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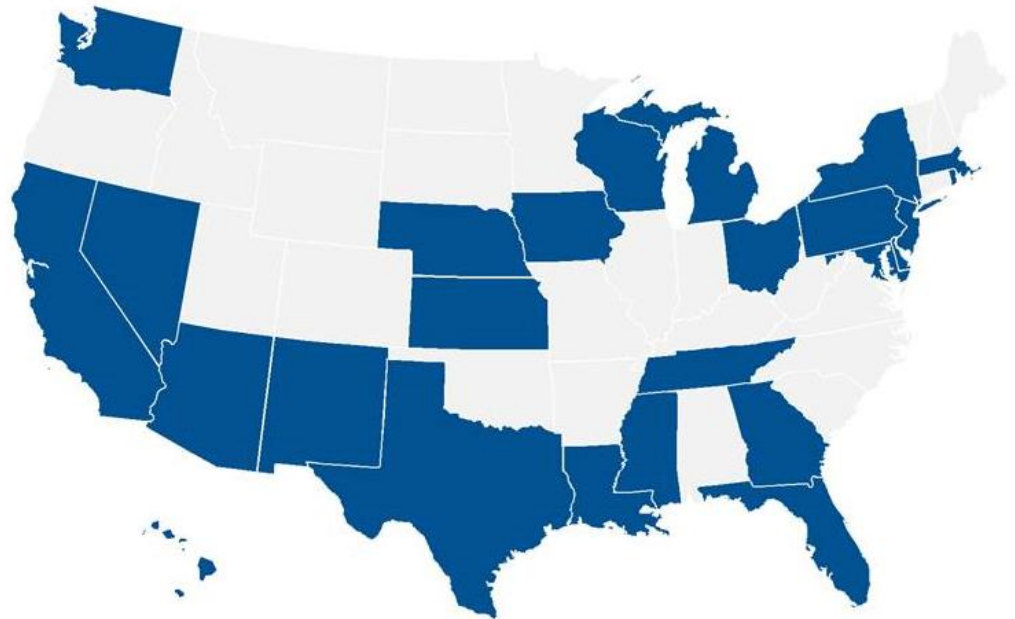
# Serving Children with Special Healthcare Needs

Financing, Program and Policy Considerations

# Our Experience

## UnitedHealthcare Community & State

- Operate in 24 states plus Washington D.C.
- Serve more than 5 million individuals
- Offer acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs
- We serve the children with special health care needs in nearly all of our Medicaid markets – including specialty CSHCN programs in AZ, TX, and MI.
- One of four businesses of UnitedHealthcare, the health benefits company of UnitedHealth Group.



# Discussion Agenda

- We have a shared vision for improved care, why is it so challenging to get there?
- States and employers are balancing increased costs, needs and competing pressures with desire/need to serve more people with more comprehensive services
- CSHCN are being impacted by reform trends in the Medicaid program and healthcare delivery broadly
  - Payment
  - Delivery
  - Integration of Benefits
  - Transition to Managed Care
- Medicaid managed care for CSHCN
  - Considerations for Serving CSHCN
  - Essential Elements

# The Current Landscape

## The Goal

- Person/Family-Centered Approach to Services and Care
- Comprehensive and Holistic View of the Goals/Needs of the Individual/Family
- Community-Based Care
- Easy to Access and Navigate
- Improved Quality of Life

## The Barriers

- Fragmented Funding and Program Administration
- Lack of Consistency Across Programs – Populations, Requirements, Priorities
- Not All Kids Covered By Public Options
- Limited Funding, Increasing Needs and Cost
- Limitations in Data and IT

## Medicaid

- State Plan Benefits
- EPSDT
- ABD/SSI
- Waiver
- School Based Services
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) or TEFRA like programs
- Buy-in Programs

CHIP

School Based Health Services – Schools, Dept. of Education, Medicaid

Special Education Services - Schools, Dept. of Education

SAMHSA CMH Block Grants – Dept. of MH, BH, SUD, Counties, Medicaid Agency

Maternal Child Health Title V – Dept. of Health

Title IV-E – Child Welfare Agency

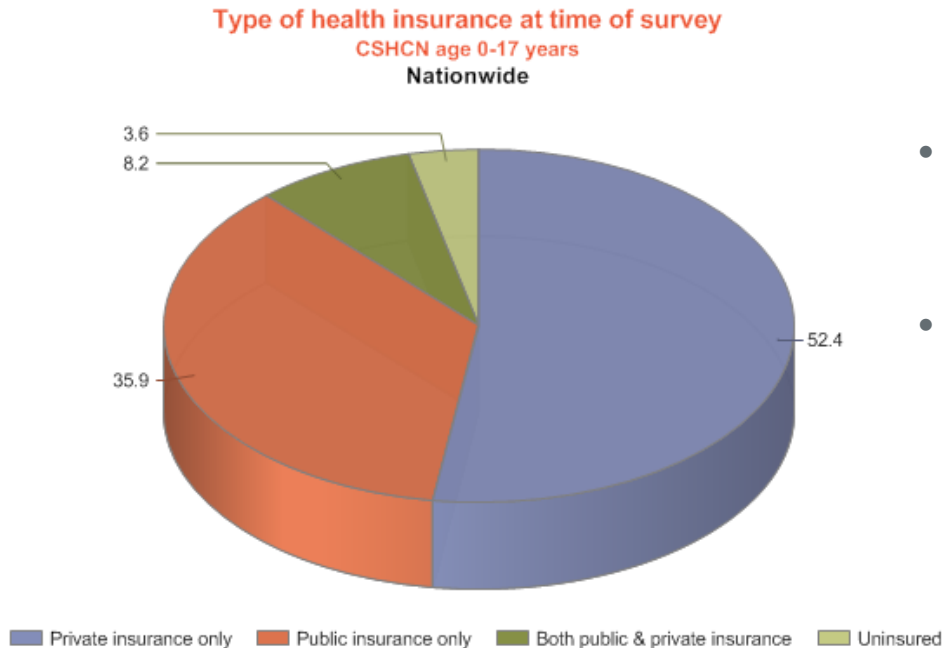
Tribal Health Funding – Tribal Governments, Tribal Health Dept.

State- Specific Health Programs – Varies

Commercial Health Insurance – Managed Care

SSI – Social Security Administration

# Breakdown of Payers



- CSHCN Survey Data from 2009/2010 – Pre-ACA Implementation
- Between 2013-2014 Children 0-18 uninsured rate nationally went down 17%
- As of 2014, Children (not just CSHCN) breakdown for coverage was:
  - 47% employer
  - 39% Medicaid
  - 6% uninsured
  - 5% non-group
  - 2% other coverage

Sources:

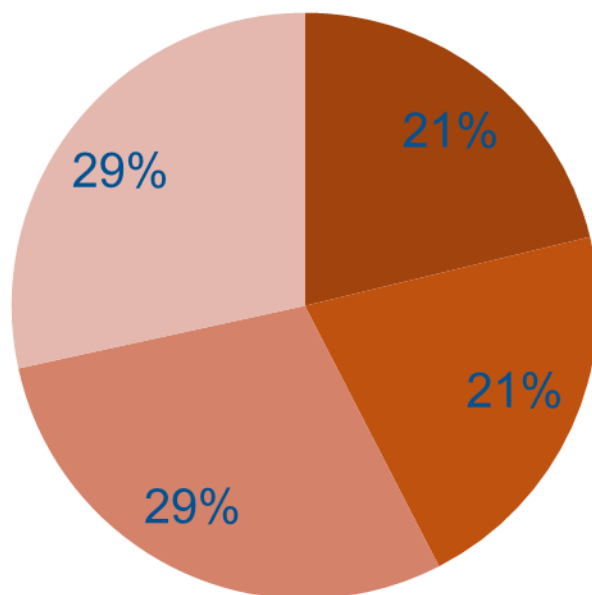
2009/10 National Survey of Children with Special Health Care Needs <http://www.childhealthdata.org/browse/survey/results?q=1810&r=1&chart=pie>

Kaiser Family Foundation estimates based on the Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplements).

# Income Breakdown

## CSHCN 0-17 by Household Income

■ 0-99% FPL     ■ 100-199%FPL  
■ 200-399% FPL   ■ 400% +



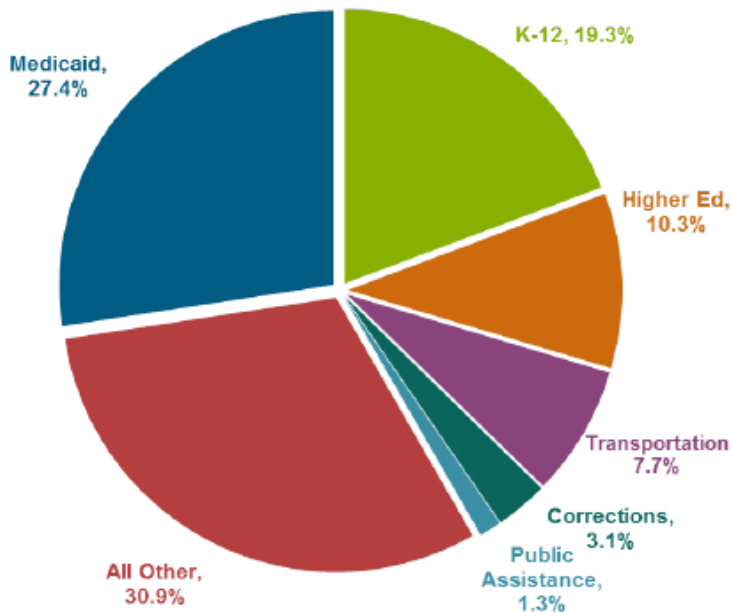
- Not all CSHCN are going to qualify for Medicaid
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), TEFRA like programs and buy-in programs provide additional opportunities for families to access (often more robust) Medicaid services
- Exchange and Employer-sponsored coverage impact a significant portion

# Medicaid Impacts State Budgets

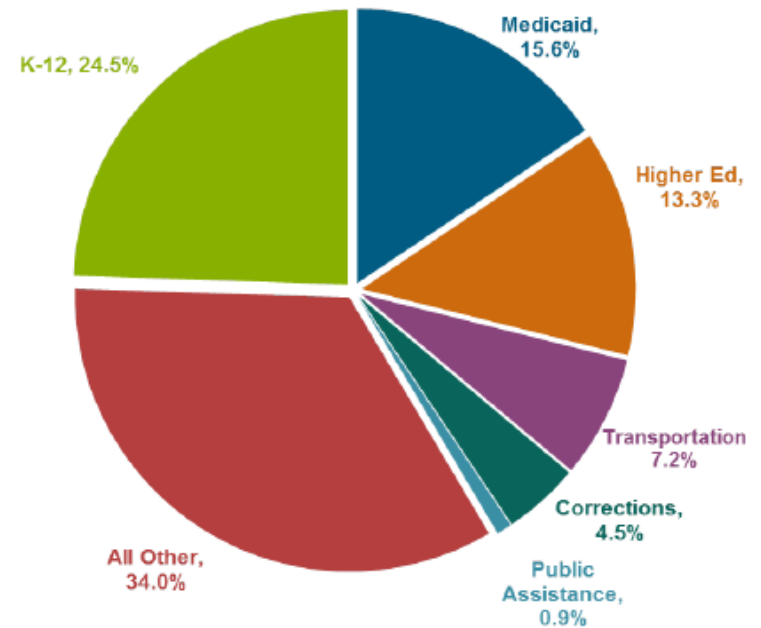
## Expenditures by Function

(Estimated Fiscal 2015)

### Total State Expenditures



### State Funds



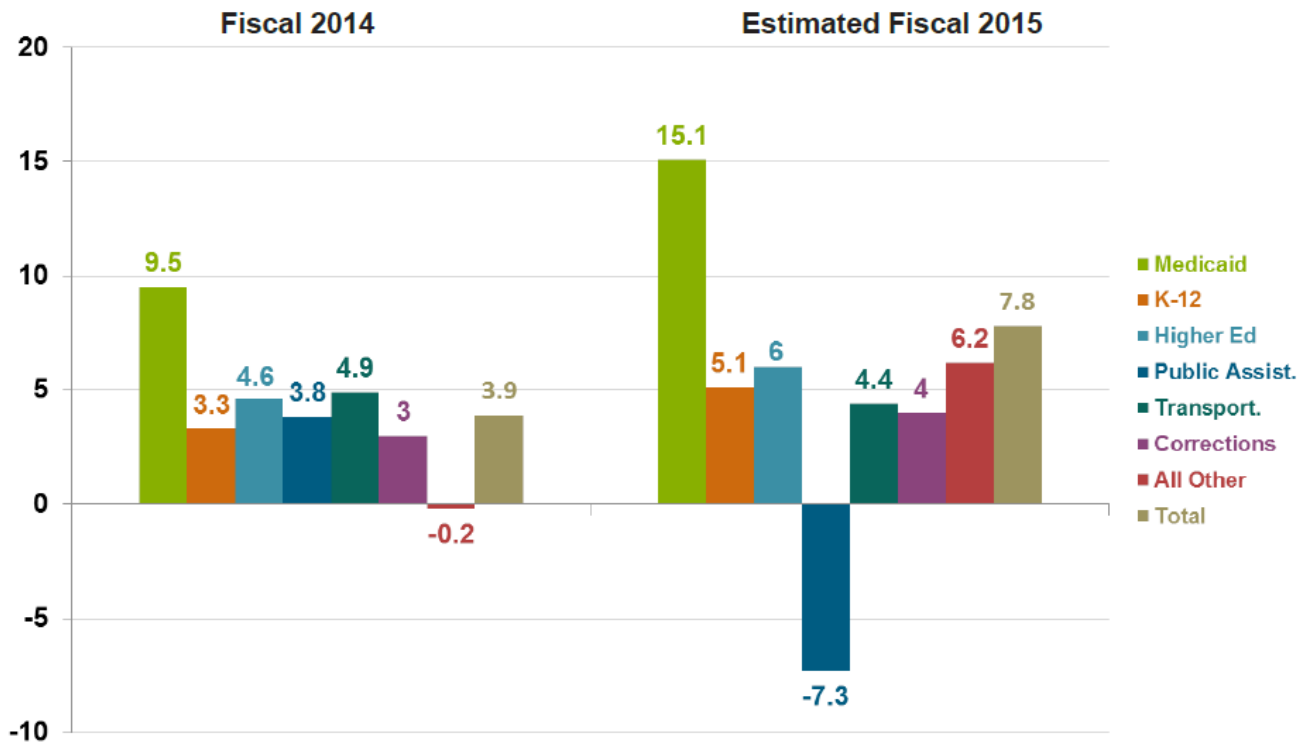
*State funds are general funds and other state funds combined, excluding bonds. Total state expenditures are all federal and state funds.*

Source: National Association of State Budget Officers Annual Survey



# Medicaid Impacts State Budgets

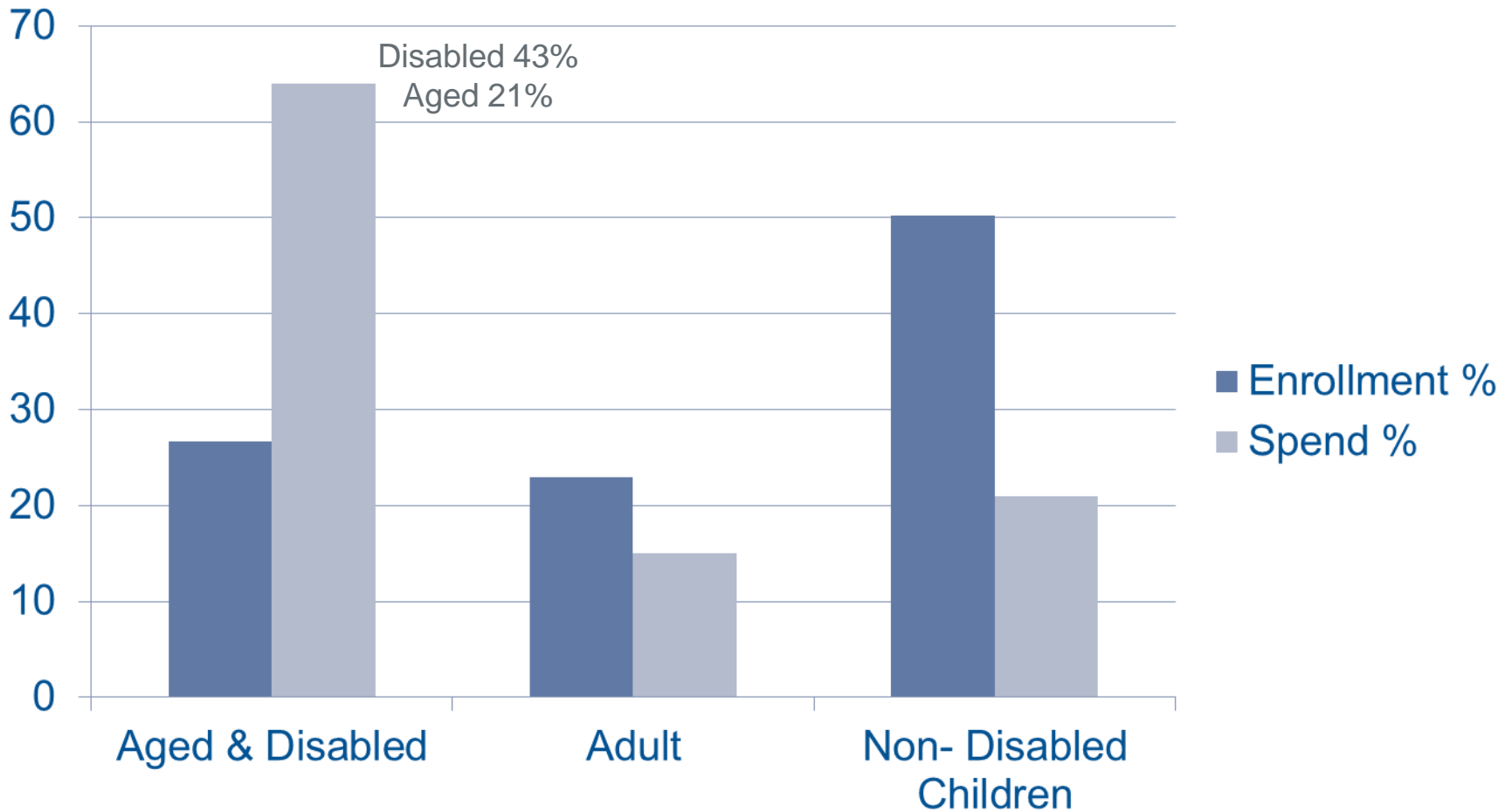
## Total State Expenditures Percentage Spending Growth by Program Area



\*Total state expenditures include spending from general funds, other state funds, bonds, and federal funds to states

Source: National Association of State Budget Officers Annual Survey

# Medicaid Spending vs. Enrollment

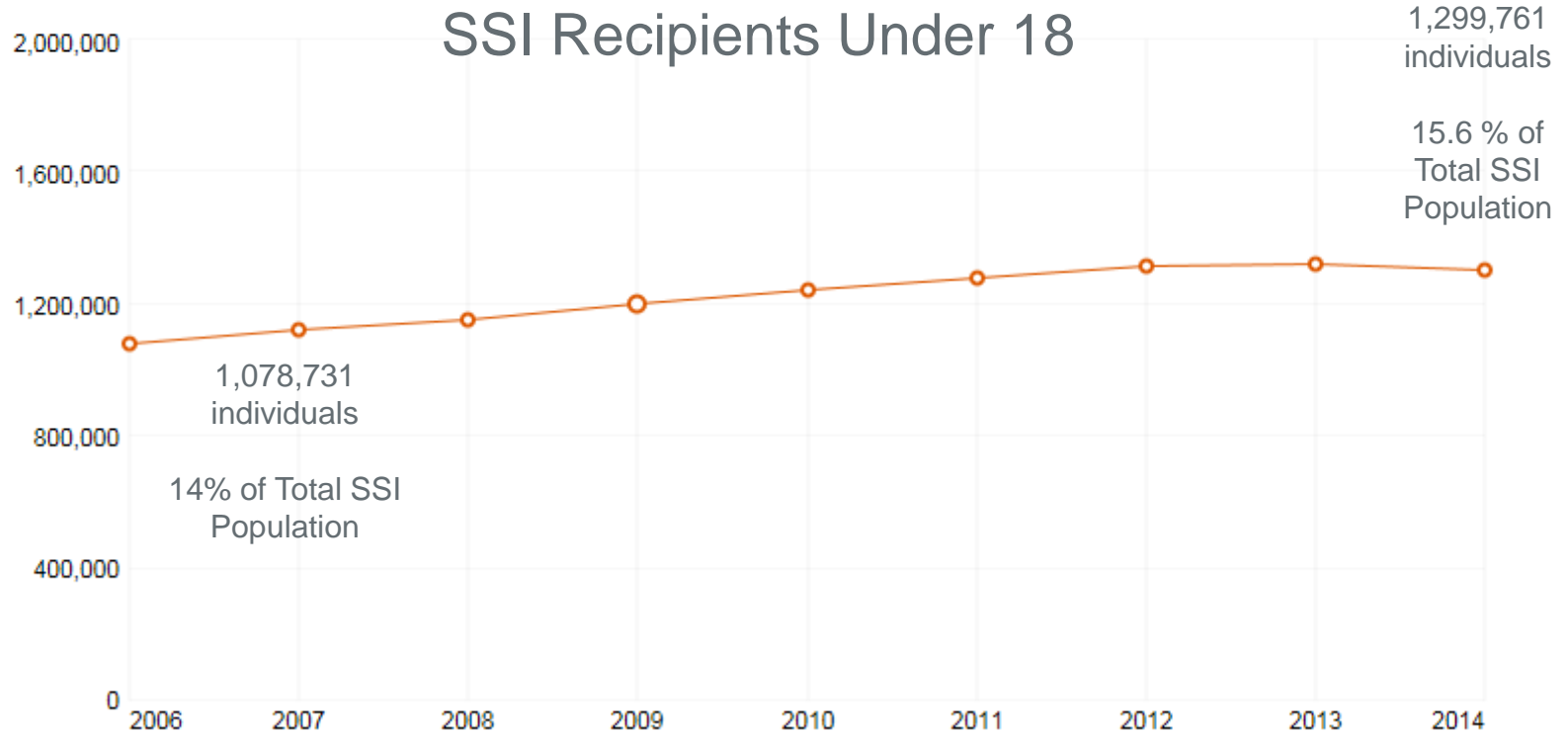


Source: Kaiser Family Foundation State Health Facts

Compiled by Health Management Associates (HMA) from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured (KCMU).

Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

# Growth Continues



Location: ● United States

Characteristics: Under 18

*NOTE: Approximately 8% of CSHCN receive SSI Nationally, 11,203,616 CSHCN (2009/10)*

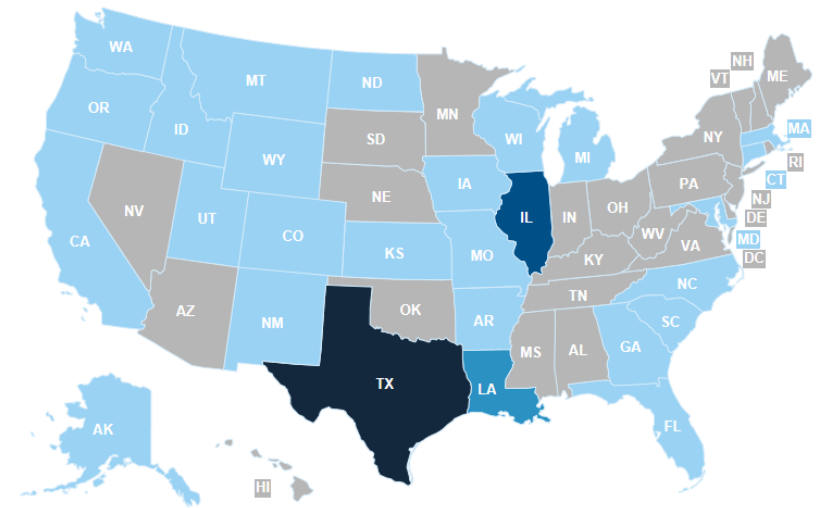
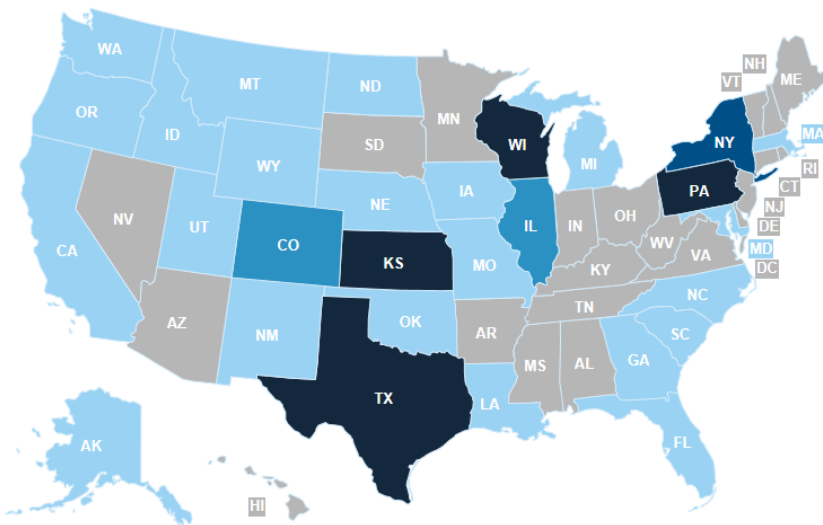
Sources:

- SSI Annual Statistical Report, 2014. Social Security Administration, Office of Retirement and Disability Policy, Office of Research, Evaluation, and Statistics. SSA Pub No. 13-11827, October 2015.
- Kaiser Family Foundation State Health Facts
- 2009/10 National Survey of Children with Special Health Care Needs

# Unmet Need Continues

## Children on 1915c Waivers

## Children on 1915c Waitlists



- Approximately, 41,950 children are served through 1915c waivers
- *Note: CSHCN could be receiving services in 1115, SPA*

- Approximately, 58,635 children on 1915c waiver waitlists
- 349,511 individuals (adults and children) on IDD waiver waitlists

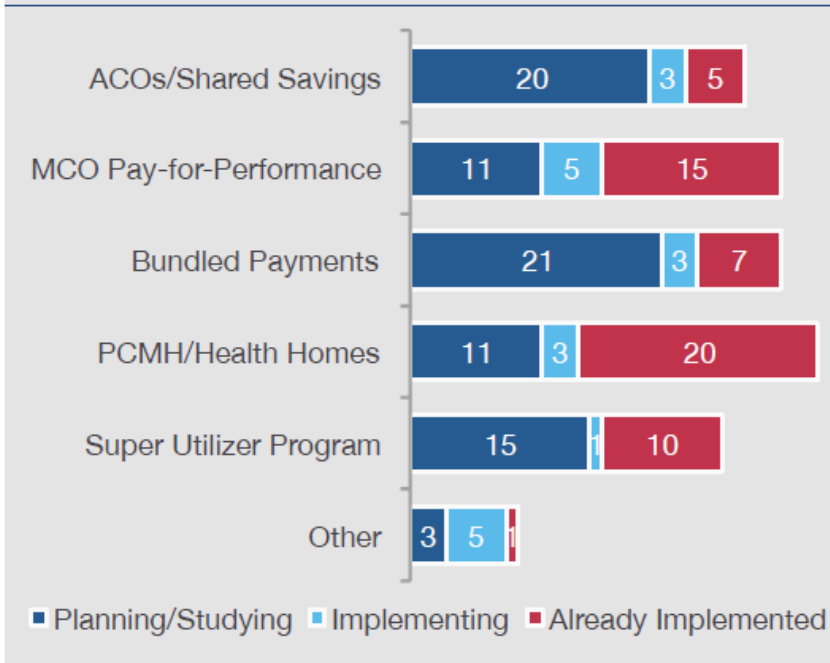
Sources: KCMU and UCSF analysis of Medicaid Section 1915(c) Waiver Policy Survey, 2015.

# Health Care Reforms

## States continue to take on health care related reforms at unprecedented rates

**Figure 10: Payment and delivery reform top Medicaid agency innovation efforts**

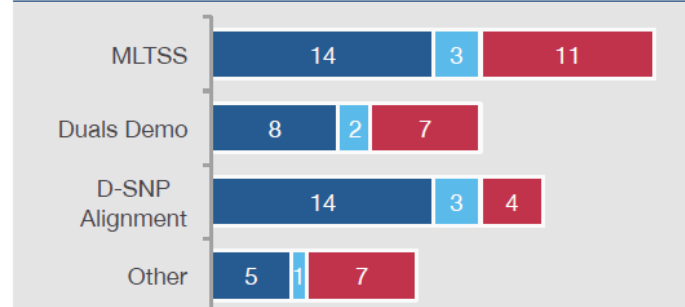
*Please describe the status of any payment and delivery system reforms in FY2015:*



Source: National Association of Medicaid Directors 2015 Annual Operations Survey

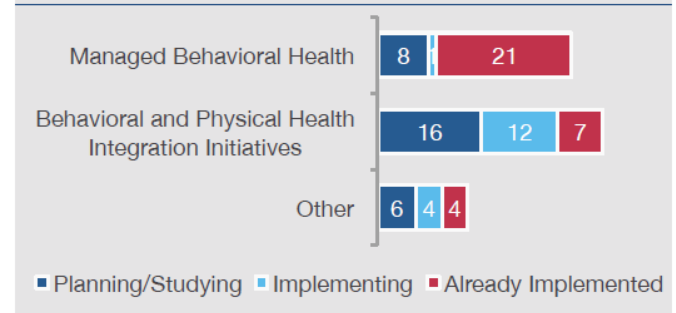
**Figure 11: Managed long-term services and supports is a priority for most Medicaid agencies**

*Please describe the status of any long-term services and supports reforms in FY2015:*



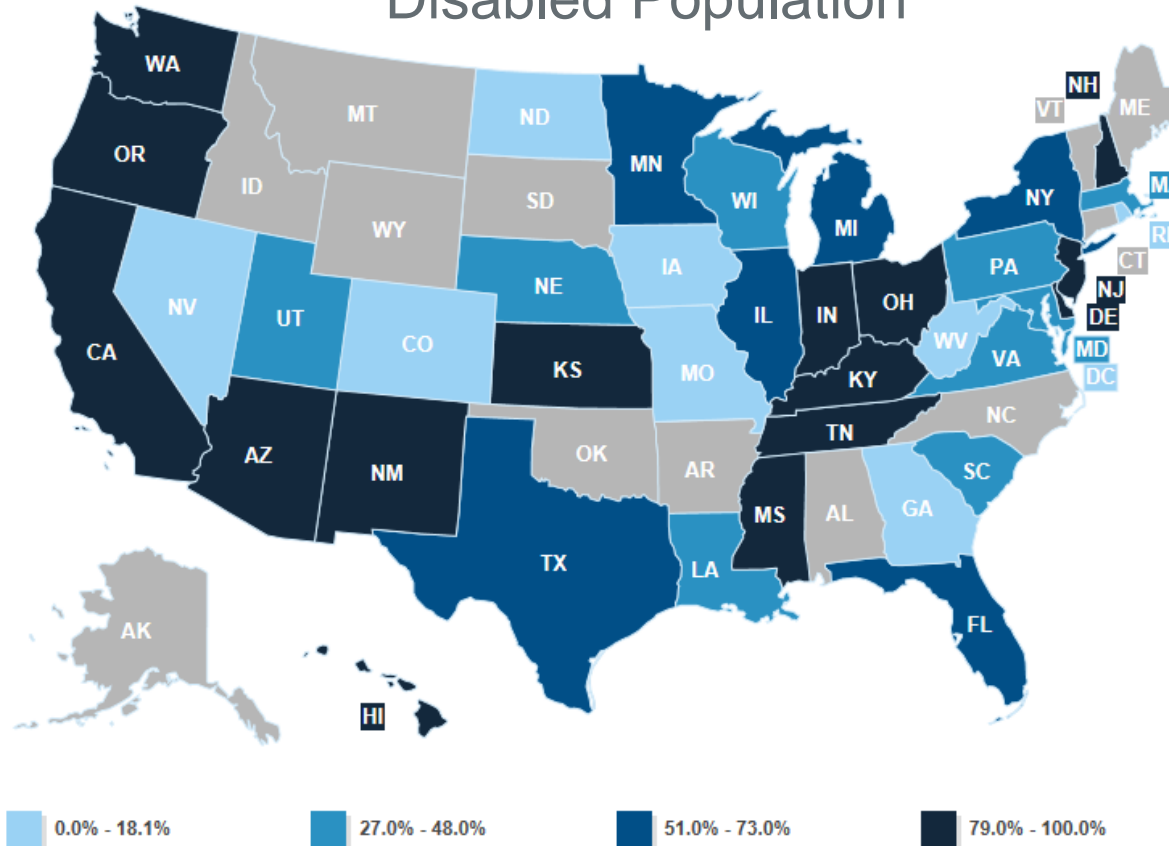
**Figure 12: More Medicaid agencies are working to integrate physical and behavioral health care**

*Please describe the status of any behavioral health reforms in FY2015:*



# Growing Interest in Managed Care

## Penetration Rate for Medicaid Managed Care for Aged and Disabled Population



N/A

Source: Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates; and Robin Rudowitz, Laura Snyder, and Elizabeth Hinton, Kaiser Commission on Medicaid and the Uninsured. [Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016](#), The Henry J. Kaiser Family Foundation, October 15, 2015.

## Health Plan Considerations - Admin

- Running a health plan within a health plan. From an operational standpoint, there are a lot of additional work and resources to make sure the programs run correctly.
- Much of the work is case-by-case basis and needs to be.
- Strong need for health plan expertise. Finding the right staff – especially in leadership roles.
- States (or court orders) often have specific programmatic requirements, timelines or staffing parameters that must be accounted for in planning and costs.
- Appropriate legal counsel and advisors are critical.

# Health Plan Considerations - Benefits

- From a benefits standpoint plans need adequate flexibility within the system; however, ensuring rates that allow for this flexibility can be challenging.
- Depending on the state, the benefits package can be very robust.
- Not all benefits and services CSHCN receive are included in MCO contracting. Sometimes services are anticipated to be provided without proper inclusion in rate setting or without the encounter data available to include in rates.
- Integrated benefit design limits cost shifting and improves ROI on investments in care and comprehensive solutions. Integration of behavioral health with physical health is critical.
- EPSDT requirements, CMS guidance and state definitions for medical necessity can have significant impacts on the scope of services provided.



# Health Plan Considerations - Network

- Network development is unique. There is additional need to verify provider ability and willingness to serve the population.
- Caregivers will go anywhere to get services if they feel services aren't adequate where they are located. There is often limited expertise for very unique conditions or diagnoses. There is a lot of movement within the networks and families often seek services outside of network.
- Environmental needs and home modifications are frequent and critical need. Need to consider this when thinking about network.
- Provider education is often needed. Not all providers, but many.

# CSHCN Essential Elements - Financing

- Rates must be actuarially sound and financially viable
- Rate cell development will need to be informed by historical claims experience specific to CYSHCN, the regional characteristics of the delivery system and quantify the state's costs for existing case management activity and other expenses
- Rate methodologies should be transparent and appropriately incentivize the use of home and community-based services.
- Periodic rate reviews and adjustment if rates are not adequate during the first few years of operation.

# CSHCN Essential Elements - Financing

- Quality incentives should be additive to performance and based on administrative metrics for year 1 with quality criteria phased in for subsequent years.
- Programmatic designs, such as benefit carve outs, continuity of care periods and case management delegation should be appropriately accounted for in savings assumptions
- Clear documentation and discipline regarding market practices and delineation of what can and cannot be influenced by health plans should be established with rate development.
- Managed care savings applied to the rate should be based on reasonable savings opportunities and should take into consideration population specific utilization trends, presence of third party payers and the ability of the health plan to influence utilization.

# CSHCN Essential Elements - Network

- Flexibility - Health plans should be afforded sufficient flexibility to develop dynamic, high-performing networks – defined as optimal quality and value.
- Implementation - The States should determine reimbursement during implementation and consider developing incentive models to encourage provider participation in managing care for CYSHCN.
- Requirements - Network adequacy requirements should reflect the geographic limitations in the state that can impact access to pediatric specialty providers such as pediatric centers of excellence and multidisciplinary teams of pediatric specialty providers.
- Innovations - The state should encourage the use of innovative alternative delivery such as telemedicine and other innovative programs.

## CSHCN Essential Elements - Other

- Stakeholder Engagement – Early, often and structured for on-going engagement
- Benefits – Comprehensive medical, behavioral, home & community-based, pharmacy and any additional waiver benefits targeted for CYSHCN, to ensure holistic, person and family-centered approach to care and demonstrated cost effectiveness.
- Care Coordination—Program requirements should align, consolidate and simplify to allow for holistic person/family-centered coordination.
- Community Based Collaborations - Program design should encourage innovative collaborations between health plans, providers, and other community based organizations to improve quality, access and promote the sharing of information across the delivery system.

# Contact Information



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