



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7590 Security Boulevard
Baltimore, MD 21244-1850

October 5, 1998

Dear State Medicaid Director:

This letter transmits the enclosed final version of the guidance entitled "**Key Approaches To The Use Of Managed Care Systems For Persons With Special Health Care Needs.**"

Background

This final version of the guidance, which was originally transmitted in draft in April 1998, reflects changes stemming from comments received by the Health Care Financing Administration (HCFA) from a variety of organizations, including State Medicaid agencies, State health departments, consumer and advocacy groups, and provider organizations. In general, the guidance was well received in its draft form and the changes that have been incorporated are intended to clarify certain issues and expand upon ideas that needed further elaboration (e.g., compliance with Americans with Disabilities Act requirements, differentiating between children and adults).

This final version of the guidance is not mandatory. In our view, however, it does serve as a valuable resource to State Medicaid agencies as well as a broad statement of HCFA's goals for care delivery systems intended to serve persons with special health care needs. The Medicaid Managed Care Notice for Proposed Regulation has been released and requires each State to have a quality care system for managed care enrollees. This document provides a framework for States to consider when designing and implementing quality strategies for persons with special health care needs. When planning Medicaid managed care programs for persons with special health care needs (section 1115 and 1915(b) waivers, voluntary programs, and new State plan option programs) States should consider using this guidance to:

- o quantify this population's needs;
- o identify individual's special characteristics relevant to their access and use of primary and specialty services;

- o tailor purchasing specifications and delivery systems contracts to create value-based systems of care; and
- o identify problems and provide solutions that assure adequate access to quality medical services and adequate provider networks, while addressing this population's social and support needs.

HCFA is aware of at least one major advocacy organization that has used this guidance as a framework for developing its own guidance for a specific population group, the homeless. We encourage these and other efforts that use this guidance as a tool in developing managed care

programs for special health care needs populations. This document has already proved useful in serving as a catalyst for dialogue and discussion at the Federal level, and we expect it will do the same among States, managed care organizations, providers, consumers, and advocacy groups. Once again, we encourage you to share this document with other individuals or organizations interested in this topic. We have posted this final version of the guidance on HCFA's Internet website (www.hcfa.gov) to assure the broadest dissemination possible of this document.

This document is one step in our ongoing effort to provide technical assistance to you, particularly as in the area of purchasing strategies for persons with special needs.

In addition, as you may know, an additional provision in the Balanced Budget Act requires the Secretary to conduct a study concerning safeguards that may be needed to ensure that the health care needs of Medicaid managed care enrollees who have special health care and chronic conditions are adequately met. We will use this framework as a starting point for discussions with you and other stakeholders to identify additional areas for technical assistance and further research.

Any comments or questions on the final version of the guidance should be directed to Matt Barry, Center for Medicaid and State Operations, Mailstop S2-01-16, 7500 Security Boulevard, Baltimore, Maryland 212~ , (410) 786-1176, or e-mailed to MBarry@hcfa.gov.

Sincerely,

Sally K. Richardson
Director

Enclosure

ccs: Dr. Earl Fox, HRSA Administrator

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All HCFA Regional Administrators

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***KEY APPROACHES
TO THE USE OF
MANAGED CARE SYSTEMS FOR
PERSONS WITH SPECIAL
HEALTH CARE NEEDS***

**Guidance for States Considering the Development of Medicaid Managed
Care Programs for Persons With Special Health Care Needs**

OCTOBER 1998

This guidance was jointly developed by the Health Care Financing Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Office of Disease Prevention and Health Promotion, and was reviewed and commented on by the Managed Care Technical Advisory Group, the Medicaid Purchasing Group, and the Center for Health Care Strategies' Stakeholder Group on Special Needs and Managed Care.

Health Care Financing Administration

October 1998

**KEY APPROACHES TO THE USE OF MANAGED CARE SYSTEMS FOR
PERSONS WITH SPECIAL HEALTH CARE NEEDS**

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KEY APPROACHES TO THE USE OF MANAGED CARE SYSTEMS

FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS

Introduction

This guide is provided to States for review and consideration during the planning stages of Medicaid managed care programs (Section 1115 and 1915(b) waivers, voluntary programs, and new State option programs) for persons with special health care needs. The medical, social and financial needs of persons with special health care needs are often complex and unique to each individual. The application of these key approaches hopefully will assist States in identifying and resolving potential problems associated with providing adequate access to quality medical services, assuring an adequate provider network for these populations, and addressing social and support needs. This guide is not mandatory, and serves as a resource to States as well as a broad statement of HCFA's goals for care delivery systems intended to serve persons with special health care needs. While the guidance is written from the standpoint of service delivery within a managed care setting, the vast majority of the guidance is appropriate regardless of the service delivery model being employed by a State. The intent for this guide is to help facilitate actions at the State and community level as programs are initially conceived and developed in order that the issues raised in this guide are addressed by a State.

Before presenting these approaches, it is important for States to develop a comprehensive profile of the health of the specific population and their service needs. The development of this profile should be epidemiologically-oriented and based on the following processes:

(1) assessing the incidence and prevalence of medical conditions within a community as well as specific social and demographic features associated with Medicaid eligibility and service use; (2) assessing health-related service (as well as social and other support services) needs necessary for improving the population's health; and (3) identifying and coordinating existing public and private resources to create a system to meet the needs of Medicaid beneficiaries in the new health delivery system.

Based on the above process, States will be able to quantify the population's need, identify social or demographic characteristics related to the access and use of primary and specialty services, and tailor purchasing specifications and delivery systems (considering existing funds or structures) to create cost-effective systems of care for adults and children with special needs. This information may also contribute to identifying population-based variations in expenditure patterns for purposes of rate setting and risk adjustment. Data

that are commonly available to State Medicaid agencies include: vital statistics; reportable events (tuberculosis, HIV/AIDS); statewide surveys such as the National Immunization Survey and the Behavioral Risk Factor Surveillance System; and, intra-agency data exchanges.

The following framework covers six broad areas related to the planning and development of care delivery networks - the environment, purchasing strategy, access and quality, evaluation and reporting, benefits and the delivery system, and finance. Each area includes a series of statements which reflect those items that should be considered when including persons with special health care needs in managed care systems.

Finally, the framework contained in this guidance is not targeted at any specific special needs populations, although, where appropriate, the guide reflects differences between the needs of children and adults. This guide identifies core elements that are shared by most special needs populations. Thus this guidance, while not targeted, does address many of the issues shared by all special needs populations. It is also important to recognize that this guidance will evolve as the knowledge base in the field continues to evolve (it may further evolve and change based on the ongoing implementation of the many Medicaid related provisions contained in the Balanced Budget Act of 1997). Further, HCFA recognizes that care delivery systems for persons with special health care needs are designed for the unique needs of a population within a particular State or region. As such, all State programs are different and at varying stages of development and therefore this guidance may be more useful to States that have less historical experience in the area of managed care for special needs populations. However, States that have experience in this area can always learn from the experiences (good and bad) and best practices of other States.

To this end, this document may serve as a catalyst for dialogue and discussion among States, managed care organizations, providers, consumers, advocacy groups, and any other organizations that could shed new light on this matter. In value-based purchasing, the goal is to improve systems of care for the persons for whom the State is purchasing and this guidance is a starting point in efforts to purchase for persons with special health care needs.

KEY APPROACHES TO THE USE OF MANAGED CARE SYSTEMS FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS

I. THE ENVIRONMENT

Critical to the success of any State managed care initiative is the building of understanding and support from the grassroots level (which includes relevant State and local public agencies, advocacy groups, consumers, providers, and managed care organizations (MCOs)) for the value-based purchasing approaches being considered and developed by the State. Such stakeholder involvement should begin early in the conceptual stages of the project and is needed in order to receive feedback on the feasibility of a State's proposal and the degree of knowledge and support of the provider community, the beneficiary community (or the advocates who represent them), as well as the MCO community. Such efforts can be formally built into a process in the form of advisory councils, ombudsman programs, and routine public forums to name a few possible options.

States should consider:

Developing processes to ensure early, ongoing and adequate input from key stakeholders such as other public agencies serving this population (e.g., mental health and substance abuse agencies), private purchasers, beneficiaries and families, MCOs, providers, consumer advocacy groups, and professional associations (e.g., advisory committees, focus groups, etc...).

- Establishing a key stakeholders advisory committee that has regular meetings and a formalized structure and provides direct, documented input in the development and implementation of the strategy design and implementation. Examples of the types of functions the committee could address include:
 - identifying the goal of the strategy;
 - reviewing different interventions and oversight mechanisms;
 - identifying appropriate health care outcome measures; and,
 - assessing tools to improve the quality of care for special needs populations;
 - Defining key terms related to the use of purchasing strategies for persons with special health care needs, such as: populations considered to have

special needs, case management, case worker, utilization review management, supports, practice guidelines, performance measures, types of gatekeepers, medical necessity.

- Assuring that definitions of special needs populations are not limited to nor equated solely with Supplemental Security Income (SSI)-eligibility. While individuals on SSI most likely are persons with special needs, using only SSI is limiting and may miss key elements of a target population (e.g., seriously and persistently mentally ill adults, seriously emotionally disturbed children, etc...).
- Monitoring access and satisfaction measures for persons with special health care needs, such as ongoing meetings between Medicaid staff and MCO management, medical directors, beneficiaries and family members, providers, and advocacy groups.

II. PURCHASING STRATEGY

The focus of the Medicaid program, whether it is a program specifically designed for persons with special health care needs or a more general approach, is moving from paying health claims to purchasing high quality health care services. The goal of this effort is to protect and improve the health and satisfaction of beneficiaries. To this end, developing and implementing a strategy to buy quality health care services that gives value for the dollar to beneficiaries and purchasers needs to be a priority for States. While seeking the lowest possible cost, a value-based purchasing strategy is one that does not seek the lowest price in isolation. It recognizes that there must be value in return for the investment. This is of particular importance when addressing purchasing strategies for persons with special health care needs wherein a singular focus on saving money could put the health and well-being of individuals at undue risk.

This strategy encompasses fee-for-service and capitation reimbursement mechanisms; acute, long-term, and continuing care; voluntary, mandatory, Section 1915(b), Section 1115, and State Plan option approaches. Value-based, quality-focused purchasing seeks to enhance performance and accountability in a quality health care delivery system one that is affordable, effective and safe, while protecting, improving enrollee health and satisfaction, and responding to the specific health needs of each individual.

An effective strategy is one that will continually manage the improvement process, set priorities, involve stakeholders, identify and adopt performance measures, collect appropriate data, identify improvement opportunities and implement appropriate improvement interventions. Improvement interventions would function as tools in a toolbox and would include enforcing performance standards and guidelines; using purchasing specifications; giving technical assistance to care delivery systems and providers; giving beneficiaries assistance and information; using payment and coverage mechanisms for quality goals; monitoring; and rewarding performance. To meet these goals,

States should consider:

- Identifying potential beneficiaries, through effective outreach, bringing potential beneficiaries into the Medicaid program and facilitating the effective enrollment of each Medicaid beneficiary into the most appropriate care delivery system. States should also consider whether and how approaches must vary in order to be most effective for enrolling children versus adults into a program.
- Determining who to contract with through the use of tools such as performance standards, purchasing specifications, past performance data, "quality" as a factor in selection, adequate choice, etc. Further, States should consider collaborating with appropriate Federal and State agencies and with public and private purchasers to identify and obtain information on successful and not-so-successful purchasing policies and strategies.
- Identifying where Medicaid coverage and benefits end and where other systems of care, either other Federal programs (e.g., Medicare, Title V grants, Ryan White CARE Act) or State or local funding sources begin to assure coverage across the continuum of care and ways to maximize those collective resources (e.g., group purchasing strategies) in a manner that enhances quality of care. Efforts that do not look to non-Medicaid funding sources will be limited in their efficacy by such an approach, most notably by the Upper Payment Limit restrictions that are imposed by Federal statute upon Medicaid managed care programs (i.e., the managed care program cannot exceed the cost of delivering the same set of services to a comparable population in a fee-for-service environment). Examples of this type of activity include: joint purchasing efforts with the same network by the

Medicaid agency and Mental Health agency, and the Medicaid agency purchasing on behalf of the Mental Health agency as is the case in Massachusetts.

- Determining what to contract for in assessing the contracted benefit package for each specific population in relationship to the overall State Medicaid Program benefit package. This includes what remains in fee-for-service, what goes through a Primary Care Case Management (PCCM) service, what is included in a partial capitation contract, what is included in a full-risk contract, etc.
- Determining where and when to contract, including a process to define "adequate" capacity/capability regarding network specifications, geographic dispersion, linguistic capacity, cultural diversity, the ability of potential contractors to meet contract standards/criteria and the development and implementation of standards for contractor compliance.
- Determining how to monitor through a "quality oversight system" using tools that are developed or are being developed.

While it is important for States to develop a broad-based purchasing strategy focused on value and cost effectiveness, it is equally important for States to articulate the specific goals they want to achieve in developing a program to serve persons with special health care needs. These are issues such as:

- Are you trying to improve access to care or build capacity in a particular area?
- What priority do you place on protecting the revenue base of "safety net" providers?
- Are you trying to move services away from an institutional bias?
- Are there existing or potential partnerships with other public programs (e.g., Title V, Ryan White, Medicare) that you do not wish to disrupt?

III. ACCESS AND QUALITY

Of fundamental importance to any health care service delivery system is the ability of enrollees to access appropriate services in a timely manner. Issues that impact upon access include: efforts by a State to market the program to beneficiaries; outreach and education efforts to increase the rate at which beneficiaries choose and access their MCO or provider; the availability of written materials in threshold languages along with staff capable of communicating in those threshold languages; assuring that the provider network is experienced and has the expertise needed to care for persons with special health needs; whether and how the State's auto-assignment process takes into account time sensitive and continuity of care issues for persons with special health needs; and what steps the State is taking to comply with relevant Federal statutes regarding persons with disabilities (e.g., the Americans with Disabilities Act) when designing, implementing and monitoring its care delivery systems. Together, the issues identified below should be given due consideration in order to assure access to services for persons with special health needs.

States should consider:

- Assessing the types of assistance or information that will be targeted to persons with special health care needs (beyond the standard material given to all enrollees) to assist their understanding of the capacity of various MCOs in meeting their special health needs.
 - Enrollment materials should be made available for persons with sight or hearing impairments or for people who do not speak English. Also, the establishment of thresholds for these materials should be considered by the State. These individuals need to be identified by the State prior to initiating the enrollment process.
 - Multi-language materials (written and audiovisual) should be made available at an appropriate comprehension level (based on community standards).
 - Assurances should be provided that services (to aid in enrollment) are available for persons with cognitive impairments (or their guardians) during the MCO selection process.
 - Mechanisms should be developed to reach homeless beneficiaries and

others without a phone/mailbox.

Outreach materials and intake services should be made available at locations that are especially convenient to persons with special health care needs.

- Assessing the adequacy of access to care delivery systems recognizing and accounting for the distinct and fundamental differences (e.g., developmental, physiological) between children and adults with special health care needs.
- Complying with all relevant provisions of the Americans with Disabilities Act (ADA), along with other relevant Federal statutes, in relation to the development of care delivery systems for persons with special health care needs. A complete listing of ADA resources is available at the U.S. Department of Justice's ADA Home Page Internet website at: <http://www.usdoj.gov/crt/ada/adahom1.htm>.
- Developing condition-specific training for State and contractor staff involved in the enrollment process.
- Advising persons with special health care needs of how they can continue to obtain care from their current system or provider under the new strategy or how to transition to a new system/provider. States should consider conducting an assessment of the health care risks for special needs beneficiaries if critical patient-provider relationships are severed.
- Developing mechanisms to use a "health needs assessment" process or other process (such as review of past Medicaid claims data) to identify existing or undiagnosed medical conditions. This process could be used to assist beneficiaries in selecting appropriate MCOs and providers based on identified medical and social needs. This process could include trained enrollment counselors or community-based organizations offering face-to-face, confidential enrollment information to assist persons with special health care needs during the enrollment process.
- Developing beneficiary enrollment materials that include information regarding each MCO's network of services and providers available to special needs populations. These materials should clearly describe enrollment

options, including:

- options for MCO/provider selection and the selection of specialty providers as gatekeepers;
 - pre-authorization and referral guidelines, covered specialty services and available specialists;
 - availability of any special services, expertise, and experience offered by providers and MCOs;
 - exemption options;
 - disenrollment provisions;
 - lock-in periods and rules for changing MCOs/providers;
 - excluded services.
-
- Offering a beneficiary enrollment hotline. If the State chooses to do so, it should assure that beneficiary enrollment hotline operators are knowledgeable of enrollment options and MCO service and provider capabilities for persons with special health care needs. Further, the State should consider ways to assure that the hotline is able to address the language needs of non-English speaking persons with special health care needs.
 - Demonstrating that patient confidentiality is assured throughout the enrollment, disenrollment, default assignment, and care delivery processes and that penalties are associated with breaches of privacy or confidentiality. Communications with MCO enrollees must be consistent with the ADA prohibition on unnecessary inquiries into the existence of a disability.
 - Providing assurances that persons with special health care needs are assigned to MCOs capable of serving their particular needs (if the State permits auto-assignment for persons with special health care needs), both for children and adults. States should further consider what unique variables are most appropriate in the auto-assignment algorithm that address the needs of persons with special health care needs. And, States should consider developing a process to investigate those instances where there are a significant number of persons with special health care needs being auto assigned and a process to take corrective action if appropriate.
 - Exploring how to develop an auto-assignment process that assigns persons

with special health care needs first to a managed care entity (MCE .MCO or primary care case manager) that includes their current Medicaid provider of care. States should further explore ways to determine how to obtain, identify and account for this variable. The significance of the traditional provider of care relative to current health status should also be taken into consideration (e.g., rehabilitation therapists may be less important than an oncologist under certain circumstances).

- Incorporating into their default assignment processes providers who have demonstrated experience and expertise in the provision of care for people with special health care needs. [Note: the State should consider describing any standards/process for designating providers as "experienced" or "expert" in providing care for persons with special health care needs.]
- Providing assurances that once default has occurred that notification to the beneficiary of his/her MCO assignment occurs within the shortest possible time. States should also consider ways to provide assurances that life-sustaining, ongoing treatment needs are provided for during transition periods and that financial responsibility for care provided during this period is clearly articulated.
- Developing mechanisms to take advantage of the data currently accessible regarding individuals enrolled in Medicaid but who will be transitioning to a care delivery system versus individuals newly eligible for Medicaid. Specifically, how will this available information be used by a State or a designated organization such as an enrollment broker regarding current patient-provider relationships, the type(s) of special needs of enrollees, etc?
- Developing mechanisms to permit individuals to choose from not less than two managed care entities (either MCOs or primary care case managers).

The delivery of quality care and the ability to monitor MCO performance are vital functions that a State must be able to perform (directly or through its contractors). Quality improvement (which includes maintenance of functional status for persons with special health care needs) activities (including the development and deployment of tools to enhance data collection to support quality improvement efforts) have increased in scope and importance as Medicaid MCO enrollment has become more common. The use of data generated from these efforts needs to be systematically incorporated into monitoring efforts

in order to hold MCOs and providers accountable for their performance under that system.

States should consider:

- Developing a plan describing how it intends to monitor MCO compliance with Federal and State requirements. Specifically, how the State will monitor whether:
 - MCOs allow enrollees, to the extent possible, to choose their health practitioner, maintain a program that allows enrollees to voice complaints, and provide for timely resolution of grievances;
 - MCOs have complied with appropriate access standards;
 - MCOs are not discriminating against enrollees on the basis of health status or need of health services;
 - MCOs have not terminated enrollment based on an adverse change in an enrollees's health status; and,
 - MCOs have maintained an internal quality assurance program that addresses special need populations.
- Developing mechanisms that assure that the complaint and grievance processes are expedited for people with life-threatening conditions such as AIDS, and that such mechanisms provide maximum expected time-frames for resolution of complaints and grievances for such individuals.
- Requiring HEDIS performance measures for its MCO's quality assessment and improvement programs and assessing the need for and utility of performance measures specific to special needs populations (e.g.. measures of functional status).
- Conducting consumer satisfaction surveys of persons with special health care needs. Such an effort should address the need for over-sampling in the general survey population to assure fair and adequate representation.
- Developing a strategy for assessing specific aspects of quality care for persons with special health care needs enrolled in MCOs for purposes of early identification of potential problem areas and for long-term assessment. States should further consider the need to conduct targeted quality of care studies or investigations by external entities to assess quality of care for

persons with special health care needs as a part of their external reviews.

- Developing continuous quality improvement (CQI) goals to incorporate as part of contractual agreements with MCOs for the purpose of building MCO capacity in meeting the needs of persons with special health care needs.
- Evaluating patterns of referrals to specialists and subspecialists.
- Developing safeguards on conflict of interest issues as they relate to providing adequate assurances that organizations that conduct enrollment, guardianship, or eligibility determination activities on behalf of the State are not the same organizations that ultimately become MCO contractors with the State.

IV. EVALUATION AND REPORTING

MCOs must be held accountable based on systematic and objective evaluations of their performance under Medicaid purchasing strategies, particularly ones that serve persons with special health care needs. Such efforts need to take into consideration the human and financial resources needed to commit to such an undertaking, the target population(s) to be served, what outcome measures are most meaningful for those groups, the systems needed to collect, process, and validate the data being collected, and how the findings from these efforts are translated into improved systems of care and improved health outcomes. To ensure that the information that is collected, analyzed and reported is useful to consumers, States, MCOs and other interested parties, the State should engage these groups from the outset in the design of its data collection strategy in order to gauge the feasibility and utility of its proposed efforts.

States should consider:

- Developing a mechanism to collect encounter, or other patient-level data, from MCOs for persons with special health care needs. Such an approach should account for current resources (financial and personnel) available and what additional resources are necessary to accomplish this task. Also, such an approach should describe the State's time frames for developing and validating a data collection methodology and what specific strategies the State will employ to collect information on special needs populations.

- Conducting studies using person-level encounter data among persons with special health care needs, such as:
 - patterns of health service use, including patterns of under utilization,
 - access to providers servicing special needs groups,
 - movement of high cost patients between MCOs, and
 - patterns of adverse selection by selected diagnosis.
- Developing specific outcome measures for special needs populations (in addition to any utilization review activities). Such measures if developed should describe how these outcome measures will be used to assess MCO performance, whether such measures will be tied to financial incentives, and how the results of these efforts are linked to improving (or maintaining the functional status or independence) the health status of Medicaid beneficiaries (e.g., Massachusetts and Arizona have undertaken such initiatives).
- Conducting an assessment to determine any differences in access and use of services based on racial or ethnic factors or other access priorities based on review and analysis of prior utilization patterns.
- Undertaking medical record reviews, consumer surveys, focus studies, or other types of studies to assess the quality of care within MCOs for persons with special health care needs.

V. BENEFITS AND THE DELIVERY SYSTEM

The system of care for persons with special health care needs must be capable of responding to both the routine and unique medical and social needs of these enrollees. As a result of this uniqueness, there is no single model of care that is most appropriate. Creativity and flexibility needs to be encouraged to assure responsiveness to individual needs in a timely manner. There are issues, however, which all models share and which must be addressed. Among the issues that all care delivery models must address are:

assuring the availability of adequate numbers of providers to care for the target population, assessing provider experience and expertise against the population to be enrolled, assuring linkages with non-Medicaid services needed to care for the target population, and any special accommodations needed in order to care for persons with special health care needs.

An essential component of providing successful care and services to individuals with special health care needs is the effective provision and coordination of needed supports. The generic term "supports" means material and personal assistance that is directly related to the individual's ability to experience the best possible outcomes from the medical care provided. For example, the provision of consumer-directed personal assistance services has been shown to be a major variable in both avoiding institutionalization and in improving physical health and quality of life for persons with special health care needs. The State needs to demonstrate how its network of inter-related health services and supports operates to achieve the best possible outcomes for the consumer, including improved consumer satisfaction, quality of life and physical health. This and other important benefits and delivery system issues are identified below and should be taken into consideration in the State's design.

States should consider:

- Approaches for delivering services to persons with special health care needs that encourage innovation along with improved, more efficient service delivery. Such approaches include, but are not limited to:
 - Selective contracting with MCOs that want to develop new approaches for care delivery.
 - Risk adjustment (see Finance section) so as not to penalize MCOs that provide needed services in an exceptional manner.
 - Partnering with MCOs to jointly develop new or better service delivery models.
 - Tailoring contract specifications for special needs populations to the geographic area being served. Approaches in rural communities where there are often a lack of any services, not just specialty care, varies from large urban settings.
- Including providers that possess the technical expertise and experience needed to care for special needs populations into the provider network for delivering services (e.g., Title V programs for children with special health care needs, Ryan White CARE Act programs for HIV/AIDS).
- Defining the benefits package for special needs populations, for both children and adults, and describing the range of services (and any limits on those services) provided for the physical and mental health needs of

beneficiaries.

- Developing policies and procedures for assuring that special needs beneficiaries enrolled in MCOs will be referred by the MCO to fee-for-service Medicaid-covered benefits covered as State Plan services carved out of the capitated rate (e.g., pharmaceuticals, dental care, mental health services, substance abuse treatment) or under 1915(c) programs.
- Providing adequate assurances on the extent to which new pharmaceuticals (e.g., multiple drug therapies for HIV care), related tests, and new treatment modalities will be accessible in the care delivery system environment.
- Making the delivery system accessible to beneficiaries with mental and physical disabilities in accordance with the ADA. Further, the State should describe the mechanisms it has identified to respond to situations in which services are not accessible or persons with disabilities experience discrimination in attempting to access services.
- Determining appropriate mechanisms, in conjunction with MCOs, to permit specialists, when appropriate, to act as gatekeepers for persons with special health care needs. Further, States/MCOs should consider establishing procedures to permit persons with special health care needs to obtain standing referrals to a specialist in-network or out-of-network if the MCO does not have a provider with appropriate training and experience. And, States should consider ways of determining appropriate training and experience.
- Assessing how the State intends to address medical necessity in the contract and how this relates to what is contained in their State Plan. Such discussions should consider issues involving maintenance and increased functional status versus traditional medical models which focus more on the issue of improvement. Further, medical necessity discussions need to be held in the context of the total spectrum of services needed by persons with special health care needs and whether all those services are available under the Medicaid program or whether appropriate linkages and service agreements need to be made with other providers with alternative sources of funding (e.g., Title V, Ryan White CARE Act, Medicare).

- Assessing whether there are additional services that would be of particular benefit to persons with special health care needs, not contained in the State Plan or in the State's definition of medical necessity, that the State could include in its contracts with MCOs that go beyond the standard benefit package (e.g., habilitative care). However, no additional Federal payment from the Medicaid program (FFP) would be available for such additional services.
- Assessing the role of gatekeepers and/or specialists in determining authorization for services. Further, States should consider ways to assess the role of the case manager and patient in the use of specialty providers and services.
- Establishing linkages with social programs such as special education, criminal justice, welfare, transportation, housing, and other public assistance programs. States should assess the extent to which efforts are being made (by the State and through the State's contracts with MCOs) to coordinate non-Medicaid health care services and enabling services.
- Developing a mechanism to assess and provide access to specialized adaptive equipment and medication that are covered in their State Plan.

The need for case management and care coordination for persons with special health care needs in a care delivery system is important to assure identification of service needs, timely receipt of services, the sharing of information within the care system, and efficient use of resources. The integration and coordination of services (and information related to those services) is of particular importance to individuals with special health care needs who often receive services from multiple providers in multiple locations. In addition, as some special health needs populations receive some of their care through an MCO and the remainder outside the MCO, the need for case management and coordination is even more critical to assure appropriate receipt of services, quality monitoring, and reimbursement.

States should consider:

- Assessing the availability of case management services to coordinate services and gauge the types of training case managers receive. Further, States should consider efforts to develop and utilize individual care plan or health needs assessment tools to assist in management decisions based on

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goals along with ways to assess how effective case managers are in procuring needed services for persons with special health care needs. And, States should consider developing qualifications (e.g., degree, license, experience) that case managers need to participate.

- Ensuring that services are coordinated between acute care and long term care needs, where appropriate, to assure integration, coordination, and nonduplication of services and payments.
- Identifying the most appropriate ways patients with complex medical conditions are managed - e.g., designated advocates (with specific training in needs of patient), "exceptional needs coordinators". general case manager, tracking authorization of services, or others.
- Enabling persons with special health care needs and their families/care givers to participate in the development of care plans and to have informed choice of providers.

VI. FINANCE

The manner in which States decide to reimburse MCOs and providers for the delivery of services plays a major factor in how those systems of care operate and how enrollees access services. The methodologies used by State's to reimburse MCOs and providers continue to evolve, particularly as State's contemplate serving persons with special health care needs. The issues States face when providing services to special needs populations include a recognition that resource use is more frequent and intense and that MCOs and providers experienced in the delivery of care to special needs populations may cost more. Therefore reimbursement methodologies should not place MCOs and providers at undue risk for caring for these groups. It should be noted that reimbursement approaches vary widely, from risk-based approaches to fee-for-service or hybrid models, each having its own set of pros and cons, both from the standpoint of a purchaser and as a provider of care. This issue is raised at the outset so as not to leave the impression that the choice of managed care as a delivery system for persons with special health care needs necessitates a particular reimbursement approach.

States should consider:

- Developing rates of payment to MCOs, prior to enrollment of persons with special health care needs, that assure adequate payments. These methods could include risk-based, capitated strategies or lower [financial] risk, fee-for-service or primary care case management (fee-for-service plus monthly case management fees) reimbursement strategies.
- Developing reimbursement methodologies (e.g, diagnosis-based risk adjusted capitation rates, fee-for-service, risk sharing, risk corridors, stop-loss protection, reinsurance coverage) that address concerns related to the possibility of adverse selection (e.g., protections against undue financial risk or MCOs de-marketing their services to avoid financial risk resulting from enrollment of persons with special health care needs).
- Determining whether new pharmaceuticals or other new technologies or treatment modalities (e.g., for HIV care) are to be provided within a capitation rate and what adjustments will be made to account for these potentially costly new drugs or treatments.
- Providing appropriate financial incentives to providers and MCOs to encourage appropriate delivery of care to persons with special health care needs. Such approaches also must recognize that serving individuals with special health care needs takes more time and resources than with healthier patients and that treatment of persons with special health care needs is an ongoing investment that may entail higher short-term expenditures but will result in longer term savings due to appropriate and timely treatment.