CATALYST CENTER

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

Medicaid and the Children's Health Insurance Program: Funding, Service Delivery, and Quality

July 18, 2012

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Introducing today's speakers…

Beth Dworetzky, Assistant Director, Catalyst Center

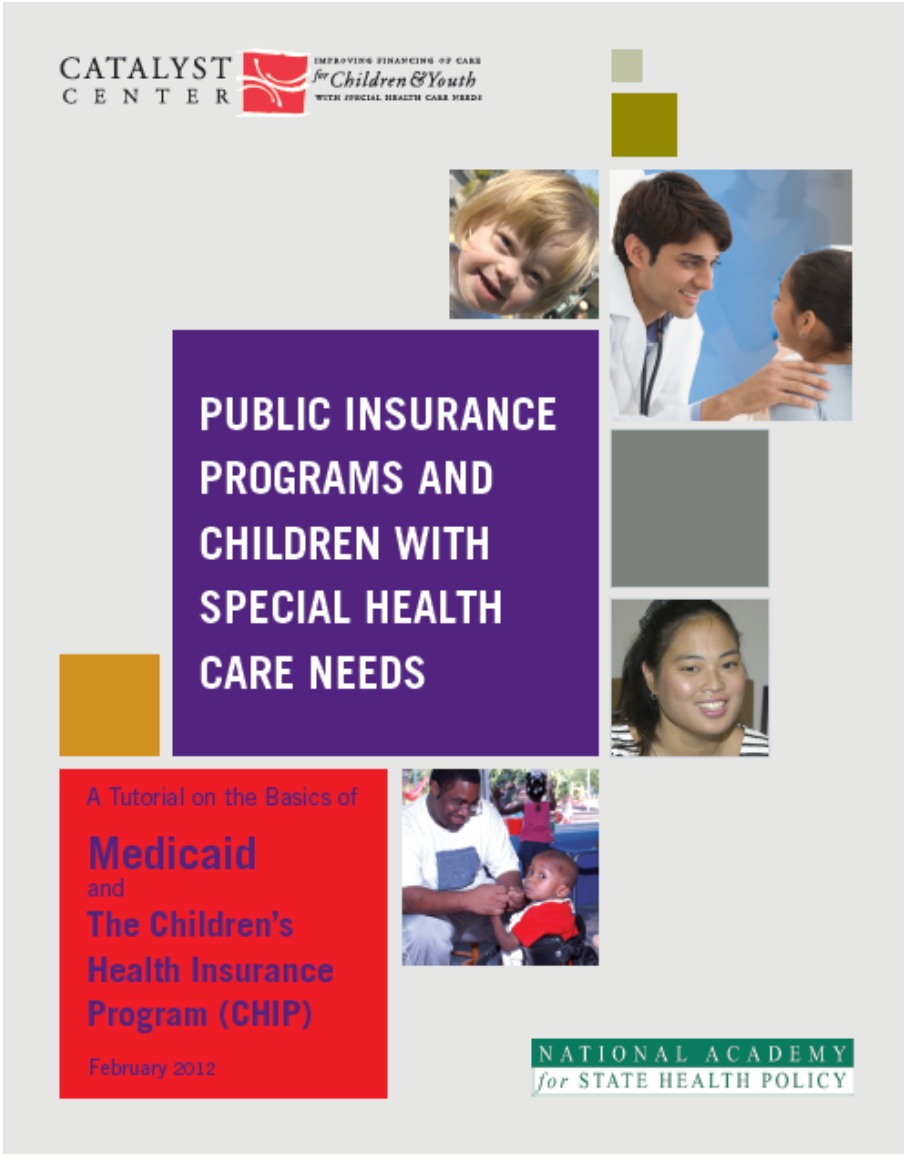
Sally Bachman, Research Director, Catalyst Center

Gina Rogers, Project Director, Massachusetts Child Health Quality Coalition

Meg Comeau, Project Director, Catalyst Center

The Catalyst Center: Who are We?

- **Funded by** the Division of Services for Children with Special Health Needs within the federal Maternal and Child Health Bureau
- **A project of** the Health and Disability Working Group at the Boston University School of Public Health
- **The National Center dedicated to the MCHB outcome measure**: "…all children and youth with special health care needs have access to adequate health insurance coverage and financing"



"The Tutorial":
a stepping stone
to developing effective
partnerships with
Medicaid and CHIP
programs, so we can all
better serve CYSHCN
and their families....

Found at:
http://www.hdwg.org/catalyst/medicaid-tutorial

Tutorial Learning Objectives

By completing the tutorial, participants will:

- Increase their understanding of state Medicaid and CHIP programs and policies
- Learn how partnerships with other stakeholders can maximize Medicaid and CHIP program capacity to meet the needs of CYSHCN
- Begin to identify specific opportunities to promote partnerships with the Medicaid and CHIP programs in their own state

Financing: How Do Medicaid and CHIP Dollars Flow?

- Medicaid and CHIP account for over 15% of total U.S. health care spending
- Medicaid is often one of the largest state budget line items
- Medicaid uses state and federal funding
- Federal Medical Assistance Percentage, better known as FMAP or the “federal match”
  - FY 2011 state FMAP ranged from 50-75% for medical services
  - States with lower per capita incomes receive higher FMAP rates
  - For example, New York FMAP is 50% and Mississippi is 74%
  - Medicaid state share usually financed by state general funds

Financing: How Do Medicaid and CHIP Dollars Flow?

- States receive 50% matching federal funds for their *administration* of Medicaid
  - Title V may engage in outreach or consumer assistance activities and be able to claim federal Medicaid matching dollars for these activities
  - Medicaid and Title V can build cooperative agreements using Medicaid to fund partnership activities

Financing: How Do Medicaid and CHIP Dollars Flow?

- CHIP funding is also state and federal, but:
  - Unlike Medicaid, federal CHIP funds are capped and allotted for two years
  - States receive an enhanced federal matching rate ranging from 65% to 83% for CHIP – sometimes called the eFMAP

Find out in your state....

- Find out the FMAP in your state: http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4
- Find out the eFMAP in your state: http://www.statehealthfacts.org/comparetable.jsp?ind=239&cat=4
- Does your state Title V program currently receive Medicaid reimbursement for either direct health services or administrative activities?
- Could any of your state's Title V services or activities currently funded through state dollars be supported through federal funds by the Medicaid match?

Service Delivery Models: How Do States Deliver Health Care Services to Children Enrolled in Medicaid and CHIP?

- States deliver Medicaid and CHIP health services by:
  - Contracting with managed care organizations (MCOs) to deliver care and pay providers
  - Some services may be carved out of managed care
  - Primary care case management
  - Paying health care providers directly on fee-for-service basis for each service provided
  - A combination of these

Service Delivery Models: Managed Care Organizations (MCO)

- MCOs are paid a set amount per person per month to run the program and pay providers for care of enrolled CYSHCN
- Payment called “capitation rate” or “per-member-per-month rate” (PMPM)
- Capitation payments place MCO at financial risk if the MCO provides more services than capitation payment covers
- Capitation methodology may create financial disincentive to provide services

Service Delivery Models: Managed Care

- Capitation rates paid to MCOs must be "actuarially sound"
  - o Developed by professional actuaries
  - o Based on previous health care expenditure experience for group
- Capitation rates are usually "risk adjusted" according to characteristics such as age, gender, category of assistance, geography, etc.

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Service Delivery Models: The importance of risk adjustment

- Risk adjustment allows states to pay plans more for more costly populations and less for less costly populations – it helps "level the playing field"
  - For a more detailed analysis of the importance of risk adjustment to CYSHCN and a description of various models, see the Catalyst Center brief

    Risk Adjustment and Other Financial Protections for Children and Youth with Special Health Care Needs at http://hdwg.org/catalyst/risk

Service Delivery Models: MCO standards include...

- Contractual requirements such as:
  - Adequacy of the MCO's provider network to serve enrollee population
  - Monitoring and evaluation of health care quality
  - Ability of Medicaid beneficiaries to appeal decisions about health care benefits
  - Specific quality benchmarks or special programs or services

Service Delivery Models: MCO enrollment can be mandated

- States can mandate managed care enrollment through a CMS sponsored 1915(b) “freedom of choice” waiver
- 1997 Balanced Budget Act (BBA) allows states to mandate managed care enrollment through Medicaid state plan, although several groups are excluded
- Excluded children include those who are eligible through SSI, in home- and community-based settings, in foster care or other out-of-home placement, or receiving services through a family-centered, community-based coordinated care system receiving Title V grant funds

Service Delivery Models: Primary Care Case Management

- PCCM programs are common Medicaid delivery systems combining aspects of managed and fee-for-service care
- PCP agrees to deliver primary care services, manage access to specialty services, and coordinate care
- Health care providers are paid on fee-for-service basis when they deliver care
- Primary care provider is often paid an additional fee per person for managing the care

Service Delivery Models: What are opportunities for Title V?

- Help Medicaid develop and monitor contracts with managed care plans (including standards)
- Help participate in building the medical home model and improving preventive and developmental care in pediatric primary care practices
- Help design and administer the health home option (Section 2703) under the ACA for children with certain chronic conditions
  - To learn more about health home option, go to http://hdwg.org/catalyst/news/2011-12-03/1

Service Delivery Models: What are opportunities for Title V?

- Play a role in linking pediatric primary care providers who provide EPSDT screenings to referral resources for diagnosis and treatment
- Help assure that education and other community-based programs that screen children link back to the child's health care providers
- Help ensure managed care provider networks include critically important CYSHCN service providers
- Provide assistance to Medicaid on quality improvement strategies and implementation of Bright Futures

Service Delivery Models: Find out in your state

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

Quality Measurement and Improvement

- Medicaid state plan reporting requirements
  - Medicaid required to report annually on EPSDT
  - Annual report includes information on number of children who receive medical and dental screens and number referred for diagnostic work-up or treatment
  - Data are important for determining if children are routinely screened and whether the children identified receive appropriate follow-up
  - Each state is required to list the quality measures it is using, how they will be measured in the CHIP state plan, and to report on measures annually to CMS

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Quality Measurement and Improvement: Requirements for MCOs

- States required to include provisions in MCO contracts to assess quality and appropriateness of care and services furnished by MCOs
- One provision is a requirement to evaluate care provided to children and adults with special health care needs
- When the MCO is paid on a per-member-per-month (PMPM) basis for each enrollee, both Medicaid and CHIP are required to engage an independent External Quality Review Organization (EQRO) to evaluate quality, timeliness, and access to care furnished by MCO
- EQROs evaluate quality of care through Performance Improvement Projects (PIP), which is a structured process to identify an issue, collect data about the topic, and make improvements

Quality Measurement and Improvement: Specific child health care quality measurements

- Under CHIPRA, the federal government is required to develop child health care quality measures for voluntary use by states in Medicaid and CHIP
- HHS published 24 initial core measures in 5 areas:
    - Prevention and health promotion
    - Management of acute conditions
    - Management of chronic conditions
    - Family experience of care
    - Availability of care

Quality Measurement and Improvement: Consumer satisfaction reporting

- CHIPRA requires CHIP programs to report annually on consumer satisfaction measures
  - Many states use AHRQ's CAHPS Child Medicaid Survey to measure consumer satisfaction
  - All CHIP programs are required to submit CAHPS data by December 31, 2013
- Medicaid reporting of CAHPS data is voluntary
- CAHPS has a set of questions for assessing satisfaction with care for children with chronic conditions; includes a five-item screener to identify them

Massachusetts CHIPRA Grant

Support the development and maintenance of an integrated approach to measurement and improvement across all settings of

child health care delivery that will lead to transformational gains in

children's health and outcomes

Project Overview

Core Measures-Cat A

- Calculate and analyze results from commercial and Medicaid data
- Report to providers and families (practice level) and CMS (Medicaid level)
- Determine usefulness of measures and reports as QI support tool and for health care decision making

Medical Home-Cat C

- Transform 13 primary care practice sites to medical homes
- Support transformation through a Learning Collaborative
- Provide state supported care coordination resources
- Disseminate lessons learned

Project Overview

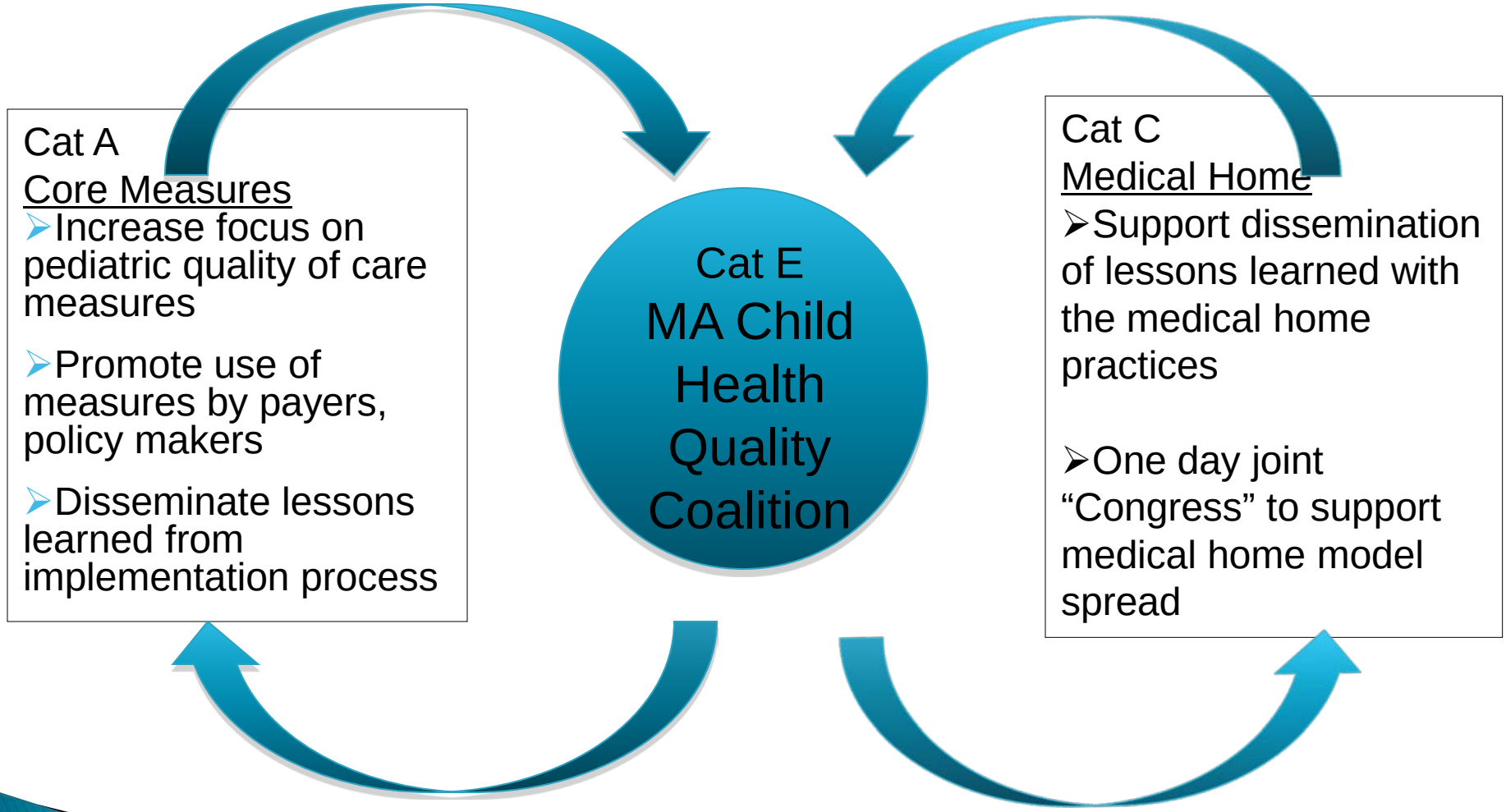
Coalition Building-Cat E

- Create a statewide, multi-stakeholder Child Health Care Quality Coalition
- Support an integrated approach to child health care quality and measurement

New Measures-Cat E

- Identify areas in need of new measurement in the priority areas of Coalition focus
- Support development of new measures

Coordination Across Three Grant Tracks



Quality Measurement and Improvement: What are opportunities for Title V?

- Collaborate with CHIP and Medicaid in interpreting children's health quality data across all programs
- Monitor EPSDT screening ratios and collaborate on strategies to reach the 80% screening benchmark
- Analyze service utilization data for CYSHCN enrolled in Medicaid and CHIP to improve care delivery

Quality Measurement and Improvement: What are opportunities for Title V?

- Collaborate with Medicaid and CHIP to develop PIPs on quality measures that impact CYSHCN
- Work with Medicaid and CHIP or Managed Care Organizations to train PCPs in caring for CYSHCN
- Collaborate with Medicaid on state's targeted case management and EPSDT services structured to improve care coordination for CYSHCN

Quality Measurement and Improvement: Find Out in Your State

- What data on service utilization and outcomes does your agency have for CYSHCN who are enrolled in Medicaid or CHIP?
- If your state Medicaid program operates under a managed care environment, who is the contracted EQRO? Does or will CHIP use the same EQRO?
- What pediatric quality measurement and reporting is required from providers or plans by your state Medicaid agency?

Quality Measurement and Improvement: Find Out in Your State

- What kind of training is provided in your states for primary care providers who care for CYSHCN? Who provides this training?
- What is your state's EPSDT screening rate?
- Are any statewide or community-based learning collaboratives focused on improving care?

Questions and Discussion....

To make a comment or ask a question:

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(Press *6 again to re-mute it)

Moderator: Beth Dworetzky

Please join us for the last webinar in this series

- What Changes Can I Expect from the ACA and How Do I Make the Case for Partnership in My State?
- Wednesday, September 19th, 2012
- 2:00 pm - 3:00 pm EDT

Questions and Comments...

Please fill out a webinar participant survey at:
https://www.surveymonkey.com/s/tutorial4

Thank you for joining us!

For more information,
please contact us at:

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