Improving State Medicaid Contracts and Plan Practices for Children with Special Needs

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Abstract

The rapid transition of state Medicaid beneficiaries into fully capitated managed care plans requires a special focus on children with chronic or disabling conditions, who often depend on numerous pediatric physicians and other specialty services for health care and related services. Because managed care arrangements for this population are growing in popularity nationwide, it is important that states craft managed care contracts to address the unique needs of children with complex physical, developmental, and mental health problems. Based on the research reported in this article, in-depth interviews with state Medicaid agency staff, interviews with medical directors and administrators of managed care plans serving Medicaid recipients, and input from experts in pediatrics and managed care, a set of recommendations is made for tailoring managed care contracts to meet the needs of this vulnerable group of children.

Six contracting elements that should be adopted by state Medicaid agencies include (1) clarifying the specificity of pediatric benefits, (2) defining appropriate pediatric provider capacity requirements, (3) developing a medical necessity standard specific to children, (4) identifying pediatric quality-of-care measures, (5) setting appropriate pediatric capitation rates, and (6) creating incentives for high-quality pediatric care.

Nine approaches that should be adopted by managed care practices interested in providing high-quality care for children with special needs also are identified. These include (1) ensuring that assigned primary care providers have appropriate training and experience, (2) offering support systems for primary care practices, (3) providing specialty consultation for primary care providers, (4) establishing arrangements for the comanagement of primary and specialty pediatric services, (5) arranging for comprehensive care coordination, (6) establishing flexible service authorization policies, (7) implementing provider profiling systems that adjust for pediatric case mix, (8) creating financial incentives for serving children with special needs, and (9) encouraging family involvement in plan operations.

Implementing these changes to managed care contracting could have a major impact on the quality and comprehensiveness of health care received by children with special needs. Successful implementation, however, requires strong support from both state Medicaid agencies and the managed care plans dedicated to serving this population.

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Medicaid-eligible children are being enrolled in fully capitated managed care plans at a rapid rate as states make the transition from fee-for-service to capitated arrangements. This transition is part of an effort to control spiraling Medicaid costs and to provide recipients with “medical homes” for most of their health care services. This shift to Medicaid managed care may have its most profound effect on poor children with chronic or disabling conditions, because of their reliance on a wide variety of physician and other specialty services. Under fee-for-service arrangements, these children sometimes had their primary and preventive care neglected, but they generally were able to receive specialty care through tertiary care centers, specialty clinics, and independent practitioners experienced in the treatment of children’s developmental or mental health problems. Their care was often coordinated through public health providers reimbursed by Medicaid. Under fully capitated managed care arrangements, children with chronic or disabling conditions, like other children, receive their care in a system that is designed to control the use of specialists, especially those outside of their plans’ networks. While research reveals that children enrolled in fully capitated plans may be receiving equivalent or better levels of preventive and primary care compared to children receiving care under fee-for-service Medicaid, the limited studies on specialty care suggest that enrollment in managed care decreases utilization of specialists by children.1

State Medicaid agencies, however, still are in the early stages of the transition to fully capitated managed care for special needs populations. Substantial opportunities remain for states to examine the best ways to serve children with various kinds of chronic or disabling conditions through managed care. This article reviews the options available to states and the plans for tailoring managed care policies to meet the unique needs of children with complex physical, developmental, or mental health problems. Information was gathered during 1995 using a variety of research methods, including an extensive review of the literature on Medicaid managed care for children with developmental, behavioral, emotional, and complex physical conditions. To learn about state policies governing managed care, telephone interviews were conducted with Medicaid administrators in the 29 states that were using fully capitated managed care plans to serve Medicaid children as of March 1995. Also, managed care contracts were analyzed, and on-site interviews were conducted with state Medicaid agency staff in eight states. To learn about plan practices, telephone interviews were conducted with the medical directors or administrators of 22 highly regarded plans serving Medicaid recipients. Finally, an advisory group was convened, and key informant interviews were conducted with experts in the pediatric and managed care fields. Based on the information collected, recommendations were developed. Strategies to improve state Medicaid managed care contracting are discussed in the first section of this article; the second section covers strategies to encourage health plan innovations for children with special health care needs.
Improving State Medicaid Managed Care Contracts

As states gain more experience in contracting with managed care plans on a full-risk basis and begin to enroll children with complex conditions, they are demanding greater value for their premium dollar. State Medicaid programs will need to set special requirements for plans that want to serve these children. Six key elements of contracting and oversight for this population are described in this section.

State Contracting Elements

1. Specificity of Pediatric Benefits

Many commercial plans are likely to have only limited knowledge about the nature and scope of benefits to which children are entitled under Medicaid. These plans may be unfamiliar with the statutory and regulatory requirements of the program, the content of a state's Medicaid plan, or the needs of the Medicaid child population. A number of states have begun to address this problem by providing in their managed care contracts fairly extensive explanations about many of the pediatric services covered under Medicaid.

In developing contract language for plans serving children with chronic or disabling conditions, states need to list and describe pediatric benefits as distinct from those for adults. States may specify the range of interventions that are meant to be included under each benefit category and indicate appropriate delivery settings, health professionals who may provide the services, and, where appropriate, conditions or situations for which the services would be required. States also may find it useful to include a glossary, because managed care plans may interpret many terms and concepts differently than Medicaid agencies. Some Medicaid benefits for children that may need defining include rehabilitation services; outpatient mental health services; therapy services; and medical equipment, supplies, and corrective appliances. The appropriate use of these services for children also may require clarification. Regular informational meetings with plan medical directors can be used to further clarify the scope of Medicaid benefits for children.

It is particularly important that states provide a clear explanation of the early and periodic screening, diagnosis, and treatment (EPSDT) program. States also need to specify what is meant by a developmental assessment, anticipatory guidance, vision and hearing testing, and appropriate laboratory tests, and explain what is intended by the federal requirement to provide all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit. Plans need to know that they have broader service delivery responsibilities for children than they do for adults.

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2. Pediatric Provider Capacity Requirements

Commercial plans, for the most part, have not had to construct provider networks that focus on furnishing comprehensive packages of acute and chronic care benefits for children. As a result, they tend not to include in their networks many of the kinds of providers that Medicaid-eligible children with chronic or disabling conditions may require. Plan enrollment may cause a substantial disruption in these children’s care or place them with providers insufficiently trained to meet their needs. These problems have led some states to include more elaborate pediatric provider requirements in Medicaid contracts, and a few states have established separate reporting requirements regarding pediatric provider participation.

Before enrolling children with chronic or disabling conditions in a managed care plan, states should require that the plan’s provider network is appropriately configured to deliver all contracted services to this diverse population. States should condition the receipt of a contract on meeting pediatric provider network standards, particularly for primary care pediatricians, pediatric specialists, mental health providers, hospitals, home health agencies, and ancillary therapists. The standards could specify the types of providers with pediatric expertise who must be participating in the network or available through other arrangements, require that these providers be available in community-based settings, and stipulate that the numbers and locations of providers be sufficient to assure that care will be delivered in a timely manner. In addition, plans should be required to demonstrate satisfactory arrangements for ensuring access to specialty centers (both in and out of state) for the diagnosis and treatment of rare pediatric disorders. For certain types of services, states may want to stipulate that providers be certified by another state agency, such as the program for child and adolescent mental health services or the Title V Children with Special Health Care Needs (CSHCN) program.

States should require that plans collect and maintain, as part of their credentialing process, information from pediatricians, pediatric specialists, and other licensed practitioners about the nature and extent of their experience serving children with chronic or disabling conditions. This information can be reviewed by the state and included in the member handbook provided to families.

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Another important policy that states can establish is each plan’s obligation to promote the appropriate use of integrated and multidisciplinary provider arrangements for children. Primary and specialty care for children with chronic or disabling conditions should be coordinated to the maximum extent possible, and in certain instances furnished by providers working collaboratively at the same site. This is particularly important with respect to primary care and mental health services for children with secondary mental health problems whose primary diagnoses are complex physical or developmental conditions. Multidisciplinary teams or clinics also may be needed to treat children with conditions such as anorexia nervosa, cerebral palsy, or pervasive developmental disorder, who have multiple symptoms requiring the expertise of various types of providers.

3. Medical Necessity Standard for Children

Plans use the term “medical necessity” to set limits on their benefit coverage and reduce health care utilization. Often, plans require that for items and services to be medically necessary, they must be cost effective or of proven effectiveness, although the pediatric literature in this area is almost nonexistent. In 1995, several states had developed medical necessity standards that reflect children’s needs and omit excessively restrictive criteria; one state had adopted a medical necessity standard specific to children.

Given the lack of consensus about medical necessity criteria, it is essential that states using managed care plans to serve children with chronic or disabling conditions provide in their contracts pediatric medical necessity
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criteria that are consistent with EPSDT and distinct from the criteria used for adults. The easiest way for states to define medical necessity would be to adopt the language of EPSDT, though other definitions consistent with EPSDT policy could be crafted (see Box 1). The language used should convey children’s need for services that maximize age-appropriate functioning and prevent deterioration, and should not incorporate phrases that would deny coverage of potentially useful services.

States also need to stipulate in their contracts that medical necessity decisions for children should be based on peer-reviewed publications, expert pediatric and psychiatric medical opinion, and medical community acceptance. In recognition of the evolving development of pediatric medical knowledge, states may want to require that experimental treatments for rare disorders not be automatically excluded from coverage, but that decisions regarding their medical necessity be considered by pediatric medical review boards. In addition, states may want to require that routine costs associated with investigational procedures that are part of an approved research trial be considered medically appropriate. States need to make clear that Medicaid law prohibits the use of any medical necessity standard that arbitrarily limits coverage on the basis of the illness or condition itself.

Finally, states need to require that each plan communicate its pediatric medical necessity standard to Medicaid providers, along with any practice guidelines or other criteria that the plan will use in making medical necessity definitions. This standard should be included in the plan’s subcontract document, contained in its member handbook, and further explained to parents by each child’s primary care provider.

4. Pediatric Quality-of-Care Measures

Plans’ quality-assessment activities for children typically focus on primary and preventive care and do not distinguish children with chronic or disabling conditions from those who are generally healthy. The only measure widely used by plans to monitor quality of care for a specific pediatric diagnosis is the rate of hospitalization and emergency room use for asthma, the most prevalent chronic condition in childhood. Most other pediatric diagnoses have such low prevalence rates that it is difficult to examine them separately. Recognizing this gap in quality assessment, in 1995, a few states had begun to work with plans to undertake focused studies for selected pediatric conditions other than asthma, and about a dozen states had begun requiring that plans report on certain Medicaid Health Plan Employer Data and Information Set (HEDIS)3 measures that may capture quality of care for at least some subgroups of children with special needs.

Measuring the effectiveness of children’s care—whether in terms of observable health outcomes, the provision of efficacious services, adherence to professional guidelines, family satisfaction, or access to and utilization of services—presents considerable challenges (see the articles by Szilagyi and by Bergman and Homer in this journal issue). Because of a variety of factors, including the low prevalence of most pediatric conditions, the variability of outcomes, and the nature

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Box 1

**Possible Definitions of Medical Necessity for Children**

- Using the *early and periodic screening, diagnosis, and treatment (EPSDT)* program language, a service would be considered medically necessary if it were necessary to prevent, diagnose, correct, or ameliorate a physical or mental illness or condition identified through a screening service.

- An *alternative* approach might be that a service would be considered medically necessary if it were for the maintenance of health or the diagnosis and treatment of a physical or mental condition, or if it were necessary to prevent the deterioration of that condition or to promote the development or maintenance of age-appropriate functioning.
of pediatric interventions, tools for assessing the quality of care provided to children, particularly those with special needs, lag behind those for adults. States need to move forward in this area. As more children with chronic or disabling conditions are enrolled in managed care, states must consider what types of data can be collected through electronic databases, chart audits, or surveys, and analyzed to assess the quality of care for this population. At a minimum, Medicaid HEDIS measures should be adopted. For children with special needs, measures related to the percentage of patients hospitalized for major affective disorders who received follow-up care may be useful. To the extent that states have developed guidelines for the care of children with chronic or disabling conditions, adherence to these guidelines should be monitored. Other potential quality measures could be considered as well (see Box 2).

Given the paucity of reliable tools for measuring effectiveness, it is critical that states require plans to survey parents of special needs children about their children's care. At a minimum, plans should be required to oversample these parents in general family-satisfaction surveys and to report results for them separately. Ideally, plans should be required to administer an additional set of questions at least to a subset of parents whose children have chronic physical or mental health conditions. To achieve comparability across plans, a uniform set of questions addressing quality indicators could be developed by each state (see Box 3).

States also should require that plans report separately on the use of services by children with chronic or disabling conditions. To accomplish this, encounter data for ambulatory care must be disaggregated to isolate information on discrete services such as outpatient mental health, ancillary therapy, home health, and case management. States could ask plans about the percentage of children with special needs who received more than a specified number of visits in each of these service areas. This information could be used to monitor trends within each plan and to identify variations across plans that might require closer examination. However, interpreting the meaning of different levels of utilization within or across plans also should involve assessment of other outcome or process measures, because a higher or lower percentage of visits might reflect either better or worse practice patterns depending on the individual patients' circumstances.

Finally, states need to consider children with special needs in establishing and assessing compliance with access standards. Indicators of access for which standards may be developed include appointment waiting times; travel times to appointments; telephone call-back waiting times; prior authorization response times; and after-hours handling of emergencies. For these children, access standards must apply to specialty as well as primary care services.
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The task of assessing quality for children with chronic or disabling conditions may benefit from a statewide quality oversight committee that includes medical directors of plans serving these children, parents, pediatric subspecialists and other specialty providers, and experts in the field. This committee could provide guidance to the state regarding the identification of appropriate quality standards; the selection of effective tools and techniques for measurement; requirements for data collection, analysis, and reporting; and the significance of particular quality findings. State policies would be needed for dealing with any plans found to provide poor-quality care to children with special needs.

5. Appropriate Pediatric Capitation Rates

States that enroll special needs children in managed care plans need to give the issue of capitation serious attention. Typically, capitation rates for children are adjusted only for demographic variables such as age, gender, and eligibility category, though there is some evidence to suggest that prior expenditure patterns or diagnoses consistently predict future health care costs better than demographic variables alone. Because these crude adjustments may not predict utilization patterns with much accuracy, plans have little incentive to appropriately care for children with the highest-cost conditions, or children with complex conditions who are otherwise ineligible to receive Supplemental Security Income (SSI) payments. The selection of children into health plans based on risk status is a major concern, except where a single plan is being used to serve all children with special needs in a given geographic area on a mandatory basis. Recognizing the inadequacy of current pediatric risk adjusters, in 1995, a few states (Maryland, Michigan, Missouri, Ohio, and Wisconsin) had begun to experiment with more sophisticated methodologies to adjust capitation rates based on the mix of high- and low-risk children that each plan enrolls.

When developing pediatric capitation rates, state Medicaid programs need to arrive at payment systems that account for differences in the risk levels of children across plans and that appear reasonable to plans. In doing so, states need to take into account a variety of factors related to the types of plans that will be participating; the size of the child population to be enrolled; and the extent to which some plans will disproportionately enroll higher- or lower-risk patients. Various approaches to a pediatric risk-adjusted capitation system, using age and at least some other demographic variables, are possible, though they are still being evaluated in this population (see Box 4).

Under any pediatric risk-adjusted payment approach, a state would need to consider

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**Potential Quality Indicators for Children with Special Health Care Needs**

- The percentage of children with chronic or disabling conditions whose primary care providers conducted assessments of their cognitive, emotional, and parent-child functioning and provided appropriate counseling, referral, and follow-up services.
- The percentage of children receiving early intervention or special education services whose primary care providers contributed to the development of their individual service plans and maintained periodic communication with program staff.
- The percentage of children with specific chronic or disabling conditions whose primary care providers developed and implemented plans of care in consultation with families and appropriate specialty providers.
- The percentage of children with chronic or disabling conditions who were readmitted to hospitals within 30 days for the same diagnosis.
- The percentage of children denied psychiatric hospital admission who had alternative plans of care in effect.
whether prior Medicaid utilization data alone constituted a fair experience base from which to calculate capitation rates. A state might need to adjust the rates upward if, for example, a substantial number of children with known chronic or disabling conditions showed no prior-year costs as a result of underutilization, data entry problems, or nonreporting of charity care and public program coverage. Upward adjustments also might be needed in instances in which the state anticipated enrollment of substantially higher-risk children, either for a given plan or for all plans enrolling children with special needs under voluntary arrangements.

Because no pediatric risk-adjustment techniques can predict future resource utilization completely, state policies regarding reinsurance or shared-risk arrangements, designed to protect plans against substantial losses accrued by enrolling high-risk patients, are particularly important. To adequately protect plans against high costs and, at the same time, assure the state that plans will not experience windfall profits, at least two types of reinsurance should be offered (see Box 5).

### 6. Incentives for High-Quality Pediatric Care

Plans have few incentives to provide a higher level of care than required for children with special needs. Plans that fail to meet minimum pediatric quality measures stand to lose their Medicaid business, but those that provide the best care are not rewarded and may incur higher costs by attracting higher-risk patients. In 1995, only one state had instituted policies for rewarding the best-performing plans.

States must consider how to encourage and reward managed care plans for continuous improvement in the care of children with chronic or disabling conditions. For example, plans could be rewarded for making substantial investments in infrastructure and processes to serve these children more effectively, and to the extent that data are available, for improvements in health status or functional outcomes. A state might reward plans that achieved goals related to the early identification and treatment of children with chronic conditions, colocaiton of mental health and primary care services, the provision of comprehensive and coordinated care, parent involvement in plan policymaking, reduced school absences.

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**Possible Questions for a Family-Satisfaction Survey**

- What is the primary care provider’s knowledge, expertise, and training to care for the child?
- What is the primary care provider’s willingness to listen and learn from the parent?
- What is the child’s access to pediatric specialists, mental health professionals trained in children’s care, other health professionals with pediatric expertise, and care coordinators?
- Is there the ability to obtain a second opinion?
- What is the length of time the parent has to wait for a specialty service appointment?
- What is the length of time the parent has to wait for plan approval of a recommended service?
- What is the level of coordination and communication between the child’s physicians and other health care professionals?
- Is there an adequacy of information provided to the parents about the child’s condition and techniques for managing it?
- Is there an adequacy of information provided to the parents about coverage policies and grievance procedures?

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Improving Recommended Elements of Managed Care Practices

In addition to meeting state-established standards for the care of children with chronic or disabling conditions, plans themselves are better suited to serving high-risk children, a state might give preference to plans that had subcontract arrangements with such providers—including early intervention programs, community mental health programs, substance-abuse programs, and specialty medical clinics—and could show evidence of being committed to integrating these providers into their networks. A state might also give preference to plans that had created or integrated into their networks multidisciplinary clinics and other pediatric team practice arrangements.

Potential Approaches to a Pediatric Risk-Adjusted Capitation System

- Calculate a single capitation rate for all children with chronic or disabling conditions and separate rates for perhaps as many as three groups of children with extremely expensive conditions. Plans would be paid for outliers—who could be identified on the basis of prior expenditures or diagnoses or both—based on a separate payment per child with the condition, or using a fee-for-service arrangement. There would have to be a mechanism for identifying outliers after enrollment, but overall, this type of capitation system would be relatively easy for states and plans to administer. It might be most appropriate where children had only one plan in which they could opt to enroll.

- Calculate a number of rates, perhaps as many as seven or eight, based on the prior expenditure patterns of all Medicaid children, including those without chronic conditions. For newly eligible children with no prior utilization experience, an average rate would be paid, but there would be an end-of-year reconciliation to adjust for actual cost experience. This approach, which might be used where several plans were competing to serve all categorical groups of children, would be fairly complex to administer.

- Pay each plan serving children with chronic or disabling conditions a blended rate for this population based on the diagnostic classifications of the children it enrolls. Diagnostic classification groupings with similar prior cost experience would be established and assigned a specific payment amount, which would be added to the baseline capitation amount. Children with multiple chronic conditions would be counted in as many categories as appropriate. To the extent that only SSI-eligible children were included, diagnoses would be available through existing data sources, although some end-of-year reconciliation policy would be necessary to account for children whose diagnoses had changed. This approach might be appropriate where multiple plans were being used to serve SSI-eligible children. If plans also were serving other categories of children, however, it might be necessary to have in place a state-financed mechanism for determining disability among non-SSI children. Undoubtedly, a diagnostic approach to pediatric risk adjustment would be very difficult to develop and implement, and it would be feasible only if the child population were sufficiently large to offer an adequate database in each diagnostic category.

Rewards could include end-of-year bonuses or rate increases for meeting or exceeding quality-of-care objectives, offering longer-term contracts, providing funding for initiating and evaluating new approaches to care, or offering more Medicaid patient volume through mandatory assignments. For such a reward system to work, however, the standards for measuring success and the specific data that would be used would need to be understood by the plans.

In addition to giving rewards for the best-performing plans when awarding contracts, states should consider giving preference to plans with specific features that promote the highest quality of care for children with chronic and disabling conditions. For example, in cases for which there is documented evidence that traditional Medicaid providers for asthmatic children, or other measures.

Box 4

Potential Approaches to a Pediatric Risk-Adjusted Capitation System
may want to initiate new financing and service delivery approaches to serve this population more effectively. The extent of resources that a plan might want to commit and the recommendations that it might elect to introduce would vary, depending in part on the number of children with special needs enrolled and the existing capacity of its provider network.

**Managed Care Plan Elements**

1. **Assignment of Appropriately Trained and Experienced Primary Care Providers**

   As more Medicaid-insured children with chronic or disabling conditions are enrolled in managed care, it is essential for plans to ensure that the primary care physicians who serve them have the requisite training and experience. Mechanisms should be in place for collecting information about the qualifications of pediatric primary care providers and for identifying the provider requirements of children with special needs enrolled and the existing capacity of its provider network.

2. **Support Systems for Primary Care Practices**

   If a plan is unable to find appropriate primary care providers for Medicaid special needs children, it may want to offer office and clinical support to providers interested in developing or expanding their capacity to serve this population. In 1995, few, if any, plans provided this type of support, which could encompass appointment scheduling; consolidated record keeping; telephone advice by nurses; educational materials for families; electronic communication among providers; and treatment guidance regarding predictable symptoms, potential comorbidities, and appropriate referrals. On-site training of nursing staff and office management personnel could be provided, and new computer programs might be offered as well.9

3. **Specialty Consultation for Primary Care Providers**

   A host of complex medical conditions often affect children enrolled in Medicaid, and may be complicated by adverse socioeconomic circumstances. Given the nature
of these conditions and primary care providers’ increased responsibility for managing patients’ care, plans may need to make available specialty pediatric backup teams to offer consultation and support. In 1995, consultation occurred only on an ad hoc basis, though formal specialty teams created at the plan level could provide more consistent consultation services. These teams, which often would be multidisciplinary, could assist primary care physicians with diagnosis, medical management, and other aspects of treatment planning. The teams also could perform comprehensive evaluations and conduct education and training. As one example, a pediatric developmental disability team might consist of a neurologist, occupational therapist, speech therapist, physical therapist, and psychologist.

4. Comanagement of Primary and Specialty Pediatric Services
The management of complex conditions among Medicaid-eligible children could be improved by promoting comanagement of primary and specialty services for high-risk children to ensure the continuity and quality of care and increase the primary care providers’ expertise. Although most plans are not structured with incentives for collaboration, plans should alter their practices to facilitate collaboration in a number of ways. For example, they could develop lists of pediatric conditions that might benefit from comanagement, including spina bifida, cerebral palsy, leukemia, AIDS, eating disorders, and ventilator dependency. They also could establish protocols defining effective collaborative roles and responsibilities for particular conditions. Comanagement of physical and mental health problems may require particular attention by plans, especially those in which behavioral health benefits are administered separately.

5. Arrangements for Comprehensive Care Coordination
Given the complexity of the problems that many Medicaid-enrolled children confront and their historic reliance on publicly funded programs, plans may want to offer comprehensive care coordination services for specific high-risk enrollees. Although most plans offer medical case management only for children with the highest-cost conditions, care coordination services could be expanded to include developing and implementing individualized care plans, tracking client progress and referrals, authorizing and monitoring the provision of health and related services, assessing public program eligibility, and providing family support and caregiver training. These services could be provided by a specially trained nurse, social worker, health educator, or behavioral health specialist in regular communication with the child’s primary care provider. Primary care practices that serve a substantial number of children with special needs could expand or reorganize their staffs to include care coordinators. For small practices and staff-model arrangements, the plan could hire or subcontract with these care coordinators.

6. Flexible Service Authorization Policies for Children
A significant number of Medicaid-enrolled children with chronic or disabling conditions require ongoing use of multiple specialized services, and others may require additional services because of problems
related to adverse socioeconomic circumstances. To deal with the needs of this population, plans should establish more flexible and efficient service authorization policies to alleviate burdensome requests from primary care providers and families. Plans that currently authorize requested services only for a specified period of time and limited number of visits should revise their policies to permit extended authorization periods for ancillary therapies, home health care, mental health treatment, and chronic care medications; permit self-referrals for evaluations of behavioral, emotional, and developmental problems; and allow same-day visits with multiple providers. These changes could be developed with input from child health advisory committees that also would review service authorization decisions.

**7. Provider-Profiling Systems with Pediatric Case Mix Adjustments**

Physician-profiling systems should take into account differences in the population of children served among individual physicians and practices, because the number and duration of office visits and the use of other therapeutic interventions are predictably higher among those who care for children with special needs. In 1995, profiting systems used by most plans did not distinguish among primary care practices. In designing profiling systems sensitive to variations in the types of children cared for across providers, plans may want to take advantage of new or existing products that adjust for pediatric case mix. Alternatively, plans may want to collect data from primary care physicians on the proportion of children in their practices who meet certain chronic care criteria, and use this information to identify groups of providers with comparable caseloads. Primary care providers could then be judged against their peers, and pediatric peer-review committees could be used to evaluate practice patterns that are atypical.

**8. Financial Incentives for Identifying and Serving Children with Special Needs**

Creating financial rewards for primary care providers who care for children with complex conditions is essential to building network capacity for this population. However, most plans pay capitation rates that do not account for expensive, high-risk cases, and bonuses typically reward cost savings only, offering providers little incentive to expend the considerable time needed to treat these children appropriately. To restructure financial incentives, plans need to offer enhanced capitation payments that adjust for factors such as prior utilization, diagnosis, or eligibility for public programs such as SSI or foster care. Plans also may want to consider offering end-of-year bonuses to reward pediatric providers who care for significant numbers of children with complex conditions and achieve reductions in emergency room use or high scores on family-satisfaction surveys related to special needs.

**9. Family Involvement in Plan Operations**

Given the major role that families play in implementing home-based therapies and monitoring and identifying changes in their children’s health status, plans should actively involve them in their ongoing operations. Although parents could offer valuable feedback regarding access to services and the overall quality of care, family involvement in managed care plans is minimal. The role of parents in plans could be strengthened through participation in committees that develop policies and procedures, preparation and review of materials, and assistance in the design and evaluation of quality-performance measures. Parents also could assist as planners or speakers for in-service education programs, and as consultants for new-member orientation programs, health education sessions, and care coordination activities. Finally, parents could establish family support groups, building on the parent networks already existing in many communities. A family resource center, including a telephone help line, could provide information on chronic conditions and various public and private programs offering health care and other forms of assistance.
Conclusion

The enrollment of children with chronic or disabling conditions in fully capitated managed care arrangements poses several new challenges for state Medicaid agencies. One challenge is that children with chronic conditions—other than those receiving SSI—are not easily identifiable. Unlike those of adults, their conditions are likely to be rare, to vary in severity over time, and to be exacerbated by family and environmental situations. These children’s service needs typically extend beyond those of healthy children and often include intensive preventive and primary care services, a wide array of pediatric specialty services on a regular basis, and comprehensive service coordination with schools and other family support and community-based programs.

Another challenge is that many managed care plans have had little experience in delivering the full scope of services that are available to children under Medicaid. Their experience has been primarily contracting to deliver standard commercial benefits. Not surprisingly, plans’ provider networks often do not include the array of pediatric specialists, ancillary therapists, mental health providers, and equipment vendors required to serve Medicaid-insured children. Further complicating the issue of pediatric provider capacity is the fact that the majority of states now contract separately with behavioral health plans. Difficulties in accessing services from these separate service systems have repeatedly been reported for children with chronic conditions.

Still another challenge for states in the transition to managed care for children with special needs is the dearth of research regarding actuarially sound capitation rates for children with various chronic conditions at different severity and disease progression levels. Plans assume significant risk when they take on more children with chronic conditions, and there are few incentives for plans to develop new and improved service systems for this population.

Each of these challenges represents a major barrier for states, plans, and families as they move toward a more uniform and integrated system of service delivery and financing for Medicaid-insured children. In this article, several strategies have been proposed for states to improve their contracting policies and for plans to encourage best practices. Implementing the recommended set of state contracting policies—on pediatric benefit specifications, pediatric provider capacity requirements, a children’s medical necessity standard, quality-of-care standards for chronic childhood conditions, appropriate pediatric capitation rates, and incentives for high-quality pediatric care—constitutes a substantial investment. In 1995, a growing number of states were beginning to pursue initiatives in these areas, but few were considering the entirety of these contracting recommendations. As states gain greater experience in managed care contracting and oversight, however, they will be in a stronger position to negotiate for the best products on behalf of children. Achieving the recommended set of state contracting policies will require greater oversight and investments on the part of states and the Health Care Financing Administration.

Implementing the recommended elements of managed care practice is likely to require a greater concerted effort, involving both public and private support. Successfully placing special needs children with primary care providers who have the requisite training, infrastructure, and support to link with specialized providers and related service systems has not been achieved in the fee-for-service sector, in which management of chronic childhood conditions is primarily in the domain of pediatric specialists. Restructuring medical practices to meet the needs of children with chronic conditions more effectively is an awesome task. Demonstration projects to identify best practices are essential to assure more accessible, quality care for these children, but they are not sufficient. Long-term planning and investment on the part of all plans will be required.

2. The advisory group members included Howard Arkans, medical director, U.S. Healthcare; Marsha Gold, senior health researcher, Mathematica Policy Research, Inc.; Richard Nelson, director, Iowa Child Health Specialty Clinics, University of Iowa; Ann Page, director of program development, National Committee for Quality Assurance; Blair Sadler, president and CEO, San Diego Children’s Hospital and Health Center; and Vernon Smith, director, Medical Services Administration, Michigan Department of Social Services.

3. Medicaid HEDIS is an adaptation of the National Committee for Quality Assurance’s Health Plan Employer Data and Information Set (HEDIS 2.5) for use in managed care plans. Available from the National Committee for Quality Assurance Publications Center, P.O. Box 533, Annapolis Junction, MD, 20701-0533.


5. In 1995, the only practice guidelines developed by the American Academy of Pediatrics pertained to immunizations, otitis media, and asthma.


7. Regardless of whether a risk-adjustment system is based on prior expenditure patterns or diagnoses, it will be derived from historical cost data, and rates will need to be recalculated periodically on the basis of multiple-plan or statewide cost experience.

