# MANAGED CARE FOR WOMEN, CHILDREN, ADOLESCENTS & THEIR FAMILIES:

## A DISCUSSION PAPER WITH RECOMMENDATIONS FOR ASSURING IMPROVED HEALTH OUTCOMES AND ROLES FOR STATE MCH PROGRAMS





Association of Maternal and Child Health Programs
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**The Association of Maternal and Child Health Programs (AMCHP)** is a national non-profit organization which brings together state public health programs addressing the needs of women in their reproductive years, children, youth, and families. The mission of AMCHP is to provide state and national leadership to assure the health of all mothers, children, and families. In collaboration with other national organizations, AMCHP works to accomplish this mission by disseminating information on MCH needs and services, and recommending and advocating for improved policies and programs. AMCHP also fosters the exchange of ideas and assists state programs in assuring statewide systems of coordinated, community-based care for families, especially for children with special health care needs due to chronic or disabling conditions, for low-income families, and for families with limited access to care.

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# EXECUTIVE SUMMARY

State public health agencies are mandated by Title V of the Social Security Act "to improve the health of all mothers and children consistent with ... national health objectives ... for the Year 2000". Questions about managed care's impact on these objectives led the Association of Maternal and Child Health Programs (AMCHP) to develop a discussion paper. The paper makes recommendations to promote the effectiveness of managed care in contributing to improved health outcomes for women, children and adolescents. These recommendations build on AMCHP's Maternal and Child Health Framework for Analyzing Health Care Reform Plans, which includes criteria for personal health services and for population-based health systems infrastructure. The framework endorses "use of managed care arrangements in conjunction with MCH provider and service quality controls and monitoring". Concern that managed care may be planned and implemented without sufficient attention to quality assurance and monitoring specific to the needs of women, children, and youth, or to the necessary linkages with other child, family and health services systems -- including public health -- led AMCHP to elaborate on the framework. The issues which must be addressed in planning and implementation of managed care include:

- **While managed care holds promise for containing costs and improving access and outcomes, evaluation has been limited and the results mixed.** Further, risk-based financing methodologies can create disincentives to reaching and appropriately serving individuals with special or complex health needs. These factors underline the need for careful, collaborative planning and for effective quality assurance and monitoring.

- **Women and children are being enrolled first, making specific attention to their needs imperative.** Managed care is growing under Medicaid, and many health care reform initiatives would start by phasing in coverage of women and children. All women, children and adolescents have unique service needs. Families stressed by such problems as poverty, homelessness, or substance abuse require additional and more intensive services, as do children with chronic or complex medical conditions or disabilities. These basic and special needs of women, children and adolescents must be addressed in design of managed care.

- **Managed care must fit with initiatives developing comprehensive, family-centered, community-based systems of health, social and education services.** Public policies and public-private partnerships are supporting new, better integrated approaches to child and family services. Services increasingly are being provided at easily accessible sites, including schools, day care and Head Start, and the home. Public and non-profit providers, bound by missions and mandates and subsidized to reach culturally diverse, high-risk and special needs groups, aim to provide coordinated community services that promote healthy growth and development of children and support families. Managed care must be a functional component of these existing and evolving systems.

- **Public health's responsibility for the entire population's health must be recognized in planning for managed care.** Managed care systems may assure access to high quality health services for individuals they serve. However, they may not be able to provide all of the preventive health and related support services currently delivered through the public sector. Managed care plans certainly cannot assume responsibility for population-based health promotion and disease prevention services such as eliminating sources of lead or analyzing health outcomes, such as infant mortality, for the entire population. Nor will managed care plans be responsible for availability of services outside their service area borders. These are public responsibilities carried out through core public health functions of assessment, policy development and assurance. Managed care can contribute to or undermine these public health responsibilities, with provisions for financing, data collection, and quality assurance particularly critical to public health's ability to promote the health of the entire population.

## RECOMMENDATIONS RELATED TO MANAGED CARE AND PERSONAL HEALTH SERVICES FOR WOMEN, CHILDREN AND ADOLESCENTS

1. **Families must be able to make an informed choice among a number of available qualified providers, including among competing managed care plans, among practitioners within managed care arrangements, or between managed care and fee-for-service providers.** Objective and complete information on providers and the services they offer must be provided in languages and through methods that will reach diverse groups in the community. Voluntary enrollment should be an option for women, children and adolescents with special needs if managed care providers are unable to assure the scope of services these families require.

2. **Comprehensive preventive, primary, specialty and support services must be available to women, children, adolescents, and their families in the managed care service area, whether provided through managed care or separately financed providers.** National or state standards for comprehensive health care for women, children and adolescents should be incorporated in health care financing plans, including state Medicaid plans, with specification of which services will be provided through managed care arrangements and which through other providers. These standards also should be incorporated in managed care contracts, specifying which services will be provided directly, which by subcontract, and which by referral to other community providers.

3. **Families must have access to preventive, primary and specialty care providers who are trained and skilled in serving women, children, and adolescents. Services must be offered in settings that are easily accessible to women, children, adolescents and their families.** Standards for primary and specialty care staffing, including mid-level professionals and para-professional or community workers, should be developed and incorporated in managed care contracts. Public and non-profit providers experienced in serving low-income, high-risk and special needs groups should be allowed and encouraged to participate in managed care arrangements, or be otherwise funded if necessary to meet these populations' needs. Services should be provided in easily accessible community settings, including the home, day care and school settings.

4. **Financing methodologies must be structured to assure adequate funding for preventive, primary and specialty health care and family support services for women, children and adolescents.** Capitation rates must cover the costs of efficiently providing the full scope of preventive and primary care services needed by women and children. Rate setting must account for the underfinancing, cost-shifting and subsidization characterizing current health care financing methods. Provisions must be made for financing specialty and enhanced services for women, children, and adolescents requiring services beyond routine preventive and primary care. Funding for provision of health services outside managed care arrangements must be assured for those population groups or those necessary services not encompassed within managed care.

5. **Effective and ongoing mechanisms for quality assurance are key to assuring that managed care systems reach, appropriately serve and improve the health of women, children, and adolescents.** Managed care providers should be required to collect and report a uniform set of data that allows public officials and consumers to evaluate and compare performance. Community agencies and consumers should be involved in design of and be ongoing participants in quality assurance systems. Managed care providers should be required to participate in development and implementation of individual and family service plans, such as those for early intervention and special education, in collaboration with community agencies which have lead responsibility for those plans.

## RECOMMENDATIONS RELATED TO MANAGED CARE AND HEALTH SYSTEMS INFRASTRUCTURE

1. **In determining revenue sources and developing financing methodologies for managed care plans, funding for personal health services and for population-based health services must be distinguished and assured.** One state (WA) estimates that no less than 5% of total health care expenditures are needed to support public health functions of assessment, policy development and assurance. These public health functions are necessary to promote and protect health; prevent death, disease and disability; and assure access to and quality of health care for the entire population. The above cost estimate is exclusive of third-party reimbursable personal health services. Currently, public health resources are heavily devoted to subsidizing personal health services for the uninsured and Medicaid-insured. Assessment, policy development and other means of assurance beyond directly providing care are inadequately funded. Specific examples of these services include epidemiology, communicable disease surveillance, community-wide health education campaigns, investigation and control of environmental hazards, assessment and development of services to meet community needs, outreach and information, and licensure and certification. Financing methods and sources for managed care must not redirect resources supporting public health infrastructure, which are already inadequate. Washington State estimates that the amount currently being spent on public health functions in that state is about half of what is needed in a reformed system.

2. **Managed care plans must be publicly accountable for the quality of care and health outcomes of populations they are intended or required to serve, and contribute to assuring the health of all women, children, adolescents, and families.** Managed care providers should report a set of uniform data for community, state, and national purposes of: assessment of availability, access and utilization of services; surveillance of death, disease and disability rates and contributing factors; and evaluation of and planning for services to prevent disease and promote health. Data requirements should be developed by or in close collaboration with public health agencies, and should be reported to or shared with public health agencies. Other monitoring and oversight mechanisms should be developed and implemented by or in conjunction with public health agencies. Public health not only has relevant mandates and expertise, but can act as a check-and-balance to public authorities responsible for financing, where cost containment objectives may overshadow access and outcome objectives. Public health agencies also should provide or collaborate in providing consultation, training and technical assistance to managed care providers in effectively reaching and serving women, children and adolescents.

3. **Current health system deficiencies must be addressed in designing managed care.** Many families today face a host of barriers to obtaining the health services they need. In addition to lack of adequate financial coverage, these barriers include shortages of providers in some areas, lack of linguistically, culturally, or developmentally appropriate services, lack of transportation and child care, and insufficient consumer knowledge of when and how to obtain services. As more families obtain financial coverage and if other systems barriers are effectively addressed, the current shortage of providers in some communities or in some specialty areas, especially obstetrics, will be compounded by the increased numbers of families seeking access to care. Public health and financing agencies should collaborate to delineate necessary and appropriate preventive, primary and specialty service capacity at community, regional and state levels. These public agencies should also collaborate to recruit and assist appropriate providers, including current public and non-profit providers, in developing and operating managed care arrangements that reduce or eliminate existing barriers to health care.

## ROLES FOR STATE MCH PROGRAMS IN ASSURING QUALITY MANAGED CARE

Building on an almost sixty-year history, recent collaborative roles in implementing Medicaid expansions, as well as current Title V mandates, state MCH programs can contribute to the success of managed care in a number of ways. State MCH programs must be concerned first and foremost with assuring access and promoting health for all women, children, and adolescents. A role in providing personal health services should be maintained to the extent necessary to achieve these objectives. **Therefore, consistent with their population and system-wide responsibilities for assessing health status and services and developing plans and programs to improve them, some of the specific roles for MCH programs in a managed care environment include:**

- **Outreach, Information and Enrollment** -- MCH programs can continue to be effective in designing and implementing strategies to reach women, children, adolescents and families in need of health care, particularly culturally diverse populations, and high-risk and special need groups. Public health involvement in outreach, information and enrollment could counteract incentives for managed care plans to selectively market their services;

- **Service Planning and Care Coordination** -- Particularly for high-risk, high-need women, children, and adolescents, and for children with chronic illnesses or disabilities, MCH programs could continue to be involved in developing individual and family service plans, and help families to coordinate health, social and education services.

- **Developing Managed Care Service Capacity Through Provider Recruitment, Certification, Training and Technical Assistance** -- Working with state financing agencies and with existing or potential managed care providers, MCH programs can assist in recruiting individual practitioners; developing service networks, including linkages with related community agencies; and providing initial and ongoing training and technical assistance in serving women, children, and adolescents, especially those who are high-risk or who have special needs.

- **Providing Services Where Needed** -- Both the current shortage of providers in some areas and the capacity, experience and community ties of existing public and non-profit providers argue for their inclusion in managed care plans. MCH-supported providers can serve as primary or subcontractors within managed care networks, depending on their capacity and community needs. State and local public health agencies may be able to provide certain services or serve specific populations more effectively than private sector providers joining managed care plans. Adolescents, with interrelated medical, social and educational needs, often are reluctant to utilize traditional medical providers, and may continue to be most effectively served through alternative community providers, including schools. Services for children with chronic illnesses and disabilities, which include multiple specialists, extensive outpatient and inpatient care, and family support services, might best be delivered through existing Children with Special Health Care Needs provider networks, at least until managed care systems specifically designed and financed to meet their needs are developed.

- **Developing Standards, Contracts and Data Systems; Quality Assurance, Monitoring and Evaluation** -- Public health involvement in these areas is absolutely critical to assuring quality of care and to improving the health of entire communities. MCH public health expertise regarding services that are effective in improving the health of women, children and adolescents must be utilized in developing standards, contract data, and quality assurance requirements, and evaluation methodologies for managed care plans. MCH programs can also be effectively utilized in monitoring and oversight activities. Absolutely critical to improving the health of the entire population is a role for public health agencies in analyzing data to assess access to and outcomes of care.

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# INTRODUCTION

Managed care has moved to the forefront of state and national strategies to reform health care financing and delivery. While variously and often loosely defined, managed care generally means health care provided through a single point of entry and controlled to reduce inappropriate utilization and costs. Managed care is often associated with capitation or other risk-based financing methodologies intended to achieve cost savings. The appeal of potential cost savings from managed care is compelling. Health care expenditures now consume 14% of the United States' total economic output, and 14% of all state spending in 1991 was accounted for by Medicaid. If unchecked, the proportion of state budgets dedicated to Medicaid could double, to 28% by 1995.[1] While strongly motivated by the potential cost savings, managed care proponents also believe that it is a vehicle for assuring access to quality health care and thereby for contributing to improved health outcomes.

The growing interest in managed care is evident in increased enrollment under current public and private insurance plans, and in proposals for health care reform. The proportion of Medicaid recipients enrolled in managed care jumped 35% in 1992, with 3.6 million or 12% of the total enrolled, compared to 9.6% in 1991 and just 2% in 1982. Half of the Medicaid recipients enrolled in managed care in 1992 lived in states where federal waivers restricted their choice to such arrangements. Managed care is being incorporated in most state and national proposals for health care reform, and has been embraced by the Clinton Administration. A December 1992 National Governors Association policy statement, endorsed by other state and local public official and business association representatives, backed a managed competition strategy that includes capitated health plans.[2]

This surge in interest in managed care comes in advance of solid evidence of its ability to reduce or even contain costs, and data on its impact on access, quality and outcomes of health care is limited. The last major evaluations of Medicaid managed care were conducted in the mid-1980s, before the recent growth and changes in forms of managed care. These evaluations generally found no major differences between Medicaid managed care and fee-for-service enrollees on the few health outcomes studied, such as immunization and low birthweight rates. However, these evaluations failed to assess differential impacts by age, need or chronic conditions. Additionally, recent expansions of Medicaid have led to coverage of new groups of children and pregnant women. Therefore, many questions about managed care's impact on the most vulnerable groups of women and children remain unanswered.[1]

Questions about managed care's impact on access, quality of care and health status for women, children, and adolescents led the Association of Maternal and Child Health Programs (AMCHP) to develop this discussion paper. AMCHP is a national nonprofit organization representing state and territorial public health programs addressing the needs of reproductive-age women; infants, children and adolescents, including children with special health care needs due to chronic or disabling conditions; and their families. AMCHP's mission derives from and is consistent with Title V of the Social Security Act (the Maternal and Child Health Services Block Grant). Title V's mandate is "to improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the Year 2000". State Title V programs also are charged by the legislation to develop and support family-centered, community-based, comprehensive systems of preventive, primary and specialty care that are coordinated with other child and family services.

Managed care represents a significant change in the financing and delivery of care. Given the fragmentation, duplication and cost inefficiencies of current public and private health care financing and delivery systems, a shift to managed care could represent a change for the better -- better access, better care, and better health. State MCH programs have a long history and current responsibilities under both Title V and Title XIX Medicaid in developing, providing, financing, and monitoring health services, particularly for underserved, low-income and special needs families. Based on this experience and expertise, state MCH program leaders believe that the promises of managed care can only be realized with specific attention and safeguards to assure that managed care systems reach, appropriately serve, and are accountable for the health of women, children and adolescents. Poorly designed or inadequately financed managed care arrangements could have a detrimental impact on our communities' and our nation's ability to achieve national health objectives for the Year 2000, and on public health agencies' ability to assure progress in meeting those objectives.

In its Maternal and Child Health Framework for Analyzing Health Care Reform Plans,[3] AMCHP outlined criteria necessary to assure the health of women and children. The criteria address health systems infrastructure (including disease prevention and health promotion; planning and quality assurance; and provider and service availability) as well as personal health services coverage and administration. As these criteria are relevant regardless of the form that health care delivery and financing reforms take, they are applicable to design of managed care systems. The framework's criteria include cost controls, and endorse "use of managed care arrangements in conjunction with MCH provider and service quality controls and monitoring". Concern that managed care arrangements may be planned and implemented without sufficient attention to quality assurance and monitoring specific to the needs of women and children, or to the necessary linkages with other child, family and health service systems components --

including public health services -- leads AMCHP to elaborate on its framework. This paper discusses more specifically considerations for designing managed care systems to achieve managed care objectives and national health objectives. The paper also describes the roles that MCH public health programs can play in contributing to the success of managed care.

As part of their broad responsibilities to improve health, state MCH programs today directly support health care for well over five million women, children and adolescents, primarily those who are uninsured and, increasingly, Medicaid-insured. Nearly 60 years ago, MCH programs got into the "business" of providing or financing personal health care because there was no other recourse to assure access for many women and children to services which contribute to improving health status. Improved health status is the "profit" that public health programs seek to produce from their investments in personal health services. Concern about whether this "profit" of improved health will be realized through managed care systems, rather than concern about maintaining current public health investments in personal health care service delivery, underlies MCH programs' concerns about managed care. These concerns are most immediate for women, children and adolescents currently served by public providers or covered by Medicaid. However, the concerns extend to the impact of increasing enrollment in managed care under state and national health care reform initiatives, particularly since many of these initiatives phase in coverage by starting with children and pregnant women. Women and children are coming first in our experiments with containing costs and improving access. If our nation is not to remain among the last in assuring the healthy growth and development of its future generations, managed care plans must be carefully designed and monitored to meet the needs of women, children, and adolescents, especially those who have not been reached or well served by mainstream health care in the past. MCH programs have expertise, experience and mandates that can contribute to assuring this outcome.

# ISSUES AND RECOMMENDATIONS FOR MANAGED CARE FOR WOMEN, CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

State MCH programs' concerns about managed care fundamentally center on an overarching question. That question is whether these arrangements have the capability, incentives and accountability to provide components of and be functional parts of comprehensive service systems for women, children, youth and families, particularly those who have been underserved or have special needs. Comprehensive service systems include not only the personal health services provided directly to individual women, children, adolescents or their families, but also the systems' infrastructure. Health systems infrastructure assures the health of the entire population through health promotion and disease prevention services; data and monitoring to plan and evaluate services; and mechanisms to assure the availability of appropriate services and providers in all communities.

## PERSONAL HEALTH SERVICES

All children, adolescents, and reproductive-age women have unique health care needs. Effectively addressing these needs requires specific services from providers specifically trained and qualified to provide them. Low-income women, children and youth at higher risk for a range of health problems, families affected by such problems as substance abuse, mental illness or homelessness, and children and youth with chronic illnesses or disabilities require additional and specialized services. Promotion of healthy social, emotional and physical growth and development of children and youth requires a comprehensive approach that coordinates if not integrates services traditionally delivered through different systems, including health care, day care, education and social services. Local, state and national policy goals and program initiatives are aiming to promote access to family-centered, integrated services. Services

increasingly are being provided where they are most easily accessed by children, youth and families, including at home, at day care (including Head Start) and school sites.

Major personal health care components of comprehensive services for women, children, adolescents, and their families include:

- Outreach, especially to underserved or high-risk groups, such as those who are homeless or substance abusers, to engage and maintain them in the service system;
- Health education and guidance to reproductive-age women, to parents and to adolescents;
- Reproductive Care and Family Planning, including screening for HIV, STDs, breast and cervical cancer;
- Early and Continuous Prenatal Care, including risk assessment, nutrition, and social services, and access to regionalized specialty care when needed;
- Preventive and Primary Pediatric and Adolescent Health Care including all services currently covered through the Medicaid EPSDT program;
- Specialty Pediatric Care and Family Support Services for children with special health care needs due to complex medical, chronic or disabling conditions, including AIDS;
- Tracking and Follow-up, especially for prevention and treatment of communicable diseases (e.g., immunization or STD-related services) and environmentally linked conditions (e.g., lead poisoning);
- Care Coordination and Linkage with other community services, such as WIC nutrition programs, early intervention and special education programs, domestic abuse, substance abuse, and mental health-related prevention and intervention programs.

These services currently are delivered by a wide variety of providers, including: private physicians, clinics and hospitals; non-profit community-based agencies, including federally funded community and migrant health centers; and public health departments and hospitals. While these services are largely Medicaid reimbursable, Medicaid generally does not adequately reimburse for the full scope of services outlined above. Additionally, Medicaid does not cover all low-income families. Therefore, many providers, particularly non-profit and public providers,

also rely on other revenue sources, such as public and private grants, to provide services to low income and special need families. Non-profit and public providers have another distinguishing characteristic. They are bound by their missions, funding requirements, and in the case of public health agencies often by law, to serve their entire communities. These providers are funded to and have expertise in reaching and serving high-risk, special-need women, children, and adolescents. Incentives and requirements for non-profit and public providers also aim to ensure coordination and integration with other child and family services in the community. These missions and mandates lead public and non-profit providers to design and deliver services to reach and meet the needs of culturally diverse populations, increasingly in settings other than the clinic or office, including day care, Head Start, schools and in the home. The extent to which managed care providers may lack similar mission, expertise, incentives, requirements and revenues to appropriately serve women, children, adolescents, families and communities is of concern. Capitation or other risk-based financing methodologies may act as disincentives to enrolling and providing initially costly comprehensive services to high-risk and special needs populations. This is especially true under the current Medicaid system, where women and children go off and on the Medicaid rolls, thereby diminishing or eliminating future cost savings to the provider of investing in preventive or therapeutic services.

At the same time, the current multiplicity of providers and financing streams as well as provider and funding shortages contribute to costly fragmentation, duplication and gaps in services. Managed care, with its emphasis on a single point of entry and on coordination, may be a vehicle for remedying some of these deficiencies, but only if both the strengths and weaknesses of current service and financing systems are addressed in its design.

## RECOMMENDATIONS

Whether developing managed care for Medicaid or for universal systems, policy makers and planners need to address the following considerations for all women, children and families:

### 1. Enrollment

Families must be able to make an informed choice among a number of available qualified providers, including among competing managed care plans, among practitioners within managed care arrangements, or between managed care and fee-for-service providers.

- Objective and complete information on services available through different providers, including such aspects as location, hours, and qualifications, particularly for serving children with chronic illnesses and disabilities, must be provided in languages and through methods that will reach diverse groups in the community;

- Voluntary enrollment should be an option for individuals and families with special needs (such as high-risk pregnant women; children with chronic illnesses or disabilities requiring multi-disciplinary and specialty care; or adolescents reluctant to utilize traditional sources of medical care) if managed care plans are unable to assure appropriate, comprehensive quality care for these populations directly or by contract.

### 2. Scope and Content of Services

Comprehensive preventive, primary, specialty and support services must be available to all women, children, adolescents, and families in the area served by a managed care plan, whether provided through the managed care plan or separately financed providers (AMCHP's Framework details these services, which also were summarized earlier in this paper).

- State or national service standards developed by or in collaboration with MCH public health experts should specify required components of care for each of the subgroups of the MCH population: reproductive-aged women, including pregnant women and adolescents; infants; children; adolescents; and children with special health care needs;

- Health care financing plans (including current state Medicaid plans) should specify which services (mandatory and optional) must or may be provided through managed care plans(whether Health Maintenance Organization [HMO], Prepaid Health Plan [PHP], Primary Care Case Management [PCCM] or other new arrangements which may be developed) and which services, and under what conditions, will be paid on

a fee-for-service or other basis;

- Managed care contracts should specify and incorporate standards for those services which will be provided by the managed care plan, directly or through subcontracts, and which will be referred to other providers.

### 3. Service Providers and Settings

Families must have access to preventive, primary and specialty care providers who are trained and skilled in serving women, children and adolescents. Services must be offered in settings that are easily accessible to women, children, adolescents and families. Practitioners must include not only primary and specialty care physicians specifically trained in the care of women, children and adolescents, but dentists, advanced practice nurses, nutritionists, social workers, mental health clinicians, and specialty therapists (OT, PT, etc.). Trained outreach workers, home visitors and case managers can not only assist in assuring comprehensive, coordinated services, but can provide many services at lower cost than more highly skilled professionals.

- Standards for primary and specialty care staffing for women, children and adolescents should be developed and incorporated in contracts for managed care;

- Public and non-profit providers currently serving Medicaid recipients and/or specializing in the care of specific MCH populations (including high-risk pregnant women, children with special health care needs, adolescents, families affected by HIV) and able to meet service and staffing standards should be allowed and encouraged to participate in managed care arrangements as primary or subcontractors. Given current provider shortages, inclusion of these providers will likely be necessary to assure access. Given their experience and expertise in serving these populations, their participation should contribute to assuring access and quality of care, promote continuity of care, and reduce out-of-plan service use;

- Public and non-profit providers should continue to provide (and receive funding for) essential services if managed care plans are unable to assure availability and appropriate utilization of such services. Services to prevent, treat and provide follow-up for communicable diseases and environmentally related conditions (e.g., lead poisoning) should receive special consideration due to their implications for the public's health;

- Services should be provided at community sites that are easily accessible to women, children, adolescents and families, including the home, day care, worksite and school settings.

## 4. Financing

Financing methodologies must be structured to assure adequate funding for preventive, primary and specialty health care and family support services for women, children and adolescents. As previously discussed, this full scope of services is currently financed through a wide variety of sources, with cost shifting and cross-subsidization occurring. The interaction and adequacy of these financing streams must be analyzed in developing financing methodologies, particularly capitation rates that may be derived based on historical charge experience. In the case of Medicaid, reimbursement rates have historically fallen below usual and customary rates of private providers or the actual costs of public providers, with other federal, state and local revenues subsidizing care for Medicaid recipients.

- Capitation rates should be based on the total costs of efficiently providing the full scope of preventive and primary care services needed by all women, children, adolescents and families. This means, for example, ensuring that costs of immunization services, which have often been shifted to public health services, be fully accounted for in capitation rates;

- Specialty, enhanced and additional services above and beyond routine preventive and primary health care should be financed to ensure incentives rather than disincentives to their provision. Methods could include: fee-for-service reimbursement to the managed care plan or other providers to provide additional services; stop-loss or risk-sharing protections for high-need, high-cost individual children and families; or special capitation rates adjusted to cover the service needs of these populations;

- Funding for MCH services which managed care entities do not provide or for populations for which no source of coverage is available should be maintained. Again, maintenance of funding for traditional public health clinical preventive services, particularly those related to communicable disease, is critical if managed care plans do not provide these services or coordinate tracking and follow-up with health departments. Financing options include: fee-for-service; grants; or dedicated funds within global budgets.

## 5. Quality Assurance

Effective and ongoing mechanisms for quality assurance are key to assuring that managed care arrangements do reach, appropriately serve and improve the health of women and children. Coupled with public monitoring (to be discussed in the next section of this paper) and standards

for content of services and provider qualifications, comprehensive quality assurance programs can promote not only quality clinical care, but also responsiveness to family and community needs. Quality assurance requirements that rely on family and community involvement can help to create the mission and mandates that currently govern the delivery of services through public and non-profit providers.

- Managed care plans should be required to collect and report a uniform set of data that will allow public officials and consumers to evaluate and compare performance in reaching families in the community, in providing them appropriate, comprehensive services, and in improving outcomes, as measured not only by health status indicators, but also by developmental and functional indicators;

- Consumers, families and community health, social service, and education agencies should be involved in the design and be an ongoing part of quality assurance systems. Options include establishment of community governing or advisory bodies, and ongoing surveys of family and community satisfaction with services;

- Managed care providers should be required to participate in development and implementation of individual and family service plans in collaboration with community agencies with primary responsibility for those plans. Such service plans are mandated under the Individuals with Disabilities Education Act (IDEA) for qualifying children from birth to age three, and for preschool and school-aged children with special health care needs. Service plans for children with special health care needs, including children eligible for Supplemental Security Income (SSI), are developed by Title V agencies. Additionally, service plans may be developed through other community agencies for families affected by domestic violence, substance abuse, mental illness, homelessness or other psychosocial problems.

## HEALTH SYSTEMS INFRASTRUCTURE

As discussed and detailed in AMCHP's MCH Framework for Analyzing Health Care Reform Plans, meeting the needs and improving the health of women, children, adolescents and families entails more than financing health services for individuals. AMCHP and others have used the term "infrastructure" to encompass those services and activities which are beyond those that can or should be delivered by health care providers. These infrastructure services and activities fall into three major areas:

- Disease prevention and health promotion for the entire community or population;
- Population and system-wide needs assessment, monitoring, evaluation, planning and policy development; and
- Assuring that appropriate services are available and accessible to all women, children, adolescents and families in every community.

If well designed, managed care arrangements may provide an organized, coordinated and comprehensive range of medical services. However, it is unclear whether managed care plans could or should provide related social and family support services, such as: transportation; parenting education and training, including training for adolescent parents or training on home care of children with chronic illnesses or disabilities; or day care and respite care for families. Managed care plans certainly will not assume responsibility for assuring that water supplies are fluoridated and have safe levels of lead, or that community or statewide infant death statistics are analyzed to pinpoint major risks and causes amenable to prevention, or that regionalized services are in place to assure appropriate levels of care and allocations of specialty resources. These are public responsibilities which must be assigned to public agencies, with specific and complementary roles at federal, state and local levels. These are functions which the Institute of Medicine ascribed to public health and defined as assessment, policy development and assurance.[4]

State MCH programs are concerned that managed care arrangements may be designed without consideration for how they should be integrated with this health systems infrastructure, and may even inadvertently weaken the infrastructure that is currently in place through public health agencies. This can occur in several ways. For example, funding which is supporting these core public health functions may be withdrawn and redirected to managed care entities because of lack of understanding about these functions and how they are funded. Public health agencies currently use block and categorical grant programs and state and local revenues to support both infrastructure and personal health services. For example, categorical childhood lead poisoning prevention grants support outreach, screening and treatment as well as environmental investigation and remediation for individual children and families; and community-wide needs assessments, outreach and education. Public health nurses, who currently are supported by a mix of grant funding, state and local revenues, and third-party reimbursement, may be responsible for community-wide health education; provision of personal preventive health services in clinic, home and school settings; and home assessments of environmental risks to children's health and safety, including lead as well as potential causes of injuries. The Title V Block Grant supports MCH systems infrastructure at state and local levels, as well as personal health services delivery. Infrastructure services are largely inadequate and under-funded, as public health agencies have been forced by gaps in personal health care financing and delivery systems to invest scarce resources in direct personal health services. If managed care is financed by redirecting funds that were supporting public health functions, this problem will only be compounded.

Another way in which design of managed care arrangements can either contribute to or inadvertently undermine infrastructure is by altering the collection, reporting and analysis of data necessary to assess needs, monitor health services and health status, and evaluate and plan

interventions. Public agencies rely on a variety of data sources to carry out this assessment function: vital statistics records of births and deaths; Medicaid and EPSDT claims data; special surveillance, data registry and tracking systems, particularly for communicable diseases and related services (e.g., immunizations, STDs, HIV, tuberculosis); public program data (e.g., WIC, public prenatal and well-child clinics, etc.); hospital discharge data; and special surveys and studies. Public agencies are struggling to match and integrate these data sets and compensate for gaps in data from privately financed or delivered health care to produce the information needed. Reporting of uniform data by managed care entities to public agencies could considerably strengthen our ability to assess needs, monitor health problems and diseases, and evaluate and plan for personal and public health services. On the other hand, even current health data collection, analysis and assessment functions could be seriously undermined through the loss of data currently collected by or from publicly funded programs. An example of loss of critical information with managed care can be found within the current Medicaid program. Federal EPSDT program reporting requirements have not included information on numbers of children enrolled in managed care arrangements who have received required screening services. While these screening statistics must be reported under fee-for-service, children enrolled in Medicaid managed care arrangements are automatically counted as having received these services. Recognizing that the exemption of managed care arrangements from these reporting requirements undermines accountability for meeting national EPSDT goals, the Federal Medicaid agency is currently revising the reporting requirements.

## RECOMMENDATIONS

Policy makers and planners designing managed care systems for all women and children or for subgroups, including Medicaid recipients, need to consider and address how these arrangements will fit with and contribute to population and system-wide health infrastructure. The following considerations should receive particular attention:

### 1. Funding for Public Health Functions

In determining revenue sources and developing financing methodologies for managed care plans, policy makers and planners must distinguish between and assure funding for personal health services and for population-based health services. The Washington State Health Care Commission, drawing on the work of a Task Force on Core Public Health Functions, made just such a distinction in its recommendations. Core public health services were defined within the Institute of Medicine framework of assessment, policy development and assurance. These services (excluding third-party reimbursable personal health services) were estimated to require funding of no less than 5% of total health care expenditures. Today that cost would be approximately $100 per capita annually; the state estimated it is currently expending less than half that per capita amount.[5]

- Financing for reformed health care systems must include funding for public health functions. Financing could be through grants, line-item appropriations, or through dedication of funds within global budgets;

- Financing sources and methodologies for Medicaid managed care arrangements must not result in a reduction of resources supporting health systems infrastructure, or core public health functions. Public health and Medicaid officials should work with Executive and Legislative leaders to assure adequate funding of both personal and public health service system components.

## 2. Requirements and Public Agency Responsibilities for Assessment and Quality Assurance

Managed care plans must be publicly accountable for the quality of health care and health outcomes of the populations they are intended or required to serve, and contribute to assuring the health of all women, children, adolescents and families. Accountability should be assured through standards and contract requirements, reporting requirements, and other mechanisms including periodic chart and site reviews, and vehicles for family and community involvement. Quality of care also should be promoted through training and technical assistance activities, particularly in care of high-risk and special needs women, children, adolescents and families, and including new and emerging service-modalities and program models. Responsibility for these assessment and assurance functions should be assigned to or shared with public health agencies. These agencies not only have relevant mission, mandates, and expertise, but can provide a safeguard, or check and balance, to public authorities responsible for overseeing financing, where cost containment objectives may overshadow access and outcome objectives.

- Managed care (and other) providers should report a set of uniform data for purposes of: assessment of the availability, accessibility and utilization of health services, particularly for high-risk and special needs groups; monitoring of the incidence and prevalence of leading or emerging causes of death, disease and disability; evaluation of the efficacy of health services in preventing or treating adverse health conditions; and planning and designing community-wide or individual clinical interventions to prevent disease and promote health. Such data should be reported to or shared with public health agencies;

- Other monitoring and oversight mechanisms should be developed and implemented by or in conjunction with public health agencies. Options include: chart reviews; site visits; review and approval of individual or family service plans for children with special health care needs. Monitoring of out-of-plan service use and grievances should be included;

- Consultation, training and technical assistance in effectively reaching and serving women, children, adolescents and families should be provided by or in close collaboration with public health agencies.

## 3. Strategies and Public Agency Responsibilities for Developing Adequate and Appropriate Service Capacity in Every Community

Policy makers and planners must address current health care system deficiencies in developing managed care. Many families today face a host of barriers to obtaining the health services they need. In addition to lack of adequate financial coverage, these barriers include shortages of providers in some areas, lack of linguistically, culturally or developmentally appropriate services, lack of transportation and child care, and insufficient consumer knowledge of when and how to obtain services. As more families obtain financial coverage and if other systems barriers are effectively addressed, the current shortage of providers in some communities or in some specialty areas, especially obstetrics, will be compounded by the increased numbers of families seeking access to care. Public agencies must be responsible for assuring that the service capacity exists to meet this demand. This responsibility historically has been lodged with public health agencies, rather than financing agencies such as Medicaid. Federal public health programs, including community and migrant health centers and the National Health Service Corps; and state and local public health programs with federal block grant support, have succeeded in developing service capacity that has assured access to millions of families who otherwise would lack a source of health care. Federal and state financing and public health agencies must continue to work together and with local health agencies and communities to develop sufficient and appropriate capacity under managed care arrangements.

- Public health and financing agencies should collaborate to delineate necessary and appropriate service capacity within defined geographic areas at community, regional and state levels;

- Public health and financing agencies should collaborate to recruit appropriate providers (including current public and non-profit providers), and provide initial and ongoing assistance in developing and operating managed care arrangements.

## ROLES FOR STATE MCH PROGRAMS IN ASSURING QUALITY MANAGED CARE

State MCH programs, as currently authorized and partially supported through the Title V MCH Services Block Grant, are carrying out a range of activities in a still predominantly fee-for-service environment that should be examined for their relevance in a managed care environment. The current environment also is characterized by increasing numbers of both uninsured and Medicaid-insured women and children, and the role of MCH public health programs in an environment of universal health care coverage also warrants examination.

As stated in the introduction to this paper, the Title V mandate is to improve the health of all mothers and children consistent with national health objectives for the Year 2000. More specifically, the legislation provides funds to enable states to:

- Provide and assure access to quality MCH services;
- Reduce infant and child morbidity, mortality, and the need for in-patient and institutional care;
- Promote the health of mothers and children;
- Provide prenatal, delivery and postpartum care for at-risk, low-income women;
- Provide preventive and primary care services, including immunizations, screening, diagnosis and treatment for low-income children;
- Provide and promote family-centered, community-based, coordinated care systems for children with special health care needs (including SSI eligibles) and their families.

These legislative requirements can be seen to fall into the two components of AMCHP's framework of health systems infrastructure and personal health services. Title V programs are to: assure and promote the health of all women, children and adolescents and their access to quality, family-centered, community-based, coordinated care; and to provide health care for low-income and special needs populations. To the extent that the concerns of MCH programs have

been recognized by federal and state officials developing policies and plans for managed care, these concerns sometimes unfortunately have been viewed as concerns about protecting turf in providing personal health care. The underlying concern of state MCH programs is for effective maintenance of a public, governmental responsibility, acknowledged nearly sixty years ago in enactment of Title V of the Social Security Act, for assuring the health of women and children and their access to quality care. State MCH programs must be concerned first and foremost with assuring access and promoting health, and with maintaining a role in providing personal health care services to the extent that such a role is needed to achieve these objectives.

Questions about the role of state MCH programs emerged in the past decade, well before the current emphasis on managed care, related to expansions in Medicaid coverage of MCH populations and services. Some questioned whether increased financial coverage would diminish the need for MCH programs, which largely were understood to directly provide and finance care for the uninsured. The actual experience over the past decade, which has been well documented by the National Governors Association[6] and others, is that many state MCH programs, including programs for children with special health care needs, have played an instrumental, collaborative role in implementing Medicaid expansions to improve access to and outcomes of health care. The mission, mandates, expertise, and established professional and provider relationships and networks of state MCH programs were found to be valuable and even necessary to planning and implementing Medicaid expansions.

The roles which evolved for state MCH programs in working with Medicaid agencies to expand enrollment and improve access to a more comprehensive scope of services include:

- Outreach -- media campaigns, toll-free phone lines and other informational activities; outreach workers;
- Eligibility Determinations -- presumptive, on-site;

- Service Planning/Prior Authorization -- particularly for children with special health care requiring care from multiple specialists;

- Care Coordination (case management) -- especially for pregnant women and for children with special health care needs;

- Standards Development -- for perinatal care, for EPSDT screening and periodicity protocols, and for specialty care;

- Provider Recruitment -- direct outreach to professional societies and individual obstetric, pediatric and specialty providers;

- Provider Certification -- usually related to qualifications to provide enhanced prenatal support services, to conduct comprehensive child health screening, or to provide specialty care;

- Provider Training and Technical Assistance -- on appropriate care, particularly new service interventions in areas such as risk assessment, pre-term labor prevention or primary care for children with chronic illnesses;

- Service Provision -- comprehensive or limited (e.g., prenatal care; immunizations; EPSDT screening; specialty care);

- Quality Assurance/Monitoring -- through review of provider data, site visits, and other methods;

- Evaluation -- through methods such as linking public health vital statistics with claims data to assess health outcomes.

Many of these roles are explicitly or implicitly included in current Title V or Title XIX legislative requirements. Nearly all of the functions listed above must be carried out in a managed care environment (eligibility determination may become unnecessary depending on the financing mechanisms of the future, but formal enrollment with managed care providers will likely be required). MCH's mission, mandates, expertise, and established relationships with providers are equally relevant, and state MCH and CSHCN programs can make comparable contributions to planning and implementation of managed care as they have to Medicaid expansion. The specific means by which state MCH programs carry out these roles, and the balance in resources devoted to each will need to change. Medicaid expansion occurred in an environment of a shortage of providers willing to serve this population. To the extent that Medicaid managed

care initiatives or more universal financing and delivery reforms are able to enlist participation of more providers willing and capable to serve low-income and special needs populations, the role of state MCH programs in directly providing or financing care should decrease.

Revisiting and grouping the above roles in the context of managed care, the following constitute some of the roles which state MCH programs can play in achieving the aims of managed care to reduce costs, increase access and improve health:

- **Outreach, Information and Enrollment** -- MCH programs have been and can continue to be effective in designing and implementing strategies to reach women, children, adolescents and families in need of health care, particularly culturally diverse populations, and high-risk and special need groups. In addition to the advantages of experience and expertise, public health involvement in outreach, information and enrollment could counteract incentives for managed care providers to selectively market their services;

- **Service Planning and Care Coordination** -- Particularly for high-risk, high-need women, children, and adolescents, and for children with chronic illnesses or disabilities, MCH programs could continue to be involved in developing individual and family service plans, and assisting families to coordinate health, social and education services. Again, there is existing MCH expertise and capacity in this area which could be applied to managed care arrangements. Public health programs could provide these services to women and children enrolled with other managed care providers on a contractual or fee-for-service basis, or be funded through grants or other sources;

- **Developing Managed Care Service Capacity Through Recruitment, Certification, Training and Technical Assistance** -- With nearly a sixty-year history in developing and supporting health services for low-income and special needs groups, state MCH programs have had substantial experience in recruiting, certifying, training and assisting health care providers. This MCH experience and expertise was employed in recent years in many states to recruit providers for the Medicaid program. Working with state financing agencies and with existing or potential managed care providers, state and local public health agencies can assist in recruiting individual practitioners; developing service networks, including linkages with related community agencies; and providing initial and ongoing training and technical assistance in serving women, children, and adolescents, especially those who are high-risk or who have special needs;

- **Providing Services Where Needed** -- As discussed earlier, both the current shortage of providers in some areas and the capacity, experience and community ties of existing public and non-profit providers, argue for considering their inclusion in managed care arrangements. The determining factors should be: (1) community need for services; and (2) a lack of other appropriate providers or

a stronger capacity in the public sector to meet those needs. Local health departments, which are the primary providers of Title V-supported care, can serve as primary or subcontractors within managed care networks, depending on their capacity and community needs. State and local public health agencies may be able to provide certain services or serve specific populations more effectively than private sector providers joining managed care networks. Services for adolescents, which necessarily focus on medical, social and educational concerns, and where services should be delivered confidentially in settings where teens are comfortable, may continue to best be delivered through the public sector, including schools. Services for children with chronic illnesses and disabilities, which include multiple specialists, extensive outpatient and inpatient care, and family support services, might best be delivered through existing Children with Special Health Care Needs provider networks, at least until managed care systems specifically designed and financed to meet their needs are developed.

- **Standards, Contracts and Data Systems Development; Quality Assurance, Monitoring and Evaluation** -- While all of the above MCH program roles could contribute to the effectiveness of managed care in reaching and appropriately serving women, children, adolescents and families, public health involvement in these last areas is absolutely critical to assuring quality of care and to improving the health of entire communities. MCH public health expertise regarding the scope and methods of service delivery that are most effective in improving and maintaining the health of women, children and adolescents must be drawn upon in developing standards, contracts, quality assurance requirements, and evaluation methodologies for managed care providers. Given their expertise and their primary goal of improving health, MCH programs can also be effectively utilized in monitoring and oversight activities. Absolutely critical to achieving their mission of improving the health of the entire population is a role for public health agencies in developing requirements for and analyzing data that allows assessment of access to and outcomes of care.

These last roles for MCH programs in relation to managed care are a direct link and are necessary to effective discharge of the primary public health mission of preventing disease and promoting the health of the entire population. Regardless of the shape that health care financing and delivery reforms take, public health programs must have the authority and resources to **assess** the health and service needs of the entire population within communities; **develop policies and plans** to address identified health problems; and **assure** that these policies and plans are implemented and necessary personal health and community-wide public health services implemented. Title V currently authorizes and provides some resources to carry out these roles for women, children, adolescents, and their families. These mandates and resources

should be applied to development and implementation of managed care to assure that it increases access to cost-effective, quality health care that improves the health of women, children and adolescents.

## CONCLUSION

In this paper, the Association of Maternal and Child Health Programs has described issues of concern to state MCH programs as the nation and the states move ever more rapidly toward implementing managed care, a shift that will necessarily change existing financing and delivery systems and will first and most heavily impact on care for women and children. The nature of that change and its impact on access and outcomes for women, children and adolescents must be of concern to all those involved in development and implementation of managed care. The very speed at which this change is being advanced calls into question whether adequate time and attention are being devoted to consideration of the issues outlined in this paper. The lessons learned in experience to date with managed care must be heeded. Take, for example, the experience described by Milwaukee Health Commissioner Paul Nannis:

> It is my belief that we were ill-prepared to successfully implement the HMO program in 1984. The emphasis, unfortunately, was on cost-containment at the expense of access to care. The HMOs left much up to the public sector to do, despite their contractual obligations, and there was little or no dialogue between the public and private sectors. The ongoing structural problems in the health care delivery system were not addressed, let alone resolved, by the Initiative. The 1989-90 national measles epidemic hit Milwaukee too, just as badly as other cities without managed care. This brought our problems to the fore, forcing us to confront them...my intent is not to be critical, but to help others avoid repeating the mistakes which occur when such a complex changeover first takes place. In Wisconsin, we have corrected many of our deficiencies and continue to work on those remaining...keep in mind that we are serving women and children, while trying to reduce costs. If in the end, services aren't improved and preventive health care isn't delivered, nothing worthwhile has been accomplished.[7]

Unfortunately, current experience in many states and localities, and even at the national level is one of little or no dialogue between public sector health and financing agencies, much less between the public and private sectors in regard to managed care. Adequate and collaborative

planning that addresses ongoing structural problems in the health care delivery system must occur in effecting the complex changeover to managed care.

AMCHP hopes that this paper will be a useful tool to promoting early and ongoing dialogue on how best to address current problems and improve health care delivery so that in the end we will have accomplished improved access to and outcomes of health care for women, children and adolescents.

## ENDNOTES


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