

**PURCHASING MODELS FOR CHILDREN
WITH SPECIAL HEALTH CARE NEEDS:
STREAMLING PROJECT
POLICY OPTIONS**

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Commissioned Paper

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HCPF Streamlining Project Assumptions

HCPF staff and an external HIFA advisory committee have provided the following guidance regarding streamlining project assumptions and objectives:

- The program will streamline state operations (e.g., eligibility, enrollment, purchasing) and clinical service provision for income-eligible Medicaid and SCHIP clients.
- Medicaid and SCHIP clients will continue to have their care financed through Titles XIX and XXI, respectively.
- While the system for delivering benefits will change under the streamlining project, current benefit levels will be maintained or augmented for all children eligible for and participating in either Medicaid or SCHIP. In particular, Colorado will continue to meet federal requirements with respect to EPSDT benefits and medical necessity requirements for Medicaid clients.¹
- The streamlining project will focus on SCHIP clients and income-eligible Medicaid clients. Medicaid clients who qualify for services on the basis of their disability (SSI, children's waivers) or involvement with the foster care system (foster care, foster-adopt, 4E adoption) will not be required to participate in the streamlined project.
- Access to culturally-competent health care services will be increased as a result of the streamlined project.
- A single "core" benefit package will be offered to all children in the streamlined project. The core benefits will be efficient, cost-effective, and sufficiently comprehensive to fully meet the needs of a majority of eligible and enrolled children. The core package will focus on primary prevention and early intervention services that promote healthy children at all levels of development (physical, mental and emotional). (See companion paper for a detailed discussion of core benefits).²
- If a wrap-around benefit package is proposed to serve the individualized needs of children with special health care needs (CSHCN), it will be implemented such a way that it maximizes seamlessness to families and providers.
- All financing options for the streamlining project under consideration by the state are managed purchasing models, including any fee-for-service models.
- The design of mental health services is critically important to the success of the streamlining project, but it will not be addressed at this stage of the HIFA planning process.

Executive Summary

Introduction and Background

The State of Colorado's Department of Health Care Policy and Financing (HCPF) proposes "to improve the way it purchases and provides health care services for low-income children and families".³ In its project summary, HCPF describes streamlining the Medicaid, Child Health Plan Plus, and the Colorado Indigent Care Program, "into a single health care program that provides comprehensive benefits to all participants, including the expansion of services to children who require more extensive care. This would make it easier for children and families to consistently receive the benefits they need without being shifted between state programs depending on fluctuations in family income." The streamlining project does not currently plan to *require* the participation of foster care, adoption, SSI, and children's waiver populations. These populations require much more intensive services than other Medicaid clients, and they are much less likely to move between the Medicaid and SCHIP programs.

However, a number of children with special health care needs (CSHCN) are income-eligible for Medicaid and SCHIP and would therefore be included in the project scope. They include children with chronic conditions, children with less-disabling conditions, and children who could potentially qualify for SSI. Disruptions in coverage due to "bouncing" between programs can be particularly problematic for these children. Proper clinical management of asthma, juvenile diabetes, cerebral palsy, and teen pregnancy, for example, requires consistency in coverage and providers.

The coordination challenges between low-income health insurance programs are not unique to Colorado. Many states are looking to better integrate Medicaid and SCHIP.^{4,5} HCPF will consider many different purchasing options and risk arrangements for implementing a streamlined program. HCPF recognizes that these various purchasing models have different implications for CSHCN. This paper offers two main policy options for CSHCN – a wrap-around model and a population carve-out model -- for the state to consider.

Policy Options

Based on the streamlining project assumptions, objectives, and prior research, Health Policy Solutions has identified two main policy options for handling children with special health care needs (CSHCN) under the streamlining project. The preferred option proposes the creation of a wrap-around benefit package for CSHCN. Specifically, CSHCN would be "mainstreamed" with other children under a common delivery system and purchasing strategy for "core" benefits. Additional "wrap-around" benefits would be provided through a separate financing arrangement, most likely fee-for-service. Total streamlined program benefits consist of the "sum" of core and wrap-around benefits. This paper details a number of implementation recommendations to maximize seamlessness in program administration: CSHCN identification, benefit design, delivery systems, reimbursement and cost-sharing, and case management strategies.

However, if these key wrap-around design features cannot be met, the second policy option recommends excluding (“carving-out”) CSHCN from the streamlining project. The CSHCN population carve-out model proposes identifying children who need services beyond core benefits and excluding them from the streamlining project. Rather than merging (mainstreaming) CSHCN with other populations, this model treats them as a separate and distinct group, requiring different benefits, delivery systems and purchasing arrangements. They are therefore “carved out” of the programs and systems that serve other children. This paper details several operational recommendations to related a population carve-out option, including: CSHCN identification, reimbursement and cost-sharing, case management, and sustainability strategies.

The carve-out model is presented as a “second choice” to the “preferred” wrap-around model because of the value that CSHCN advocates and providers place on integrated programs and due to concerns about the long-term sustainability of a population carve-out. Policy option implementation recommendations are summarized in the section entitled, “Policy Options and Recommendations”. A detailed analysis and justification are provided for each in a subsequent section entitled, “Detailed Policy Analysis”.

Criteria for Evaluating Purchasing Models for CSHCN

The policy options and associated recommendations presented in this commissioned paper draw upon state-defined streamlining project assumptions, interviews with stakeholders, and a review of the CSHCN literature. The latter activity (literature review) reveals that researchers have adopted varied approaches to describing and evaluating Medicaid/SCHIP purchasing strategies and their implications for CSHCN.^{6,7,8,9,10,11,12} Health Policy Solutions has considered the breadth of this literature in developing evaluation criteria, drawing especially on the CSHCN-specific purchasing recommendations delineated in the “Evaluating Managed Care Plans for CSHCN: A Purchasers Tool”. The purchasing tool is an evaluation tool that has been described as providing a “common framework for adequately describing the characteristics of health plans/health systems that are most salient to children’s health”.¹³ The purchasing tool was designed for use by families and policy analysts and to be broadly applicable to public and private insurance models.^{14,15}

The purchasing tool defines four broad features to assess when purchasing for CSHCN:

- Coverage for pediatric services (e.g., comprehensive benefits and medical necessity definitions)
- Cost-sharing requirements for CSHCN (e.g., mechanisms to limit out-of-pocket expenditures for CSHCN)
- Pediatric provider network capacity (e.g., pediatricians, chronic care specialists, pediatric sub-specialists, and medical home provisions)
- Quality management (e.g., clear service authorization procedures, case management and care coordination, quality assurance plans, satisfaction surveys)

These features are discussed at greater length in a published summary of the purchasing tool and in a separate research paper by Health Policy Solutions.¹⁶

Policy Options and Recommendations

POLICY OPTION 1: IMPLEMENTING A WRAP-AROUND PACKAGE

Policy Option Description: Under the proposed wrap-model, CSHCN would be “mainstreamed” with other children under a common delivery system and purchasing strategy for “core” benefits. Additional “wrap-around” benefits would be provided through a separate financing arrangement, most likely fee-for-service. Total streamlined program benefits consist of the “sum” of core and wrap-around benefits.

Rationale: The rationale for implementing the streamlining project through a wrap-around model includes purchasing, delivery system stability, primary care access, benefit management, and operational considerations.

Recommendations:

- 1A) Administer wrap-around benefits as a “package”, rather than individually or as groups of services.
- 1B) Contract for the administration of wrap-around services with the same plans that provide core benefits.
- 1C) Define clear boundaries between the core benefit package and the wrap-around package.
- 1D) Implement multiple strategies to identify CSHCN who may need wrap-around services.
- 1E) Blend the strengths of private and public approaches to case management, disease management, and care coordination.
- 1F) Develop exception processes to ensure that individual children are placed in the most appropriate program (streamlining project vs. traditional Medicaid).
- 1G) Encourage participation from traditionally commercial plans as well as safety net providers as a way to ensure network adequacy and foster competition
- 1H) Risk-adjust plan rates and encourage plans to provide enhanced rates to providers who serve CSHCN.
- 1I) Ensure that any proposed cost sharing provisions do not impose unreasonable financial burdens or other unintended consequences for CSHCN.
- 1J) Provide SCHIP CSHCN with access to wrap-around services using program designs that balances fairness, innovation, and administrative efficiency considerations.
- 1K) Identify and maximize operational synergies and efficiencies for CSHCN served by the streamlining project and CSHCN served through the traditional Medicaid program.

POLICY OPTION 2: IMPLEMENTING A CSHCN POPULATION CARVE-OUT

Policy Option Description: The CSHCN population carve-out model simply proposes identifying children who need services beyond core benefits and excluding them from the streamlining project. Rather than merging (mainstreaming) CSHCN with other populations, this model treats them as a separate and distinct group, requiring different benefits, delivery systems and purchasing arrangements. They are therefore “carved out” of the programs and systems that serve other children.

Rationale: The population carve-out model recognizes that the operational challenges of a wrap-around model can result in a program that “mainstreams” CSHCN but fails to serve them well. In contrast, implementation of a population carve-out permits the development of a program that specializes in CSHCN service provision. The carve-out model is presented as a “second choice” to the “preferred” wrap-around model because of the value that CSHCN advocates and providers place on integrated programs as well as concerns about the long-term sustainability of the carve-out model.

Recommendations:

- 2A) Prioritize the allocation of any streamlining project cost-savings toward providing a “population carve-out” option for SCHIP CSHCN.
- 2B) Implement multiple strategies to identify CSHCN who need to be carved-out.
- 2C) Ensure that any proposed cost sharing provisions do not impose unreasonable financial burdens or other unintended consequences for CSHCN.
- 2D) Assess network adequacy and sustainability of a population carve-out program prior to its implementation.
- 2E) Blend the strengths of private and public approaches to case management, disease management, and care coordination.

Detailed Policy Analysis

POLICY OPTION 1: **IMPLEMENTING A WRAP-AROUND PACKAGE**

Policy Option Description

Under the proposed wrap-model, CSHCN would be “mainstreamed” with other children under a common delivery system and purchasing strategy for “core” benefits. Additional “wrap-around” benefits would be provided through a separate financing arrangement, most likely fee-for-service. Because core benefits would fully cover the service needs of a majority of streamlined clients, these wrap-around benefits would be used nearly exclusively by CSHCN. Total streamlined program benefits consist of the “sum” of core and wrap-around benefits. Since federal Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions define the scope of the benefits for Medicaid-eligible children, the scope of wrap-around benefits for the streamlining project would be defined largely by Medicaid benefit entitlements that are not covered under the core benefit package. Budget neutrality calculations would determine to what extent SCHIP beneficiaries would have access to these additional benefits. The boundaries between core and wrap-around packages would be co-determined. (See implementation recommendation C).

Rationale: The rationale for implementing the streamlining project through a wrap-around model includes purchasing, delivery system stability, primary care access, benefit management, and operational considerations.

Purchasing

From a value purchasing perspective, one maximizes purchasing power and minimizes administrative overhead by contracting for health services for Medicaid and SCHIP clients collectively, rather than separately. While Medicaid benefit entitlements are clearly broader than those of SCHIP, there is a substantial overlap in covered services. This overlap in coverage, referred to as “core services”, corresponds to commercial coverage. Segmenting benefits into core and wrap-around packages therefore permits multiple purchasing strategies. The state could establish risk-based contracts with a broad array of carriers for the provision of core benefits to *all* streamlining participants. A separately purchased (e.g., fee-for-service) wrap-around package provides a means to manage the differences in benefit entitlements for Medicaid and SCHIP clients.

Delivery System Stability

From a CSHCN perspective, a wrap-around model permits CSHCN to enjoy the advantages of a streamlined program. Specifically, the streamlining project would enable CSHCN who “bounce” between Medicaid and SCHIP to experience fewer disruptions in service delivery systems due to small changes in family finances. Disruptions due to “bouncing” between programs can be particularly problematic for CSHCN who, even more than the typical child, benefit from consistency in providers. In addition, mainstreaming CSHCN with other children means that children a change in health status does not trigger a change in health delivery systems.

Primary Care Access

The national literature on enrolling public insurance recipients into commercial insurance programs suggests that “mainstreaming” can improve access to and satisfaction with “core” child health services, especially, primary care and dental services.¹⁷ In Colorado, for example, dental penetration rates are higher for SCHIP clients than for Medicaid.¹⁸ A North Carolina study specific to CSCHN in Medicaid, SCHIP, and privately-insured programs found that SCHIP parents report fewer unmet needs for primary care and most specialty care services, as compared to Medicaid parents.¹⁹ Explanations for improved primary care access and satisfaction under commercial models are varied and difficult to disentangle: higher provider rates, greater provider participation, more positive provider and client perceptions, and income-driven health-seeking patterns. Conceptually, however, the proposed wrap-around model aims to blend the strengths of a commercial/SCHIP model with the broader benefits available under the Medicaid program.

Benefit Management

As described, a wrap-around model provides a means to manage the differences in benefit entitlements for Medicaid and SCHIP clients. While Medicaid clients would clearly be entitled to all medically necessary core and wrap-around services, the streamlining project could provide SCHIP clients with access to all, some, or none of the wrap-around package, depending on budget-neutrality considerations. Because the core benefit package will employ commercial-like benefits, the streamlined program will “push” many CSHCN-specific services into the wrap-around package. While this decision clearly places a greater premium on managing the core and wrap-around package boundaries, it has the design advantage of removing from managed care plan purview many services (e.g., therapies, durable medical equipment, home health services, etc.) that have been difficult for MCOs to implement well. (See the CSHCN Research Synthesis paper for a more detailed discussion of this issue).²⁰ The state, on the other hand, has relatively more experience with delivering these “wrap-around” services and can translate these “lessons learned” into the wrap-around package design. Again, the concept is to align core and wrap-around benefit packages with Medicaid/SCHIP program requirements and potential vendor/administrator strengths.

Operational Experience

Finally, HCPF staff have expressed preferential interest in a wrap-around model design, assuming that operational challenges can be addressed. Wrap-around models are commonly used in Medicaid managed care. They reflect state interests in using multiple purchasing strategies to implement broad benefit packages. Wrap-around models are also increasingly in use for the SCHIP program.²¹ In Colorado, the Medicaid managed care program has operated in recent years as a wrap-around model. The state traditionally has negotiated with plans to define an explicit and fixed scope of services (known as Exhibit A). These contract agreements have been broader than commercial plan coverage, but nonetheless represent a subset of all covered Medicaid benefits for children. Services not included in the managed care contract are “wrap-around” services.

This Colorado-based experience with wrap-around services informs the policy options and recommendations presented in this paper. In particular, the proposed wrap-around model aims to address known operational issues with Colorado Medicaid's wrap-around design. It emphatically does not intend to recreate this model. Wrap-around models have the potential to blend the strengths of commercial and public models. However, as the implementation recommendations emphasize, equal attention needs to be devoted to the design of the core benefits package *and* the wrap-around *package*. Otherwise, their poor design or implementation may introduce serious barriers to access.

The following section presents eleven key wrap-around model implementation recommendations for the streamlining project. If these key recommendations cannot be implemented, a CSHCN population carve-out (policy option #2) is preferred. The state may want to consider modeling both a wrap-around and a carve-out option before making a final design decision.

Wrap-Around Model Implementation Recommendations

1A) Recommendation: Administer wrap-around benefits as a “package”, rather than individually or as groups of services. This “package” concept differs from the current Medicaid MCO wrap-around services. Specifically, a wrap-around package features proactive identification and referral of CSHCN in need of wrap-around services, clarifies and centralizes access to services, provides care coordination, and preserves provider relationships such that services are delivered within established plan networks. Ideally, one administrative entity would be responsible for administering *all* benefits and providing care coordination services. Exceptions to this centralized administration (e.g., dental services) undermine the concept of a “package” and must be minimized.

Rationale: This recommendation reflects the care coordination challenges that Colorado and other states have experienced when administering wrap-around benefits individually or in service clusters. It is also based on the successes some states have had in centralizing the access to, and administration of, wrap-around services.

Colorado Medicaid separately administers each of the following “wrap-around services”: certain home health services, mental health, developmental disability services, family planning clinic services, dental, vision, transportation, skilled nursing, hospice, residential treatment, school-based services, among others. Each service has separate service authorization and provider reimbursement procedures. Taken collectively, these separately-administered wrap-around services constitute an unwieldy and uncoordinated “program” that is expensive (staff-intensive) to administer and difficult for clients and providers to navigate. It also often results in lack of continuity in care because managed care benefits and wrap-around services are delivered through separate provider networks.

These problems are not unique to Colorado. A recent California Task Force on CSHCN concluded: “There are significant challenges in improving care coordination for CSHCN enrolled in Medi-Cal managed care plans. Foremost . . . is the complexity of California’s child health system. Multiple programs, each with complex eligibility and operational requirements, operate in their own silos, with legal, financial and organizational constraints on their ability to weave a whole system of care for CSHCN.”²²

Connecticut’s SCHIP programs provide an alternative example of a wrap-around model. In this model, the “Husky B Plan” provides core benefits to all enrolled children. CSHCN are eligible for Husky Plus Physical and/or Husky Plus Behavioral that provide enhanced wrap-around benefits that mirror Title V-funded services. (See Appendix A for a list of Husky Plus benefits.) Access to wrap-around services is centralized through a single administrative entity, the Title V agency. In addition, the Title V agency provides care coordination and family advocacy to assist families with navigating the benefits and coordinating with their medical homes. Wherever possible, enrolled CSHCN continue to receive services at same hospitals, clinics, providers they use for their primary care coverage through the core benefits package (Husky Plan B).

The following recommendation (recommendation B) builds on this largely successful Connecticut model and adapts it for Colorado.

1B) Recommendation: Contract for the administration of wrap-around services with the same plans that provide core benefits. While the core benefits would be provided through a capitated or other risk-based arrangement, the wrap-around services would most likely be reimbursed on a fee-for-service basis.²³ The proposed fee-for-service reimbursement strategy still requires that the health plans have a financial (billing) relationship with wrap-around service providers who would bill the plan for their services. (The plan would then bill the state on a fee-for-service basis.) This model therefore assumes that health plans have, or would be willing to establish, financial relationships with a wide variety of providers. It would also require contracting with entities that provide specialized services to Medicaid clients with disabilities, e.g., residential treatment facilities. Past experience suggests that the state should investigate and not assume willingness on the part of health plans to establish contractual relationships of this sort.

Rationale: This recommendation is informed by the experiences of Colorado and other states that separately administer core and wrap-around benefits. These states attribute low referral rates, access delays, poor coordination, and on-going training challenges to separate administration of core and wrap-around benefits that often requires detailed operational understanding of multiple systems at the provider and client levels.²⁴ Even in Connecticut, where access to SCHIP wrap-around benefits has been centralized, consumer advocates report that “knowing that Husky Plus exists” remains the most significant barrier to access.²⁵ Failing to understand how to access services in wrap-around models is a common consumer complaint; one that has been litigated successfully. In *Pediatric Specialty Care v. Arkansas Department of Human Services*, the court observed that, “the state may not shirk its responsibilities to Medicaid recipients by burying information about available services in a complex bureaucratic scheme.”²⁶

In contrast, integrated administration of core and wrap-around benefits also centralizes within a single administrative entity the knowledge about *all* covered benefits (core and wrap-around). Consumers often depend on their health plans or providers for knowledge about benefits. Having the health plan administer both core and wrap-around benefits also means that the clients can access the same provider network when seeking core and wrap-around benefits. This facilitates the streamlining project objective of “seamlessness” and maintains child-provider relationships. Thus, integrating the administration of core and wrap-around benefits has the potential to simplify access, result in prompt referrals, and improve coordination of care.

Finally, plan-administered core and wrap-around benefits provides claims experience that could lead to alternative financing arrangements in the future. For example, Florida’s Children’s Medical Services (CMS) is a capitated specialized system of care for CSHCN, administered by Title V agency that began as a wrap-around only program. CMS architects, however, felt that the original wrap-around program created unacceptable coordination of care issues. So, the program expanded over time from a wrap-around to a comprehensive program for CSHCN, with the explicit aim of better facilitating medical home and service coordination.²⁷ The prior years of operation as a fee-for-service wrap-around program provided the financial basis on which to calculate capitated rates.

1C) Recommendation: Define clear boundaries between core benefit package and wrap-around package. Contracting language can mitigate or exacerbate the potential for boundary confusion and cost-shifting. To minimize disputes around financial responsibility, core and wrap-around contracts must: describe and quantify benefit responsibility precisely, use a consistent Medicaid definition of medical necessity, and define a process for the timely resolution of disputes. To the extent that the core benefit package includes services that may be unfamiliar to commercial plans (e.g., lead screening), appropriate provisions around training and monitoring should be developed.

Rationale: Because managing the boundaries between benefit packages is a known challenge to wrap-around models, seamlessness requires clearly defined boundaries between core and wrap-around packages. Disputes over payer responsibility are common and can result in cost-shifting. For example, assuming that wrap-around services are delivered on a fee-for-service basis, plans would have a financial incentive to substitute wrap-around services (e.g., skilled nursing) for capitated (e.g., hospital) services. Clear contracting language paired with a state-controlled service authorization function is necessary to prevent perverse utilization patterns. (See recommendation E for service authorization recommendations.)

Contract language should implement a consistent Medicaid definition of medical necessity for both core and wrap-around benefits. Because insurers apply medical necessity criteria after they have determined benefit coverage, streamlining plans' financial risk would extend only to core benefits.²⁸ The literature documents differences in commercial, Medicaid and SCHIP definitions of medical necessity and delineates implications for CSHCN.^{29,30} Due to these documented differences in interpretation, a consistent Medicaid definition of medical necessity is judged to best achieve the goal of seamlessness. Using a commercial definition for core benefits would likely invite cost-shifting and legal challenges.

From a consumer perspective, financial disputes can impede access because many payers will not authorize services and providers will not provide services, until financial responsibility is clarified.³¹ Procedural remedies need to consider timeliness. For example, a California Task Force on CSHCN documented access delays due to the MediCal requirement that privately-insured individuals provide written service denials from the insurer before authorizing Medicaid payment. An alternative approach, that considers timeliness, is a "pay-and-chase" mechanism in which Medicaid pays for the service and then seeks reimbursement from ("chases") the appropriate payer.³²

Specific benefit assignments to core and wrap-around packages are the subject of a subsequent operational paper. Generally, the package boundaries will be co-determined according to a strategic assessment of: benefit management, volume considerations, and purchasing considerations. As already described, commercial inexperience with a particular benefit represents a prima facie argument for its assignment to wrap-around status, where appropriate provision can be better ensured. However, too great a volume of children seeking wrap-around services risks overwhelming the system and introducing access barriers. So, boundary drawing will balance these competing considerations.

1D) Recommendation: Implement multiple strategies to identify CSHCN who may need wrap-around services. Identification strategies must target three conceptual categories of CSHCN: children who have diagnosed conditions and on-going needs, children who have a newly-diagnosed conditions, and children with a time-limited needs (e.g., post-surgical therapy). An application-based screening tool is recommended. The tool would need to be brief and sensitive to service needs beyond core benefits. In addition to identification at application, referrals to wrap-around services should be accepted from providers, MCO case managers/staff, and families. Contract language with plans should require MCO and staff training about wrap-around benefits and the development of automated processes for identifying CSHCN in need of referrals, based on certain triggering diagnoses or events: inpatient admissions, traumatic injuries, certain diagnosis and procedure codes, etc.

Rationale: Identifying and referring those children eligible for wrap-around services is key to making services seamless. Multiple methods for identifying CSHCN are necessary to ensure adequate access.^{33,34} The rationale for a brief screening tool at the point of application rather than the plan level is intended to maximize screening rates. At least one Colorado HMO reports that a large percentage “welcome calls” to new members are thwarted due to incomplete or inaccurate contact information.³⁵ Some clients do not have a fixed address. Others move frequently. Many experience disruptions in phone service. These problems of client transience are well-documented in the literature on serving low-income populations.³⁶

The literature has documented that lengthy validated CSHCN screening tools can be adapted to “short forms” without seriously undermining their ability to detect CSHCN.³⁷ The Colorado SCHIP program previously used a short screen to identify CSHCN. But because the tool was poorly aligned with the programmatic need (identifying children potentially eligible for Title V services), it over-identified CSHCN and was abandoned. A variety of CSHCN tools exist reflecting the multiplicity of definitions and program purposes for identifying them. Once the state has better refined its program purpose (e.g., identifying children potentially in need of wrap-around services), it can select an appropriate tool. The state will also need to address whether the screening tool should additionally identify other populations of CSHCN for other program objectives.

As noted, consumers often depend on their health plans or providers for knowledge about benefits. According to pediatric experts, provider-initiated referrals to wrap-around services depend more on provider knowledge of benefits than any other factor.³⁸ MCO staff and provider training and information systems technology are therefore an essential complement to an efficient wrap-around referral system. Health plans are innovators in the area of disease management programs that make creative use of information systems to identify and track the health status and utilization of enrolled beneficiaries. This concept and the related systems can be extended to the identification of CSHCN in need of wrap-around services. Finally, permitting families to self-refer, as Connecticut does, provides a safety-valve in the event that formal systems for CSHCN identification fail.

1E) Recommendation: Blend the strengths of private and public approaches to case management, disease management, and care coordination to ensure that key functions (e.g., service authorization, access-facilitating services, cost-shifting protections) are well-implemented. Case management, disease management, and care coordination are “terms of art” that are variously used to describe a wide array of functions: utilization review, clinical care communications, CSHCN identification, health status tracking, eligibility assessment, care planning, service authorization, access-facilitating services, information and referral (including non-medical services), family support services, regulatory compliance activities (e.g., EPSDT education and information; HCBS waiver cost-containment reporting), among other functions. Therefore, the development of case management model(s) for the streamlining project should proceed first by identifying the desired functions. Although not an exhaustive list of “desired functions”, seamless implementation of wrap-around services clearly requires attention to: CSHCN-specific service authorization procedures (e.g., “tiers”), other access-facilitating services and cost-shifting monitoring. The final case management model should blend commercial sector strengths (e.g., disease management programs) with public sector expertise (e.g., access facilitation, cultural competency, knowledge of CSHCN-specific services).

Rationale: This recommendation recognizes that the final streamlining project “case management” design is the focus of a subsequent operations-specific paper. It is therefore more directive about process (e.g., function identification prior to final model selection) than content.

One function important to CSHCN is tailoring service authorization procedures and utilization controls to the unique health needs of CSHCN. Service utilization patterns differ for healthy children and CSHCN. Therefore, administrative safeguards against unnecessary utilization need to be responsive to these differences.

As noted, “benefit tiers” are a recommended means for developing CSHCN-specific service authorization procedures. The “tiered” concept is a private sector strategy that dovetails nicely with the core and wrap-around benefit design. The core benefits could be considered “tier one” and core plus wrap-around benefits “tier two”. However, while the core and wrap-around terminology refers primarily to reimbursement strategies, the “tiered” concept of benefits relates to service authorization mechanisms and case management designs. Children would be assigned to benefit tiers according to their health status. Consistent with the core benefit design assumptions about comprehensiveness, a majority of children would qualify for tier one, signaling the expectation that core benefits would fully meet their service needs. Tier two would be reserved for CSHCN. Tier assignments do not limit access to benefits but allow plans to adapt service authorization procedures to the different health needs represented in each tier.

For children in tier one, timely access to quality preventive services would be emphasized. Utilization controls would aim to reduce unnecessary utilization of highly specialized services and emergency room visits by a population that does not typically

require such intensive service use. For these children, wrap-around service requests (e.g., for post-operative therapy services) might need to be prior authorized to ensure appropriate utilization. In contrast, tier two is comprised entirely of CSHCN. Tier two service authorization procedures can therefore be structured around the unique utilization patterns of CSHCN. For example, children in tier two would be permitted expedited access (e.g., standing referrals) to core specialty services and wrap-around services (e.g., maintenance therapies). Children can move between tiers as their health status improves or worsens. In sum, tiers permit the adaptation of utilization controls and case management models to different subpopulations of children.

Beyond service authorization issues, a seamless boundary between core and wrap-around services requires attention to other aspects of benefit coordination. As defined here, “benefit coordination” focuses on the relatively small percentage of children using both core and wrap-around benefits and seeks to facilitate their access to services. While the managed care entity would be responsible for paying providers, the benefit coordination function would include: making service referrals, making appointments, arranging transportation, assisting with service authorization procedures, and supporting the consolidation of clinical information into a “medical home”. Arguably these activities reflect a “social model” of case management that has been more commonly implemented in public sector programs.

Another important component of benefit coordination would be to monitor utilization patterns that might signal cost-shifting from core to wrap-around services. Benefit coordination would therefore entail expertise in benefits, providers, service authorization procedures, contract requirements, and claims systems. The benefit coordination function could physically reside at the health plans, although it might be separately funded (e.g., using EPSDT or Title V funds).

Again, a subsequent paper on case management will seek to identify core functions (including CSHCN-specific service authorization mechanisms and benefit coordination) and integrate them into a comprehensive case management plan.

1F) Recommendation: Develop exception processes to ensure that individual children are placed in the most appropriate program (streamlining project vs. traditional Medicaid). Advocates for children with disabilities have argued for a voluntary enrollment provision in the streamlining project on an *exception basis* for categories of Medicaid other than 1931 and BabyCare/KidsCare. This recommendation is consistent with the original state *presumption* that *most* of these CSHCN would be “carved out” of the streamlining project. As a *voluntary* option, these categories of CSHCN would also be permitted to remain in traditional Medicaid programs. A parallel exception process is recommended to permit income-eligible Medicaid CSHCN to opt-out of the streamlining project. Once a program choice has been made, lock-in provisions would need to be developed to prevent a new form of “bouncing”. The state and plans would need to collaborate on criteria for these exception processes.

Rationale: Depending on the final design choices, the streamlining project could be a more efficient model for receiving Medicaid benefits for certain children with disabilities. For example, a wrap-around package designed to “fit” around commercial coverage may be especially attractive to Medicaid SSI and waiver clients who have primary private insurance. An SSI child with commercial insurance, for instance, may find it beneficial to receive all services (commercial and Medicaid) through the same carrier. This would be possible if the carrier in question participates in the streamlining project. The inclusion of additional categories of CSHCN with third party coverage in the streamlining project would not expose plans to adverse selection because, as in the example, the child is already a member of the commercial plan and the streamlining wrap-around services are paid fee-for-service. The alternative is an awkward coordination of benefits between the commercial carrier and the state’s fee-for-service Medicaid delivery system. From an operational perspective, a streamlined program that anticipates some CSHCN enrollment creates stronger incentives to ensure that mechanisms for CSHCN are incorporated in the original program design (rather than “retrofitted”) and have sufficient volume to work well.

Creation of an exception process that permits income-eligible Medicaid CSHCN to opt-out of the streamlining project is also recommended. This recommendation recognizes some fundamental tensions between project goals and operational considerations. On the one hand, the streamlining project aims to purchase care such that CSHCN may be largely mainstreamed with other children. On the other hand, given the broad benefit entitlements of the Medicaid program, there are likely to be services used by a relatively small number of CSHCN that may be difficult to administer in a wrap-around package. Residential treatment may be an example. Children who use these services should therefore be identified and be allowed to opt-out of the streamlining project. If the wrap-around design is inadequate to the needs of large numbers of CSHCN, it starts to beg the question of the design choice itself. Ideally, the exception process is a temporary “safety-valve” solution that is phased out as the comprehensiveness of wrap-around package is achieved.

1G) Recommendation: Encourage participation from traditionally commercial plans as well as safety net providers as a way to ensure network adequacy and foster competition. States have typically framed “network adequacy” as a contracting or quality assurance activity. This recommendation clarifies that broader purchasing decisions are equally important to ensure adequate networks for CSHCN. Several purchasing considerations for CSHCN are highlighted here: multiple competing plans, state negotiating power, market stability, and safety net issues.

Rationale: Ensuring pediatric network adequacy and capacity are critically important to mainstreaming CSHCN in the streamlining project. Traditionally, network adequacy provisions have been broadly defined as provider counts per geographic area.³⁹ The literature reveals little consensus on measuring network adequacy, even for healthy populations.⁴⁰ Network adequacy considerations become even harder to measure for CSHCN due to their idiosyncratic needs. Therefore, CSHCN advocates have concluded that network adequacy/capacity is most likely to be achieved when they have a choice of plans.⁴¹

States also benefit from competition. Medicaid and Medicare-Choice administrators have found that their negotiating power with health plans diminishes as markets shrink. This principle is true generally, but takes on special significance for CSHCN. As will be described again in recommendation H, the history of commercial plan involvement in Medicaid, Medicare-Choice, and FEHP has been one of instability. The state cannot afford to “put all eggs in one basket” in the streamlining project by contracting with just one or two plans. In this scenario, the state could be compromised in its ability to negotiate contract provisions beneficial to CSHCN. In addition, a sudden plan pull-out would be especially concerning for CSHCN who could face serious health consequences if large numbers were suddenly required to find new providers.

The state should also ensure that commercial plans and safety net providers are represented among the competing plans that provide health services for the streamlining project. The many strengths of attracting commercial plans to the streamlining project are discussed elsewhere within this document, so will not be reiterated here. The rationale for ensuring the inclusion of safety net providers recognizes that children not only “bounce” between Medicaid and SCHIP, but they “bounce” between public programs and being uninsured. Safety net providers can provide continuity of care for these clients, including CSHCN. An extensive literature documents the other advantages that accrue to states by contracting with safety net providers, including: cost-effectiveness, cultural competency, and public program experience and stability.^{42,43,44}

In sum, CSHCN interests align with a streamlining purchasing strategy based on multiple competing plans with substantial participation by the commercial sector and safety net providers.

1H) Recommendation: Risk adjust plan rates and encourage plans to provide enhanced rates to providers who serve CSHCN. This recommendation is not directive with respect to the specific model of risk adjustment employed except that it should account for enrollees' health status.⁴⁵ The recommendation does, however, distinguish risk adjustment from other strategies that aim to minimize plans' financial risk in serving CSHCN (e.g., wrap-around benefit design, reinsurance, demographic adjustment, etc.).⁴⁶ To successfully mainstream CSHCN in a core benefits package requires that plans are willing to develop networks appropriate to their core and wrap-around service needs. This assumption should be explored with potential health plans. Risk adjustment is critical to aligning financial incentives with this "mainstreaming CSHCN" program goal.

Rationale: Health status-related risk adjustment strategies are necessary because they mitigate financial incentives for plans to avoid adverse selection or to under-serve CSHCN. The literature on the Federal Employees Health Benefits Program (FEHBP) and Medicare-Plus, clearly demonstrates that in the absence of risk adjustment, plans will implement policies to discourage the enrollment of people with chronic conditions and disabilities.⁴⁷ Strategies to avoid adverse risk selection include: inadequate specialty networks, preferentially marketing to healthy individuals, restrictive formularies, high cost-sharing requirements, narrow medical necessity definitions, and limited benefits.⁴⁸

Risk adjustment strategies are also essential to market stability for the streamlining project. Instability in private plan participation in Medicare, Medicaid and FEHBP is well-documented.^{49,50,51,52} One multi-state study documented that since the inception of Medicaid managed care, the number of participating plans had declined in five states and remained stable in one. Another state reported increased plan participation, but this had not prevented the increasing concentration of enrollment into two plans.⁵³ Adverse risk selection contributed to this instability. In the early 1980s, for example, adverse risk selection nearly resulted in Blue Cross withdrawing from FEHBP, potentially requiring 45% of federal employees find alternative coverage.⁵⁴ Disruption in coverage due to plan pull-outs has potentially serious consequences for CSHCN who have complex health care needs. A recent review of the FEHBP concluded: "The primary challenge facing a system of competing private plans is the stability of plan participation and experience with adverse risk selection. If plans succeed in attracting relatively healthy enrollees, their [costs] will be lower not because they are more efficient, better managers of care, or because they attract a higher-performing network of health care providers, but because they avoid high-cost patients."⁵⁵ The streamlining project faces the same challenge.

The exclusion of most of the categorically disabled group from the streamlining project does not eliminate the need for risk adjustment. For example, a comparison of (simulated) reimbursement strategies based on SCHIP claims data concluded that wrap-around models do not "in and of themselves" reduce over-payments (due to advantageous selection) and under-payments (due to adverse selection). However, appropriate reimbursements can be achieved when a service carve-out (wrap-around model) is paired with a risk-adjustment. A reinsurance strategy combined with risk adjustment performed even better.⁵⁶ A similar "aligning financial incentives" argument can be made for contract language requiring risk-adjustment at the provider-level.

1I) Recommendation: Ensure that any proposed cost sharing provisions do not impose unreasonable financial burdens or other unintended consequences for CSHCN. If the streamlining project imposes new cost-sharing requirements, the final costs-sharing design should be appropriately calibrated to a low-income population and recognize the unique utilization patterns of CSHCN. In particular, total out-of-pocket cost should be limited.

Rationale: Health policy analysts generally concur that well-designed cost-sharing provisions can be used to discourage inappropriate health care utilization in favor of more appropriate health seeking behavior (e.g., seeking non-emergency services from a primary care provider rather than through the emergency room).⁵⁷ For example, many cost-sharing models intend to make health care consumers sensitive to the price differences in accessing services in different settings (e.g., primary care vs. emergency room) by requiring higher cost-sharing to receive care in more expensive settings.⁵⁸ Similarly, cost-sharing provisions that accrue at the time of service (e.g., co-payments) aim to discourage unnecessary visits.⁵⁹ Health services research has also demonstrated that cost-sharing provisions need to be designed carefully, because cost-sharing that is too onerous risks discouraging both inappropriate and appropriate utilization.⁶⁰

Under current regulations, Medicaid generally permits no cost-sharing for children. In contrast, SCHIP legislation permits cost-sharing for families with incomes above 150% FPL, up to 5% of the family income. For SCHIP families below 150% FPL only “nominal cost sharing is allowed”.⁶¹ These federal regulations have limited the extent to which cost-sharing may be used to control inappropriate utilization for Medicaid and SCHIP. As a waiver project, the streamlined program may waive these provisions and impose new cost-sharing requirements.

Cost-sharing design requires special considerations for CSHCN. CSHCN are by their very definition a high-utilizing population that requires “health and related services of a type or amount beyond those required by children generally”.⁶² Cost-sharing provisions that anticipate the utilization patterns of average healthy children should be analyzed for unintended consequences for CSHCN. For example, definitions of appropriate and inappropriate use of emergency and specialty services may need to be adapted for this population. Given the higher use of services for CSHCN, even “nominal” cost-sharing for services can become significant. Limits on out-of-pocket cost limits that encompass all the various forms of cost-sharing (premiums, deductibles, co-payments, etc.) are therefore a critical feature of programs that serve low-income CSHCN populations. There is already some precedent in commercial products for lower cost-sharing provisions for CSHCN.⁶³

1J) Recommendation: Provide SCHIP CSHCN with access to wrap-around services using program designs that balance fairness, innovation, and administrative efficiency considerations. While Medicaid clients would clearly be entitled to all medically necessary core and wrap-around services, the streamlining project could provide SCHIP clients with access to all, some, or none of the wrap-around package, as determined by budget-neutrality considerations. HCPF has commissioned an analysis of SCHIP claims to estimate how many SCHIP children would qualify for wrap-around services. The projected budget per SCHIP eligible is currently unknown and could be high, medium or low. The final model should balance fairness, innovation, and administration. Examples for different budget scenarios are presented in the rationale section.

Rationale: If the estimate of the number of SCHIP clients needing wrap-around benefits is small, the streamlining project could give them access to full wrap-around benefits. This option represents a “fully-streamlined” program in which there are no benefit distinctions between Medicaid and SCHIP beneficiaries. Differences in benefits are driven by health status, not program eligibility. Budget permitting, this model is preferred due to its administrative simplicity and equitable design.

If the above-described “fully-streamlined model” fails to meet budget neutrality requirements, a voucher system may be an alternative. This model calls for providing SCHIP CSHCN who meet certain state-defined criteria with a cash “voucher” to use wrap-services. Colorado is an innovator in the consumer-direction of long-term care services, and the streamlining project may be able to build upon this experience and existing systems for voucher management. This voucher model assumes that the total budget is sufficiently large that the per capita voucher has reasonable purchasing power.

The streamlining project savings may end up being modest relative to the wrap-around service needs of SCHIP CSHCN (e.g., a few dollars per eligible client). In this event, the streamlining project should reframe the issue as one of core services enhancement. This recommendation is based on the assumption that the cost of programming very limited access to wrap-around benefits would likely consume most of the available budget. It would therefore be preferable to “add” to or enhance the core benefit package. In this “low budget” model, wrap-around benefits would be limited to Medicaid-eligible clients.

1K) Recommendation: Identify and maximize operational synergies and efficiencies for CSHCN served by the streamlining project and CSHCN served through the traditional Medicaid program. The HCPF assumption that “traditional Medicaid” (and not the streamlining project) would continue to serve SSI, Children’s Waivers, and foster care is premised on documented differences in their eligibility spans and service utilization patterns, as well as financing considerations. However, some of the requisite systems changes and infrastructure development (e.g., wrap-around package design) associated with the streamlining project implementation could benefit clients in the traditional Medicaid program and vice versa. A “shared” wrap-around package infrastructure is consistent with the administrative services organization (ASO) concept that Medicaid has already been exploring. The state should seek to identify and maximize opportunities to improve both programs as it develops its operational plan.

Rationale: In Colorado, the Medicaid managed care program has operated in recent years as a wrap-around model. Traditionally, the state has negotiated with plans to define an explicit and fixed scope of services (known as Exhibit A). The financing of these plan-administered benefits has varied over the years. Services *not* included in the managed care contract are “wrap-around” services, primarily administered by the state.

As described elsewhere in this paper, these separately-administered wrap-around services constitute an unwieldy and uncoordinated “program” that is expensive (staff-intensive) to administer, difficult for clients and providers to navigate, and nearly impossible to monitor in any comprehensive sense. Many of the streamlining recommendations regarding the design of wrap-around benefits respond to this Medicaid wrap-around experience. Wrap-around administrative structures developed to support the streamlining project could also potentially serve the “traditional” Medicaid program and address some of the above-described issues.

For example, Connecticut has implemented a contractor-administered wrap-around package concept for SCHIP and Title V. The service packages are similar for both programs; the financing is almost entirely separate. The SCHIP and Title V programs merely “share” the same wrap-around infrastructure. By analogy, the Colorado streamlining project could provide the impetus for developing a plan-administered wrap-around package that could also be used by the traditional Medicaid program.

POLICY OPTION 2: **IMPLEMENTING A CSHCN POPULATION CARVE-OUT**

Policy Option Description:

The CSHCN population carve-out model simply proposes identifying children who need services beyond core benefits and excluding them from the streamlining project. Rather than merging (mainstreaming) CSHCN with other populations, this model treats them as a separate and distinct group, requiring different benefits, delivery systems and purchasing arrangements. They are therefore “carved out” of the programs and systems that serve other children. In particular, the CSHCN population carve-out model dispenses as “unworkable” the notion of a wrap-around package for some or all CSHCN. Instead, it proposes enrolling healthy Medicaid- and SCHIP-eligible children in a program modeled after the current SCHIP program.

Service delivery options for CSHCN would depend on eligibility and budgetary considerations. For Medicaid children, the population carve-out would allow them to continue to receive their benefit entitlements under the traditional Medicaid program. The CSHCN carve-out would likely be restricted to Medicaid clients, unless the streamlining project had sufficient funds to make partial or full Medicaid benefits available to SCHIP CSHCN. In the latter scenario, SCHIP CSHCN could also be “carved out” of the streamlining project.

Rationale: The rationale for implementing the CSHCN population carve-out recognizes the challenges associated with implementing wrap-around models that function well for CSHCN. After implementation of the streamlining project, the “traditional” Medicaid program would necessarily evolve into a program that specializes in the care of CSHCN. The carve-out model is presented as a “second choice” to the “preferred” wrap-around model because of the value that CSHCN advocates and providers place on integrated programs and due to concerns about the long-term sustainability of a population carve-out. However, a population carve-out program that is sustainable and adapted to the needs of CSHCN is preferable to a poorly designed wrap-around package that may introduce access barriers.

Wrap-Around Implementation Challenges

The wrap-around model implicitly assumes that CSHCN within the SCHIP and Medicaid populations can be well served under a model that mainstreams them with healthy children, at least for core benefits. The population carve-out model makes the opposite assumption. It concludes that the operational challenges of a wrap-around model, as reviewed elsewhere in this paper, demonstrate that mainstreaming CSHCN with other children serves neither population well, especially CSHCN.

Carve-Out Model Advantages

Clearly one motivation to carve-out CSHCN is to allow them to opt-out of programs that may not be well-suited to their special needs. For example, HCPF had already planned to “carve out” from the streamlining project certain Medicaid eligibility categories (SSI, children’s waiver, and foster care categories). Beyond this primarily reactive motivation, population carve-outs can be more constructively premised on the desire to design programs, tailor services, and build networks that respond to the unique needs of CSHCN. Discussions with Medicaid staff indicate there is interest in evolving the Medicaid program into a program that specializes in the service provision to CSHCN. The Children’s Medical Services (CMS) program in Florida is another example of a specialty program that serves *only* CSHCN (Medicaid, SCHIP, Title V and uninsured) under a population carve-out model.

This paper sidesteps, for now, taking a position on whether CSHCN would be better served under a wrap-around or carve-out model. It instead concludes that evaluation of either model requires a careful analysis of data not yet available: claims analysis, budget-neutrality calculations, and operational details. For this reason, the paper’s recommendations explicitly link policy options with implementation assumptions. The following section presents five key carve-out model implementation recommendations for the streamlining project. The state may want to consider modeling both a wrap-around and a carve-out option before making a final design decision.

CSHCN Population Carve-Out Model Implementation Recommendations

2A) Recommendation: Prioritize the allocation of any streamlining project cost-savings toward providing a “population carve-out” option for SCHIP CSHCN. As described, the motivation for the CSHCN carve-out is aimed at allowing them to opt-out of a program that may not be well-suited to their special needs. As described, HCPF had already planned to allow certain CSHCN (SSI, Waiver, and Foster Care eligibility categories) to opt-out of the streamlining project. However, this “carve-out” model assumes there is an alternative model (e.g., traditional Medicaid) to “opt-into”. That alternative model is currently lacking for SCHIP CSHCN who, unlike Medicaid-eligibles, are not entitled to full Medicaid benefits. However, this recommendation calls for extending a carve-out option to SCHIP CSHCN.

Rationale: The carve-out model works best if *both* Medicaid and SCHIP CSHCN populations are carved out. As described in the introduction, a major objective of the streamlining project is to address the “bouncing” between Medicaid and SCHIP programs and the concomitant service delivery disruption this movement between programs causes. CSHCN will not benefit from the streamlining program if only Medicaid-eligibles are carved-out and SCHIP CSHCN remain “carved in”. CSHCN will continue to “bounce” between delivery systems as their eligibility status shifts between the SCHIP and Medicaid programs.

If the estimate of the number of SCHIP clients needing wrap-around benefits is small, the streamlining project could grant access to full Medicaid benefits through the carve-out option. In this model, differences in benefits are driven by health status, not program eligibility. Healthy children are enrolled in commercial-like plans; CSHCN are provided more comprehensive Medicaid coverage. Budget permitting, this model is preferred due to its administrative simplicity and equitable design. In particular, SCHIP CSHCN would benefit from access to an evolved Medicaid program that aims to develop tailored services and build networks that respond to the unique needs of CSHCN.

If budget neutrality requirements preclude the extension of full Medicaid benefits to SCHIP CSHCN, HCPF could explore the systems implications of programming benefit limits into the “evolved” CSHCN-specific Medicaid program. Independent of the streamlining project, the Colorado Medicaid program is undertaking its own reexamination of purchasing strategies. In particular, it is exploring an administrative service organization (ASO) model with a fee-for-service reimbursement strategy. The SCHIP CSHCN carve-out could be designed into request for proposals.

2B) Recommendation: Implement multiple strategies to identify CSHCN who need to be carved-out. The CSHCN identification needs for the carve-out model parallel those required under the wrap-around model. Identification strategies must target three conceptual categories of CSHCN: children who have diagnosed conditions and on-going needs, children who have a newly-diagnosed conditions, and children with a time-limited needs (e.g., post-surgical therapy). An application-based screening tool is recommended. The tool would need to be brief and sensitive to service needs beyond core benefits. In addition to identification at application, referrals to the carve-out option should be accepted from providers, MCO case managers/staff, and families. Contract language with plans should require MCO and staff training about the carve-out program and the development of automated processes for identifying CSHCN in need of referrals, based on certain triggering diagnoses or events: inpatient admissions, traumatic injuries, certain diagnosis and procedure codes, etc.

Rationale: Multiple methods for identifying CSHCN are necessary to ensure adequate access to needed services.^{64,65} The rationale for a brief screening tool at the point of application is to prevent inappropriate CSHCN enrollment in the streamlining project.

The literature has documented that lengthy validated CSHCN screening tools can be adapted to “short forms” without seriously undermining their ability to detect CSHCN.^{66,67} The Colorado SCHIP program previously used a short screen to identify CSHCN. But because the tool was poorly aligned with the programmatic need (identifying children potentially eligible for Title V services), it over-identified CSHCN and was abandoned. A variety of CSHCN tools exist reflecting the multiplicity of definitions and program purposes for identifying them. The state should review this literature to identify tools that are specific to the program purpose: identifying those with “extra-core” service needs.

As noted, consumers often depend on their health plans or providers for knowledge about benefits. MCO staff and provider training and information systems technology are therefore an essential complement to an efficient carve-out referral system. Health plans are innovators in the area of disease management programs that make creative use of information systems to identify and track the health status and utilization of enrolled beneficiaries. This concept and the related systems can be extended to the identification of CSHCN in need of the population carve-out program. Finally, permitting families to self-refer, as Connecticut does, provides a safety-valve in the event that formal systems for CSHCN identification fail.

In contrast to the wrap-around model, a sudden decline in health status (e.g., due to a traumatic injury) may require a change in provider networks as the child moves from the streamlined program into the carve-out program. The program design will need to address necessary systems to ensure a smooth transition between programs. Colorado may be able to look toward Florida’s population carve-out model for operational strategies.

2C) Recommendation: Ensure that any proposed cost sharing provisions do not impose unreasonable financial burdens or other unintended consequences for CSHCN. If the streamlining project imposes new cost-sharing requirements, the final costs-sharing design should be appropriately calibrated to a low-income population and recognize the unique utilization patterns of CSHCN. In particular, total out-of-pocket cost should be limited.

Rationale: Health policy analysts generally concur that well-designed cost-sharing provisions can be used to discourage inappropriate health care utilization in favor of more appropriate health seeking behavior (e.g., seeking non-emergency services from a primary care provider rather than through the emergency room).⁶⁸ For example, many cost-sharing models intend to make health care consumers sensitive to the price differences in accessing services in different settings (e.g., primary care vs. emergency room) by requiring higher cost-sharing to receive care in more expensive settings.⁶⁹ Similarly, cost-sharing provisions that accrue at the time of service (e.g., co-payments) aim to discourage unnecessary visits.⁷⁰ Health services research has also demonstrated that cost-sharing provisions need to be designed carefully, because cost-sharing that is too onerous risks discouraging both inappropriate and appropriate utilization.⁷¹

Under current regulations, Medicaid generally permits no cost-sharing for children. In contrast, SCHIP legislation permits cost-sharing for families with incomes above 150% FPL, up to 5% of the family income. For SCHIP families below 150% FPL only “nominal cost sharing is allowed”.⁷² These federal regulations have limited the extent to which cost-sharing may be used to control inappropriate utilization for Medicaid and SCHIP. As a waiver project, the streamlined program may waive these provisions and impose new cost-sharing requirements.

Cost-sharing design requires special considerations for CSHCN. CSHCN are by their very definition a high-utilizing population that requires “health and related services of a type or amount beyond those required by children generally”.⁷³ Cost-sharing provisions that anticipate the utilization patterns of average healthy children should be analyzed for unintended consequences for CSHCN. For example, definitions of appropriate and inappropriate use of emergency and specialty services may need to be adapted for this population. Given the higher use of services for CSHCN, even “nominal” cost-sharing for services can become significant. Limits on out-of-pocket cost limits that encompass all the various forms of cost-sharing (premiums, deductibles, co-payments, etc.) are therefore a critical feature of programs that serve low-income CSHCN populations. There is already some precedent in commercial products for lower cost-sharing provisions for CSHCN.⁷⁴

The population carve-out design facilitates the tailoring of the cost-sharing strategies to CSHCN and this opportunity should be exploited.

2D) Recommendation: Assess network adequacy and sustainability of a population carve-out program prior to its implementation. The successful creation of a separate CSHCN carve-out program requires that a sustainable delivery system can be developed that is appropriate to their comprehensive service needs. Adequate financing of this network is a key ingredient to long-term program sustainability.

Rationale: Prior to the completion of the streamlining project's claims analysis, it is difficult to forecast the potential size of the CSHCN carve-out population. However, a separate streamlining market analysis has concluded that a volume of 30,000-50,000 enrolled lives is necessary to promote managed care plan stability.⁷⁵ HCPF estimates that the *total* enrollment for children in SSI, foster care, and children's waiver categories is approximately 21,000. Based on this very preliminary analysis, it seems likely that a population carve-out program would need to be administered by a single plan, or more likely, on a fee-for-service basis.

Ensuring pediatric network adequacy and capacity are critically important to CSHCN-specific carve-out model. Several providers and advocates raised concerns about whether providers would continue to participate in the Medicaid fee-for-service program if it served only CSHCN. According to state staff, some providers already restrict their participation in the Medicaid program to serving as providers on managed care plans because of the administrative requirements associated with the fee-for-service program, especially service authorization requirements. Since CSHCN are a high-utilizing population, these administrative burden concerns are likely to be exacerbated under a carve-out model.

Nationally, Medicaid provider rates are a persistent provider complaint.^{76,77} The concern is especially acute for providers of CSHCN. For example, providers report that it takes longer on average to serve CSHCN, especially for primary care services.⁷⁸ Current rates do not adjust for longer than average primary care visits at the provider level. Anecdotally, providers describe managing this risk by restricting the number of Medicaid clients, and especially the number of Medicaid CSHCN, admitted to their practice.

Compensatory adjustments to rates may be necessary to prevent a population carve-out program from collapsing due to unsustainably low provider participation. The Florida population carve-out model, for example, operates under a managed care model and pays rates that are ten (10) times higher than those paid to the plans that do not serve CSHCN.⁷⁹

Beyond attending to rate setting issues, the state should formally assess -- *prior to implementation* -- provider willingness to participate in a CSHCN-only carve-out program, especially in rural areas.

2E) Recommendation: Blend the strengths of private and public approaches to case management, disease management, and care coordination to ensure that key functions (e.g., service authorization, access-facilitating services, cost-shifting protections) are well-implemented. Case management, disease management, and care coordination are “terms of art” that are variously used to describe a wide array of functions: utilization review, clinical care communications, CSHCN identification, health status tracking, eligibility assessment, care planning, service authorization, access-facilitating services, information and referral (including non-medical services), family support services, regulatory compliance activities (e.g., EPSDT education and information; HCBS waiver cost-containment reporting), among other functions. Therefore, the development of case management model(s) for the streamlining project should proceed first by identifying the desired functions. Although not an exhaustive list of “desired functions”, seamless implementation of wrap-around services clearly requires attention to: CSHCN-specific service authorization procedures, and other access-facilitating services. The final case management model should blend commercial sector strengths (e.g., disease management programs) with public sector expertise (e.g., access facilitation, cultural competency, knowledge of CSHCN-specific services).

Rationale: This recommendation recognizes that the final streamlining project “case management” design is the focus of a subsequent operations-specific paper. It is therefore more directive about process (e.g., function identification prior to final model selection) than content.

Assuming the population carve-out would operate under a fee-for-service arrangement, case management and care coordination services represent one of the few network management strategies to influence appropriate utilization patterns and to facilitate access to care. One function important to CSHCN is tailoring service authorization procedures and utilization controls to the unique health needs of CSHCN. Service utilization patterns differ for healthy children and CSHCN. Therefore, administrative safeguards against unnecessary utilization need to be responsive to these differences. The population carve-out design facilitates the tailoring of service authorization strategies to CSHCN and this opportunity should be exploited. The CSHCN literature documents many strategies that states can use to adapt service authorization procedures to CSHCN, including: PCP prior authorization authority for most or all services, standing referrals for CSHCN specialty care, and electronic “paperless” referral systems.^{80,81}

If SCHIP CSHCN are permitted participate in the population carve-out model, a case management function may provide the means for managing any benefit differences between SCHIP CSHCN and Medicaid CSHCN. Florida’s CMS program integrates Medicaid and SCHIP CSHCN into a single delivery systems (while maintaining separate benefit entitlements) and may provide a model for Colorado.⁸²

Again, a subsequent paper on case management will seek to identify core functions (including CSHCN-specific service authorization mechanisms) and integrate them into a comprehensive case management plan.

ENDNOTES

¹ Federal EPSDT requirements described in 42 U.S.C. § 1396d(a) define medical necessity as that which is necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening even if the condition cannot be prevented or cured. According to the State Medicaid Manual "... the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan." HCFA, State Medicaid Manual §5110).

² Price M. Benefit Package Recommendations for a Streamlined Program. Commissioned Paper for the State of Colorado Department of Health Care Policy and Financing. 2004; MA: MDF and Associates.

³ "Low income families and children" refer to those categorically eligible for Medicaid under 1931 and BabyCare/KidsCare programs.

⁴ Fox HB et al. Resource Paper: SCHIP Innovations for Children with Special Needs in Managed Care. 2003(February); Washington, DC: MCH Policy Research Center.

⁵ Dutton M et al. Creating a Seamless Health Insurance System for New York's Children. 2001(February); New York, NY: Children's Defense Fund – New York.

⁶ Kaye N. Children with Special Health Care Needs: An Assessment of State Activities and their Relationship to HCFA's Interim Criteria. 2000(February); Washington, DC: National Academy of State Health Policy.

⁷ Fox HB et al. 2003(February).

⁸ Shenkman E and Bono C. Florida KidCare Program Evaluation Report. 2003(January); Gainesville, FL: University of Florida Institute for Child Health Policy.

⁹ Family Voices. Beginning the Conversation: A Report of Family Voices's Interviews with Seventeen Managed Care Organizations. (Revised) 2001(November); Family Voices.

¹⁰ Hanes PP. 1997 OHP Parent Satisfaction Survey. 1998; Portland, OR: Child Development and Rehabilitation Center.

¹¹ Fox HB et al. The Strengths and Weaknesses of Private Health Insurance Coverage for Children with Special Health Care Needs. 2002; Washington, DC: MCH Policy Research Center. p ii.

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