



## Section 7

## SERVICE DELIVERY MODELS

## How Do States Deliver Health Care Services to Children Enrolled in Medicaid and CHIP?

Most states deliver Medicaid and CHIP health services by 1) contracting with a managed care organization (MCO) to manage care and pay providers, 2) paying health care providers directly on a traditional fee-for-service basis for each service they provide, or 3) a combination of both.

### Managed Care

As of March 2017, Medicaid beneficiaries in 38 states and the District of Columbia received care through prepaid capitated MCOs.<sup>49</sup> In these models, the MCO is paid a set amount per person per month 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” or a “per-member-per-month” (PMPM) payment. In contrast with the fee-for-service payment system where 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.

Managed care organizations offer several potential opportunities to improve the delivery of care for children with special health care needs (CSHCN). 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 shopping in multi-specialty clinics.

In addition, capitation payment methodology reduces the financial incentive to deliver as many services as possible, regardless of their utility or cost, an incentive that is prevalent in the fee-for-service health care system. If MCOs can control service utilization and costs, they retain the saved dollars. 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, or encourage the use of generic drugs. Techniques for managing health care are

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<sup>49</sup>Kaiser Family Foundation, State Health Facts, Total Medicaid MCOs (March 2017). Retrieved August 15, 2017 from <http://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/>

# SERVICE DELIVERY MODELS

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rapidly evolving in both managed care and in traditional fee-for-service programs.

Federal regulations establish certain standards and safeguards in managed care, because of the concern that MCOs will limit service use in order to control costs. These standards include the adequacy of the MCO's provider network to serve their enrollee population, the 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 denied a service wrongfully. In addition, states can require MCOs to meet specific quality benchmarks or implement special programs or services as part of the managed care contract.

In some states managed care enrollment is mandatory, and in other states it is voluntary. Within a given state, enrollment may be mandatory for some groups but voluntary for others. In the past, if a state wanted to mandate enrollment in managed care, they needed to seek a 1915(b) "freedom of choice" waiver from the federal government, because they would be restricting provider choice through managed care. However, the Balanced Budget Act (BBA) of 1997 changed the rules governing the Medicaid program to allow states to mandate Medicaid managed care enrollment through their Medicaid state plan rather than seeking a waiver. Many CSHCN were excluded from this new rule, such as children receiving SSI benefits, children receiving foster care or adoption subsidies, institutionalized children, and children recognized as having special needs under the Maternal and Child Health Title V Block Grant Program.<sup>50</sup> States are still required to obtain a federal waiver in order to mandate the enrollment of these groups of CSHCN in Medicaid managed care.

States vary as to which groups of Medicaid beneficiaries they require to enroll in a managed care plan. States require a waiver to make managed care enrollment mandatory for

disabled SSI recipients. However, many children enrolled in Medicaid managed care plans may still have special health care needs, as 48.8% of CSHCN are covered by Medicaid or CHIP.<sup>51</sup>

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

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 on a fee-for-service basis or through a different managed care plan. Often, 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 the schools, are carved out of the managed care plan. The contract between a state and a managed care organization 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.

Capitation rates paid to MCOs must be "actuarially sound" - developed by professional actuaries and 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. Risk adjustment is 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

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<sup>50</sup>Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (1997, October). *Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 (P.L. 105-33) with Prior Law*. Retrieved Dec. 22, 2011 from <http://www.kff.org/medicaid/2091-index.cfm>

<sup>51</sup>National Survey of Children's Health. NS-CH 2016. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved September 13, 2017 <http://www.childhealthdata.org/browse/survey/results?q=4562&r=1&g=638>. A Catalyst Center calculation based on preliminary NS-CH data. The calculation was performed using the population estimate of CSHCN with public insurance (n=5,739,375) and the population estimate of CSHCN with public and private insurance (n=1,049,865), divided by the estimate of the total CSHCN population (n=13,901,999).

# SERVICE DELIVERY MODELS

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chronic illnesses, such as CSHCN. By definition, CSHCN use more health care services than children typically do, and are consequently more costly to cover.<sup>52</sup>

If a child with special health care needs is in a managed care plan where the capitation rate is set, for example, on the average cost of care for all children in the plan, he or she will likely cost more than the average child. Thus MCOs may have an incentive to discourage CSHCN from enrolling in their plan because it is likely that CSHCN will cost more than the average child. This is known as “selection bias.” Selection bias may result 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 result 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 CSHCN, plans will find it easier to finance the comprehensive care that CSHCN 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:

- Are CSHCN going to be required to enroll in managed care, will it be optional, or will they all receive care on a fee-for-service basis?
- If CSHCN 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 a carve-out plan?
- Will the MCO or the Medicaid program be responsible for EPSDT, dental coverage, or mental health coverage?
- What is the process for ensuring that the appropriate pediatric providers are included in the provider network?
- What is the process for authorizing specialty care and services that are uniquely used by CSHCN?
- How do the grievance and appeals processes work when a child is denied a service?

These are some of the issues that should be addressed in the managed care contract between the Medicaid program and the 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. The RFP and contract development process is often when these decisions are initially made and is a good time for Title V programs to bring their expertise and judgment to some of these decisions.

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.

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<sup>52</sup>McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P., Perrin, J., Shonkoff, J., Strickland, B. *A New Definition of Children With Special Health Care Needs*. Pediatrics Jul. 1998, 102 (1) 137-139).

# SERVICE DELIVERY MODELS

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## 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 care. Typically, in PCCM, the primary care provider refers patients to specialty services, and these referrals may be required in order to access care. In this system, the health care providers are paid each time they deliver a service on a fee-for-service basis. In addition, the primary care provider is paid an additional fee per person for managing the care.<sup>53</sup> This is usually a set amount such as \$2 or \$5 per member per month (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 CSHCN. 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 have complex health care needs.

## The ACA and Service Delivery

The Affordable Care Act (ACA) offers several opportunities to change the way care is delivered for CSHCN in order to align financial incentives with the delivery of high-quality care rather than simply a high volume of care. These 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, and funding to create incentives for health behaviors. More detail is provided in [Section 9](#).

## Where Are the Opportunities for Title V Programs?

Bringing the expertise of Title V programs to help shape Medicaid policies that affect the delivery of care to CSHCN is critical. Assessing and addressing the gaps in services for CSHCN 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 CSHCN. For example:

- Title V programs can help Medicaid develop contracts with managed care plans and help set and monitor standards for the managed care networks.<sup>54</sup>
- Title V programs can participate in building the medical home model and

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<sup>53</sup>Hanlon, C. (2010). *Improving the Lives of Young Children: Opportunities for Care Coordination and Case Management for Children Receiving Services for Developmental Delay*. Retrieved Jan. 12, 2012 from the Urban Institute website: <http://www.urban.org/publications/412289.html>

# SERVICE DELIVERY MODELS

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improving preventive and developmental care in pediatric primary care practices.<sup>55</sup>

- Title V programs can help design and administer the health home option (Section 2703) under the ACA for children with certain chronic conditions.<sup>56</sup>
- Title V programs can play a role in linking pediatric primary care providers who provide Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings to referral resources for diagnosis and treatment, and, conversely, assure that community and educational programs that screen children link back to the children's health care providers.<sup>57</sup>
- Title V programs, based on historically strong relationships with providers of CSHCN services, can ensure managed care provider networks include critically important service providers.

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<sup>54</sup>NASHP, (2017). Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid. Retrieved August 16, 2017 from <http://www.nashp.org/strengthening-the-title-v-medicaid-partnership/>

<sup>55</sup>National Center for Medical Home Implementation: Title V & Medicaid collaboration around implementation of Medical Home. Retrieved August 16, 2017 from <https://medicalhomeinfo.aap.org/tools-resources/Pages/Webinars.aspx>

<sup>56</sup>Centers for Medicare and Medicaid Services. Health Home Information Resource Center. Retrieved August 15, 2017 from <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>

<sup>57</sup>Centers for Medicare and Medicaid Services. The State Medicaid Manual. Chapter 5: Early and Periodic Screening. Retrieved August 15, 2017 from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

This document is part of *Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and the Children's Health Insurance Program (CHIP)*, available in its entirety at <http://cahpp.org/resources/Medicaid-CHIP-tutorial>

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C E N T E R



IMPROVING FINANCING OF CARE  
for *Children & Youth*  
WITH SPECIAL HEALTH CARE NEEDS

NATIONAL ACADEMY  
for STATE HEALTH POLICY



## 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 CSHCN through managed care organizations, fee for service, PCCM or more than one of these service delivery options?
2. If MCO's are enrolling CSHCN, 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 CSHCN?
4. Has your state considered the health home option (Section 2703) for children with chronic conditions?

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