CMSA Standards of Practice for Case Management, Revised 2002.

⁸ American Academy of Pediatrics, Committee on Children with Disabilities Policy Statement Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs. *Pediatrics*. 1999;104.

⁹ Health Systems Research 1996 Policy Document.

“Health Care Managers” (HCM) would be employed as part of this model, to arrange, coordinate, monitor and evaluate basic and comprehensive care, treatment and services for the child. An HCM is a clinical specialist who can coordinate services, ensure access to services in accordance with the Medicaid program, and facilitate health care management for children in out-of-home placement.

Ideally, for children in out-of-home placement, MCO care management would include linkages, at a minimum, to child welfare agencies, hospital emergency departments, mental health agencies, public schools, and early intervention/special education programs. MCOs also would have mechanisms for referrals to medically necessary, specialty, secondary and tertiary care to meet physical, mental/behavioral, and developmental needs.

I. Assuring Quality Care, Plan Performance, and Child Outcomes

The target population for this RFP is the Medicaid eligible children in out-of-home care living in Milwaukee County, who are under the child welfare/child protection system in the County. The population eligible to enroll in an contracting MCO will include children who are in foster care, court-ordered kinship care or subsidized adoption and are not participating in a Home and Community Based Waiver (HCBW) Program.¹⁰

The State is strongly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of “best practices” and use of encounter data-driven performance measures. General areas for performance measurement are described below. More specific performance improvement topics must take into account: the prevalence of a condition among, or need for a specific service by, the MCO enrollees served under this agreement, enrollee demographic characteristics and health risks, and the interest of consumers or purchasers in the aspect of care or services to be addressed.

What are the State’s objectives?

- **The State of Wisconsin process objectives are that all children in out-of-home placement will:**
 - a. Receive coordinated, comprehensive, quality health care within a medical home;
 - b. Have a coordinated health care service plan based on their comprehensive health assessment that involves all providers and identifies a health care manager who communicates with the family;
 - c. Be evaluated within six weeks after enrollment (comprehensive assessment), then periodically (as defined by the HealthCheck / EPSDT periodicity schedule at a minimum) for medical, behavioral/mental health, developmental and oral health care needs;
 - d. Receive the transitional planning and follow-up services necessary to ensure continuity of health care; and
 - e. Have foster families of children that are satisfied with the health education and services that they receive.

Examples of process topics to measure

- **Timeliness process measure examples:**
 - a. percent of initial intake screens completed on schedule,
 - b. percent of comprehensive assessments/evaluations completed on schedule,

¹⁰ Child in out-of-home care: A child under the age of nineteen who consistent with §1932 (a) (2) (A) of the Social Security Act, 42 U.S.C. §1936 u-2(a) (2) (A) is: a child described in 1902 (e) (3) of the Social Security Act, 42 U.S.C. §1936a(e)(3); a child receiving foster care maintenance payments under §472 of the Social Security Act, 42 U.S.C. §672; a child receiving adoption assistance under §473 of the Social Security Act, 42 U.S.C. §673; or a child who is in foster care or otherwise in an out-of-home placement.

- c. percent of children screened according to the State’s HealthCheck periodicity schedule,
 - d. percent of children with up-to-date immunizations,
 - e. average waiting times for an appointment to see a primary care provider or medical specialist or to receive a specialized service or piece of equipment,
 - f. percent of child enrollees who had an ambulatory mental health visit within 7 days of hospital discharge, and
 - g. number of filed grievances related to timing of services.
- **Individual care process and cultural competency measure examples:**
 - a. rate of HealthCheck screens equal to or greater than 80 percent of the expected number of screens,
 - b. percent of children with an up-to-date care plan (consider age adjusted ratios),
 - c. percent of children who had a medical home provider trained in pediatric care,
 - d. measures of translator availability,
 - e. reading level of information and enrollment materials,
 - f. rate of access to specialized transportation services (based on requests or estimated need), and
 - g. rate of providers speaking most prevalent non-English language spoken in Milwaukee population.
 - **System of care process measures:**
 - a. percent of required MOU signed and operational,
 - b. percent of required data collection/reporting completed,
 - c. quality assessment/performance improvement (QAPI) committee and plan in place,
 - d. percent of advisors or board members who are self-identified foster or adoptive parents of children served through the child welfare system,
 - e. percent of foster parents reporting satisfaction with the MCO services and supports, and
 - f. percent of those covered services in court-ordered plans that were received by child.
 - **Network Adequacy:**
 - a. number of mental health providers with training in early childhood issues per child enrollee under age six,
 - b. percentage of pediatric primary care providers who have training in developmental or behavioral issues,
 - c. percentage of prescribing clinicians who have training in established guidelines for prescribing medications for behavioral health conditions (could be adjusted for percentage of children that receive such medications),
 - d. adequacy of the behavioral and mental health network with regard to geographic accessibility to its members.

Examples of child outcomes measures

- **Children’s general health outcomes:**
 - a. percent of enrolled children under age six who had emergency room visits for non-urgent care,
 - b. percent of enrolled adolescents (ages 12-19) who had an STD or confirmed pregnancy, and
 - c. percent of enrolled children who improve results on standardized developmental tests.
- **Children’s mental health outcomes:**
 - a. percent of enrolled children under age six who have received evaluation and/or treatment for mental/behavioral health conditions,
 - b. percent of enrolled school age children/adolescents whose unexcused absences have decreased while receiving services,
 - c. rate of children/adolescents per 1,000 of the eligible population diagnosed with mental health or substance use disorders that have received both mental health and alcohol-drug treatment, and
 - d. percent of children/adolescent in behavioral health services who have improved, maintained, or reduced levels of need/symptoms.

- **Child welfare and family preservation outcomes:**
 - a. percent of enrolled children adopted, reunited, or in permanent placement within expected time frames, and
 - b. percent of enrolled children who had recurrence of maltreatment.

Setting Quality Standards to Monitor Health Services for Children in Out-of-Home Placement

Sample Categories for Performance Measures/Goals Used by States/Plans

- **Administration measures**
 - a. Affect on members
 - Interval between enrollment and PCP assignment/selection
 - Grievances and appeals within time frames
 - b. Affect on Medicaid
 - Paying claims for covered services “out-of-network” (e.g., emergency room, public health)
 - Paying clean claims on time
 - c. Information technology
 - Ability to integrate/report clinical data in a timely manner
 - Use of decision-support software
- **Access measures**
 - a. Availability/access
 - b. Prompt initiation of services
 - c. Access to primary care provider (PCP) (e.g., interval from enrollment to first PCP visit)
 - d. Annual dental visits (or in first 6 months)
 - e. Travel times/geographic access
 - f. Time between requests and appointments (e.g., time between assessment referral and completed visit for mental health services)
 - g. Time spent in waiting rooms
 - h. Language access (translation)
- **Effectiveness of care**
 - a. Immunization up-to-date
 - b. Asthma care (ER, disparities, medications)
 - c. Antibiotics for young children with sickle cell
 - d. Reduced mental health symptoms after treatment
 - e. Follow-up after hospitalization for mental health
 - f. Ratio of clinicians trained to manage psycho-pharmacology for children
 - g. STD screening for adolescents
- **Quality and Satisfaction**
 - a. Racial/ethnic disparities
 - b. Satisfaction
 - Satisfaction survey data
 - c. Perceptions
 - Received services needed
 - Services received promptly
 - Received quality services
 - Services were accessible
- **Clinical care measures**
 - a. Preventive care
 - Immunizations up to date
 - EPSDT screening visits / child or adolescent well care visits
 - First pediatric visit for infant
 - b. Chronic care
 - Asthma
 - Behavioral health
 - Children with special health needs
 - Diabetes
 - Epilepsy
 - c. Urgent/emergency services (e.g., members seeking ER receive services immediately)
- **Use of Services**
 - a. EPSDT screening visits on schedule
 - b. Well-child visits on schedule
 - c. Non-essential emergency room visits
 - d. Inpatient discharge for mental health concerns
 - e. Inpatient discharge for chemical dependency

HEDIS 2005 Summary Table of Child Health-Related Measures

Child Health Measure	Medicaid	Commercial	Comments
Effectiveness of Care			
Childhood immunization status	✓	✓	
Adolescent immunization status	✓	✓	
Treatment for children with upper respiratory infection	✓	✓	
Appropriate testing for children with pharyngitis	✓	✓	
Comprehensive diabetes care	✓	✓	
Use of appropriate medications for asthma	✓	✓	
Access/Availability of Care			
Child & adolescent access to PCP	✓	✓	
Annual dental visit	✓		
Use of Service			
Well-child visits in the first 15 months	✓	✓	
Well-child visits in the 3 rd , 4 th , 5 th , and 6 th years	✓	✓	
Adolescent well-care visits	✓	✓	
Mental health utilization	✓	✓	
Satisfaction with experience of care			
CAHPS child survey	✓	✓	
Plan descriptive information			
Board certification (pediatricians & pediatric specialty)	✓	✓	
Diversity of Medicaid membership	✓		

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II. Screening and Assessment for Children in Out-of-Home Placement

In clinical practice, the terms screening, assessment, and evaluation have general, but not precise meanings and are sometimes confused in usage. Assessment is often confused with screening. Professionals within and across fields do not use these terms consistently, in part because the terms are confused in Medicaid/EPSDT guidance to States. Since these terms are not precise, it's important to reach agreement on what they mean in this context.

Screening is used to identify possible problems, and intended to be followed-up with additional tests if a problem is suspected. In most cases, screening is brief and has a structured format. Screening tools can be specific to a disorder (e.g., autism or fetal alcohol syndrome), be focused on one area or domain of development (e.g., language or motor skill), or be general.¹¹ Ideally, developmental and mental/behavioral health screening tools for children should: identify those children with or at risk of problems, be quick and inexpensive to administer, be of demonstrated value to the patient, provide information that can lead to action or follow-up, and be sensitive and specific enough to avoid mislabeling many children.¹² Screening does not result in diagnoses.

When a possible problem is identified through screening, the next step is assessment (also sometimes called evaluation). Assessment is more in depth and helps child health professionals to determine the nature of the condition and to consider possible treatments. Assessment tools or (more often) processes might be considered diagnostic. An assessment may measure a child's condition on a specific area such as physical, cognitive, or behavioral development. A "comprehensive assessment" looks across domains of development and is designed to yield information about the child's overall condition.

How does this fit with Medicaid and EPSDT/ screening?

In this context, the word "**screening**" also reflects the definition in Medicaid's Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) program,¹³ known in Wisconsin as HealthCheck.

- EPSDT/HealthCheck covers comprehensive screening (check-up) visits and treatment for any health problems found during the checkup including medical care, mental health services, vision, hearing, and dental care. This is essentially a comprehensive well child examination.
- By law, an EPSDT/HealthCheck screening examinations include comprehensive and age-appropriate: health history, physical exam, developmental tests, blood and urine lab tests, immunizations, and health education/anticipatory guidance.
- Under Federal law, screening visits/exams may be provided according to the State established (periodicity) schedule or on an interperiodic basis, as necessary. Hearing, vision, and dental

¹¹ See information from the Centers for Disease Control and Prevention, National Center for Birth Defects, Developmental Disabilities, and Disability Health. <http://www.cdc.gov/ncbddd/child/tools.htm>

¹² Bergman D. *Screening for Behavioral Developmental Problems: Issues, obstacles, and opportunities for change.* National Academy of State Health Policy. August, 2004.

¹³ Rosenbaum S and Sonosky C. *Federal EPSDT Coverage Policy*, Prepared by the George Washington University Center for Health Services Research and Policy under contract to the Health Care Finance Administration, 2000.

screening must have their own periodicity schedules, based on appropriate professional guidelines. Children age three and older must be referred to a dentist.

What are the proposed components of a Comprehensive Assessment?

For children in out-of-home placement, a HealthCheck screen is the basis for a comprehensive assessment; however, these children need enhancements that go beyond the basic HealthCheck screen protocol. Such additional elements include, but are not limited to:

- Inspection for and documentation of any signs of child abuse, neglect, or maltreatment.
- Observation of “goodness of fit” between the child and the foster family.
- More detailed assessment/evaluation of developmental status.
- Behavioral/mental health screening, with full evaluation to follow, if indicated (see below).
- Review of family background, stressors, strengths and weaknesses, and home environment (e.g., provides emotional safety, comfort, appropriate structure, discipline).
- Anticipatory guidance including education and counseling on topics specific to foster care, such as:
 - a. General adjustments to new home, grief and loss issues ,
 - b. Behavioral problems that may have surfaced,
 - c. Appetite/unusual eating habits,
 - d. School problems behavioral/academic,
 - e. Interaction with foster parents and other children in the home,
 - f. Contact with birth family including difficulties around visits.
 - g. Sexual abuse, and for adolescents sexual activity.

What about evaluation of behavioral/mental health and developmental needs?

According to the American Academy of Pediatrics (AAP),^{14 15} the mental health assessment/evaluation would review: mental health; circumstances of placement, family life event, traumatic events; regulation of affect and behavior in different settings; relatedness and relationship to family members, caregivers, peers, examiner; interests and activities; strengths and coping style; and preferred mode of expression with attention to culture and ethnicity. The professional conducting a mental health evaluation should also look for signs and symptoms of: 1) risks for suicide and/or violence; 2) substance exposure, misuse, abuse, and addiction; 3) maltreatment, including physical, sexual, emotional abuse and neglect; 4) risk of placement disruption; 5) risk of sexual behavior; and 6) risk of antisocial behavior.

Developmental screening is a basic component of an EPSDT screen for a child or adolescent of any age and, thus, should be part of a comprehensive screen. If developmental problems are suspected or detected as part of a screen, a more thorough developmental assessment by a trained professional (e.g., developmental pediatrician, child development specialist) should occur as soon as possible.¹⁶ While measurement tools will vary depending upon the child’s age and developmental stage, developmental screening and evaluation should include measurement using standardized tools of the following domains: gross and fine motor, cognitive, language, psycho-social, and activities of daily living skills. Children under three years of age can be referred to the Birth to Three Early Intervention Program for more comprehensive evaluation.

¹⁴ American Academy of Pediatrics, District II, NYS. Copyright, 2001.

¹⁵ Jellinek M. *Bright Futures in Practice: Mental Health—Volume I. Practice Guide*. Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University, 2002.

¹⁶ VanLandeghem K, Curtis D, and Abrams M. *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System*. Portland, ME: National Academy for State Health Policy, October, 2002.

Examples of Possible Contract Specifications for Screening and Assessment

- For a child in out-of-home care, an initial screen should occur no later than [*to be inserted for final contract*] after the Bureau of Milwaukee Child Welfare takes custody of the child. The purpose of this “initial” or entry screen is to identify health problems that would affect placement or require immediate medical, dental, or mental health care.
- HealthCheck routine screens should be provided according to the periodicity schedule. Interperiodic screens should be completed within [*to be inserted for final contract*] days of a the request from a caregiver or case worker who suspects the existence of a physical, mental or developmental health problem (or possible worsening of a preexisting physical, mental or developmental health condition). In addition, a comprehensive assessment (or evaluation) of the child should be conducted within [*to be inserted for final contract*] days of enrollment.

III. Provider Networks for Children in Out-of-Home Placement

- **Assure equal access.** The MCO should provide medical care to its Medicaid enrollees, which is as accessible to them, in terms of timeliness, amount, duration, and scope, as those available to non-enrolled Medicaid recipients within the MCO service area.
- **Assure that the MCO provider network is appropriate for this special needs population.** Specific network considerations include: a) the number and types of providers required to furnish the contracted services, b) the geographic distribution of providers and enrollees, c) accessibility of provider sites for persons with disability, and d) the experience of providers in caring for children in out of home placement.
- **Give families and caregivers of enrolled children the option of choosing the child’s primary care provider for their medical home.** The term “medical home” describes a coordinated medical care for children with special needs. The medical home provider might be either (1) a primary care practitioner, or (2) a specialist in pediatrics, including pediatric medical sub-specialists, pediatric surgical specialists, and child psychiatrists and psychologists. Regardless of the providers’ credentials, the medical home assists in early identification of special needs; provides ongoing primary care; and links with a broad range of other services.
- **Use memoranda of understanding (MOU) to define interagency connections.** The MCO must negotiate and sign a MOU with the Bureau of Milwaukee Child Welfare (BMCW) for collaboration including coordination of Medicaid-covered services for children in out-of-home care. To assure a systems approach, MCOs also need a MOU with School-Based Services, Birth to Three agencies, other Medicaid/BadgerCare MCOs, Wraparound Milwaukee, and other child health providers (e.g., local health departments, WIC, community-based organizations, hospitals).
- **Assure expertise in/arrangements for mental/behavioral health care.** MCOs arrange for screens and assessments that include developmental and mental/behavioral health components. When mental/behavioral needs are suspected or identified, MCOs arrange for exams and treatment by providers with expertise and experienced in mental health/substance abuse issues of children and adolescents. MCOs also arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse and neglect and domestic violence.
- **Encourage involvement of “traditional” providers in an MCO network:** A “traditional” provider has experience serving a substantial number of uninsured low-income children, including: 1) Federally qualified health centers (FQHCs), 2) rural health clinics, 3) city or county health departments operating clinics, 4) other maternal and child health clinics receiving funds under Title V, 5) providers funded under the Ryan White Comprehensive AIDS Research and Education Act, and 6) family planning clinics receiving funds under Title X.

Appendix 4

Materials for Kansas Leadership Workshop



This document was prepared for a Leadership Workshop on Managed Care and Child Health held on September 9-10, 2004 in Topeka, Kansas. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss “pay-for-performance” and other approaches to ensure that plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting; and Jeff Levi, Center for Health Services Research and Policy under contract with HRSA.

I. Pay-for-Performance as a Strategy for Managed Care Purchasing

Why consider a pay-for-performance (P4P) approach?

- The Institute of Medicine Health Care Quality Initiative has heightened consumers’ and purchasers’ awareness of the need for improvements in the health care system. In 1996, the Institute of Medicine (IOM) launched a concerted, ongoing effort focused on assessing and improving the Nation's quality of care, which is now in its third phase. In 1999, *To Err is Human*¹ delivered a “wake-up call” about patient safety and put quality issues squarely on the national agenda. In 2001, *Crossing the Quality Chasm*² called for fundamental change in the health system, including payment methods. “*The goal of any payment method should be to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended.*”³ In 2002, *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*^{4 5} recommended that all health-related programs of government, including Medicare and Medicaid, begin paying performance bonuses.⁶
- The reasons given in the typical business case for P4P is driven by these basic points:
 1. Current provider reimbursement strategies do not reward quality or performance. Neither fee-for-service nor capitated payments have effective incentives for quality improvement.
 2. Report cards on performance – prepared by regulators, accrediting bodies, and/or consumer advocates – typically focus at the plan, not individual provider level.
 3. When individual managed care organizations (MCOs) or integrated health systems issue their own report cards on their physician groups, the public is faced with “dueling scorecards” and non-comparable (or incomprehensible) data.
 4. In most States, MCOs contract with many of the same physician groups. Thus, no one MCO has an incentive to invest in quality improvement of a physician group because it will benefit the competitors.
 5. While different initiatives focus on different methods, the general motives for adopting P4P approaches are to: reduce medical errors, improve patient outcomes, reduce acute treatment/urgent care, minimize clinical practice variations, link dollars to improvement, collect and publish quality data, and advance information technologies.⁷

¹ Institute of Medicine. *To Err Is Human: Building a Safer Health System*. L. T. Kohn, J. M. Corrigan, and M. S. Donaldson, eds. Washington, D.C: National Academy Press, 1999.

² Institute of Medicine. *Crossing the Quality Chasm: A new Health System for the 21st Century*, Washington, D.C: National Academy Press, 2001.

³ *Crossing the Quality Chasm*, p. 193.

⁴ Institute of Medicine. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*, Washington, D.C.: National Academy Press, 2002.

⁵ Webcast of Public Briefing: Leadership by Example: Coordinating Government Roles in Improving Health Care Quality. <http://www.iom.edu/?id=12746>

⁶ Institute of Medicine. *Priority Areas for National Action: Transforming Health Care Quality*. K. Adams and J. M. Corrigan, eds. Washington, D.C.: National Academy Press, 2003.

⁷ Deverich M. Pay for Performance. Washington, DC: PriceWaterhouseCoopers. <www.pwc.com>

What are the main approaches to performance incentives?

The National Health Care Purchasing Institute⁸ has identified 11 current and potential health care provider incentive models, using both financial and non-financial incentives. The models that use financial incentives are: bonuses, compensation at risk, performance fee schedules, quality grants (typically, direct and competitive), reimbursement for care planning, and adjusted cost sharing for patients. The non-financial incentives are: performance profiling, publicizing performance, technical assistance for quality improvement, contract sanctions (threats for loss of a contract), and reduced administrative requirements.

The fundamental principles of P4P are:

1. Develop a collaborative approach, based on input from MCOs, physicians, researchers, and consumer advocates;
2. Use a common set of measures (metrics) based on consensus across areas of performance;
3. Commit significant financial payments based on performance;
4. Share the facts about performance; and
5. Leverage the “power of multiples” by making improvements across a larger number of physician practices and groups.

What are the key decisions in adopting P4P?

- **What is the target?** Will rewards go to those who can reach a standard benchmark, those who improve, and/or those who are top ranked?
- **What is the unit of measure?** For what unit will data be reported? Is the performance to be measured that of an individual physician, a provider group, or an MCO?
- **How will measures be weighted?** Most projects weigh performance in different areas. For example, Rhode Island assigns administration 20 percent, access 30 percent, and clinical care 50 percent. In the Statewide initiative in California, clinical measures are weighted at 50 percent of the overall score, with patient satisfaction at 40 percent and the information technology at 10 percent.
- **How to distribute payments?** Will funds be distributed annually or monthly? Will payments be lump sum, per member, or per service? Will it be quality bonuses (in which an annual payment is made to those who meet performance targets), adjusted fee schedules, and/or withholds for “reimbursement at risk” (in which the funds are held back and paid if/when minimum performance standards are met)?
- **Where will the money come from?** Will the State reduce payments (in other words withhold) some Medicaid managed care dollars at the beginning or commit new dollars? Will MCOs create incentive pools? Early efforts suggest that MCOs need to offer an amount equal to 10 percent of a physician’s earning potential in order to change practice behavior (and, hopefully, in turn get desired results).

⁸ National Health Care Purchasing Institute. Provider Incentive Models for Improving Quality of Care. <http://www.futurevision.com.ua/nhcpi/>

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II. Lessons Learned by Other States and Special Projects

- A report from the National Academy of State Health Policy (NASHP)⁹ found that, of the 28 States studied, 27 used penalties and 8 had begun to use financial incentives. Based on State reporting, NASHP said that successful efforts have:
 1. Experience in performance measurement and goal-setting, which helps States build baseline data and holds plans accountable;
 2. Extensive efforts to solicit public input, identify priorities and objectives, and develop public and legislative support; and
 3. A collaborative relationship with plans, to reach fair targets and ensure that the State will work with them to resolve problems.
- In 2001, the Integrated Healthcare Association (IHA), a collaborative leadership group in **California**, launched a Statewide P4P initiative.¹⁰ This year, after three years of planning and development, the IHA will begin to make performance-related payments. Patient satisfaction, clinical, and information technology scores are being used. Patient satisfaction measures address four areas: communication with the doctor, specialty care, timely care and service, and an overall rating of care. The six clinical measures cover mammograms, pap smears, and childhood immunizations, plus a measure for asthma, diabetes, and coronary artery disease. The clinical measures are weighted at 50 percent of the overall score, with patient satisfaction at 40 percent and the IT measure at 10 percent. Each participating health plan makes its own decisions about the source and amount of performance-based payments to its physicians. Funds may come from: (1) set-asides from future premium increases received from purchasers; (2) funds already budgeted for quality incentives; (3) the total amount budgeted for capitation payments.
- **Rhode Island** has concentrated on improving Medicaid managed care quality through use of performance contracting, by setting up clear expectations and rewarding those that reach preset goals. The State adopted an incentives-based, P4P approach in 1998. The State's Medicaid managed care program, RItE Care, developed 22 goals in the areas of administration, access, and clinical care, with the areas weighted 20, 30, and 50 percent, respectively. At the end of the first full year, RItE Care paid \$713,000 in bonuses to the plans -- about half of what was available. In the first year after the RItE Care program started in Rhode Island, both hospital days and emergency room use decreased by one-third. The State also has achieved success in improving rates of early prenatal care, childhood immunization, and lead screening. For example, Rhode Island offers bonus payments to MCOs in

⁹ Kaye N and Bailit M. Innovations in Payment Strategies to Improve Plan Performance. Portland, ME: National Academy of State Health Policy 2000.

¹⁰ Questions regarding the initiative should be directed to Ann Bowers of the Integrated Healthcare Association, e-mail abowers@iha.org. Also see: <http://www.iha.org/payfprfd.htm>.

which most physicians test for lead. The most recent figures show that 79 percent of Rhode Island physicians do lead screening — four times higher than the national average.¹¹

- **Rewarding Results** is a joint initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation with grantees in Michigan and California. Data are collected on six indicators: childhood immunization, cervical cancer screening, breast cancer screening, appropriate use of medication for people with asthma, LDL-cholesterol screening following cardiovascular events, and diabetes testing.
- Beginning in 2003, a coalition of large employers and health plans began to pay cash bonuses to physician networks in Boston, Cincinnati, and Louisville. The program, **Bridges to Excellence**, is a quality bonus model incentive plan and is funded by the Robert Wood Johnson Foundation and supported by the Federal Center for Medicare and Medicaid Services. The program is concentrating on diabetes care, cardiovascular care, and patient care management. Physicians qualify for an annual per-patient bonus (up to 10 percent of annual income) when they achieve targets. For example, a physician receives \$100 per patient if he or she becomes a member of the American Diabetes Association's Provider Recognition Program. Employers in this coalition include General Electric, Verizon Communications, Ford Motor Co., Procter & Gamble, and United Parcel Service.¹²
- **Arkansas** and **Maine** each have aimed to use information as incentives in their Medicaid primary care case management programs. Arkansas releases a "physician report card" so doctors can compare referrals, hospitalizations and emergency room use in their own practices to those of other primary care physicians. Maine's incentive program measures rates such as well-child visits and immunizations and provides bonuses to doctors who demonstrate high performance.¹³
- **Wisconsin** has long been using performance measurement to guide purchasing and provide incentives for quality in child health. Perhaps as a result, four of the MCOs under Medicaid contract are among the top 15 performers nationwide, according to the National Committee for Quality Assurance. Note that Wisconsin withholds a portion of a health plan's compensation if it does not meet screening standards for lead exposure, developmental problems or vision difficulties.¹⁴

¹¹ Griffin JF, Hogan JW, Buechner JS, and Leddy TM. The Effect of Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island. *Am J Pub Health* 1999; 89:497-501; Carrol-Silow S. Building Quality into Rite Care: How Rhode Island is Improving Health Care for its Low-Income Populations. New York: The Commonwealth Fund, 2003; Brousseau, DC, Dansereau LM, Linakis JG, Leddy T, and Vivier PM. Pediatric Emergency Department Utilization within a Statewide Medicaid Managed Care System *Academic Emergency Medicine* 2002; 9:296-299.

¹² Endsley S, Kirkegard M, Baker G, and Murckko AC. Getting Rewards for Your Results: Pay for Performance Programs. *American Academy of Family Physicians*. 2004. <http://www.aafp.org/fpm/20040300/45gett.html>

¹³ Governing, City & State 2000.

¹⁴ Dyer MB, Bailit M, and Kokenyesi C. Are Incentives Effective in Improving the Performance of Managed Care Plans? Princeton, NJ: Center for Health Care Strategies, 2002.

This document was prepared for a Leadership Workshop on Managed Care and Child Health to be held on September 9-10, 2004 in Topeka, Kansas. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss "pay-for-performance" and other approaches to ensure that plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting; and Jeff Levi, Center for Health Services Research and Policy under contract with HRSA.

III. Quality Standards to Monitor Child Health Services and Outcomes

An editorial in American Medical Association News in January 2003 commented that: *"On the surface... pay for performance has the potential, depending on the bonus structure, to align physician and payer interests in providing the best care for the least cost. However, when it comes to pay for performance, the question is: Who is defining quality?"* At the same time, the Institute of Medicine has found that a lack of consistency in measurement requirements, absence of standardized performance measures, and lack of a conceptual framework to guide the selection of performance measures are key barriers to closing the quality gap.

Sample Categories for Performance Measures/Goals

- **Administration measures**
 - a. Affect on members
 - Interval between enrollment and PCP assignment/selection
 - Grievances and appeals within time frames
 - b. Affect on Medicaid
 - Paying claims for covered services "out-of-network" (e.g., emergency room, public health)
 - Paying clean claims on time
 - c. Information technology
 - Ability to integrate/report clinical data in a timely manner
 - Use of decision-support software
- **Access measures**
 - a. Geographic/travel time access
 - b. Time between requests and appointments
 - c. Interval between enrollment and first PCP visit
 - d. Time spent in waiting rooms
 - e. Language access (translation)
- **Clinical care measures**
 - a. Preventive care
 - Immunizations up to date
 - EPSDT screening visits / child or adolescent well care visits
 - First pediatric visit for infant
 - Lead screening
 - Breast and cervical cancer screening
 - Early prenatal care
 - b. Chronic care
 - Asthma
 - Behavioral health
 - Cardiovascular
 - Children with special health needs
 - Diabetes
 - Epilepsy
 - c. Urgent/emergency services (e.g., members seeking ER receive services immediately)
- **Quality**
 - a. Patient/member satisfaction
 - b. Racial/ethnic disparities

Post-workshop Summary

September 27, 2004

MEMORANDUM

TO: Participant in the Advanced Leadership Workshop on Purchasing Quality Child Health Services under Medicaid and HealthWave (SCHIP) Managed Care Contracts

FROM: Kay Johnson, Johnson Group Consulting, Inc.
Jeffrey Levi, George Washington University

SUBJECT: Summary of key conclusions from the September 9, 2004 meeting

This memo provides a summary of the key consensus points emerging from the workshop on pay-for-performance in managed care purchasing as well as a series of “next steps” and possible strategies identified by the participants. This workshop was conducted with support from the Health Resources and Services Administration’s Maternal and Child Health Bureau and facilitated by Kay Johnson and Jeffrey Levi under contract with HRSA.

Perhaps the most important consensus points were:

- A belief that pay-for-performance is achievable in managed care purchasing in Kansas, particularly for child and family health services.
- A belief that a pay-for-performance approach should provide incentives, rather than be punitive.
- A belief that key players in health care purchasing and delivery, both within the Medicaid system and beyond, need to be part of a continuing dialogue as discussions become more specific about implementation and to assure consistency in approach to pay-for-performance for all Kansans receiving third-party paid health care.

A. A pay-for-performance initiative should maximize the State’s purchasing power and take advantage of other related policy initiatives.

- While the focus of the discussion was on Medicaid and HealthWave managed care purchasing, it was recognized that the State purchases health services through a variety of mechanisms (managed care, primary care case management, and fee-for-service), through Medicaid and HealthWave as well as through other insurance programs, such as the State employee health insurance programs. It was agreed that to the degree possible, measures that established a single standard of care, regardless of purchasing mechanism, should be sought. Given the overlapping networks of providers among the various public and private insurance approaches, this could be achieved through targeted application of pay-for-performance approaches.
- There was general consensus among participants that initial efforts at introducing pay-for-performance in Medicaid and HealthWave might build on other initiatives that have received broad support in the State, such as the recommendations of the Blue Ribbon Immunization Task Force and independent efforts regarding disease management for conditions such as asthma.

B. Pay-for-performance should focus on providing incentives for providers, not punishing them.

- There was a unanimous belief among participants that a pay-for-performance approach will be most successful if it provides incentives to providers (e.g., enhanced payments or bonuses if

certain performance targets or outcomes are achieved), rather than punishing providers who do not meet a certain standard.

- There was also support for a progressive approach to pay-for-performance – rewarding both good performance (i.e., achieving a particular standard) *and* rewarding improvement from a baseline for a provider.
- Participants also believed it was important to focus on provider performance both because the State uses only one managed care organization for children in Medicaid and HealthWave and because many providers see children on a fee-for-service (FFS) or primary care case management (PCCM) basis.

C. Introduction of pay-for-performance will need to be gradual to demonstrate its value to purchasers, providers, and consumers and to permit the building of an infrastructure (i.e., electronic medical record systems) necessary for effective pay-for-performance approaches.

- A short-term implementation step would be required participation by managed care pediatric providers in a State childhood immunization registry (consistent with the Blue Ribbon Task Force’s recommendations). This would serve an important quality objective (increasing immunization rates and coordination of immunization activities among multiple funders and providers) while also demonstrating to all parties the value of better data collection in assuring quality outcomes and more efficiently targeting various funding streams.
- One mid-term objective would be the development of consensus on measures related to child health performance. To develop consensus, key stakeholders (including more pediatric leaders) should be engaged in an ongoing process. Further examination of current performance on Health Employee Data and Information System (HEDIS), EPSDT, and external quality review organization (EQRO) data related to child health would be the basis for identifying measures. The group agreed on the importance of balancing preventive and high-impact acute care measures. They also identified mental health and prenatal care as areas likely to be challenging under a pay-for-performance approach.
- Another mid-term objective would be the adoption of electronic medical records systems by providers participating in Medicaid and HealthWave. An electronic medical records system is critical to effective quality monitoring and improvement. It was suggested that using standards for well-child care could be used as the prototype. Funding to build this infrastructure among providers was identified as a critical issue; creative use of funding might be needed (e.g., bioterrorism preparedness funds could be used since electronic medical records could enhance surveillance of new pathogens).
- The long-term objective would be to use electronic medical records to assure the “virtual” integration of various funding streams, so that providers could know where an individual patient or client is receiving services, regardless of payer, and so those services could be better coordinated and not duplicated.

D. More players need to be part of the discussion of pay-for-performance. It was generally agreed that for this approach to be successful, additional parties needed to be part of the discussion. Those mentioned include, but are not limited to (in no order of priority):

- Office of Health Planning and Finance
- Governor’s Office, Lt. Governor’s Office
- Kansas Medical Society
- American Academy of Pediatrics
- American Academy of Family Physicians
- State medical managers association
- Kansas Hospital Association
- State employee health plan
- Key legislative players

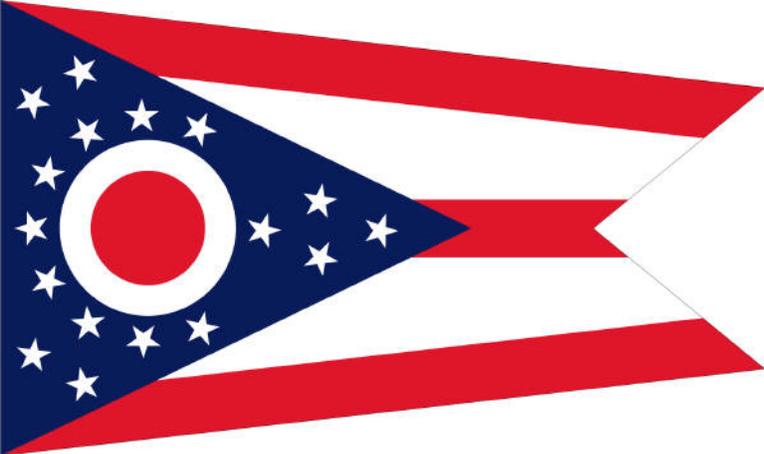
- Children's health advocates
- Immunization program
- Blue Ribbon Task Force leadership

E. As the discussion of pay-for-performance for children in managed care moves forward, a number of strategic issues need to be addressed. These include:

- A broader discussion of the State's expectations regarding quality is needed. What is the State willing to commit to in terms of new or redirected resources to assure greater quality and optimal performance is achieved?
- If women and children are the focus of initial quality efforts, a strong case needs to be made for the value of this targeting, given that greater costs to the State occur in providing for the disabled and long-term care.
- Why focus on preventive health issues rather than chronic diseases? Should the commitment be to linking pay-for-performance to both types of services?
- What data is now available that could be the basis for pay-for-performance?
- How do funding streams now meld at the provider and client level?
- One-pagers are needed for policy makers on the rationale for quality and pay-for-performance and why certain measures or populations are being targeted.
- More information is needed on what other States are doing in this area.

Appendix 5

Materials for Ohio Leadership Workshop



This document was prepared for a Leadership Workshop on Managed Care and Child Health to be held on September 28, 2004 in Columbus, Ohio. The workshop is based on work by the Center for Health Services Research and Policy at The George Washington University (GWU), and conducted with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCHB) and the Managed Care and Health Services Financing Technical Assistance Center (MCTAC). Senior policy makers and professionals attending the workshop will discuss approaches to ensure that plan enrollees receive the highest quality pediatric care. This information was designed to provide a framework for discussion, offering options for solutions to concerns shared by State agencies, managed care organizations, and consumer advocates. These documents have not been endorsed by Federal or State officials. Prepared by Kay Johnson, Johnson Group Consulting and Jeff Levi, The George Washington University under contract with HRSA-MCHB and MCTAC.

I. Planning and Financing for Child Development Services

Promoting Early Childhood Development in Medicaid and Medicaid Managed Care

While child health professionals agree about the importance of early childhood development services,^{1 2 3} financing child development services through Medicaid is not simple. One reason is that current Federal guidance does not specifically define "child development services."^{4 5} Despite overlaps between coverage for young children in Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program and early child development services, the final determination as to whether Federal Medicaid matching funds are allowable for a particular service is made by the Centers for Medicare and Medicaid Services (CMS). A second reason is that Medicaid was designed to finance health care, while child development services often are provided by education or social service agencies. Third, each State has flexibility to make rules about which providers are qualified. Finally, because some child development services also are funded by other public programs (e.g., early intervention, mental health, or children with special health needs), it may be difficult to understand which eligibility rules apply and who should pay for what services.

At the same time, Medicaid managed care offers clear opportunities to promote early childhood development. Medicaid managed care contracts typically include prevention and early intervention through EPSDT, as well as treatment. States can work with MCOs to improve care, using their power as purchasers to ensure the quality and appropriateness of services provided. Researchers at the George Washington University have prepared purchasing specifications to assist States in efforts to finance child development services through Medicaid managed care. (This work was financed by the Commonwealth Fund. See <http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/child/>)

¹ Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack P. Shonkoff and Deborah A. Phillips, (Eds), Washington, DC: National Academy Press, 2000.

² Brown B, Weitzman M, et al. *Developmental Needs of Many Children Not Being Met Early Child Development in Social Context: A Chartbook*. New York, NY: Commonwealth Fund, 2004.

³ VanLandeghem K, Curtis D, and Abrams M. *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System*. Portland, ME: National Academy for State Health Policy, 2002.

⁴ Rosenbaum S, Proser M, Schneider A, and Sonosky C. *Room to Grow: Promoting Child Development Through Medicaid and CHIP*. New York, NY: Commonwealth Fund, 2001.

⁵ Perkins J. *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Intervention Services*. Los Angeles: National Health Law Program, 2002.

Benefits and Services to Promote Early Childhood Development

- **Use the GWU purchasing specifications on child development to develop contract language that clearly communicates policies on developmental services to managed care plans.** While Medicaid has over 30 benefit categories, no category is labeled "child development services." The purchasing specifications identify a range of covered services linked to child development
- **Improve and clarify the description of developmental assessment under EPSDT.** For example, States may distinguish a routine developmental screening conducted as part of an EPSDT screen from developmental exams or diagnostic assessment (evaluation) conducted by a medical social worker, public health nurse, or developmental pediatrician. States also could encourage use of professionally recommended screening tools appropriate for young children.
- **Encourage pediatric provider sites to promote healthy development.** State Medicaid agencies could reimburse primary pediatric practitioners for providing preventive mental health care and development services (see Bright Futures). Medicaid also might pay for developmental services provided by social workers and child psychologists co-located in pediatric practices.
- **Clarify rules on Medicaid payment for services delivered through other public programs,** such as IDEA Part C Early Intervention, children's mental health, child welfare, and Head Start. For example, Medicaid can finance early childhood mental health consultation for children in child care settings. Many contracts require MCOs to sign memoranda of understanding with public agencies.

Opportunities identified by NASHP

With the support of the Commonwealth Fund, the National Academy of State Health Policy (NASHP) has defined some examples of activities that a State might use to improve the health, mental health, development, and well being of young children and their families.⁶ These included the following:

- **Managed care contract provisions** that specify coverage of child development services and parent education, as well as require local interagency coordination agreements;
- **Incentives** (in pay-for-performance or other arrangements) for pediatric providers to screen children and families for risk factors and provide appropriate guidance and counseling;
- **Structured capitation payments** to plans, enhanced primary care case management (PCCM) fees, and/or payment to providers for the inclusion of certain child development services; and
- **Adopt benefits definitions and billing codes for diagnostic assessment and intervention services to reduce risk factors** that can impede healthy development, such as family depression or other mental illness, smoking, substance abuse, potential for child abuse and neglect, injury hazards, lead poisoning, inadequate nutrition, developmental delays, or behavioral problems.

Other no cost / low cost opportunities

- **Collaborative planning** – States that have established more comprehensive and/or coordinated approaches appear to do a better job at serving vulnerable and at-risk children (e.g., FL, HI, IN, MI, MN, and NC). In 2003-04, States have used Title V discretionary grant funds, called Comprehensive Early Childhood Care Systems (CECCS), to support planning efforts (e.g., CT, IL, MA, and NM).
- **Maximize use of Federal entitlement funds and State/local dollars available for matching** – Whether Medicaid, SCHIP, CCDBG, or IDEA, designation of State and local dollars is an essential step for drawing down available Federal funding.

⁶ Johnson K and Kaye N, *Using Medicaid to Support Children's Health Mental Development*. Portland, ME: National Academy for State Health Policy, 2003.

- **Clarify the definitions of children at risk** – While no State can afford to extend eligibility to all children at-risk, use of broader and clearer definitions can help include more young children in need of early interventions to help them achieve school readiness.

Clarify and Adopt Billing Codes for Early Childhood Development Services

Without clear billing codes and payment rates, providers are less likely to deliver developmental services. Some States have found that billing codes tailored to young children’s conditions (using the *Diagnostic Classification for Children 0 – 3 - DC:0-3*)⁷ helped to reduce unnecessary spending, minimize fraud, and maximize early intervention. For example:

- In North Carolina, Child Service Coordination is case management services to children at risk for or diagnosed with special needs. Diagnosis codes that support medical necessity for Coordination include: V11.9 -Unspecified mental disorders; V15.86 - Exposure to lead; V15.9 - Unspecified personal history presenting hazards to health; V17.2 - Other neurological diseases.
- A workgroup report from King County (WA) studied the potential role of the DC:0-3 and emphasized the importance of training and a standardized “crosswalk” between the two sets of codes.
- Florida has developed guidelines and a tool for professionals to use with the DC:0-3. For example, in a “crosswalk” between the two codes: DSM-IV 700 “Disorders of Relating and Communicating” is clarified in DC:0-3 as “Psychoses with origin specific to childhood (299.0 – 299.9)” and/or “Developmental disorder NOS (319.5).”

II. Screening and Assessment for Young Children

In clinical practice, the terms screening, assessment, and evaluation have general, but not precise meanings. Professionals do not use these terms consistently. Because these terms are confused in Medicaid/EPSDT guidance to States, it is important to reach agreement on what they mean in this context.

Screening is used to identify possible problems and presumes follow-up with additional tests if a problem is suspected. Screening tools can be general, be specific to a disorder or be focused on an area of development (e.g., language or motor skills).⁸ Ideally, developmental screening tools should: identify children with or at risk of problems, be quick and inexpensive to administer, be of demonstrated value to the patient, provide information leading to follow-up, and be sensitive and specific enough to avoid mislabeling many children.^{9 10} Screening does not result in diagnoses.

When a possible problem is identified through screening, the next step is assessment (also sometimes called evaluation). Assessment is more in depth and helps child health professionals to determine the nature of the condition and to consider possible treatments. Assessment tools or (more often) processes might be considered diagnostic. An assessment may be comprehensive or measure a child’s condition on an area such as physical, cognitive, or behavioral development.¹¹

⁷ Zero to Three: National Center for Infants, and Toddlers and Families. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)* (1994) and *DC:0-3 Casebook*. Washington, DC: Zero to Three Publications, 1997.

⁸ Centers for Disease Control and Prevention, National Center for Birth Defects, Developmental Disability, and Disability Health. <http://www.cdc.gov/ncbddd/child/tools.htm>.

⁹ Bergman D. Screening for Young Children. Portland, ME: National Academy of State Health Policy, 2004.

¹⁰ Glascoe FP and Shapiro HL. “Developmental Screening,” from the web site of Developmental-Behavioral Pediatrics Online Community (www.dbpeds.org/articles/detail.cfm?id=5) 5/5/2004

¹¹ American Academy of Pediatrics Committee on Children with Disabilities “Developmental Surveillance and Screening of Infants and Young Children” *Pediatrics* 2001;108:192-196.

How does this fit with Medicaid and EPSDT/ screening?

In this context, the word “*screening*” also reflects the definition in Medicaid’s Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) program.¹² EPSDT screening (a comprehensive well-child check-up), diagnostic assessment, and treatment for any health problems found during the checkup including medical care, mental health services, vision, hearing, and dental care. By law, an EPSDT screen is comprehensive and includes age-appropriate: health history, physical exam, developmental tests, blood and urine lab tests, immunizations, and health education/anticipatory guidance. Screening visits may be based on the State established (periodicity) schedule or on an interperiodic basis, as necessary. Hearing, vision, and dental screening also are required and have their own periodicity schedule. Children age three and older must be referred to a dentist.¹³

Developmental screening is a basic component of an EPSDT screen for a child or adolescent of any age and, thus, should be part of a comprehensive screen. If developmental problems are suspected or detected as part of a screen, a more thorough developmental assessment by a trained professional should occur as soon as possible. While measurement tools vary, developmental screening and diagnostic assessment/evaluation should include measurement using standardized tools of the following domains: gross and fine motor, cognitive, language, psycho-social, and activities of daily living skills.

III. Early Childhood Mental Health Services

Research has shown that early child health and development services can effectively address the needs of many children who are considered at risk of cognitive, social, or emotional problems.^{14 15} While effective early interventions and treatments do exist once a child is identified, the challenge is to identify those children in need. Surveys indicate that care for the social-emotional-behavioral development of children lags behind that of other preventive and developmental services recommended by the AAP.¹⁶ Financing early childhood mental health services poses particular challenges.¹⁷

Challenges related to Serving Young Children

- **Definitions of eligibility for the child** – Our silo approach to programs for children and families creates gaps and overlapping authority. This particularly affects IDEA Part C, Part B Preschool, Head Start, child welfare, and Medicaid/SCHIP programs.
- **Lack of eligibility for parents** –Promoting or repairing a child-to-caregiver relationship is fundamental for child mental health, especially if the parent is battered, abusing substances, or depressed. This requires treating parent and young child together.
- **Difficulties in distinctly diagnosing conditions among young children** – Can the child’s condition be specifically diagnosed? Is the condition considered a medical, social, or educational problem? Is the appropriate provider trained in medicine, social work, mental health, or child development?

¹² Rosenbaum S and Sonosky C. *Federal EPSDT Coverage Policy*. Prepared by the George Washington University Center under contract to the Health Care Finance Administration, 2000.

¹³ States’ Medicaid Manual Part 5: Early and Periodic Screening, Diagnosis, and Treatment. Centers for Medicare and Medicaid Services (CMS).

¹⁴ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, 1999.

¹⁵ Op cit. *Neurons to Neighborhoods*. Washington, DC: National Academy of Sciences, 2002.

¹⁶ Bethell C, Peck C, Abrams M, Halfon N, Sareen H, and Scott-Collins K. *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid: Results from a Survey Assessing the Quality of Preventive and Developmental Services for Young Children Enrolled in Medicaid in Three States*. New York, NY: The Commonwealth Fund, 2002.

¹⁷ Johnson K, Knitzer J, and Kaufmann R. *Making Dollars Follow Sense: Financing early childhood mental health services to promote healthy social and emotional development in young children*. New York, NY: National Center for Children in Poverty, 2002.

- ***Dilemmas of primary care providers about where to refer children for diagnostic assessment and treatment.*** Surveys of pediatricians indicate problems with the number of referrals, the willingness to refer, and the linkages to referral resources. These data suggest systemic barriers for children.¹⁸

Opportunities to Promote and Protect Socio-Emotional Development

- ***Clarify State Medicaid guidance on screening, assessment, and treatment related to early childhood mental health development.*** Specifically, States might clarify benefits covered, better define developmental screening and assessment, put protocols into place for developmental services, and define a set of providers qualified to receive reimbursement.
- ***Encourage pediatric provider sites to promote healthy mental development.*** State Medicaid agencies might reimburse primary pediatric practitioners for providing preventive mental health care and development services as defined under the Bright Futures Mental Health Guidelines.¹⁹ Alternatively, Medicaid might designate specific payment rates for social workers and child psychologists co-located in pediatric practices and clinics to promote healthy emotional development through assessment, referrals, and treatment.
- ***Eliminate treatment barriers created by requiring providers to diagnose young children as having a mental or behavioral health condition in order to obtain intervention and treatment.*** Such requirements are established at the State level. States might review State mental health or Medicaid mental health rules that require a diagnosis prior to Medicaid mental health financing and identify opportunities to finance early interventions that promote healthy mental development.
- ***Use the revised Child Abuse Prevention and Treatment (CAPTA) law as a stimulus.*** Congress revised the CAPTA legislation, which now requires each State to submit a plan for early intervention referrals among children ages birth to three with confirmed cases of child abuse and neglect. Some States are using this opportunity to restructure the linkages between child welfare, Part C early intervention, and Medicaid.
 - ***New protocols for screening.*** One starting point is to provide more uniform and appropriate early childhood assessment for children entering foster care based on protocols developed by professionals, as well as approved for financing by Medicaid. Such protocols could be used as the basis for enhanced EPSDT screening.
 - ***New professionals in Part C.*** In most States, the sites conducting early intervention assessments are not well equipped or trained in providing assessments/evaluations for children with a history of abuse and neglect or in providing treatment for infants and toddlers with high levels of social-emotional need.
 - ***New referral patterns.*** For staff in local child welfare agency, TANF, Medicaid, and Part C programs, an aggressive response to the intent of new CAPTA rules will be a big change in practice. The State agencies can help by providing suggestions or guidance about how and when children should be referred between programs.
- ***Target other at-risk populations already eligible for Medicaid benefits.*** This includes groups such as children in protective services/foster care or in IDEA Part C Early Intervention Programs. Specific efforts might involve activities such as:
 - ***Better linking EPSDT and IDEA.*** Some Medicaid agencies require the signature of a primary care provider, as prior approval on each child's IFSP under the IDEA Part C

¹⁸ Rushton J, Bruckman D; Kelleher K. "Primary Care Referral of Children with Psychosocial Problems," *Archives of Pediatric and Adolescent Medicine* 2002;156:592-598

¹⁹ Jellinek M, Patel BP, and Froehle MC. eds, *Bright Futures in Practice: Mental Health*. Arlington, VA: National Center for Education in maternal and Child Health, 2002.

program. Since these populations already use services, this is an opportunity to reduce long-term costs and improve children’s mental health outcomes.

- **Focusing on children with special health care needs.** Children with special health care needs (CSHCN) can be defined as children under 21 who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, and require health and related services of a type or amount beyond that which is required by children generally. However, not all CSHCN programs include children with social-emotional-behavioral needs.

Other no cost / low cost opportunities

- **Conduct joint training of professionals** –Facing shortages of professionals trained to provide appropriate mental health services to young children and their caregivers, some States – such as Florida, Indiana, Louisiana, Michigan, and Vermont – have aimed to provide training to “grow their own” crop of professionals. Training dollars are available in many programs.
- **Monitoring children at risk** – Children at-risk are more likely to fall into the cracks between various service systems (and associated eligibility definitions). Several existing mechanisms could be used by States to monitor or track children at risk. Children whose EPSDT periodic screening exams indicate high risk for social-emotional or developmental delays may receive more frequent “interperiodic” screening to assess their progress and need for treatment.²⁰

IV. Financing for home visiting – Medicaid and funding streams

Home visiting is a long-standing, well-known prevention strategy used by States and communities to improve the health and well-being of women, children, and families, particularly those who are at risk. One home visitation program evaluation found that children in participating families made 35 percent fewer visits to the emergency department, had 40 percent fewer injuries, and 45 percent fewer behavioral and parental coping problems noted in their physicians’ records than children in the comparison group.²¹ Mothers visited by nurses provided home environments that were more conducive to child development.²² Overall, comprehensive home visitation or pediatric programs can save society money in the long run, due to reduced welfare dependency, teen parenthood, and violence.²³

Characteristics of effective home visiting projects

- **Provide specific services, social supports, and referrals.** States are using home visiting to help transition families from welfare to work, strengthen early childhood development programs, and provide support to first-time families. Matching services to goals is essential.
- **Quality services.** Recent national evaluation research underscores the importance of improving the implementation and quality of home visiting services. Staff training is a fundamental element of quality. Ongoing monitoring and evaluation helps to ensure that quality is maintained.
- **Integrated strategy.** Effective home visiting efforts must be connected to other child and family services and supports. For the many home visiting programs designed to provide care coordination and social support linkages, this is a critical aspect of the program.
- **Maximize Federal funding streams.** A variety of Federal funding streams are available to support home visiting - including Medicaid, the State Children's Health Insurance Program (SCHIP), the Title

²⁰ Johnson K and Knitzer J. *Finance and Policy Strategies to Promote Socio-Emotional Development for School Success*. New York, NY: National Center for Children in Poverty. In press. November 2004.

²¹ Olds, D.H., Henderson C., and Kitzman H., “Does Prenatal and Infancy Nurse Home Visitation Have Enduring Effects on Quality of Parent Caregiving and Child Health at 25 to 50 Months of Life?” *Pediatrics* 1994;93: 89-98.

²² Kitzman et al., “Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries and Repeated Childbearing,” *Journal of the American Medical Association* 1997;278: 637-643.

²³ Karoly, L.A., Greenwood, P.W., Everingham, S.S. et al, *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, Santa Monica, CA: RAND, 1998.

V Maternal and Child Health Services Block Grant (Title V), and Temporary Assistance to Needy Families (TANF) - some of the largest and most common sources of Federal support. Blended funding is associated with long-term program survival.

The Status of Home Visiting Policies

From Alaska to Florida, States have advanced home visiting programs and policies. At the beginning of Fiscal Year 2003, a total of 21 States had laws establishing home visiting programs. Among these 21 States, 31 laws were in effect, with the authority typically assigned to Departments of Public Health (33 percent) or to Departments of Education (23 percent). Just over half of these laws mentioned a specific program model, and nearly half specified a funding source.²⁴ Other States operate home visiting programs without specific legislative authority. Most State home visiting programs are adaptations of pre-existing program models, including Healthy Families America (HFA), the Nurse-Family Partnership (Olds model), Early Head Start, Home Instructional Program for Preschool Youngsters (HIPPPY), and Parents as Teachers (PAT).²⁵

Home Visiting Policies and Financing

- A survey of 30 State-based home visiting programs conducted in 1999-2000 found that:²⁶
 - State dollars were used to fund home visiting programs by virtually all of these 30 States, with nearly half using State general revenue funds and others using categorical funding streams.
 - Both large and small States have made substantial public investments in home visiting. The largest reported State spending was in Florida, Illinois, Michigan, New York, Ohio, Oklahoma, and Washington; however, on a per capita basis, small States such as Delaware, Hawaii, and Rhode Island are spending well above the average.
- A more recent survey of home visiting programs in 37 States found that:¹
 - State funds were the primary source of funding for home visiting programs.
 - Federal dollars accounted for about 45 percent of home visiting budgets.
 - Local public and private dollars also were being used as matching and supporting funds.
- Leading sources of funding from specific Federal programs include the following:
 - **Medicaid** State-Federal matching funds, particularly to finance targeted case management and care coordination delivered through home visits.
 - States have found a fit between home visiting and **Title IVB** (of the Social Security Act) program, with goals to address child abuse and neglect and promote safe and stable families.
 - Temporary Assistance for Needy Families (**TANF**) Federal dollars and State maintenance of effort dollars have been used to fund home visiting, which fits with program purposes.
 - **Early Head Start** has launched a major initiative to enhance home visiting.
 - **Maternal and Child Health Block Grant** dollars from Federal set-aside funds, Federal block grant allocations to States, and State matching funds are being used to support home visiting.

²⁴ *Home Visiting Legislation and Funding: Lessons from Healthy Families America*. Healthy Families America, April, 2003. <<http://www.healthyfamiliesamerica.org>>

²⁵ Home Visiting Forum, 2003. <<http://www.gse.harvard.edu/~hfrp/projects/home-visit/research.html>>

²⁶ Johnson K. *No Place Like Home*. New York, NY: Commonwealth Fund, 2000.

- **Part C Early Intervention Program** of the Individuals with Disabilities Education Act (IDEA) Federal, State, and local dollars for children birth to age three with disabilities.
- **Other Federal grant dollars** from various programs such as the Social Services Block Grant, Adolescent Family Life Grant, Americorps, and domestic violence prevention.

Opportunities through Medicaid and Medicaid Managed Care

Medicaid is used to finance home visits in more than a dozen States. A number of States -- including Illinois, Michigan, Kentucky, Oklahoma, and Wisconsin -- are using some version of Medicaid case management to finance home visiting services to at-risk families. Medicaid may finance all or part of the cost of home visiting services. Some States are using "target case management", which would require Federal approval and is matched as a medical assistance service. Others are using "Administrative Case Management", which does not require special Federal approval and is matched at the 50/50 administrative rate. A few States use fee-for-service payments for various services. States use various resources for matching; for example, Kentucky uses a combination of Medicaid and tobacco dollars.

- The **Illinois Medicaid Family Case Management** program provides intensive service coordination for pregnant women and infants, using Medicaid's administrative case management approach. The target group includes pregnant women and mothers with infants. Local agencies under contract include health departments and community-based organizations. Program guidelines are set out in State regulations.
- In **Michigan**, the Medicaid Maternal and Infant Health Advocacy Services (MIHAS) program provides outreach, health education, and care coordination to pregnant women and their infants. To qualify for services, a pregnant woman must be Medicaid eligible and have one or more risk factors (i.e., single marital status, social isolation, younger than age 20, history of abuse or neglect, maternal depression, low intellectual functioning or educational level, and HIV/AIDS risk). Services include case management and assistance with making and keeping prenatal care appointments, referrals to other needed services, transportation assistance, needs/risk assessments, and health education related to pregnancy and parenting.

Appendix 6

Materials for Pennsylvania Leadership Workshop 2



This document was prepared for the Second Roundtable on Children's Health and Managed Care to be held on May 10, 2005 in Harrisburg, Pennsylvania. The more than 35 senior policy makers and professionals attending the workshop will discuss approaches to care coordination for children enrolled in Medicaid and SCHIP health plans. These documents have not been endorsed by Federal or State officials. The workshop was based on work by Johnson Group Consulting and the George Washington University (GWU). This work is being conducted with support from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. Thanks to the Pennsylvania Perinatal Partnership and other volunteer leaders on the steering committee that designed this

**Pennsylvania Second
Roundtable on Children's Health and Managed Care
Topic: Care Coordination for Children with Special Health Care Needs
May 10, 2005**

Goal of the roundtable: *To begin development of a uniform care coordination approach for children with special health care needs (CSHCN).*

Whether Medicaid/EPSDT “case-management,” Title V CSHCN “care coordination,” the SCHIP program, an AAP medical home project, or managed care strategies, Pennsylvania can do more to assist families in meeting the needs of their children, linking across service delivery systems, and managing care to reduce unnecessary spending. This Roundtable is focused on identifying strategies to improve cross-system supports and build a common framework for serving CSHCN.

There is no single definition of children with special health care needs that is commonly accepted. Definitions vary among States (e.g., definitions used by a state Title V agency may vary from that used by the same state's Medicaid agency). For this Roundtable discussion, CSHCN are defined as: “Children 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.”¹ This definition is broad, incorporating children with a range of conditions and risk.

Recent national data and special initiatives across the country indicate the following:

- An estimated 12.8 percent – 9.4 million – children under age 18 in the United States have special health care needs, and CSHCN needs are present in 20 percent of U.S. households with children.
- On average, parents rated the severity of their children's conditions as 4.2. This average rating was higher for CSHCN in families with incomes below the poverty level (5.3) and lower among CSHCN in families with incomes of 400 percent of poverty or more (3.5).
- Among children with special health care needs living in poverty, 40 percent need emotional, behavioral, or developmental services, compared to 23 percent in higher-income families.
- Findings from a national survey indicate that 8 percent of parents cited financial problems as the main reason that health care for their CSHCN had been delayed or forgone in the previous 12 months.
- For pediatrics, the standard of care for children with special health care needs is that of a “medical home” – an approach to providing care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent.
- Pilot projects coordinated by the Center for Health Care Strategies found that: overlapping care coordination programs led to increased costs and confusion, specific screening tools and protocols were effective, and effective education and informing for parents was essential.

¹ McPherson et al. A New Definition of Children with Special Health Care Needs. *Pediatrics*. 1998;102:137-140.

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Summary of the Second Pennsylvania Roundtable on Child Health and Managed Care: Care Coordination for Children with Special Health Care Needs

Welcome and Introductions

The meeting began with a welcome from Cheryl Squire-Flint, Healthy Start Pittsburgh, and Pat Yoder, Chester County Health Department, representing the Pennsylvania Perinatal Partnership and local public health leadership in maternal and child health. They described how this second roundtable was designed as a follow-up to the first roundtable held in March 2004. The agenda for the day was designed to offer an array of perspectives on strategies for enhancing care coordination for CSHCN.

The next speaker, representing the Pennsylvania Secretary of Health, was Melita Jordan, director of the Bureau of Family Health and the designate Title V program director for Pennsylvania. Ms. Jordan described the Title V mission and Federal-State partnership. More specifically, she described the mandate under Title V to designate 30 percent of the State's block grant allocation to serving children with special health care needs and their families. In Pennsylvania, program activities include: comprehensive specialty care, Parent-to-Parent support groups, a medical home initiative, and other projects and services. In terms of direct medical services, the State supports staff in each of the six community health districts. Ms. Jordan also reported on the results of a study by Health Systems Research, which found that: a) those covered by Medicaid faced access problems outside urban areas; b) no mechanisms exist to link various systems of care; c) provider payments and continuity of care continue to be important issues; and d) older CSHCN are more likely to lack access to care and need more transition assistance.

Representing the Pennsylvania Department of Public Welfare (DPW), Suzanne Campbell, told the group that that DPW welcomed ideas for improving service delivery. She also encouraged the group to think about ways to increase efficiencies in the current budget climate.

Perspectives on the Challenge

Kate Maus, MCH leader for the Philadelphia Department of Public Health, described her experiences in coordinating resources for CSHCN at the local level. For example, care coordinators in Philadelphia have to manage: the interface among five tertiary care hospitals, multiple specialty physicians, Medicaid eligibility staff, multiple health care coordination projects, and managed care special needs units, as well as providers from mental health, education, early intervention, childcare, and child welfare systems. Ms. Maus described the contrast between what exists today and the dream of family-centered care. She described the vision of parents of children with special needs as: "Nothing about me without me."

Speaking as an affected and concerned parent of a child with special health care needs, Melissa Parsons described the challenges she faces in coordinating care across medical and social systems for a young child with a chromosomal disorder that affects multiple body systems. Despite ongoing support from

Healthy Start, Mrs. Parsons has faced challenges throughout her child's first two years, negotiating through multiple surgeries, eleven doctors, many specialty evaluations, early intervention services, and related support services.

Panel Presentations on Program Models in Pennsylvania

- **SECCS Grant, Barbara Caboot, Department of Health** – All State Title V programs have used State Early Childhood Care Systems (SECCS) grant funding to plan for improved linkages among early childhood health, welfare, and education systems. Pennsylvania, now in the second year of the planning phase, has done a gap analysis. Other potential future activities include: development of a system and/or finance map, implementation of integrated programs or funding strategies, and reorganization of administrative functions for early childhood programs. Efforts to better integrate care coordination for CSHCN could be a focus for future efforts.
- **Medical Home Initiative - Alan Kohrt, MD, and Molly Gato, PA Chapter, American Academy of Pediatrics** – The American Academy of Pediatrics has advanced principles for providing a medical home to every child with special health care needs. HRSA's Maternal and Child Health Bureau (MCHB) and States have supported model program initiatives to advance the concept of a medical home. Dr. Kohrt described the current efforts in this State. In Pennsylvania, 26 physician (pediatrician) practices currently are implementing the medical home model in the context of learning collaborative. Additional practices are being added incrementally. Each practice identifies a family partner, quality improvement team leader, and care coordinator who work together to change practice behavior. For 16 of these practices, such efforts are supported by small grants (\$5,000 - \$10,000). Molly Gato described how outcome-based data are being collected (through a new time-tracking form and a patient database) for the purpose of evaluating change. The medical home model is central to the discussion and design of a more uniform approach to care coordination for CSHCN.
- **HIV/AIDS Case Management Model – Dorothy Mann, Family Planning Council** – Lessons learned from the HIV-AIDS program case-management approach operating in Philadelphia since the 1980s are useful in the context of care coordination for CSHCN. Ms. Mann described how the State uses standardized qualifications to certify case managers, who, in turn, can be hired by local service agencies. In Southeastern Pennsylvania, three managed care organizations contract with these local service agencies, despite the fact that they could opt to do this case management internally. Ms. Mann described this HIV/AIDS case management as tailored to individual needs and functioning as care coordination for outpatient services. Current reimbursement is \$35 per hour, with case managers carrying an average caseload of 25 individuals/families. No evaluation of the HIV model has been conducted.
- **Assessment of Office-based vs. Community-based Care Coordination – Ed Spahr, MD, Department of Health** – Dr. Spahr described the medical home training project operated by the Department of Health. He also discussed the attributes of office-based versus community-based approaches to care coordination. Finally, he stressed the importance of measuring family satisfaction, including measures to capture perceptions of the degree to which care coordination results in services that are family centered, culturally competent, and well coordinated.
- **Current Managed Care Contracts – Allison McCanemy, Department of Public Welfare** – In Pennsylvania, as in most States, Medicaid uses several types of managed care arrangements, including full-risk capitated HMOs and primary care case management (PCCM). DPW has contracts with private consultants to implement chronic disease management projects, which include asthma in children. These projects are designed to test the impact of a system of rewards and incentives for improved quality and effectiveness in chronic disease management. In addition, Ms. McCanemy said, in the context of full-risk contracts, Medicaid managed care

organizations have responsibility for operating “special needs” case management/care coordination units. Questions have been raised about the role of these units, that is, whether they are charged with family-focused care coordination or plan-focused cost containment. Also, anecdotal evidence suggests that some families mistrust these HMO-operated units.

- **Care Coordination Model – Loware Holiman, Department of Insurance** – The Department of Insurance (DOI) operates the State Children’s Health Insurance Program (SCHIP) plan in Pennsylvania, which is designed similar to a standard Blue Cross/Blue Shield private plan. Ms. Holiman reported that SCHIP does not currently use a care coordination model and lacks data to monitor such services. The State’s SCHIP plan does use HEDIS indicators and data to monitor program/plan performance. Right now, DOI is investigating the higher than average use of Emergency Room services by covered children. They also have survey data indicating that 92 percent of children in SCHIP have an identified regular source of care (a doctor or a nurse).

Lunchtime Presentation: What can we learn from other states?

Kay Johnson, Johnson Group Consulting

Ms. Johnson gave a presentation about what other States are doing to improve care coordination for CSHCN, particularly through the lens of Medicaid and Medicaid managed care. She briefly described other States approaches, particularly SECCS planning grants and AAP/MCHB medical home initiatives, stating that Pennsylvania has undertaken many of the same projects and activities as other States. For example, North Carolina and other States have developed data collection and referral forms similar to the one being tested in pediatric practices in Pennsylvania. Other States, such as Colorado and Connecticut have used their SECCS planning process and medical home initiatives to achieve greater coordination and support services for CSHCN. Ms. Johnson also set out a framework for thinking about these issues. She clarified that Medicaid does not finance a category called “care coordination” but does have several types of case management benefit categories that States can use. One important category is “targeted case management,” which is an optional benefit category financed at the State’s medical assistance matching rate. Other categories are administrative case management, which qualify for the 50/50 administrative matching rate. Both categories may be or have been used by other States to finance support services for CSHCN. This is only possible, however, where clear definitions and specific dollars have been identified. Ms. Johnson concluded by encouraging the group to acknowledge that lack of shared definitions (and not financing) were the greatest obstacles to achieving their goal of better integrated care coordination for CSHCN.

Summary of Discussion regarding Care Coordination for CSHCN

1. Participants discussed the need to define and achieve greater **consensus on the vision** for what they are hoping to achieve through care coordination.
2. The characteristics of care coordination they envisioned would ideally:
 - make one individual the primary point of contact;
 - assign one individual to each family as the primary care coordinator;
 - be responsible for cross-system linkages;
 - use existing resources;
 - provide more than just benefits management;
 - offer a variety of entry points;
 - be independent (of providers or payors);
 - be able to be varied by intensity & need (not one size fits all);
 - link to medical home (e.g., through paper reports, co-location); and
 - have accountability (e.g., data reporting, grievance procedures).

3. The group also identified a **basic set of principles**, including many often cited as essential for CSHCN and their families and other desirable characteristics more related to public administration. They suggested services should be: safe, effective, efficient, timely, equitable, unduplicated, family-driven and family-centered, and culturally competent.
4. The Roundtable participants discussed the need for a **shared definition of care coordination/case management for CSHCN**. In order to be useful for policy and finance discussions, this definition must be one that can be operationalized and would include:
 - provider qualifications;
 - certification standards;
 - outcome and process measures/benchmarks;
 - criteria for service eligibility (i.e., which children/families have need for this service).
5. The group also saw a need to **quantify the need and assess gaps in funding and services**. Specific questions that need to be addressed include: a) how many children by age, type of condition/severity, and level of need of family, b) how many dollars are now being spent on care coordination for CSHCN, and c) how many existing providers are available to deliver these services?

Discussion of Opportunities for Action

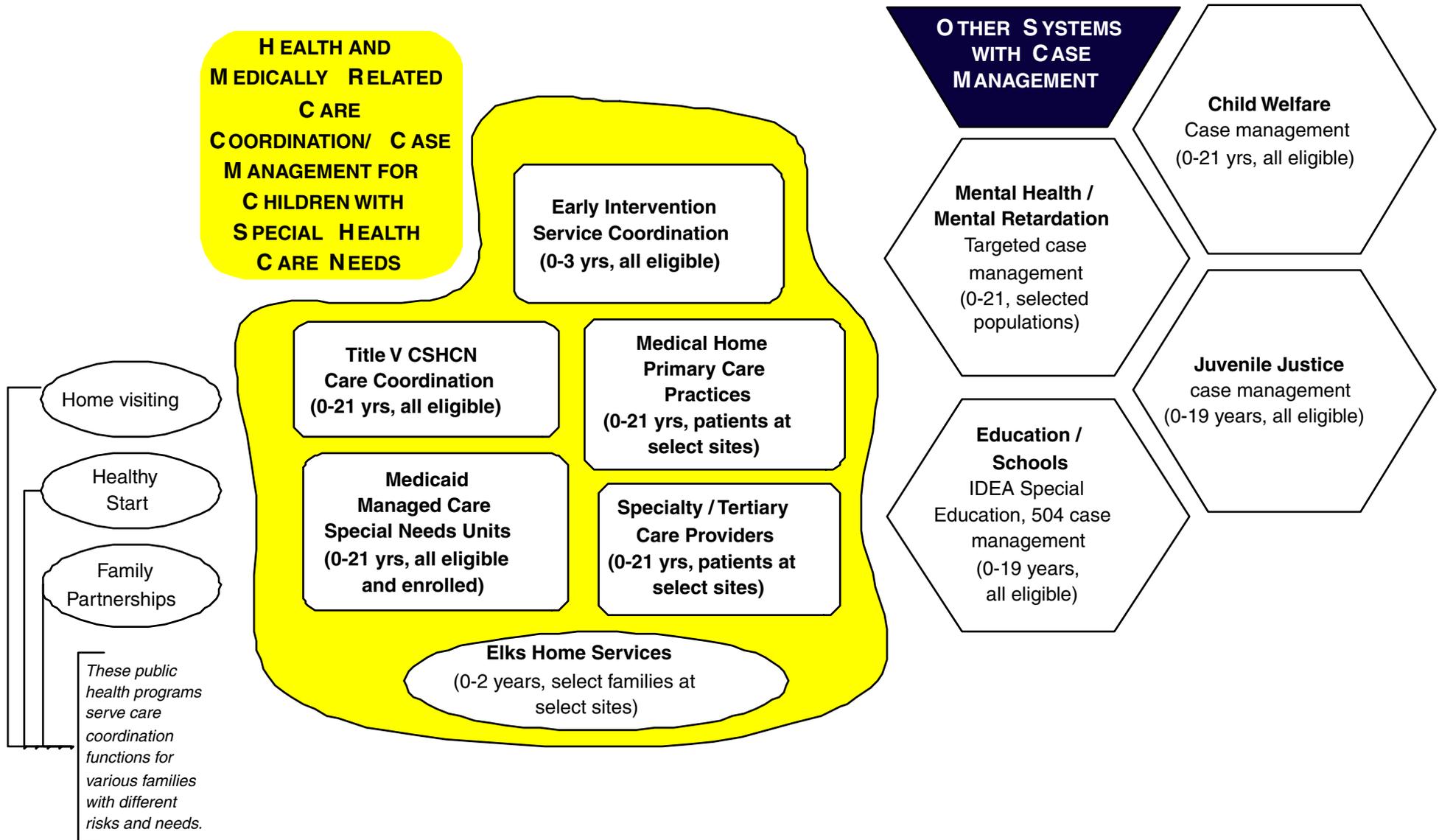
The Roundtable participants discussed two types of next steps. First, the group “brainstormed” about what type of activities might continue the momentum generated during the Roundtable and lead to progress in improving care coordination for CSHCN. The main ideas were:

- prepare a fact sheet summarizing the current situation and making the case for change;
- prepare a more detailed analysis that states the “business case;”
- continue meetings to respectfully discuss differences in models and in purposes of care coordination/case management. This is an essential step toward reaching consensus on a working definition;
- conduct a needs/gap analysis, particularly focusing on current spending and provider capacity;
- develop a consensus definition;
- develop guidelines and/or a provider handbook that can be used to increase knowledge and change practices;
- develop a core, common training curriculum;
- write and execute interagency agreements that support better integrated care coordination (e.g., billing codes, shared staff, pooled training funds, common definitions);
- develop a model for tiered billing, based on severity of need or intensity of services;
- convene additional State-level meetings to discuss and continue progress;
- encourage local meetings (particularly if tools such as a fact sheet, training materials, or guidelines can be shared).
- Finally, several members of this leadership group agreed to take future steps to advance the day’s work.

Figure 1. Pennsylvania Programs and Systems Serving CSHCN:

What care and services need to be coordinated?

Who is providing care coordination?



Handout for the Second Pennsylvania Roundtable

Extracted sections from the GWU Purchasing Specifications.



Purchasing Specifications for Children with Special Health Care Needs

Extracted Sections related to Care Coordination for CSHCN

... §104. Care Coordination Services

Commentary: The following illustrative language assumes that the Purchaser wishes to provide care coordination services to children with special health care needs through the contracting MCOs in which they are enrolled. It should be noted that States are not required to offer care coordination services to Medicaid beneficiaries generally or to this population in particular, and some States do not cover these services for this population. In addition, not all MCOs are organized to provide care coordination services to children with special health care needs or other enrolled populations through separate care coordinators; instead, they rely upon the treating physician to perform care coordination functions. Finally, if a State Medicaid program elects to cover care coordination services for this population, it may also elect to "carve out" such services from its purchasing agreements with MCOs and provide them on a fee-for-service basis through the State Title V agency or other State or local agencies, or through private organizations. For a review of the care coordination models used by Colorado, Delaware, New Mexico, Oregon, and Washington, see Rosenbach and Young, Care Coordination in Medicaid Managed Care: A Primer for States, Managed Care Organizations, Providers, and Advocates (March 2000) www.chcs.org.

The federal Medicaid statute and implementing regulations do not contain a "care coordination services" category. Thus, it is not possible to state with certainty that the care coordination services set forth in the following illustrative language would qualify for federal Medicaid matching funds. That determination can be made only by HCFA. HCFA's published guidance on coverage of case management services is set forth in State Medicaid Manual at §4302¹⁶, www.hcfa.gov/pubforms/pub45pdf/smm4t.htm.

(a) **In General** — Contractor shall comply with the requirements of this section relating to:

(1) assignment or selection of a care coordinator (as defined in [§108\(b\)](#)) under subsection (b);
and

(2) the duties of the care coordinator (as defined in [§108\(b\)](#)) under subsection (d).

Commentary: The following illustrative language assumes that the family or caregiver of an enrolled child with special health care needs has the option of refusing to accept a care coordinator for the child. It also assumes that the family or caregiver has the option of declining to accept the particular care coordinator that Contractor wishes to assign to the child. The language would not, however, require Contractor to hire or subcontract with any particular care coordinator in order to meet the wishes of the family or caregiver. The family or caregiver's choice would be limited to those care coordinators (including a primary care provider, if the family or caregiver so chooses) available within Contractor's provider network under [§204](#).

(b) Assignment or Selection of Care Coordinator

(1) In General

(A) Contractor shall, within [] days of the date described in paragraph (5), notify in writing the family or caregiver of an enrolled child with special health care needs (as defined in **§108(c)**) of the identity of the care coordinator that Contractor proposes to assign to the child to furnish care coordination services under subsection (d).

(B) This paragraph shall not be construed to require Contractor to assign to a child a care coordinator who does not participate in Contractor's provider network under **§204(e)** or with whom Contractor does not have an out-of-network arrangement under **§204(f)**.

(2) Option to Receive Care Coordination Services from Primary Care Provider¹⁷ —

Contractor shall allow the family or caregiver of an enrolled child with special health care needs to select as the child's care coordinator a primary care provider participating in Contractor's provider network who is willing to assume the responsibilities enumerated under subsection (d) with respect to the child.

(3) Option to Receive Care Coordination Services from Care Coordinator — Contractor shall allow the family or caregiver of an enrolled child with special health care needs to receive care coordination services from a care coordinator (as defined in **§108(b)**) other than a primary care provider if the care coordinator is selected by the child's primary care provider in consultation with the child's family or caregiver.

(4) Option to Refuse a Care Coordinator — Contractor shall not assign an enrolled child with special health care needs to a care coordinator (as defined in **§108(b)**) unless the child's family or caregiver (or, in the case of an adolescent, the adolescent):

(A) agrees in writing to receive care coordination services under this section from a care coordinator; and

(B) has selected a care coordinator under paragraph (2) or consulted with a primary care provider under paragraph (3).

(5) Date — The date described in this paragraph is the earlier of:

(A) the effective date of enrollment of the child; or

(B) the date on which the enrolled child has been identified as a child with special health care needs (as defined in **§108(c)**) by a provider participating in Contractor's provider network (whether or not such provider is the child's primary care provider).

(6) Responsibilities of Care Coordinator — If a care coordinator has been selected by or assigned to an enrolled child or the child's family or caregiver under paragraphs (2) and (3), Contractor shall ensure that the care coordinator carries out the duties required under subsection (d).

(c) Use of State Title V CSHCN Program Personnel

(1) Option — Contractor may meet the requirements of subsection (b) through the use of care coordinators (as defined under **§108(b)**) affiliated with [*draftee insert name of State Title V CSHCN Agency*].

(2) **Written Agreement** — If Contractor elects to use care coordinators under paragraph (1), Contractor shall enter into a written agreement with [drafter insert name of State Title V CSHCN Agency] under §206(b)(3)....

(d) **Responsibilities of Care Coordinator**¹⁸ — Contractor shall ensure that, in the case of an enrolled child with special health care needs (as defined under §108(c)) who has selected a care coordinator under subsection (a), the care coordinator, consistent with §107(b) relating to utilization management, shall:

(1) make every effort to meet with the family or caregiver of the child, in person or by telephone, within [] days of being assigned, in order to learn about the child's diagnosis and treatment needs and the needs of the family or caregiver in supporting the child;

(2) assist:

(A) the primary care provider in developing the child's care plan under §105(b)(1)(D); and

(B) the child (and the child's family or caregiver) in understanding the contents of the plan;

(3) assist the child in accessing items and services specified in the child's care plan under §105 that are:

(A) the duty of Contractor under §103(a); and

(B) required under each of the following plans (if any) that has been developed for the child:

(i) an IFSP (as defined in §108(g));

(ii) an IEP (as defined in §108(f));

(iii) a plan developed for the child by [drafter insert name of State child welfare agency]; and

(iv) [drafter insert references to other applicable treatment plans];

(4) if requested by the child (or, except in the case of an adolescent, the child's family or caregiver), assist the child, in manner consistent with §209(d) (relating to confidentiality protections), in accessing items and services that are specified in the child's care plan under §105 and are the responsibility of Purchaser under §103(b);

Commentary: The illustrative language in paragraph (5) assumes that the MCO's care coordinator has the responsibility for assisting an enrolled child's family or caregiver in having payment made for services covered under a State's Medicaid program that are not the duty of the MCO. Another approach would be for the family or caregiver to be referred to appropriate State or local agencies.

(5) if requested by the child (or, except in the case of an adolescent, the child's family or caregiver), assist the child, in manner consistent with §209(d) (relating to confidentiality protections), in accessing and identifying payment sources for items and services that are specified in the child's care plan under §105 and not the responsibility of Contractor under §103(a) or Purchaser under §103(b);

(6) consistent with **§203(f)**, assist the child in accessing pediatric specialists (as defined in **§108(j)**) and other providers participating in Contractor's provider network that are identified in the child's care plan under **§105**;

(7) refer the child to the [*drafter insert reference to responsible agencies under Part B and Part C of the Individuals with Disabilities Education Act, 20 U.S.C. §1400 et seq.*] unless the child is receiving services under an IEP (as defined in **§108(f)**) or an IFSP (as defined in **§108(g)**);

(8) if appropriate, in the case of a child age 16 or older, refer the child to the State Vocational Rehabilitation Agency under Title I of the Rehabilitation Act of 1973, 29 U.S.C. §720 et seq., 34 C.F.R. 300.347(b);

(9) facilitate, consistent with the confidentiality protections under **§209**, the exchange of information and medical records among Contractor, the child's primary care provider, and [*drafter insert reference to responsible agencies under Part B and Part C of the Individuals with Disabilities Education Act, 20 U.S.C. §1400 et seq.*];

(10) meet (in person or by telephone) with the child and the child's family or caregiver in order to track the child's progress under the child's care plan under **§105** and, based on the experience of the child and the child's family or caregiver, make recommendations to the child's primary care provider with respect to updating the care plan under **§105(b)(5)**;

(11) establish working arrangements with care coordinators or case managers (other than those employed by, or under contract to, Contractor) who have responsibilities with respect to the child;

(12) assist the child (and the child's family or caregiver) in:

(A) understanding the child's entitlement to a fair hearing under 42 C.F.R. §430.220 and to the continuation of services pending the fair hearing under 42 C.F.R. §430.230 and, in the case of denial, termination, or reduction of items and services covered under **§103(a)**, in effectuating these entitlements; and

(B) accessing, under **§209(c)**, Contractor's grievance procedures and the State fair hearing process;

(13) assist the child (and the child's family or caregiver) in documenting, establishing, and maintaining the child's eligibility for [*drafter insert reference to State Medicaid program*], the Supplemental Security Income (SSI) program under Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq., and other public program benefits;

(14) inform the child's family or caregiver of the manner in which the child's family or caregiver may participate in:

(A) voluntary networks organized for mutual support by families or caregivers of children with special health care needs; and

(B) the Family Advisory Board established and maintained by Contractor under **§101(d)(3)**; and

(15) in the case of a child with special health care needs who is an adolescent as defined in **§108(a)**, assist the adolescent in identifying and overcoming transitional issues relating to accessing items and services described in paragraph (3).¹⁹

Handout for the Second Pennsylvania Roundtable

Medicaid Case Management: Examples*

TYPE	SAMPLE ACTIVITIES	MATCH RATE
EPSDT administrative case management	<ul style="list-style-type: none"> • Outreach & informing • Assisting with covered transportation 	50/50
Administrative case management	<ul style="list-style-type: none"> • Assisting with applications • Processing prior authorization requests 	50/50
Targeted case management	<ul style="list-style-type: none"> • Help in identifying necessary services • Care coordination for persons with disabilities or chronic illnesses • Components of home visits to high-risk pregnant women and infants 	Medical services FFP rate
Case management as part of a service	<ul style="list-style-type: none"> • Care plan development in a home health visit 	Medical services FFP rate
Case management requiring expertise of skilled medical personnel	<ul style="list-style-type: none"> • Reviewing care plans • Approving provider payments • Certain referrals for specialty care 	75/25

* Table prepared by Kay Johnson for the Managed Care Technical Assistance Project, Second Pennsylvania Roundtable on Child Health and Managed Care: Care Coordination for Children with Special Health Care Needs

Definitions from Federal Regulation (www.cms.gov)

4-302. OPTIONAL TARGETED CASE MANAGEMENT SERVICES - BASIS, SCOPE AND PURPOSE ...

A. Background.--Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Prior to the enactment of P.L. 99-272, States could not provide case management as a distinct service under Medicaid without the use of waiver authority. However, aspects of case management have been an integral part of the Medicaid program since its inception. The law has always required interagency agreements under which Medicaid patients may be assisted in locating and receiving services they need when these services are provided by others. Prior to the enactment of P.L. 99-272, Federal financial participation (FFP) for case management activities may be claimed in any of four basic areas:

1. *Component of Another Service.*--Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. ...separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. *Administration.*--Case management may be provided as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Activities such as utilization review, prior authorization and nursing home preadmission screening may be paid as an administrative expense. The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, when the criteria in 42 CFR 432.50 are met.

3. *Section 1915(b) Waivers.*--Case management may be provided in a waiver granted under §1915(b) of the Act....

4. *Section 1915(c) Waivers.*--Case management may be provided as a service in a waiver granted pursuant to §1915(c) of the Act....

... (2) For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

B. Legislation.--P.L. 99-272 adds case management to the list of optional services which may be provided under Medicaid. Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the Act. This subsection, as amended by P.L. 100-203, provides that:

"(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

...

4302.2 State Plan Amendment Requirements.--Any State plan amendment request to provide optional case management services must address all of the requirements of this section.

A. *Target Group.*--Identify the target group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition (e.g., Acquired Immune Deficiency Syndrome (AIDS) or Chronic Mental Illness), or any other identifiable characteristic or combination thereof. The following examples are target groups currently receiving case management services under §1915(g) of the Act:

- Developmentally disabled persons (as defined by the State);
- Children between the ages of birth and up to age 3 who are experiencing developmental delays or disorder behaviors as measured and verified by diagnostic instruments and procedures;
- Pregnant women and infants up to age 1;
- Individuals with hemophilia;
- Individuals 60 years of age or older who have two or more physical or mental diagnoses which result in a need for two or more services; and
- Individuals with AIDS or HIV related disorders.

In defining the target group, you must be specific and delineate all characteristics of the population....

NOTE: Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred....

G. Differentiation Between Targeted Case Management Services and Case Management Type Activities for Which Administrative Federal Match May Be Claimed.--You must differentiate between case management services which may properly be claimed at the service match under §1915(g) and case management activities which are appropriate for FFP at the administrative match under the State plan, based upon the appropriate criteria. These two payment authorities do not result in mutually exclusive types of services.

There are certain case management activities which may appropriately be eligible for FFP at either the administrative or the service match rate. Examples of case management activities that may be claimed at either the administrative or the service match rate entail providing assistance to individuals to gain access to services listed in the State plan, including medical care and transportation. In cases where an activity may qualify as either a Medicaid service or an administrative activity, you may classify the function in either category. This decision must be made prior to claiming FFP because of the different rules which apply to each type of function under the Medicaid program.

1. Case Management as a Service Under §1915(g).--FFP is available at the FMAP rate for allowable case management services under §1915(g) when the following requirements are met: Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient);

- Case management services are provided as they are defined in the approved State plan;
- Case management services are furnished by individuals or entities with whom the Medicaid agency has in effect a provider agreement;
- Case management services are furnished to assist an individual in gaining or coordinating access to needed services...

Because §1915(g) of the Act defines case management services as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan. The costs of case management services provided under §1915(g) that involve gaining access to non-Medicaid services are eligible for FFP at the service match rate.

Examples of case management services provided under §1915(g) of the Act may include assistance in obtaining Food Stamps, energy assistance, emergency housing, or legal services. All case management services provided as medical assistance pursuant to §1915(g) of the Act must be described in the State plan. In addition, they must be provided by a qualified provider as defined in the State plan.

When case management is provided pursuant to §1915(g) of the Act, the service is subject to the rules pertaining to all Medicaid services. If you choose to cover targeted case management services under your State plan, as defined in §1915(g) of the Act, you cannot claim FFP at the administrative rate for the same types of services furnished to the same target group.

2. Case Management as an Administrative Activity.

...The following list of functions provides examples of activities which may properly be claimed as administrative case management activities, but not as targeted case management services. The omission of any particular function from this list does not represent a determination on HCFA's part that the function is not necessary for the administration of the plan.

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;

- Prior authorization for Medicaid services and utilization review; and
- Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid FFP at the administrative rate. For example... setting up an appointment with a Medicaid participating physician and arranging for transportation for a recipient may be considered case management administrative activities necessary for the proper and efficient administration of the Medicaid plan. However, arranging for baby sitting for a recipient's child, although beneficial to the recipient, is not an activity for which administrative FFP can be claimed.... when a caseworker suspects that physical abuse of a recipient has occurred, the referral to medical care could be considered a reimbursable administrative activity under the Medicaid program. However, assisting the victim in obtaining emergency housing and legal services, although in the best interest of the recipient, is not an activity for which administrative FFP may be claimed....

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect...

H. Case Management Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Program.--Care coordination, including aspects of case management, has always been an integral component of the EPSDT program... Section 1905(r) requires that States provide any services included in §1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether such services are covered under the State plan. While case management is required under the expanded EPSDT program when the need for the activity is found medically necessary, this does not mean §1915(g) targeted case management services. Therefore, when the need for case management activities is found to be medically necessary, the State has several options to pursue:

1. Component of an Existing Service.--Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist.
2. Administration.--Case management services may be provided to EPSDT participants by the Medicaid agency or another State agency such as title V, the Health Department or an entity with which the Medicaid agency has an interagency agreement. Administrative case management activities must be found necessary for the proper and efficient administration of the State plan and therefore must be limited to those activities necessary for the proper and efficient administration of Medicaid covered services. FFP is available at the administrative rate.
3. Medical Assistance.--Case management services may be provided under the authority of §1905(a)(19) of the Act. The service must meet the statutory definition of case management services, as defined by §1915(g) of the Act. Therefore, FFP is available for assisting recipients in gaining access to both Medicaid and non-Medicaid services. FFP for case management services furnished under §1905(a)(19) of the Act is available at the FMAP rate.

Any combination of two or more of the above is possible, as long as FFP is not available for duplication of services.