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Adapting MCH Systems in a Changing Health Care Environment: Summary of Technical Assistance Provided to the State of Nebraska

Prepared for:

Division of Maternal and Child Health
Nebraska Department of Health

Prepared by:

Health Systems Research, Inc.
Washington, D.C.

Under Contract with:

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Contract #240-92-0059

30 September 1996

Table of Contents

Foreword

Under two three-year contracts with the federal Maternal and Child Health Bureau (MCHB), Health Systems Research, Inc. (HSR) is providing direct, intensive technical assistance to state Title V programs in all 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico. These contracts, which began in 1992 and 1994, are intended to help state and local health officials develop, adapt, integrate, manage, and maximize the potential of their service delivery systems for children and their families. Nebraska was one of nine states selected to receive technical assistance in the second year of the first contract.

Like many states in the country, Nebraska has experienced significant changes in its health care delivery and financing systems in recent years, not the least of which has included the planned implementation of a statewide Medicaid managed care program by the end of 1997. To help the state's Title V program in responding effectively to these changes in the environment, Nebraska officials requested technical assistance from HSR in two critical areas: (1) hands-on consultation to state and local staff on the new roles that Title V programs could assume within a managed care environment; and (2) an Issues Seminar focusing on strategies for ensuring high-quality care to children with special health care needs enrolled in a managed care plan. This technical assistance was provided between the summer of 1994 and the summer of 1996 and consisted of three main components, as described below.

A. Initial Site Visit and Follow-up

On 28-29 June 1994, HSR Project Director Ian Hill and Policy Associate Katherine Clayton conducted an initial site visit to Nebraska to meet with officials of the Nebraska's Department of Health's Maternal and Child Health (MCH) Division and Department of Social Services Medically Handicapped Children's Program (MHCP). During the visit, the consulting team obtained critical background information about the state's existing MCH service delivery systems and outlined alternative technical assistance interventions. By the conclusion of the visit, HSR and state officials had identified a range of specific TA options. A report summarizing this site visit was submitted to state and MCHB officials in July 1994.

During the fall of 1994, HSR held a number of conference calls with key Title V staff to refine the scope of the technical assistance assignment. In November 1994, at the request of state officials and as a first step in HSR's ongoing technical assistance, HSR developed and submitted an annotated bibliography of research and policy reports exploring the implications of managed care and health care reform on MCH populations and programs.

B. Workshop on New Roles under a Reformed Health Care System

In response to rapid changes in the state's health care environment, including the reorganization of DOH, in April 1995 Nebraska officials requested that HSR provide hands-on consultation to state and local officials regarding Medicaid managed care and the potential new roles that Title V could assume within a reform environment. In particular, Title V staff expressed an interest in learning about how other states have dealt with similar issues. To meet this request, HSR secured the assistance of Sally Fogerty of the Massachusetts Department of Public Health and Phyllis Siderits of Florida's Children Medical Services Program to serve as expert consultants on the Nebraska assignment. In June 1995, the HSR consulting team incorporated the following components into a two-day on-site consultation:

- A video conference "teach-in" session for state and local officials to address the impact of health care reform on core public health functions, local funding, and children with special health care needs from both a national and state perspective;
- A meeting with MCH and MHCP Advisory Committee members to respond to issues raised during the teach-in session;
- A meeting with DSS Secretary Mary Dean Harvey and a large number of Title V grantees to discuss their views and concerns about health care reform; and
- A planning session with core Title V staff to discuss strategies to explore in redefining their role in a reformed environment.

A report summarizing this workshop was developed by HSR and submitted to Nebraska and MCHB officials in October 1995.

C. Issues Seminar on CSHCN

As a final step in the technical assistance process, Nebraska officials requested that HSR develop and conduct a seminar focusing directly on services provided to children with special health care needs enrolled in managed care. In response to this request, HSR retained the services of Carol Tobias, Director of the Medicaid Working Group, to lead an instructive on-site seminar for state officials. This two-day training was held 1-2 July 1996 in Lincoln, Nebraska and included:

- An overview of national trends in managed care and the major issues surrounding CSHCN for managed care program development;
- A discussion of possible solutions to problems or conflicts identified by Nebraska officials in providing high quality services to CSHCN; and
- Presentations from both parents of CSHCN and representatives of HMOs about their experiences and views on how managed care has met the needs of this population.

A report summarizing the discussions and outcomes of this training is being submitted to state and MCHB officials as part of this final project report.

D. Structure of this Report

As described above, following each phase of the technical assistance effort—the initial site visit, the on-site consultation, and the seminar on CSHCN—HSR produced summary reports highlighting the discussions and outcomes of each of the three meetings. These reports are presented in Parts I, II, and III of this compendium and, together, describe several of the critical steps taken by the Nebraska Departments of Health and Social Services to more effectively respond to the needs of mothers and children in the changing health care environment and to facilitate the implementation of more effective managed care systems. It is hoped that other state health officials facing similar issues and challenges can obtain insight from the processes engaged in by Nebraska officials.

PART I

Initial Site Visit Report

Technical Assistance to States Developing Comprehensive Systems of Primary Care For Children And Their Families:

Nebraska—Initial Site Visit Report

Prepared for:

The Division of Maternal, Infant, Child and Adolescent Health
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Public Health Service

Prepared by:

Katherine Clayton and Ian Hill
Health Systems Research, Inc.
Washington, D.C.

19 July 1994

I. Background

In October 1992, the Maternal and Child Health Bureau (MCHB) awarded a three-year contract to Health Systems Research, Inc. (HSR) to provide technical assistance to states in developing comprehensive systems of care for infants, children and their families. Under the project, states submit requests for assistance on projects integral to their systems development efforts. Nebraska is one of nine states selected to receive technical assistance during the second year of the contract. Over the course of the three-year contract period, 25 states will receive technical assistance from HSR.

The initial site visit to Nebraska was conducted on June 28-29, 1994 by HSR's Project Director Ian Hill and Policy Associate Katherine Clayton. They were accompanied by Bradley Appelbaum, MCH Regional Program Consultant for Region VII of the U.S. Public Health Service. The consultant team met with officials from Nebraska's Departments of Health (DOH) and Social Services (DSS) to develop an understanding of the services that are available to mothers and children and discuss possible technical assistance projects. This site visit report summarizes the discussions that occurred during the two-day site visit and outlines next steps to be taken to assist Nebraska in developing systems of care for children.

Maternal and child health officials in Nebraska have requested assistance in identifying and analyzing policy options for expanding primary care services, including an examination of alternative methods for financing primary care services. They would also like technical assistance in evaluating the current use of resources and determining ways of improving resource allocation.

Based on these goals, the initial site visit was conducted to achieve three objectives:

- To gather detailed background and contextual information on the existing primary care system for children in Nebraska, including information on DOH and DSS;

- To obtain state officials' input on the strengths and weaknesses of the existing system and, from that, identify the possible directions for future technical assistance activities; and

- To begin developing a list of technical assistance options and a preliminary work plan for the assignment.

II. Summaries of Meetings with Nebraska Officials

Tuesday, June 28

8:30 a.m. Meeting with Nebraska Department of Health (DOH) officials: David Schor, Judi Schlife, Charlotte Marthaler, Jeanne Garvin, Geri Clark, Rollie Snuttjer, Patty Flurry, Ed Schulenberg.

State officials responsible for administering Title V MCH programs in Nebraska attended this meeting. Representatives from the DOH Division of Maternal and Child Health and the DSS Division of Special Services for Children and Adults were present and provided an overview of their roles and responsibilities. State officials outlined the demographic and health needs of people living in Nebraska and described, in general terms, the organizational structure of DOH and DSS. Time was also spent discussing the extent to which local health departments provide direct services to women and children, and the relationship between private physicians and local/state-level public health providers.

Important structural and contextual information obtained from the meeting included:

- Distributed across the state are 93 counties, organized into six health planning regions. Across the state, there are only 14 local, county or multi-county health departments that provide limited health services (i.e., immunizations); nine multi-county Community Action Agencies, of which only five provide health services; and two federally-funded Community Health Centers, one of which is located in Omaha and the other in the Panhandle region of the state.

- Over the years, state health officials have been unable to institute a systematic approach to providing public health services throughout the 93 counties, in part because the private sector provides the majority of direct health services and, in part, because local health departments are under the jurisdiction of county governments rather than the state.

- Private family and general practitioners provide the bulk of primary care to Nebraskans, few of whom practice outside Omaha and Lincoln. These physicians, who provide the majority of rural primary care, have decreased in number by 40 percent over the last decade.

- Among the 93 counties, 90 are considered to be rural; of these, 71 are designated medically underserved areas (MUAs). As of September 1992, 39 counties were identified as federally-designated health professional shortage areas (HPSAs); most of five additional counties as well as some precincts, sites and census tracts within eight other counties are also HPSAs. Only 23 of the 180 pediatricians and 17 of the 139 obstetricians in Nebraska practice outside the cities of Lincoln and Omaha.

- During FY94, the MCH Division awarded 27 grants to a variety of agencies and programs, including Community Action Agencies, county health departments, DOH-affiliated programs, medical center and non-medical center projects. The number of MCH grants awarded this year decreased from 40 funded during the previous year.

- Nebraska's program for children with special health care needs, called the Medically Handicapped Children's Program (MHCP), operates out of DSS and provides eligible children with multi-disciplinary evaluation and treatment services. A total of 13 social workers, three of whom are located in the central office and ten in district offices, provide support services at 11 clinic sites. Children who live outside of the communities with MHCP clinics can receive care from traveling teams of DSS providers.

10:00 a.m. Meeting with staff from DOH, DSS, Department of Education, and the Governor's Office, including: David Schor, Judi Schlife, Charlotte Marthaler, Beverly Busch, Bruce Rowe, Wendall Harper, Mary Gordon, Meridel Funk, Adrian Thomalla, Steve Beal, Kim Wieckert, Judy Ewell, Sandi Kahlandt, Jeanne Garvin, Geri Clark, Rollie Snuttjer, Patty Flurry, Ed Schulenberg, Dave Palm, Steve Frederick, Dennis Behrens, Sue Medinger, John Sahs, Ed Schulenberg, Judy Constantin, Jeanne Garvin.

During this meeting, a larger group of state officials from multiple agencies within DOH and DSS assembled to discuss state-level systems approaches to providing health services to children. By having all agencies who serve children present, HSR learned about Nebraska's current efforts to develop integrated, multi-agency methods of delivering care. Important information gathered on DOH and DSS initiatives included:

- Integrated Health Community Service Plan. Under the direction of Nebraska's DOH, a Community Health Advisory Committee was convened

during the Summer of 1993 to develop a community health service proposal for the state. The impetus behind convening this group was that Nebraska does not have a uniform statewide system for providing health services at the local level. Under the proposed system, each of the six health planning regions would be responsible for developing its own community-based health system in which DOH regional offices would function as the point of entry into the system. State officials hope to implement the service plan by the end of 1994 in the Northeast region first, to be followed by the other five regions. The proposal has been endorsed by the DOH Director, Dr. Mark Horton, and is now being reviewed by over 250 health organizations.

- Medicaid Managed Care Plan. DOH officials are considering instituting a state-wide managed care program, based on a Primary Care Case Management (PCCM) model. Under the model, physicians would receive an administrative fee for conducting case management and be compensated on a fee-for-service basis for direct care. Before trying to implement the PCCM model statewide, DOH plans to first test the model in Douglas and Sarpy counties in July 1995 and Lancaster in 1996, and then phase-in the model in the remaining counties in 1997.

  Under the proposed PCCM model, Nebraska has created an innovative Community Health Nursing component. Under the plan, public health nurses would function in support of physicians and provide clients with a range of assessment, enrollment, and care coordination services.

- Studies on Health Care Reform. Two separate and distinct advisory groups, composed of representatives from the public sector and the private insurance industry, respectively, submitted studies on health care reform to the Governor in 1992. The first, the Inter-Agency Health Care Advisory Committee, was composed of six state-agency directors from the Departments of Health, Social Services, Aging, Education, Public Institutions, and Insurance; the Director of the Governor's Policy Research Office; and the chair of the Legislature's Health and Human Services Committee. The Committee presented the Governor with recommendations about how to alleviate health problems currently faced by Nebraskans (i.e., how to improve access to prevention and primary care, affordable care, and quality care). The second group, the Governor's Blue Ribbon Coalition to Study Health Care in Nebraska was composed of representatives from health care associations, insurance, business, medical schools, and consumers. This Coalition developed a proposal for a reformed health care system that would provide all Nebraskans with coverage under a uniform basic benefits package.

- Rural Health Initiative. Despite a predominance of rural communities in Nebraska, interviewees indicated that the state's health system serves the needs of urban communities better than rural areas. The State's Rural Health Advisory Commission developed a plan to address this issue that explored strategies for

developing integrated rural health networks. The Advisory Committee also considered how to improve access and recruit primary care and mental health providers to rural communities.

- Integrated MCH Services. Formal efforts are underway in two of Nebraska's Community Action Agencies to develop more integrated health systems. Specifically, staff in these organizations are trying to coordinate family planning, immunization, and nutritional services (i.e., WIC and the Commodity Supplemental Food Program). Under this pilot project, the State hopes to integrate assessment and certification processes for the various programs so that clients can access all services during one clinic visit. Developing an integrated data system with common participant identifiers, creating a combined financial reporting document, and cross-training staff are additional objectives of this initiative.

- Data Enhancement. For the third year, the MCH Division has worked under a Data Enhancement and Utilization grant from the federal MCHB to develop more integrated data systems. Specifically, MCH staff have worked with two community agencies to automate and integrate the data collection processes at the local level, where medical records are created and stored.

- Nebraska's "Good Beginnings" Project. Nebraska's Good Beginnings program was initiated at the recommendation of Governor Nelson's Commission for the Protection of Children. Good Beginnings is a community-based prevention effort that promotes the development of strong families and healthy children by fostering the development of service and provider networks and raising Nebraskans' awareness about health and health prevention. The program is endorsed by the State's First Lady Diane Nelson and is sponsored by the Departments of Education, Health and Social Services.

- State Systems Development Initiative (SSDI). The MCH Division has used their 1994 SSDI funds to develop more unified early intervention services. To achieve this goal, MCH officials are contracting with DSS and the Department of Education to identify ways of strengthening health and medical linkages, developing incentives to help families with disabilities, and bringing communities together. Nebraska will initiate this SSDI project at the local level in three targeted communities (Hastings, Carny, and the Winnebego Reservation) before applying the model statewide.

2:30 p.m. Meeting with DOH and DSS officials: Rita Westover, Jim Dills, Judi Schlife, David Schor, Charlotte Marthaler, Patty Flurry, Mary Gordon, Paula Eurek, Sue Medinger, Frank Harris, Susan White, Molly Uden, Adrian Thomalla.

During the afternoon meeting, many of the same people who attended the morning meeting, plus a few additional staff, discussed specific DOH- and DSS-operated programs for children.

Through this discussion, HSR consultants developed a sense of the breadth of activities and programs for children in Nebraska, as well as a more in-depth understanding of individual DOH programs. Information gathered on these programs included:

- Medically Handicapped Children's Program (MHCP). Through MHCP, Nebraska's Department of Social Services provides children who meet medical eligibility criteria with direct services, case management and access to pediatric specialists. The MHCP population includes a large number of Medicaid-eligible children.

- SSI Disabled Children's Program. The SSI Disabled Children's Program, administered by DSS, delivers home-based support services to SSI-eligible children. The majority of the SSI funds are used to provide respite care and transportation services, as all SSI children are eligible to receive primary care under Medicaid. The State has expanded home and community-based services for SSI-eligible children through four Medicaid waivers and a "Katie Beckett" plan amendment. Three of the four waivers target children, including a disabled children, mental retardation and early intervention waiver.

- Governor's Planning Council on Developmental Disabilities. The Council on Developmental Disabilities is sponsored by the federal Department of Health and Human Services' Administration for Children, Youth, and Families. The Council has targeted child development as a priority area. Although the Council does not provide direct services, it works with family-centered, community-based programs to coordinate care. Currently, the Council is working with a parent training/nurturing program, two child care programs, a diagnostic center and an Early Intervention site.

- EPSDT Outreach. Nebraska's DSS operates a fairly traditional EPSDT program in which staff at local offices are responsible primarily for Medicaid eligibility assessment and perform only minimal EPSDT informing and outreach. As such, Nebraska has historically experienced very low EPSDT participation rate — 38 percent in FY 93. Medicaid program staff expressed a strong desire to expand EPSDT outreach activities and explore strategies for maximizing federal matching funds in support of this effort.

- Supplemental Food Program for Women, Infants and Children (WIC). Fifteen local agencies in Nebraska administer the WIC program, offering services at over 90 clinic sites. Some of these clinic sites are "traveling sites" (i.e., operated out of churches, mobile vans); however, a few are integrated with primary care providers. In an attempt to better integrate these services, DOH will be issuing a Request for Proposal (RFP) for WIC systems development and integration.

- Commodity Supplemental Food Program (CSFP). CSFP is financed by the USDA and provides food to women, infants, children and adults over 65 years of age who meet financial eligibility criteria. The program complements the WIC program, in that, many of the families who are no longer considered to be at nutritional risk under the WIC program can still obtain food vouchers under the commodity food program.

- Immunization Action Plan. The majority of children in Nebraska are immunized by private physicians or receive immunizations at "volunteer clinics" (i.e., local hospitals, nursing homes, fairs). Nine counties in Nebraska, however, do not have public immunization clinics or access to private physicians. Nebraska is trying to increase the number of private providers who immunize children under the direction of the federal government's Vaccine For Children's Act.

- "Every Woman Matters" Program. Nebraska is one of 45 states receiving money from the Centers for Disease Control and Prevention (CDCP) to provide breast and cervical cancer screenings and follow-up services to at-risk women (i.e., women over 50 years, low-income, uninsured). The CDCP has granted Nebraska $2 million per year for five years to operate the "Every Woman Matters" program. To date, program staff have enrolled over 200 private physicians in the program. Under the contract, the CDCP reimburses providers $50 per screen.

- Family Planning Program. Utilizing Title X and Title V dollars, 11 subgrantees provide family planning services at 19 permanent sites and 11 "suitcase sites" (i.e., staff travel to the clients) in Nebraska. These clinics provide PAP smears, STD screening and treatment, and contraceptive services to clients. As part of the family planning outreach and educational efforts, the subgrantees distribute adolescent pregnancy prevention materials statewide and are considering supplementing outreach activities with a "deferred exam program" for clients who seek contraceptive services.

Wednesday, June 29

8:30 a.m. Meeting with Director of DOH Mark Horton and other DOH officials: Bruce Rowe, Judi Schlife, David Schor, Charlotte Marthaler, Beverly Busch.

During this meeting, Ian Hill presented an overview of the technical assistance project to Dr. Horton, and state officials summarized the issues raised at the previous day's meeting, highlighting programs that seem to be most in need of technical assistance. Dr. Horton

discussed some additional areas where technical assistance might be needed, as summarized below.

- Integrating Mental Health into Managed Care Plans. Under Dr. Horton's direction, DOH staff have been instructed to develop a managed care model that integrates primary care with mental health services. The state identified mental health as a primary concern among Nebraskans based on feedback obtained at a recent public meeting. As they work on this model, state officials strive to obtain input from mental health providers in the planning process and continue to explore several mental health/managed care issues, including: transferring appropriate primary care responsibilities to mental health providers; collecting data and information on other state models; and incorporating children who need less intensive mental health services into the model.

- Integrating Support Services and Primary Care. As referenced earlier in this report, Dr. Horton called attention to the need to integrate support services provided by WIC, immunization and family planning programs with primary care networks. Suggested areas of integration included: data collection; coordinated grant processes; and integrated program guidelines.

- Integrated Data. Dr. Horton emphasized the need to monitor access to, and quality of, care as Nebraska moves toward instituting a Medicaid managed care program. As a technical assistance project, he suggested that HSR help DOH and DSS develop a data collection system for population-based data.

- Underserved Populations. Data suggest that school-aged children, migrant populations, Native Americans and Hispanics have difficulty accessing health services in Nebraska. Medicaid school-aged children, in particular, have low EPSDT participation rates. Dr. Horton encouraged his staff and HSR to consider addressing access barriers among these underserved populations as the technical assistance project is structured.

9:30 a.m. Meeting with MCH Division, including: Beverly Busch, Judi Schlife, David Schor, Charlotte Marthaler.

During this meeting, HSR met with staff from the MCH Division to review comments from the morning meeting with Dr. Horton and the previous day's meeting. In addition, David Schor and Charlotte Marthaler described grants that had been awarded by the MCH Division this year, and shared their thoughts about plans for the second year of the SSDI grant, keeping in mind possible technical assistance ideas. Currently, the MCH Division is considering using SSDI funds for a range of initiatives, including: working with one of the 29 MCH planning regions to develop linkages among medical and health providers; expanding services provided to the

developmentally disabled population from birth to age three; and streamlining eligibility processes for all MCH programs.

III. Technical Assistance Options and Next Steps

11:00 a.m. Meeting with DOH and DSS officials, including: Judy Ewell, Judy Constantin, Sandi Kahlandt, Mary Jo Iwan, Jeanne Garvin, Geri Clark, Rollie Snuttjer, John Sahs, Meridel Funk, Beverly Busch, Judi Schlife, David Schor, Charlotte Marthaler.

During this meeting, HSR consultants met once again with the DOH and DSS Title V officials to follow-up on issues raised in previous meetings and to discuss possible directions for the technical assistance effort. Prior to an open discussion, Ian Hill presented multiple options under which HSR could provide assistance. Discussion focused primarily on the three options presented below.

- Regional/local Health Planning. Under this technical assistance option, HSR discussed the possibility of helping state officials structure and implement the regionally-based health model proposed by the Community Health Advisory Committee (discussed earlier). As outlined under this plan, officials intend to initially pilot this model in the Northeast region. Possible tasks under this project would be to develop an overall strategic plan, address the need to train regional staff, and recruit county commissioners and private providers into the regionally-based model. HSR and state officials discussed the possibility of devising formal implementation guidelines as a final product so that DOH could replicate the model in the other regions of the state.

- Community Health Nursing and Managed Care. As a second technical assistance option, it was proposed that HSR work with state officials to formalize the community health nursing component of the Medicaid program's proposed PCCM model. The group discussed how HSR might work with Medicaid and MCH officials to determine how to operationalize the model and integrate local public health providers, Community Action Agencies, and DSS professionals (i.e., social workers, MHCP service coordinators) into the model. Possible final products might include an implementation plan and a document that could be incorporated into Nebraska's PCCM waiver request.

- EPSDT Outreach. The possibility of conducting an EPSDT outreach project was discussed, in light of the State's low participation rate. The group discussed how HSR might work with state officials to design policies and strategies for conducting client and provider outreach under EPSDT. At this point in the

discussion, state officials described a pilot project currently underway in Sarpy County, which employs community health nurses in EPSDT outreach. If HSR were to conduct an EPSDT technical assistance project, state officials and HSR would want to take a closer look at the Sarpy County pilot project.

After reviewing these options, participants ranked the Community Health Nursing and managed care project and the EPSDT outreach option as the two top choices. However, those present at the meeting were unable to decide which project should be selected. At the conclusion of the discussion, DOH and DSS representatives decided that they would further discuss these options with each other, and contact HSR in July to finalize the focus of the technical assistance project.

PART II

New Roles for Title V Under a Reformed Health Care System: Summary of a Workshop for Nebraska Officials

New Roles For Title V Under a Reformed Health Care System

Summary of a Workshop For Nebraska Officials 7-8 June 1995

Prepared for:

Division of Maternal and Child Health
Nebraska Department of Health

Prepared by:

Katherine Clayton and Ian Hill
Health Systems Research, Inc.
Washington, D.C.

Under Contract with:

Maternal and Child Health Bureau
U.S. Public Health Service
Contract No.: 240-92-0059

18 October 1995 (revised 10 May 1996)

I. Introduction and Background

In October 1992, the Maternal and Child Health Bureau (MCHB) awarded Health Systems Research, Inc., (HSR) a three-year contract to provide 25 states with technical assistance in developing comprehensive systems of care for children and their families. The MCHB granted HSR a second three-year contract in July 1994 to provide technical assistance to an additional 28 states and U.S. territories. Nebraska is one of the nine states selected to receive technical assistance under the second year of the first contract.

In its technical assistance application, the Nebraska Department of Health's Maternal and Child Health Division and the Nebraska Department of Social Services' Medically Handicapped Children's Program (MHCP) asked HSR for assistance in identifying and analyzing policy options for expanding primary care services, including an examination of alternative methods for financing primary care services, and evaluating current and future uses of Title V resources. Using this request as a foundation to work from, a multi-stage process was implemented to focus the scope of the technical assistance project, which is described below:

- Initial site visit. On June 28-29, 1994, HSR Project Director Ian Hill and Policy Associate Katherine Clayton conducted an initial site visit to Lincoln. During the visit, the consultant team met with officials from Nebraska's Departments of Health (NDOH) and Social Services (NDSS) to gather background information on services available to mothers and children and discuss alternative technical assistance interventions. By the close of the two-day site visit, HSR and state officials had identified a range of technical assistance options, including devising implementation guidelines to help DOH's six regional offices develop community-based health systems, formalizing the proposed community health nursing component of Nebraska's Medicaid waiver program, and designing policies and strategies for conducting client and provider outreach under Nebraska's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, state officials were unable to select an option and decided to further discuss them with one another and refine the scope of the project during follow-up conference calls with HSR.

  After the visit, HSR prepared a report for Nebraska and MCHB officials summarizing the proceedings and outcomes of the site visit.

- Follow-up conference calls and background research. As mentioned above, HSR next scheduled several conference calls in the Fall of 1994 with key MCH

and MHCP staff (hereafter referred to as Title V staff) to follow-up on issues addressed during the site visit and refine the scope of the technical assistance project. During these calls, Nebraska's MCH Director David Schor explained that the state's technical assistance needs had changed since the site visit because of the Nebraska Medicaid program's recent effort to implement a Medicaid managed care waiver. Pending approval of a 1915(B) waiver application from the federal Health Care Financing Administration (HCFA), state officials planned to phase-in managed care in three counties in 1995, and then go statewide in 1997. To prepare for these changes, Title V officials asked HSR to collect and develop an annotated bibliography of research and policy reports exploring the implications of managed care and health care reform on maternal and child health populations and programs. This product, which consisted of a variety of national as well as state publications on health care reform, was delivered to Nebraska officials in November 1994. A copy of the letter sent to Nebraska's MCH Director, David Schor, which summarizes the selected materials, is presented as Appendix A.

- Conference calls to discuss emerging issues. Subsequently, in April 1994, a series of conference calls were held with Title V and Medicaid officials to discuss emerging service delivery issues within the state and to identify further technical assistance needs. In particular, state officials discussed how Medicaid managed care and organizational changes being implemented at NDOH could significantly alter MCH's role in service delivery. Background information on these two issues is provided below.

  - Medicaid managed care. As mentioned above, pending approval from HCFA, Nebraska planned to implement a mandatory Medicaid managed care program in three pilot counties (Douglas, Sarpy, and Lancaster) in 1995 and go statewide with its initiative in 1997. At the time of the conference call, Medicaid officials had entered into contracts with six vendors to implement the program, including a Primary Care Case Management (PCCM) network, two health maintenance organizations (HMOs), a prepaid mental health and substance abuse plan, an organization to provide enrollment/community health nursing services, and a data management company. State officials explained that the community health nursing component was developed to ease the transition to the new system by conducting outreach, educating recipients about the new system, assisting with enrollment activities (e.g., selecting a primary care provider), and providing psychosocial support services.

  - DOH reorganization. State officials also explained that the Nebraska DOH was being reorganized and, through this process, programs were being realigned and services consolidated. Under the proposed organizational structure, there would not be a dedicated MCH unit; rather, MCH activities would be conducted out of a newly created Family Health Section in the Division of Health Promotion and Disease

Prevention. In addition, a grants consultant would be responsible for overseeing the MCH Block grant.

In light of the issues described above, Nebraska officials requested that HSR provide hands-on consultation to state and local officials regarding Medicaid managed care and the potential new roles that Title V could assume within a reformed environment. In particular, Title V staff expressed an interest in learning about how other states have dealt with similar issues. To meet these needs, HSR incorporated the following components into the consultation:

- Teach-in session for state and local officials. This session was structured so that a range of state and local public health officials could participate in the consultation. Presentations conducted by HSR consultants were made before an audience of approximately 20 state officials and were also broadcast via video link-up from the NDOH building in Lincoln to 12 local sites throughout the state. The consultant team addressed issues concerning the impact that health reform could have on core public health functions, local funding, and children with special health care needs (CSHCN) from both a national and state perspective.

- Response panel consisting of MCH and MHCP Advisory Committee members. Members of the MCH and MHCP advisory committees were invited to join Title V staff in sharing their responses to issues raised during the teach-in session with the consultant team.

- Meeting with DSS Secretary and local providers. DSS' Secretary Mary Dean Harvey and Title V grantees were invited to attend a session to share their views and concerns about health reform. In addition, HSR staff responded to the issues raised and were made available for consultation on other related issues.

- Planning session with core Title V staff. During the final session of the consultation, HSR consultants and key Title V officials revisited issues raised over the two days of meetings, discussed strategies for Title V staff to explore in refocusing and enhancing their role in a reformed environment, and defined the final steps under the technical assistance project.

To prepare for the consultation, HSR first worked to identify potential consultants with experience in implementing managed care systems and dealing with transition issues similar to those faced by Nebraska Title V officials. A priority was placed on obtaining the assistance of officials from other states who could share and discuss their specific experiences. After considering several candidates, HSR recruited Sally Fogerty, Deputy Director of the Bureau of

Family and Community Health within the Massachusetts Department of Public Health (DPH), and Phyllis Siderits, Acting Assistant Health Officer for Prevention and Early Development of Florida's Children's Medical Services (CMS), to consult on the Nebraska assignment. In the weeks preceding the site visit, HSR worked with the consultants to prepare appropriate presentation materials and complete a meeting agenda, which is presented as Appendix B.

The following chapter provides a detailed summary of the content and outcomes of HSR's consultation site visit with Nebraska officials in June 1995.

II. Summary of Consultation

Wednesday, June 7

8:00 a.m. Meeting with Nebraska's Title V Staff, including David Schor, Mary Jo Iwan, Charlotte Marthaler, Rollie Snuttjer, Jeanne Garvin, Geri Clark, Roger Hilman, Judi Schlife, and Patty Flurry.

The purpose of this session was to grant the consultant team and Nebraska Title V staff an opportunity to meet one another and review issues relevant to the consultation prior to the formal meetings. For example, the team was informed that DSS officials had not yet received HCFA's approval of its Medicaid waiver. Once approved, however, the waiver would be implemented within 45 days.

Title V staff also reviewed the logistics of the video hook-up and discussed who would be attending the sessions over the two-day period. Since the level of participants' knowledge of health reform and Title V funding issues would vary during the teach-in session, the group decided that HSR consultants should provide an overview during the morning session and explore issues in more detail during the later sessions with the Secretary of DSS, MCH and MHCP advisory committee members, and Title V grantees.

9:00 a.m. Teach-In Session with state and local public health officials and Medicaid officials.

During this session, the HSR consultant team presented detailed information on how states have responded to health reform and managed care. The first presentation was made by HSR Project Director Ian Hill, who drew upon knowledge gained in providing technical assistance to 33 states under the MCHB-funded project. Following Mr. Hill's presentation, Sally Fogerty presented information on the impact that managed care and reorganization of the Massachusetts DPH had on MCH service delivery. Lastly, Phyllis Siderits discussed how Florida's CMS has ensured that the needs of the CSHCN population are met under managed care. Highlights of these presentations are provided below:

- Key questions for MCH raised by health care reform. Ian Hill began his presentation by noting that the issues being faced by Nebraska Title V officials are not uncommon. Nearly every state has implemented Medicaid managed care in some form. At the time of the site visit, 18 states had submitted 1115 waiver applications to HCFA.

  As states work to implement reform, they confront a number of key issues that Mr. Hill identified and urged Title V officials to consider. First, states need to examine the extent to which MCH should retain a role in direct service delivery. Mr. Hill explained that as families increasingly receive their primary and preventive care from private-sector managed care providers, MCH's role in direct service delivery may decrease. In the short term, however, he emphasized that the need for traditional MCH services and providers will not disappear. Mr. Hill described several critical functions that MCH programs can retain in a reformed health care system, including:

  - Serving as a primary care "safety net" provider for the uninsured;
  - Providing support services to at-risk families; and
  - Providing specialty medical care and support services for CSHCN.

  Mr. Hill then described three strategies for implementing the roles described above. He explained that MCH programs could:

  - Provide and help finance "wrap-around" services not covered by plans;
  - Function as a subcontracted provider to managed care plans; and/or
  - Function as a risk assessment provider.

Secondly, Mr. Hill noted that Title V officials need to consider whether they should enhance their capacity to perform core public health functions. As health departments across the nation redefine their roles within a reformed environment, increasing importance has been placed on core public health functions. Mr. Hill explained that the Institute of Medicine has defined core functions to include population-based needs assessments, the development of policy to meet defined needs, and assurance that high quality services are provided. He urged Nebraska Title V officials to determine which functions they currently do well, identify which functions they do not perform, and examine strategies for how they might reorganize and redirect resources to build their capacity to perform core functions.

Finally, Mr. Hill urged state officials to determine how they can facilitate the development of effective systems of care for mothers and children. He explained that, to do this, states need to define what they mean by systems development, determine whether methods used to fund local agencies promote or inhibit systems development, and, if necessary, develop approaches to more effectively promote systems development.

- Massachusetts' response to health reform and managed care. Sally Fogerty began her presentation by describing the transition that the Massachusetts Bureau of Family and Community Health has made over the past three years away from categorically-based, program-oriented services to an integrated, systems-based, community-level approach to providing care. She explained that the Bureau employed the following strategies to promote this new approach:

  - Changing from functioning as a purchaser of personal health services to a purchaser of family support services;

  - Adopting a systems approach to funding MCH services rather than one that is categorically focused, as reflected in the state's development of a streamlined RFP process that requires communities to coordinate their requests for funding;

  - Creating a community-based structure for obtaining local input and designing services that are managed by a team from DOH; and

  - Moving from a disease- to a public health-focus that promotes primary care, prevention, and core functions, including assessment, policy development, and assurance.

In addition, Ms. Fogerty explained how the public health leadership at the Bureau involved multiple agencies and individuals in its system redesign effort (e.g., government officials, payers, providers, and consumers); promoted public and private sector collaboration; facilitated integration of health, education, and social services; and involved communities in the design, delivery, and evaluation of services and programs.

At the close of her presentation, Ms. Fogerty commented on the role that the Massachusetts DPH has played in developing and implementing Massachusetts's Medicaid waiver. She explained that, from the outset, DPH was involved in developing and implementing the waiver program. Medicaid invited representation from DPH on an external advisory committee and two workgroups on internal management and HMO issues. The two agencies also engaged in the following collaborative projects:

- Assuring that perinatal services were in place in an effort to decrease infant mortality;
- Improving the delivery of EPSDT services;
- Integrating school-based health centers into Massachusetts's managed care program;
- Improving services to children with special health care needs; and
- Increasing access for all children and youth to primary care.

- Florida's experience designing systems of care for CSHCN under managed care. Phyllis Siderits began her presentation by generally describing the needs of the CSHCN population and the factors that influence managed care plans' ability to meet this population's needs. She explained that in addition to needing both primary and specialty medical care and enabling or support services, CSHCN require that service delivery be coordinated with non-medical providers (e.g., the school system). However, under managed care, the following issues may adversely affect access to, and quality of, care:
  - The qualifications, willingness, and availability of primary care providers to serve CSHCN may be severely limited, thus affecting CSHCN's access to specialty care providers;

- Plans may not develop adequate referral criteria for specialty and non-medical services thereby limiting the CSHCN population's ability to receive comprehensive, coordinated care;

- Under prepaid arrangements (e.g., HMOs), if the capitation rates are not risk-adjusted to account for the higher costs associated with CSHCN, plans will face strong incentives to avoid enrolling the population as well as strong disincentives to providing them with comprehensive care; and

- Managed care providers are not always aware that CSHCN are enrolled in their plans and, therefore, do not adequately attend to their medical and non-medical needs.

Next, Ms. Siderits outlined possible methods through which public health officials can help ensure that this population's needs are met under managed care. Before reviewing these options, however, Ms. Siderits mentioned that a state's policy direction (i.e., whether service delivery is driven by the public versus the private sector) and the capacity of states' public health infrastructure are key factors to consider as public health officials carve out a role for themselves. Ms. Siderits encouraged Nebraska officials to consider the following options:

- Developing an active quality assurance role in the Medicaid waiver program;

- Functioning as a referral source for "wrap-around" services;

- Entering into contractual arrangements with managed care plans to provide specialty care and/or case management services to plan enrollees; and

- Structuring a "carve-out" arrangement under which the CSHCN population can be exempted from enrollment in managed care so that the public health department can provide them with primary, preventive, and specialty care.

With these points in mind, the consultants made the following closing remarks:

- Based on experiences in their states, Ms. Fogerty and Ms. Siderits emphasized that Title V and Medicaid staff should meet regularly to define and modify services provided under managed care, develop implementation strategies, and engage in collaborative projects.

- In light of the reorganization of NDOH and the role that MCH may play within the organization, Title V officials should be aggressive in how they envision using MCH Block grant funding to promote systems of care for children and their families, and should consider the options explored by Massachusetts and Florida as managed care is implemented in their state.

- Lastly, Nebraska's MCH Director David Schor reiterated the importance of Title V staff seeking advice from other states that have developed strong relationships with Medicaid as well as input from providers and consumers in their communities.

2:30 p.m. Response Panel: Discussion with key Title V staff, MCH and MHCP Advisory Committees, and Medicaid officials, including Chris Wright and Sandi Kahlandt.

During this session, the consultant team met with Title V staff, members of the MCH and MHCP advisory committees, and Medicaid officials to discuss and obtain their feedback on issues raised during the teach-in session and to share more information about Massachusetts' and Florida's experiences. Participants were first asked to introduce themselves and briefly comment on their concerns about moving to a mandatory managed care system. In general, issues raised included concerns about access, meeting the needs of special populations (e.g. the uninsured and CSHCN), carving out a role for MCH, and negotiating formal arrangements with Medicaid. A detailed list summarizing the concerns identified by the group is presented in Appendix C.

Following this, Ms. Fogerty and Ms. Siderits responded to the stated concerns by identifying strategies employed in their states to address similar issues. The following key strategies were discussed:

- Ms. Fogerty emphasized the importance of Medicaid developing strong language in its contract with managed care plans that, for example, clearly outlines enrollment and referral criteria, quality assurance procedures, and performance indicators.

- To ensure that the needs of CSHCN are met under managed care, Ms. Siderits described how Florida's CMS program recruited providers with appropriate qualifications to serve the population, conducted training on CSHCN issues, and made staff available for back-up consultations. In addition, CMS involved parents of CSHCN as consultants and spokespersons for their communities.

- In Massachusetts, DPH and Medicaid jointly conducted provider focus groups in areas where managed care was not being smoothly implemented. These meetings provided a forum through which the different parties could develop trusting relationships and gain a better understanding of the government agencies' and private providers' roles under managed care.

- To obtain feedback from the community on service delivery and systems issues, the Massachusetts DPH assembled an Advisory Committee comprised of providers and consumers. In addition to discussing systems issues, the committee worked with Medicaid to shape managed care policy.

- To assure access in rural areas, Florida has promoted the development of rural health networks and Massachusetts has encouraged providers to align themselves with rural hospitals. Both of these strategies have succeeded in recruiting providers to underserved, rural areas.

In closing, participants discussed potential steps they can take to incorporate some of the suggestions presented by the consultants. Most importantly, the group agreed that Title V grantees should assume an aggressive, proactive stance in marketing their services and capabilities to managed care plans. Mr. Hill noted that the grantees need to be creative in developing contracts with the plans. With this in mind, the group felt that there may be a need to receive technical assistance from DOH on such issues as developing model contracts, negotiation skills, and marketing strategies. The consultants also identified this as an opportunity for Title V staff to provide leadership in these areas.

In addition, participants identified strategies to ensure that CSHCN's needs are met under Nebraska's managed care program. Specifically, Title V and Medicaid officials discussed the possibility of developing appropriate performance indicators, such as measuring functional improvement and the level of stress among families.

Thursday, June 8

8:00 a.m. Meeting with key Title V Staff

Core Title V staff and HSR consultants began the day by meeting to discuss the previous day's activities and the agenda for the final day of the site visit. Nebraska's MCH Director David

Schor explained that the Secretary of DSS, Mary Dean Harvey, would be attending the morning meeting with local providers. Dr. Schor noted that her attendance was timely, as DSS had just received HCFA's approval of Nebraska's waiver application during the afternoon of the previous day.

9:00 a.m. Meeting with the Secretary of DSS, key Title V staff, Medicaid officials, and local providers from Omaha and Lincoln

Secretary Harvey kicked off the meeting with local providers by announcing that DSS had just received approval of its Medicaid waiver application. She noted that Nebraska's managed care program was designed to achieve the following four goals: (1) to improve access, (2) to secure a medical home for Medicaid recipients, (3) to improve quality of care, and (4) to realize cost savings over the long term.

Following the Secretary's welcoming remarks, HSR Project Director Ian Hill provided participants with an overview of the purpose of the consultation and a summary of the events that had transpired during the first day of the site visit. Dr. Schor then asked local providers to introduce themselves, note any involvement they may have had with managed care vendors, and highlight issues and concerns they have about managed care. A summary list of comments made by providers is presented as Appendix D.

In general, local providers participating in the session were concerned that the needs of vulnerable populations would not be met under the state's managed care system. Certain subpopulations were singled out as being most vulnerable, including CSHCN, high-risk pregnant women and infants, and families residing in rural regions of the state. Participants identified the following critical aspects that they felt should be included in a managed care system: (1) providing adequate consumer education on the enrollment process, (2) ensuring that "wrap-around" case management and family support services are provided, (3) providing diversity and cultural competency training to providers, (4) integrating mental health services within managed care, (5) ensuring that the primary and specialty care needs of CSHCN are met, and (6) ensuring that adequate quality assurance processes are implemented. Despite their concerns, providers were hopeful that the managed care system would improve access to care

for families, educate consumers and providers about prevention, and better meet the needs of low-income and vulnerable populations. Finally, participants agreed that, with the proposed changes in service delivery under the state's managed care program, they would be looking to Nebraska Title V officials for assistance in understanding the new system and developing strategies to ensure that the needs of families are met.

Following the local providers' comments, the consultant team offered several strategies for state and local officials to consider as Nebraska implements managed care, as described below.

- Re-examine key aspects of the managed care program after a trial implementation period. Sally Fogerty explained that, after a six-month implementation period, Medicaid and DPH officials in Massachusetts re-examined components of their managed care program, including the enrollment process, benefits package, and referral criteria.

- Maintain a strong MCH presence in policy development and service delivery. Ms. Fogerty assured Nebraska Title V officials that it is possible for them to retain a decision-making role under managed care even if there is not a discrete MCH unit within the health department. She explained that MCH officials in Massachusetts have been actively involved in structuring and implementing the state's managed care plan without there being a dedicated MCH unit within Massachusetts' Bureau of Family and Community Health.

- Employ provider and consumer outreach strategies to avoid problems with implementing the managed care program. Ms. Fogerty described that in Massachusetts Medicaid and DOH officials conducted training sessions at local program sites and disseminated educational materials to families to assist providers and Medicaid recipients understand the managed care system.

- Employ parents of CSHCN as "Resource Parents" to work with state officials to resolve problems with managed care. Phyllis Siderits explained that in Florida, 26 "Resource Parents" have been employed by the state to work with state officials to develop an appreciation of the barriers encountered by parents of CSHCN and to work with families to negotiate a managed care system.

2:00 p.m. Wrap-Up Session with key Title V staff

During the final session of the consultation, HSR Director Ian Hill and Policy Associate Katherine Clayton met with the key Title V officials to gain their feedback on the site visit and identify areas in which they may need further technical assistance. In particular, Title V staff

discussed their need to prepare for the upcoming Title V grant cycle by considering how the changes imposed under managed care may alter their contracts with local community providers. The consultant team identified numerous issues that Title V staff may want to consider as they develop these contracts. For example, HSR discussed the possibility of drafting language that requires community providers to outline their plans to contract with managed care vendors and demonstrate why the proposed service is needed under managed care. To help providers fulfill this function, HSR consultants suggested that David Schor, as the medical consultant to the Division of Health Promotion and Disease Prevention under DOH's reorganization, assume the role of an "ambassador" through which he could travel to local communities and discuss the potential roles that community providers can play under managed care, promote strategies for local systems development, and galvanize communities to prepare for the onset of managed care.

As a final step in the technical assistance project and depending upon the availability of Sally Fogerty and Phyllis Siderits, the group decided that it would be helpful to schedule periodic phone consultations (e.g., once a month over a six month period) to review the state's progress in developing effective systems of care and to obtain guidance from the consultants on problems encountered. Specifically, Title V staff noted that it would be helpful to discuss how to approach negotiating and drafting service contracts, promote Title V's role in managed care, and network with other states engaging in similar processes.

PART III

Serving Children with Special Health Care Needs under Managed Care: An Issues Seminar for Nebraska's Title V Officials

Serving Children with Special Health Care Needs under Managed Care:
An Issues Seminar for Nebraska's Title V Officials
1-2 July 1996

Prepared for:

Division of Maternal and Child Health
Nebraska Department of Health

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and

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Washington, D.C.

Under Contract with:

Maternal and Child Health Bureau
U.S. Public Health Service
Contract No.: 240-92-0059

30 September 1996

I. Background

Under two three-year contracts with the federal Maternal and Child Health Bureau (MCHB), Health Systems Research, Inc. (HSR) is providing customized technical assistance to maternal and child health programs in all 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico. These contracts are intended to support state and local health officials in their efforts to develop comprehensive systems of services for children and their families. Nebraska was one of nine states selected to receive technical assistance in the second year of the first contract.

During HSR's initial site visit to Nebraska in June 1994, HSR staff met with officials from the Department of Health's Maternal and Child Health (MCH) Division and Department of Social Services' Medically Handicapped Children's Program (MHCP) to gather background information on MCH services in the state and to outline alternative TA interventions. Responding to the rapid changes in the health care environment, including the reorganization of DOH, in April 1995 Nebraska officials requested that HSR provide hands-on consultation to state and local officials regarding Medicaid managed care and the new roles that Title V could assume within a reform environment. This two-day on-site consultation, held 7-8 June 1995, included a teach-in session for state and local officials to address the impact of health care reform from both a national and state perspective; a response panel composed of MCH and MHCP advisory committee members; and a planning session with core Title V staff to discuss strategies to explore in redefining their role in a reformed environment. A report summarizing this workshop was developed by HSR and submitted to Nebraska and MCHB officials in October 1995.

As a final step in the technical assistance assignment, Nebraska officials requested that HSR develop and conduct a seminar focusing on strategies for providing high quality services to children with special health care needs (CSHCN) enrolled in managed care. In response to this request, HSR retained the services of Carol Tobias, Director of the Medicaid Working Group, to serve as a consultant and to lead an instructive on-site seminar for state officials, parents of

CSHCN, and representatives of HMOs. This report presents a summary of the content and outcome of the seminar conducted by Ms. Tobias on 1-2 July 1996 in Lincoln, Nebraska.

II. Workshop Summary

As noted above, the seminar took place over a two-day period. Day One involved state staff only and emphasized the technical issues related to the topic. Participants for this session included representatives from the Department of Health and the Department of Social Services—including representatives from Medicaid, Title V, the Developmental Disabilities Council, Public Assistance, and the Medically Handicapped Children's Program—and a representative from the regional office of the federal Health Care Financing Administration (HCFA). Day Two involved a broader spectrum of participants including state staff, parents of children with special needs, and managed care plan representatives. This phase of the seminar emphasized the mutual concerns and experiences shared by the participants and the development of a process to work through issues of managed care implementation over the coming months. A list of seminar participants is included as Appendix A of this report.

A. Day One

In planning an effective structure for the seminar, Ms. Tobias worked with state officials to identify three goals for participants during Day One. Specifically, it was agreed that this session would provide participants with the information and forum to:

- Develop Solutions. Participants would be able to develop both short-term and long-term solutions to policy and implementation issues resulting from the enrollment of children with disabilities into managed care. Short-term solutions were defined as those that can be implemented prior to contract renewal and long-term solutions are those that can be incorporated into the 1997 contracting process.

- Address Additional Issues. Participants would be asked to identify additional issues that are likely to emerge as the program is expanded to include additional children with disabilities and discuss strategies for addressing these issues through both a process with the HMOs and contracting and quality improvement language.

- **Prioritize Issues.** Participants would work together to determine which issues to address during Day Two of the seminar in an initial meeting with HMO representatives and decide how to structure an ongoing process to address any remaining and emerging concerns.

1. Overview of Major Policy Issues in Contracting for Managed Care for CSHCN

To provide a context for the discussion, Ms. Tobias began with a brief history of Medicaid managed care and described enrollment trends in managed care, generally, and in Medicaid managed care, specifically. She noted that 49 states now have some form of Medicaid managed care and that Medicaid managed care enrollment rose 67 percent in 1995 alone. She also noted that, of total Medicaid expenditures, 39 percent are for the disabled population and that children represent 22 percent of this group.

Ms. Tobias then presented an overview of five major program-defining issues for managed care program development, and outlined the basic issues involved in each of these program design elements. These included defining the:

- Target population;
- Covered services;
- Contracting process and eligible providers;
- Reimbursement; and
- Enrollment Process.

During this presentation, Nebraska staff described the decisions they have implemented thus far in each of these five areas. This discussion was invaluable in that it enabled all the meeting attendees to become familiar with the design of the state's current managed care program.

2. Critical Implementation Issues Facing the Current Nebraska Program

Following the framework established in the opening session, Ms. Tobias then led participants through an in-depth discussion of state officials' particular concerns in serving CSHCN under the state's managed care program, as well as potential solutions to these problems. During this

session, examples of how other states have addressed similar issues were also discussed. The discussion surrounding each of these issues is presented in detail below.

a. Covered Services

Defining the benefit package for which HMOs will be held responsible, especially with regard to coverage for children with special health care needs, is one of the key issues with which Nebraska officials are currently grappling. Ms. Tobias broke the issue down into the following three main groupings so the group could address each more effectively:

- Provider network issues in which the services are covered but the providers are not the customary providers, are unfamiliar with the population and their needs, or do not provide the full range of needed services (e.g., pediatric subspecialists, therapists, pharmacy, home health);
- Services the HMO will not provide because they are not identified as "medically necessary;" and
- Services the HMO provides but with limits that appear arbitrary and are often inconsistent with Medicaid fee-for-service coverage (e.g., therapies, home health, private duty nursing, durable medical equipment and supplies)

Meeting participants identified and discussed a number of potential solutions to address these issues, including:

- Regarding provider network issues: defining the scope of coverage for subspecialist care, increasing the completeness of information given to the enrollment counselors regarding the provider network, and requiring a transition plan for children with special needs to assure continuous services as they move from a fee -for-service to a managed care system;
- Establishing a definition of medical necessity that considers growth and development and quality of life issues;

- Excluding from the managed care benefits package some of the services which are being provided inconsistently (or limiting their coverage), and implementing a Medicaid fee-for-service wrap-around benefit to take their place;

- Developing a clear description of the scope of coverage and services the HMOs are expected to provide and sharing this with all contracting HMOs; and

- Convening a workgroup composed of HMO managers, state officials, and CSHCN family members, to develop new utilization standards for chronic care services such as therapies, home health, and durable medical equipment and supplies (recognizing that current HMO standards are not appropriate and that there are no proven outcome benefits to unlimited services).

b. New Contracting Standards

Participants also extensively discussed the need to develop new contracting standards in the following areas:

- Access to care, particularly physical access and communication access;

- Primary care physician responsibilities and qualifications, including the identification of experienced providers and professional development for providers less experienced in the care of children with special needs;

- Models of case management that include the coordination of multiple medical services and the coordination of medical care with social and support services;

- Utilization management and review procedures that involve experienced special needs providers and families;

- Health promotion and health education;

- Quality assurance and improvement activities and reports that are specific to children with special health care needs;

- Clinical indicators, outcome indicators, and clinical practice guidelines that specifically address special needs children; and

- Member services, including the capacity for referral to community based services.

c. Marketing and Enrollment

Participants also briefly discussed the related issues of marketing the CSHCN program to families with disabled children and enrolling new members. The State is currently moving ahead on these issues, with initial emphasis on providing much more extensive and complete information to consumers during the health plan selection process. A transition period between fee-for-service and managed care enrollment is being implemented which allows the managed care plans and enrollees an opportunity to identify and resolve problematic areas.

d. Family Involvement

Participants noted the importance of including the families of CSHCN as much as possible in planning systems development efforts in the changing heath care environment. Several initiatives are already in place; for example, families are currently involved in the quality assurance process and the state is convening quarterly focus groups to obtain consumer input on a quarterly basis. Meeting participants made the following two additional recommendations:

- Involving families in the process of contract development through their review of the contracting specifications prior to release; and
- Requiring HMO's to develop mechanisms (e.g. a Family Advisory Committee) to obtain ongoing family input into program implementation and management issues.

e. Reimbursement

Ms. Tobias then presented an overview of the typical distribution of health care costs among persons with disabilities. She described how this distribution can seriously impact the design of programs and the ability of plans to make profits due to subtle differences in network development or service delivery procedures. Current initiatives in developing case-mix adjusted rates and options for risk sharing and stop-loss were reviewed by meeting participants. Ms. Tobias warned participants that Nebraska is at serious financial risk under its current policies; reimbursement rates are now based on

the PCCM (fee-for-service) option and CSHCN can choose between the HMO and PCCM options and disenroll from a HMO to join the PCCM Program if their needs are not being met. Thus, if individuals with high levels of need are choosing the PCCM plan, HMOs may be overpaid by as much as 30 percent based on the case mix of the individuals who choose HMOs and remain with them.

g. Incentive to Enroll Children with Special Needs

As described above, there is little incentive for HMOs to invest in the development of consumer-responsive programs when there is no corresponding financial adjustment to compensate them for their adverse selection. Participants agreed that this is a fundamental problem since it impacts on the state's ability to make any of the changes previously discussed. Ms. Tobias emphasized that it is also a problem common to many states and is compounded in Nebraska due to the relatively low penetration of HMOs in the commercial market. Combined, these factors mean that:

- HMOs have little experience providing any services to any population in the state;
- The provider community is still fairly resistant to HMO participation; and
- Health care consumers (commercial, Medicaid, persons with disabilities) have almost no experience with managed care.

Participants discussed a number of possible strategies to counteract these factors including:

- Providing continuous education to health plans about issues specific to serving children with special health care needs;
- Resolving issues promptly and effectively as they occur;
- Waiting out changes in the marketplace; and
- Developing an optional specialized HMO program that would use providers experienced in serving CSHCN, require appropriate standards of care for this

population, and include special risk-adjusted rates to provide appropriate financial incentives to make this program attractive to HMOs.

3. Next Steps

In the final discussion of the day, meeting participants discussed next steps that would be required to successfully implement managed care programs that serve CSHCN. Participants agreed that potential future directions and collaborative work with HMOs should include the:

- Development of appropriate outcome measures;
- Development of utilization management standards for chronic care services;
- Design of a new case management model;
- Development of CSHCN quality improvement measures; and
- Establishment of CSHCN education programs for primary care providers, member services staff and case managers.

B. Day Two

The goals of the second day of the seminar focused more on encouraging an interchange of experiences and ideas by individuals who are, or will be, directly affected by the planned programs. The participants included state staff, parents of CSHCN, and representatives of HMOs. Specifically, the day's goals were to:

- Introduce the HMOs to the unique needs of children with special health needs and describe why a creative approach to managed care is necessary to appropriately serve them;
- Identify and explore some of the most pressing issues confronting the managed care program; and
- Develop consensus regarding a process to address these issues.

During this second half of the seminar, the discussions again focused on the special issues involved in serving CSHCN under managed but were structured by more formal presentations by parents of CSHCN and HMO representative, as described below.

1. Introduction and Overview of Managed Care and CSHCN

As noted above, the Day Two session was structured to facilitate presentations by all of the stakeholders to describe their concerns and perspectives on providing quality services to CSHCN under managed care. The day began with an introduction by state representatives reviewing the rationale for the meeting and stressing the importance of forums such as this where all those involved are provided with an opportunity to interact and exchange ideas. Meeting facilitator Ms. Tobias then provided a general overview of trends in Medicaid managed care and spoke in more detail about how children with special health care needs differ from the typical HMO pediatric population. This difference in care includes the need for primary care, a variety of speciality services, and the social and support services required to ensure the highest quality of life possible.

2. Presentations

This overview was followed by a number of interactive presentations by HMO representatives and parents of CSHCN. These sessions were kicked off by a presentation by Carol Tobias in which she described the Community Medicaid Alliance as an example of how one managed care plan has been organized to serve persons with disabilities. In particular, her presentation stressed the importance of adapting managed care concepts in order to be responsive to the needs of consumers.

This was followed by presentations by parents of special needs children describing their particular experiences with managed care. Parents emphasized the critical need for elements such as access to speciality care and a sensitivity to the "specialness"of this group of children. In response, HMO representatives presented their experiences with enrolling children with special needs. During this discussion, HMO representatives and others expressed concerns about the complexity and cost of services.

3. Next Steps

Based upon these presentations, a general discussion ensued in which key areas of concern to state officials, parents of special needs children, and managed care providers were identified. These included:

- The composition of benefit packages;
- Provider/service delivery standards; and
- Family involvement.

At the conclusion of the session, participants agreed to continue the dialog among the various stakeholders, as this exchange was acknowledged as critical in successfully addressing key issues related to the implementation of managed care for Nebraska's children with special health care needs.

Appendix A: Participant List

Serving Children with Special Health Care Needs under Managed Care:
An Issues Seminar for Nebraska's Title V Officials

Participant List

Day One : July 1, l996

Gay Jeffries	DSS - Medicaid Managed Care
Sandi Kahlandt	DSS - Medicaid
Peg Stessman	DSS - Medicaid Managed Care
Mary Jo Iwan	DSS - Special Services for Children and Adults
Jeanne Garvin, MD	DSS - Medically Handicapped Children's Program
David Schor, MD	DSS - Medicaid Managed Care
Gerri Clark	DSS - Special Services
Angela Corbin	DSS - Medicaid Managed Care
Betty Ferdinand	DSS - Medicaid Managed Care
Roland Snuttjer	DSS - Medically Handicapped Children's Program
Chris Wright, MD	DSS - Medicaid
Mary Fraser Meints	DSS - Human Services
George Kahlandt	DSS - Public Assistance
Judi Schife	DOH - Family Health
Paula Eurek	DOH - Family Health
Mary Gordon	DOH - Developmental Disabilities Council
Dee Wills	HCFA - Regional Office
Sharon Dickinson	HMO - Nebraska (PCCM)
Deb Thomas	DSS - Medicaid
David Cygan	DSS - Medicaid Managed Care

Day Two: July 2, l996

Marcia Alber	DSS - Special Services
Carol Lieske	DSS - Special Services for Children and Adults
Angela Corbin	DSS - Medicaid Managed Care
Mary Gordon	DOH- Developmental Disabilities Council
Jeanne Garvin, MD	DSS - Medically Handicapped Children's Program
Chris Wright, MD	DSS - Medicaid
Carole Steffen	DSS - Local Office Staff
Judi Schlife	DOH - Family Health
Roger Hillman	DSS - Medically Handicapped Children's Program
Nancy Shank	Center on Children, Families, and the Law
Paula Eurek	DOH - Family Health
Kathy Jones	DSS - Local Office Staff
Joe Nanfito	DSS - District Office Administrator

Linda Meyers	Department of Education, Headstart
Jo Dickenson	Mutual of Omaha, Lincoln
Sandi Kahlandt	DSS - Medicaid
Marsha Rekart	DSS - Medicaid
Cheyenne Autumn	United Health Care of the Midlands, SHARE
Mary Fraser Meints	DSS - Human Services
Gregg Wright, MD	Center on Children, Families, and the Law
Gay Jeffries	DSS - Medicaid Managed Care
Carol Iverson	DOH - Adolescent and School Health
Kathie Repp	DSS - Special Services and Children and Adults
Cherie Bayley	Lancaster Headstart
Janet Haley	Mutual of Omaha
Russell Hopp, MD	Creighton Department of Pediatrics
Lisa Swinton	DSS - Legal Department
Deb Scherer	DSS - Medicaid
Paula Bruland	HMO Nebraska
Kevin Bruland	HMO Nebraska
Dee Will	HCFA - Regional Office
Stacie Bleicher, MD	Provider
Sherry Bauer	ESU# 3 - Early Intervention
David Schor, MD	DSS - Medicaid Managed Care
Linda Shandera	DSS - Early Intervention
Roland Snuttjar	DSS - Medically Handicapped Children's Program
Peg Stessman	DSS - Medicaid Managed Care
Linda Thomas	DSS - District Office Administrator
William Webb	DSS - Local Office Staff
Deb Lutjens	Douglas County Health Department
Margarita Abbott	Parent
Shawn Dickinson	HMO Nebraska (HMO)
Deb Thomas	DSS - Medicaid
David Cygan	DSS - Medicaid Managed Care
Dawn Sherman	Parent