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Medicaid Managed Care

Challenges and Opportunities for Pediatric Medical Home Implementation and Children and Youth with Special Health Care Needs

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PURPOSE

Children and youth with special health care needs (CYSHCN) who have or are at risk for physical, developmental, behavioral, or emotional chronic conditions have increased needs for health-related services. In an effort to reduce health care costs and potentially improve quality of care, states are expanding managed care programs for Medicaid beneficiaries with complex conditions, including some CYSHCN.

While Medicaid and Children's Health Insurance Program (CHIP) managed care presents opportunities for enhanced care coordination, it also poses concerns and challenges related to access to pediatric medical homes for many CYSHCN and their families. A medical home is an approach to providing primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.[1]

This fact sheet presents information that pediatric medical home stakeholders, including Title V programs, clinicians, and family leaders, can use to educate themselves about the potential effect of Medicaid and CHIP managed care on CYSHCN and their families. The fact sheet includes information from the recent April 2016 Centers for Medicare and Medicaid Services (CMS) managed care Final Rule, which outlines requirements for managed care organizations (MCOs) in CHIP. These new requirements are the first major updates to Medicaid and CHIP managed care since 2002 and have the potential for significant effects on CYSHCN.[2]

This information can be used among state Title V programs, Medicaid agencies, within managed care plans, and practices to take advantage of opportunities provided within MCOs and to mitigate potential unintended negative consequences of Medicaid managed care for CYSHCN and their families. Stakeholders can also learn from promising practices and strategies conducted in other states, thereby enhancing care for CYSHCN and their families within their state.

INTRODUCTION

State Medicaid agencies are in the midst of rapid transformation of their health care delivery systems in an effort to reduce health care costs and improve the quality of health care delivery. One approach states are taking as part of this transformation is expanding managed care programs to deliver care to Medicaid beneficiaries with complex needs, including some CYSHCN. Medicaid managed care delivers health benefits to Medicaid beneficiaries through contracted arrangements between state Medicaid agencies and MCOs that accept a fixed per-member, per-month payment for health care services.[3] The recent CMS Final Rule contains significant changes for how state Medicaid agencies are required to deliver health care services. The rule requires further analyses to fully understand its potential effect.

Shifting into managed care and the aforementioned new CMS requirements may have significant implications for pediatric health care professionals as well as for CYSHCN and their families, given this population's need for access to a pediatric medical home. To date, there is limited definitive evidence on the effect of enrolling children and youth in managed care.[4]

ENROLLMENT IN MEDICAID MANAGED CARE

Approximately 80% of all Medicaid enrollees receive all or most of their health care through managed care arrangements.[3] A combination of greater experience with managed care and increasing desire to reduce health care costs continues to compel state Medicaid agencies to expand use of MCOs to reach additional geographic areas and populations.[5] Recent data indicate that enrolling publicly insured children, including some CYSHCN, in managed care is a widespread practice among states.[6]

At least 38 states and the District of Columbia have Medicaid managed care contracts, serving the majority of all Medicaid beneficiaries, including approximately 66% of children enrolled in Medicaid or CHIP.[7,8] Because MCO enrollment is not mandatory in all states, the percentage of children in Medicaid and CHIP enrolled in MCOs varies, from as low as 4% of children within a state to all pediatric Medicaid beneficiaries.[7]

With greater than one-third of CYSHCN depending on Medicaid or CHIP for coverage, state Medicaid agencies are increasingly exploring new ways to connect CYSHCN with necessary services and supports. To date, 32 states require enrolling at least some CYSHCN in managed care, 20 states report enrolling CYSHCN in managed care on a voluntary basis, and about half of states mandate managed care for at least some children with disabilities who receive Supplemental Security Income.[9]

CHALLENGES AND OPPORTUNITIES FOR THE PEDIATRIC MEDICAL HOME AND PEDIATRIC POPULATIONS

Several challenges and opportunities exist for the support, implementation, and spread of pediatric medical homes for CYSHCN as a result of a shift to Medicaid managed care arrangements for this population. Although the CMS Final Rule preserves the state option on how state Medicaid agencies enroll children in managed care (active or passive enrollment), the new rule will create both new challenges and opportunities for states to improve health care delivery for this population.

CHALLENGES

Acknowledging limited experience with providing care to CYSHCN populations.	Some MCOs may be most familiar with adults without complex needs. As such, it may be challenging for MCOs to provide and coordinate multiple necessary services and supports for CYSHCN. Unlike adults, pediatric populations have needs that evolve depending on their stage of development. Pediatric populations also have benefits that are federally mandated, ranging from acute neonatal care to adolescent transition support. Furthermore, MCOs may not be as familiar with strategies to provide family-centered care, a key component of the pediatric medical home.[10]
Identifying and enrolling CYSHCN in managed care plans.	In general, Medicaid MCOs identify CYSHCN through eligibility criteria, service type, and diagnosis, and, under the CMS Final Rule, the MCOs continue to have flexibility related to Medicaid enrollment processes.[11] State managed care plans must allow families under mandatory enrollment the option to change their child's plan and, when auto-assigning individuals to a health plan, must also ensure assignments best meet the needs of all enrollees, including CYSHCN. State Medicaid agencies are encouraged to explore opportunities to better identify CYSHCN, to accommodate appropriate enrollment, triaging, care planning, timely access to necessary care, and care coordination. Through managed care contracting, several states have already required the identification of CYSHCN as a specific subpopulation and encourage MCOs to include certain provisions tailored to their identified needs.[5]
Facilitating continuity of care.	Initially moving children to managed care plans may disrupt continuity of care, requiring children to change providers because of MCO provider networks or lack of contracts with existing providers. As a result, children and families may no longer be able to receive care within their current pediatric medical homes. This can present difficulties for families who may have to navigate a new network of primary and specialty care providers and for providers who will need to facilitate a smooth transition for these patients. Under the CMS Final Rule, state Medicaid agencies will be expected to make efforts to preserve existing provider-beneficiary relationships and include family member preferences for a health plan or provider.
Addressing limited provider capacity.	To provide appropriate services and supports to CYSHCN, Medicaid MCOs will need to create robust pediatric provider networks capable of managing various complex physical or mental health needs. Several state Medicaid agencies specifically delayed moving CYSHCN into managed care because of their concerns over network adequacy.[12, 13] The CMS Final Rule puts additional pressure on states to address this challenge by requiring time and distance standards for a specific set of providers, including primary and specialty care, behavioral health, and pediatric dental, for hospitals, and for long-term services and supports.

OPPORTUNITIES

Potential for expanding the medical home model.	Because of their significant focus on providing high-quality, coordinated care, MCOs are in a unique position to potentially promote the implementation and spread of the medical home model and benefit those children and youth served by practices that function as medical homes. Numerous factors may affect the spread of the medical home model within MCOs, including contracting standards, state and federal monitoring and oversight, and recent CMS requirements related to care coordination and supports for transitions between care settings.
Broadening and coordinating the supports and services available to CYSHCN.	Managed care organizations may positively affect care coordination for Medicaid beneficiaries through carefully managed provider networks and support of the medical home model. Additionally, particularly with the new CMS requirements, MCOs have the potential to enhance the coordination of the multiple supports and services required by CYSHCN and their families. Examples of Medicaid MCOs already working to expand services prior to the new rule are provided in the Promising Practices section below.
Providing flexible and innovative payment mechanisms.	Medicaid MCOs have the ability to define, above and beyond federal minimum standards, their own payment arrangements with providers and, as a result, can implement innovative payment mechanisms to reward practices for providing high-quality care and key functions of the medical home model, including care coordination. Payment arrangements may be created that incentivize providers to deliver quality care for CYSHCN and provide the necessary supports to do so. Risk-adjusted payment, for example, may be structured to take into account the child's age, chronicity and severity of underlying health, and behavioral, social, and other needs. To account for the additional time, attention, and coordination needed to care for CYSHCN, MCO payment models such as pay-for-performance can support key components of the medical home model, including: • Evaluation and management services • Preventive counseling • Telehealth • Team-based care • Care coordination • Evidence-based or evidence-informed pediatric quality measures that are coordinated with other payers' quality improvement structures
Creating greater capacity to hold delivery systems accountable.	In addition to recent CMS requirements, federal regulations require states to report MCO data on quality, timeliness, and access to health care, including performance measures on specific conditions such as pediatric asthma or behavioral health disorders.[7] As a result, when providing health care through an MCO, state Medicaid agencies are able to monitor MCO performance on a wide range of measures beyond cost; they are also able to hold MCOs accountable for the necessary services and supports for CYSHCN served within their managed care plans. In addition, because of the CMS Final Rule, a new Medicaid and CHIP Quality Rating System (QRS) will be established to promote quality of care and improve consumer engagement. The QRS will provide performance information to consumers on all state managed care plans and support contracting with plans that offer higher-value care.

Promising Practices that leverage Medicaid Managed Care Opportunities

- In **Louisiana,** the state Medicaid agency leveraged a managed care contract to require an MCO to facilitate medical home implementation and provided the necessary supports (eg, payment incentives and technical assistance) for their network practices to achieve medical home recognition.[14] Managed care organizations may also leverage the contracting process with providers by giving preference to practices that are recognized as medical homes, thus creating an incentive for practice transformation.
- Medicaid MCOs in **Florida** and **Ohio** provide transportation services to and from health care appointments, specialized health, wellness and care management programs, and parent and caregiver support through their Medicaid managed care plans.[15, 16]
- **Virginia's** Medicaid managed care contract contains language that discusses care coordination services for CYSHCN, including assistance with scheduling appointments, providing referrals, and identifying resources and transportation services.[11]
- **Rhode Island's** Medicaid managed care plan, RIte Care, has received national recognition as a high-performing program based on the Child Core Set of health care quality measures.[17] The program provides care for nearly 100,000 children and youth and covers primary and preventive care, acute care, behavioral health, in-patient hospital care, and pharmacy services, among others. The state enhances MCO accountability by requiring the MCO to report on pediatric-specific performance measures such as those related to behavioral health disorders.[18]

CONCLUSION

State Medicaid MCOs that serve pediatric Medicaid beneficiaries are replacing many Medicaid and CHIP fee-for-service programs. Although the expansion of Medicaid managed care plans has outpaced the research required to clearly understand the effect on CYSHCN, this fact sheet provides state Title V programs, Medicaid agencies, pediatric health care professionals, and families with an overview of some challenges and opportunities that may result from enrollment of children and youth within state Medicaid and CHIP managed care plans.[19]

The full effect of the CMS Final Rule on CYSHCN and their families remains to be seen. The rule indicates that state officials are able to leverage managed care contracts to encourage participation in delivery system reform efforts and performance improvement initiatives among managed care plans. State Medicaid agencies are also permitted to use incentive or withhold arrangements to encourage managed care plans to meet quality or performance targets established through contracts. These features will provide states multiple opportunities to affect the health care delivered to families and CYSHCN through a Medicaid or CHIP managed care plan.

Title V programs, Medicaid agencies, pediatric clinicians, and family leaders may use the information in this fact sheet when working with state Medicaid agencies, within managed care plans, and practices to mitigate potential unintended negative consequences and to leverage opportunities to improve health care delivery to CYSHCN that result from managed care plan arrangements. Stakeholders can also learn additional promising practices and strategies conducted in other states through the Health Management Associates and Urban Institute final report to the Medicaid and CHIP Payment and Access Commission, *Access to Care for Children with Special Health Care Needs: The Role of Medicaid Managed Care Contracts.*[11] Preliminary reviews of the CMS Final Rule may provide additional assessments of the changes ahead for states working with MCOs to meet the needs of the families and CYSHCN.[20-21]

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