

## SERVICE DELIVERY MODELS: How Do States Deliver Health Care Services to Children and Youth Enrolled in Medicaid and CHIP?



Most states deliver Medicaid and CHIP health services by:

- Contracting with a managed care organization (MCO) to manage care and pay providers,
- Paying health care providers directly on a traditional fee-for-service basis for each service they provide, or
- A combination of these methods.

### MANAGED CARE

As of July 2020, Medicaid beneficiaries in 40 states and the District of Columbia received care through prepaid capitated MCOs.<sup>1</sup> In these models, the MCO is paid a set amount to run the program and pay providers for the care of people enrolled in the program. In health insurance language, the payment is called a “capitation rate.” In contrast with the fee-for-service payment system, in which providers are paid a set fee each time they provide a service, capitation payments place the MCO at financial risk if it provides more services than the capitation payment covers.

MCOs offer several potential opportunities to improve the delivery of care for children and youth with special health care needs (CYSHCN). For example, they may expand provider choice by contracting with physicians or other providers who do not typically provide services to children enrolled in Medicaid. Many MCOs place a priority on access to primary care, with an emphasis on wellness and prevention. MCOs have spurred much of the progress in the monitoring and improvement of health care quality because they can collect and analyze service utilization data and laboratory results and feed this information back to their contracted providers. Some MCOs also offer “one-stop” health care in multi-specialty clinics.

In addition, capitation payments reduce the financial incentive to deliver as many services as possible, regardless of utility or cost, that is prevalent in the fee-for-service payment system. If MCOs can control service utilization and costs, they retain the saved dollars.



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1. Kaiser Family Foundation. (2018). State Health Facts. Total Medicaid MCOs. Retrieved May 11, 2021, from <http://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/>

MCOs implement numerous strategies to control costs and promote efficiency in service delivery. To achieve these goals, MCOs may decide to:

- Emphasize wellness and prevention.
- Require prior approval for certain types of treatments.
- Initiate programs to reduce emergency department use.
- Reimburse for benefits not typically covered.
- Encourage the use of generic drugs.

The use of such techniques to manage health care utilization is rapidly evolving in both managed care and traditional fee-for-service programs. Because of the concern that MCOs will limit service use to control costs, federal regulations establish certain standards and safeguards in managed care. These standards include:

- The adequacy of the MCO's provider network to serve their enrollee population,
- Monitoring and evaluation of health care quality, and
- The ability of Medicaid beneficiaries to appeal decisions about health care benefits if they believe they have been wrongfully denied a service.

In addition, states can require MCOs to meet specific quality benchmarks or implement special programs or services as part of the managed care contract.

### MANAGED CARE AND CYSHCN

States vary as to which groups of Medicaid beneficiaries they require to enroll in a managed care plan. In some states, enrollment in a Medicaid managed care program is mandatory; in others it is voluntary. Within a state, enrollment in managed care may be mandatory for some groups but voluntary for others.

In some states, children and youth who are exempt from mandatory enrollment in Medicaid managed care may enroll voluntarily, or they may be excluded from managed care enrollment entirely. When CYSHCN are not enrolled in managed care, states pay for their health care directly using the traditional fee-for-service system.

Prior to 1997, if a state wanted to mandate enrollment in a Medicaid managed care program, it needed to seek a 1915(b) "freedom of choice" waiver from the federal government because it would be restricting the enrollee's choice of providers. This changed with the enactment of the Balanced Budget Act (BBA) of 1997, which allowed states to mandate Medicaid managed care enrollment through their Medicaid state plan rather than by seeking a waiver.

Many CYSHCN were excluded from this new rule, such as children and youth receiving Supplemental Security Income (SSI) benefits, those receiving foster care or adoption subsidies, institutionalized children and youth, and children and youth recognized as having special needs under the Maternal and Child Health Title V Block Grant Program.<sup>2</sup>

States are still required to obtain a federal waiver to mandate the enrollment of these groups of CYSHCN in Medicaid managed care programs. They also require a waiver to make managed care enrollment mandatory for disabled SSI recipients.

Nevertheless, because about 45% of CYSHCN are covered by Medicaid or the Children's Health Insurance Program (CHIP), many children enrolled in Medicaid managed care plans may still have special health care needs.<sup>3</sup>

States also vary as to which benefits and services are managed and paid for by the MCO and which are "carved out" and paid for either on a fee-for-service basis or through a different managed care plan. Often,

2. Kaiser Family Foundation. (1997, September 29). *Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 (P.L. 105-33) with Prior Law*. Retrieved May 11, 2021, from <https://www.kff.org/medicaid/report/comparison-of-the-medicaid-provisions-in-the/>

3. Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 1/31/22 from <https://www.childhealthdata.org/browse/survey/results?q=9314&r=1>

services that are less typically managed by insurance companies or are unique to Medicaid—such as home-based services, medical supplies, dental care, or services delivered in schools—are carved out of the managed care plan.

The contract between a state and an MCO should always spell out what services the MCO is responsible for providing and which services Medicaid will cover on a fee-for-service basis. This is particularly critical with services that tend to be unique to Medicaid, such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or Home and Community-Based Services (HBCS).

Capitation rates paid to MCOs must be “actuarially sound,” meaning that they have been developed by professional actuaries and are based on previous health-care expenditure experience for the enrolled population. However, states can set payment rates for different groups based on their expected costs. This is an element of risk adjustment, a methodology that levels the playing field for plans that attract more expensive populations by redistributing gains and losses. This is especially important when plans cover enrollees with special health care needs, disabilities, and chronic illnesses such as CYSHCN. By definition, CYSHCN use more health care services than children typically do, and are consequently more costly to cover.<sup>4</sup>

For example, if a child with special health care needs is enrolled in a managed care plan in which the capitation rate is set at the average cost of care for all children in the plan, they will likely cost more than the average child. MCOs may therefore have an incentive to discourage CYSHCN from enrolling in their plans because it is likely that caring for CYSHCN will cost more than caring for the average child. This is known as “selection bias,” which may occur if it becomes known that a particular plan makes it difficult to obtain specialty care or requires multiple approval processes to obtain therapies or medical equipment. Selection bias may also occur if an MCO excludes certain pediatric providers from its provider network.

Risk adjustment strategies may counteract selection bias. When MCOs are paid more than the average rate for CYSHCN, plans will find it easier to finance the comprehensive care that CYSHCN need.

The following issues are important for Title V programs to address with Medicaid programs that are designing or redesigning managed care programs and contracting with MCOs:



**States can set payment rates for different groups based on their expected costs. This is called “risk adjustment.”**

**Risk adjustment allows states to pay more for more costly populations and less for less costly populations.**

4. McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P. W., Perrin, J. M., Shonkoff, J. P., & Strickland, B. (1998). A new definition of children with special health care needs. *Pediatrics*, 102(1 Pt 1), 137-140. <https://doi.org/10.1542/peds.102.1.137>

- Will CYSHCN be required to enroll in managed care, will it be optional, or will they receive care on a fee-for-service basis?
- If CYSHCN are enrolled in managed care, which services must they obtain through the MCO and which will be available through the Medicaid program on a fee-for-service basis or through a carve-out plan?
- Will the MCO or the Medicaid program be responsible for EPSDT, dental coverage, and mental health coverage?
- What is the process for ensuring that appropriate pediatric providers are included in the MCO's provider network?
- What is the process for authorizing specialty care and services that are uniquely used by CYSHCN?
- How do the grievance and appeals processes work when a child or youth with special health care needs is denied a service?

These are some of the issues that should be addressed in the contract between a Medicaid program and an MCO. Title V programs are in a good position to participate in the process of developing the Request for Proposals (RFPs) that Medicaid programs issue when procuring MCO services. Because it is often during the RFP and contract development process that decisions on these questions are initially made, this is a good time for Title V programs to bring their expertise and judgment to some of these decisions. Please see the Catalyst Center brief ["Strengthening Title V-Medicaid Managed Care Collaborations to Improve Care for CYSHCN"](#) for more information.

### PRIMARY CARE CASE MANAGEMENT

Primary care case management (PCCM) programs are common delivery systems used by state Medicaid programs that combine some aspects of managed care with fee-for-service care. With PCCM, every beneficiary must choose a primary care provider (PCP), such as a pediatrician or family practice physician. The PCP agrees

to deliver primary care services, manage access to specialty services, and coordinate the beneficiary's care.

Typically, in PCCM, the primary care provider refers patients to specialty services, and these referrals may be required for the beneficiary to access specialty care. Health care providers are paid on a fee-for-service basis each time they deliver a service. In addition, the primary care provider is paid an additional fee for managing the beneficiary's care.<sup>5</sup> This fee is usually a set amount such as \$2 or \$5 PMPM. Sometimes the management fee comes in the form of enhanced payment for certain visits or a performance bonus for meeting certain quality goals or implementing care plans.

The process of developing standards for PCPs also provides an opportunity for Title V programs to bring their expertise to the Medicaid program to help improve care for CYSHCN. States can structure their payments to PCP practices to encourage better quality outcomes; better screening, referral and preventive care; same-day access to the practice for sick care; or better care coordination when children and youth have complex health care needs.

### THE AFFORDABLE CARE ACT AND SERVICE DELIVERY

The Affordable Care Act (ACA) offers several opportunities to change the way care is delivered for CYSHCN to ensure that financial incentives are aligned with the delivery of high-quality care rather than with a high volume of care. These opportunities include:

- A new option to implement "health homes" for children with certain chronic conditions.
- The possibility of contracting with pediatric Accountable Care Organizations to provide care and meet certain health goals.
- Funding to create incentives for healthy behaviors.

See Section 9 for more details about these opportunities.

5. Hanlon, C. (2011, January 24). *Improving the Lives of Young Children: Opportunities for Care Coordination and Case Management for Children Receiving Services for Developmental Delay*. Urban Institute. Retrieved March 3, 2021, from <https://www.urban.org/research/publication/improving-lives-young-children>



### WHERE ARE THE OPPORTUNITIES FOR TITLE V PROGRAMS?

It is critical to bring the expertise of Title V programs to help shape Medicaid policies that affect the delivery of care to CYSHCN. Assessing and addressing the gaps in services for CYSHCN is also important. Primary care practices are not usually staffed or compensated for care coordination. They may need help accessing appropriate resources for further diagnosis and treatment. Title V programs may be able to partner with Medicaid programs to identify and fill these gaps and promote better quality of care for CYSHCN. For example, Title V programs can:

- Help Medicaid programs develop contracts with managed care plans and help set and monitor standards for managed care networks.<sup>6</sup>
- Participate in building the medical home model and improving preventive and developmental care in pediatric primary care practices.<sup>7</sup>
- Help design and administer “health home” options, whether under the ACA (§2703) or other legislation for children with certain chronic conditions.<sup>8</sup> The Advancing Care for Exceptional Kids (ACE Kids) Act, enacted by Congress in 2019, gives states the option of providing coordinated care for children with complex medical conditions through a health home.<sup>9</sup> For more information, please see the issue brief “[Improving Care Coordination for Children with Medical Complexity: Exploring Medicaid Health Home State Options](#).”
- Play a role in linking pediatric primary care providers who provide EPSDT screenings with referral resources for diagnosis and treatment, as well as in assuring that community and educational programs that screen children and youth link back to their health care providers.<sup>10</sup>
- Based on historically strong relationships with providers of CYSHCN services, ensure that managed care provider networks include critically important service providers.



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6. MCH Digital Library. State MCH-Medicaid Coordination. Title V and Title XIX Interagency Agreements. Accessed at <https://www.mchlibrary.org/IAA/>

7. NC-PFCMH, NASHP, and the Catalyst Center. 2017. Supporting Title V and Medicaid Collaboration in Pediatric Medical Home Implementation. [https://youtu.be/R\\_k\\_XHSq1IE](https://youtu.be/R_k_XHSq1IE)

8. Centers for Medicare and Medicaid Services. (n.d.) Health Home Information Resource Center. Retrieved May 11, 2021, from <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>

9. Advancing Care for Exceptional Kids Act (ACE Kids Act) of 2019 (H.R. 1226). <https://www.congress.gov/bill/116th-congress/house-bill/1226>

10. Centers for Medicare and Medicaid Services. (n.d.) The State Medicaid Manual. Chapter 5: Early and Periodic Screening. Retrieved May 11, 2021, from <https://www.cms.gov/media/325446>



## TEST YOUR KNOWLEDGE

- 1. True or False: If a child with special health care needs is in a primary care case management (PCCM) system, the primary care provider takes on the risk that care for the child will be more expensive than predicted.**
- 2. In a comprehensive managed care program, states must assure in their contracts with Managed Care Organizations (MCOs) that:**
  - a. Beneficiaries have adequate access to providers
  - b. Beneficiaries can appeal if they believe they have wrongfully been denied a service
  - c. An independent organization monitors and measures the quality of care
  - d. All of the above
- 3. Which of these is NOT correct: The Affordable Care Act provides states with the following opportunities:**
  - a. To design health homes for people with chronic conditions
  - b. To design and provide incentives for healthy behaviors
  - c. To give managed care organizations the right to refuse patient access to emergency department services
- 4. In a typical comprehensive Medicaid managed care program where the managed care organization (MCO) is paid a capitated rate, who bears the risk or reaps the rewards if health costs for participants are more or less than projected?**
  - a. The state Medicaid program
  - b. The beneficiaries
  - c. The federal government
  - d. The MCO



## FIND OUT IN YOUR STATE

- 1. Does your state provide services for CYSHCN through managed care organizations, fee for service, PCCM or more than one of these service delivery options?**
- 2. If MCO's are enrolling CYSHCN, are any services "carved out" of the MCO contract? If so, which services are carved out and how are they delivered?**
- 3. Does your state provide targeted case management services for CYSHCN?**
- 4. Has your state considered or implemented the health home option under the ACA (Section 2703) for children with chronic conditions?**

### ANSWER KEY

1. False. The PCP and the child's other providers are paid on a fee-for-service basis for all medically necessary care. The PCP is paid an additional fee for managing the care. 2. d 3. c 4. d

*This document is part of Medicaid and CHIP: A Tutorial on Coverage for Children and Youth with Special Health Care Needs (CYSHCN). The document is available in its entirety at <https://ciswh.org/resources/Medicaid-CHIP-tutorial>*

The Catalyst Center (U1TMC31757) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$500,000, with no financing by nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.



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