State Medicaid Health Maintenance Organization Policies and Special-Needs Children

Harriette B. Fox, M.S.S., Lori B. Wicks, J.D., and Paul W. Newacheck, Dr.P.H.

Little research has been done to ascertain what enrollment in a health maintenance organization (HMO) may mean for the care of Medicaid recipients who regularly require specialty health services. This article presents the results of a survey of all State Medicaid agencies regarding their policies for enrolling and serving special-needs children in HMOs. The survey revealed that many States have implemented one or more strategies to protect special-needs Medicaid recipients enrolled in HMOs. The survey results suggest, however, that such strategies are too limited in scope to ensure appropriate access to specialty services for all children with special health needs.

INTRODUCTION

The number of Medicaid recipients enrolled in HMOs has grown substantially in the past decade. In June 1981, about 300,000 Medicaid recipients were enrolled in HMOs. Nine years later, that number had grown to more than 1.1 million, nearly 5 percent of the total Medicaid population (Health Care Financing Administration, 1991). The increasing likelihood of Medicaid-eligible children being enrolled in an HMO suggests that more of those with special needs may be receiving services through HMOs. This prospect raises three important questions: (1) To what extent do State Medicaid agencies enroll Medicaid-eligible children with special health, mental health, and developmental delay problems in HMOs? (2) How do State Medicaid agencies ensure that special-needs children enrolled in HMOs receive the high-quality, coordinated services they require? (3) What are Medicaid agencies' experiences with HMOs serving special-needs children?

Little is known about the range and quality of services typically furnished by HMOs to Medicaid recipients with special health care needs. The only studies with specific relevance to Medicaid special-needs populations focused on patient satisfaction. One study, which evaluated the federally sponsored Medicaid competition projects, reported that a smaller percent of patients enrolled in the capitated plans were satisfied with their health care providers than those in comparison sites whose providers were paid on a fee-for-service (FFS) basis (Freund et al., 1989). A small study that assessed Wisconsin's use of HMOs to serve its Medicaid recipients found that only about one-half of the 180 respondents who had a family member with a special health care need believed that their HMO was fulfilling that need. It also revealed that less than one-half of the respondents who had requested a referral to an out-of-plan specialist were granted one (Brazner and Gaylord, 1986).

This research was funded by the Maternal and Child Health Bureau under Grant Number MCJ-063500. Harriette B. Fox and Lori B. Wicks are with Fox Health Policy Consultants and Paul W. Newacheck is with the University of California, San Francisco. The opinions expressed are those of the authors and do not necessarily reflect the views or policy positions of the Health Care Financing Administration, the Maternal and Child Health Bureau, Fox Health Policy Consultants, the University of California, San Francisco, or their sponsors.

State Medicaid programs that enter into contracts with HMOs do so primarily because of their desire to contain costs or, in some cases, achieve cost savings. As provider participation problems have grown (Lewis-Idema, 1988), however, Medicaid managed-care arrangements are increasingly being viewed in many States as a mechanism for improving provider access and care coordination among Medicaid recipients (Reilly, Coburn, and Kilbreth, 1990).

Where States choose to contract with HMOs, Federal law requires that Medicaid-eligible families must be free to decide whether to join and must be allowed to withdraw upon a month's notice at any time. There are a few situations, though, in which Medicaid children could be required to enroll in an HMO for care. States that obtain a Federal demonstration waiver can assign Medicaid recipients to an HMO or other managed-care arrangement. Those States that obtain a freedom-of-choice waiver also may assign recipients as long as they are provided with a choice among plans. In addition, States that allow Medicaid recipients to choose a federally qualified HMO can elect to require recipients to remain in an HMO for 5 months following an initial 1-month trial period.

HMO enrollment for children in the Medicaid program differs in several ways from HMO enrollment for those privately insured. First, Medicaid children may be enrolled in an HMO that is composed primarily of other Medicaid recipients. HMOs contracting with State Medicaid programs usually are required to assure that Medicaid recipients and Medicare beneficiaries comprise no more than 75 percent of their membership, but this requirement can sometimes be waived.

Second, Medicaid children enrolled in an HMO are often expected to receive some health care services outside of the prepaid arrangement. HMOs contracting to serve Medicaid recipients as comprehensive services providers must assume the financial risk associated with furnishing either inpatient hospital services and at least one other mandatory Medicaid service or any three of the following mandatory Medicaid services: outpatient hospital services; rural health clinic services; physician services; skilled nursing facility care; early and periodic screening, diagnosis, and treatment (EPSDT); family planning services; home health services; and laboratory and X-ray services. Other mandatory and optional services covered in the State's Medicaid plan can be included in the contract as well. Whatever State Medicaid plan services a State elects to exclude from the HMO contract, however, must be otherwise available to Medicaid recipients, either through the FFS sector or another prepaid arrangement.

Finally, Medicaid special-needs children enrolled in an HMO, theoretically at least, have a level of quality assurance protection not available to privately insured children. State Medicaid agencies are federally required to monitor and assure HMO quality by conducting annual independent reviews of HMOs and imposing sanctions on plans that have violated regulations or denied medically necessary care.

The purpose of this article is to shed some light on State Medicaid policies regarding HMO enrollment of special-needs children. Using our own survey of State Medicaid HMO programs, we provide information on State Medicaid agencies' HMO enrollment policies, service

coverage policies, and financial arrangements. We also use the survey to provide information on State Medicaid agencies' experiences with HMO enrollment of special-needs children.

METHODS

To determine how Medicaid children with special health care needs are served by HMOs, we surveyed the Medicaid agencies of all 50 States and the District of Columbia in 1989 about the use of HMOs to serve the Medicaid population. The structured questionnaire was designed to elicit information on: the types of organizations contracting with Medicaid for risk-based contracts; Medicaid recipient groups enrolled in HMOs; services included in HMO contracts; special arrangements made for children with special health care needs; and agencies' experiences in serving special-needs children through HMOs. States were questioned only about comprehensive capitated contracts with HMOs. No information was collected regarding capitation contracts for partial services. The telephone-administered questionnaire was pretested in several States.

An attempt was made to speak to the head of the Medicaid managed-care program in each State. If that individual was not available, we spoke with the staff member to whom we were referred. To ensure accuracy, survey results were tabulated and sent back to our survey respondents for review.

RESULTS

Overall, we found that although more than one-half of the States (27) enroll at least some Medicaid recipients in HMOs, only 8 States have policies mandating such enrollment. In a majority of these States, seriously disabled children are exempted from the mandatory enrollment policies. Moreover, in many of the States that do enroll at least some special-needs children in HMOs, strategies to protect these children have been implemented. These include paying higher premiums for special-needs children, excluding specialty services from HMO contracts and offering the services through other providers, and providing reinsurance to HMOs so that the special needs of the children will be met.

Enrollment Policies

Although most State Medicaid programs (27) enroll at least some Medicaid clients in HMOs (Table 1), only about 5 percent of the Medicaid population participates (Health Care Financing Administration, 1991). In all but 4 of the 27 States (including the District of Columbia) that contract with HMOs, enrollment is available to Medicaid recipients only in selected jurisdictions of the State. In addition, HMO enrollment in the majority of these States (19) is voluntary, and in nearly one-half of the States (12) is available only to Medicaid recipients receiving Aid to Families with Dependent Children (AFDC) payments.

The types of HMO providers used by States to serve Medicaid enrollees varies somewhat. Four of the 27 States use for-profit providers[1]; the remainder use either a combination of non-profit and for-profit providers (11 States)[2], or non-profit provid-

[1]These States are the District of Columbia, Indiana, Iowa, and Utah.

[2]These States are California, Colorado, Florida, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Ohio, Pennsylvania, and Wisconsin.

Table 1

Enrollment Policies for Medicaid Recipients, by State: 1989[1]

State	Medicaid Groups Enrolled in HMOs	Enrollment Statewide or in Limited Communities[3]	Mandatory or Voluntary Enrollment	Special-Needs Children Exempted from Participation
Alabama	AFDC, SSI	Limited	Voluntary	—
Arizona	All	Statewide	Mandatory	—
California	AFDC, SSI	Limited	Voluntary	—
Colorado	All	Limited	Voluntary	—
District of Columbia	AFDC	Statewide	Voluntary	—
Florida	All	Limited	Voluntary	—
Hawaii	AFDC	Limited	Voluntary	—
Illinois	AFDC	Limited	Voluntary	—
Indiana	AFDC	Limited	Voluntary	—
Iowa	AFDC, AFDC-related	Limited	Voluntary	—
Maryland	All	Limited	Voluntary	—
Massachusetts	All	Statewide	Voluntary	—
Michigan	All	Limited	Mandatory HMO or primary care case manager for AFDC in one county; voluntary in all others	Children eligible for CSHN services
Minnesota	AFDC, AFDC-related, non-cash assistance pregnant women	Limited	Mandatory in some areas; voluntary in others	—
Missouri	AFDC, non-disabled elderly SSI	Limited	Mandatory HMO or primary care case manager	Children eligible for disabled, DD, or AIDS waivers
New Hampshire	AFDC	Limited	Voluntary	—
New Jersey	All	Limited	Voluntary	—
New York	All	Limited	Voluntary	—
North Carolina	AFDC	Limited	Voluntary	—
Ohio	AFDC	Limited	Mandatory in some areas; voluntary in others	—
Oregon	AFDC	Limited	Mandatory HMO or primary care case manager	Children with DD
Pennsylvania	All	Limited	Voluntary	—
Rhode Island	AFDC	Statewide	Voluntary	—
Tennessee	AFDC	Limited	Voluntary	—
Utah	All	Limited	Mandatory HMO or primary care case manager	—
Washington	AFDC, foster care[4]	Limited	Voluntary	—
Wisconsin	AFDC	Limited	Mandatory in some areas; voluntary in others	Children with DD, AIDS, or ventilator dependency

[1]As of August 31.
[2]Only non-institutionalized Medicaid recipients are enrolled in HMOs.
[3]Enrollment may be limited to specific communities either because the State has received a waiver to restrict participation to certain geographic areas or because there are no qualified HMOs willing to serve Medicaid recipients in particular communities.
[4]Enrollment of foster care recipients is limited to one of the participating HMOs.

NOTES: AFDC is Aid to Families with Dependent Children. SSI is Supplemental Security Income. HMO is health maintenance organization. CSHN is Children with Special Health Care Needs. AIDS is acquired immunodeficiency syndrome. DD is developmentally disabled.

SOURCE: Telephone interviews conducted by Fox Health Policy Consultants with State Medicaid agency staff: July/August, 1989.

ers only (12 States).[3] Among those States contracting exclusively or partially with non-profit entities, the types most commonly used are those that are operated by community health centers or by local or State governments and designed to serve a predominantly low-income, Medicaid population (11 States). New Jersey is the only State that has developed its own

[3]These States are Alabama, Arizona, Hawaii, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oregon, Rhode Island, Tennessee, and Washington.

State-operated and State-owned HMO, the Garden State Health Plan. Several States (five) also use HMOs that are operated by university medical centers or tertiary care centers.

As shown in Table 1, only 8 of the 27 States using HMOs to serve Medicaid clients have policies mandating enrollment. Six of these States have taken steps, however, to allow at least some special-needs populations to remain in FFS arrangements. In all cases, they have targeted the disabled Supplemental Security Income (SSI) population for special treatment, exempting them completely from HMO enrollment.

Importantly, however, exempting disabled SSI recipients from enrollment does not exempt all, or even most, children with special health care needs. According to data collected during the 1989 National Health Interview Survey, only 9.4 percent of poor children with activity-limiting chronic conditions were receiving SSI benefits during the period of this study (Newacheck, unpublished data). Recognizing this fact, four of the States with mandatory enrollment policies have exempted other populations of special-needs children as well. Michigan exempts children who qualify for the State's Program for Children with Special Health Care Needs (CSHN) from HMO enrollment. Missouri exempts children who are eligible for Medicaid waiver programs serving the physically disabled, developmentally disabled, or children with acquired immunodeficiency syndrome (AIDS). Oregon exempts children with developmental disabilities. Wisconsin exempts individuals of all ages who have AIDS, developmental disabilities, or a condition that makes them ventilator-dependent.

Moreover, Arizona, one of the two States requiring HMO or other managed-care plan enrollment by all Medicaid recipients, has developed a special-case management program to serve severely developmentally disabled individuals. Medicaid recipients who meet the definition of developmental disability and are at risk of institutionalization have all of their health and social services coordinated by a case manager in the State's Division of Developmental Disabilities. The division is provided the Medicaid capitated payment for these individuals and uses it to contract with HMOs for acute care services and other providers for long-term care services.

Interestingly, in 10 of the 19 States that permit voluntary enrollment in HMOs, the option is closed to disabled SSI recipients. This is primarily because plans have been reluctant to assume the financial risk associated with caring for persons with severe disabilities.

Although we found that most Medicaid families with special-needs children have a choice about whether to join an HMO, or at least which plan to select, we also found that not all families receive adequate information and guidance in making these important decisions. Medicaid recipients in 18 of the 27 States that contract with HMOs are required to make enrollment decisions at the time of their eligibility determination or redetermination, but only 11 of these States[4] have taken any special steps to ensure that Medicaid recipients adequately understand the nature of HMO membership and their HMO options. Among the strategies these States have employed are special training

[4]These States are Florida, Hawaii, Indiana, Iowa, Massachusetts, Michigan, Missouri, North Carolina, Oregon, Pennsylvania, and Utah.

for case workers, development of audio-visual presentations, and allowance of direct marketing by HMO representatives in the eligibility determination offices. In the other seven States[5], Medicaid recipients receive information about managed care and specific provider options from minimally trained AFDC or Medicaid case workers.

Nine States[6] wait until after the eligibility determination process has been completed to provide Medicaid recipients information about HMO membership. All but one of these States rely on the HMOs to provide the information, permitting them to mail marketing materials directly to newly enrolled recipients. The ninth State, New Hampshire, uses child health outreach workers to meet personally with Medicaid recipients to discuss their health care provider options.

Service Policies

Regular benefit packages offered by HMOs tend to be less comprehensive than the packages provided under State Medicaid plans. Staff in more than one-half of the 27 States contracting with HMOs reported that prepaid plans usually must modify their regular benefit packages for Medicaid enrollees. Yet, the plans rarely have been willing to furnish all Medicaid-covered services (Table 2). Moreover, in States contracting with several different HMOs, the array of services covered by the Medicaid capitation payment varies according to an HMO's willingness to provide particular Medicaid services.

Only in 4 of the 27 States[7] are Medicaid recipients enrolled in an HMO required to receive all of their services through the prepaid plan. In the other 23 States, Medicaid programs have responded to the problem of narrower HMO benefit packages by arranging for Medicaid enrollees to receive some services outside the plan. Although the HMOs are expected to help coordinate this care, the recipients themselves usually must find their own providers. In five of these States[8], HMOs are permitted to furnish non-contract services on an FFS basis but, according to Medicaid staff in those States, this option is rarely used.

In negotiating HMO benefit packages for Medicaid recipients, we found that a few States specifically exclude certain Medicaid services that can be particularly important for some special-needs children. Among the Medicaid services that States exclude from HMO contracts, dental services are the most common. Dental services are excluded in 16 States, as are nursing home services in 7 States; prescription drug services in 3 States; and mental health services, home health services, medical supplies and equipment, durable medical equipment, and case-management services in 1 State each. Interestingly, one State, Tennessee, excludes all specialty services from its HMO contracts, using prepaid plans exclusively to furnish preventive and acute care services.

A less common practice is for States to negotiate contracts that limit an HMO's obligation to deliver certain services. One

[5]These States are Alabama, California, Colorado, Minnesota, New Jersey, Rhode Island, and Washington.
[6]These States are Arizona, the District of Columbia, Illinois, Maryland, New Hampshire, New York, Ohio, Tennessee, and Wisconsin.
[7]These States are Arizona, the District of Columbia, Indiana, and Minnesota.
[8]These States are Hawaii, Iowa, Maryland, Missouri, and New Jersey.

Table 2

Health Maintenance Organization (HMO) Benefit Policies for Medicaid Recipients, by State: 1989[1]

State	Medicaid Services Offered Under Fee for Service but Excluded from HMO Contracts[2]	Additional Services Provided by HMO that are not Provided Under Fee-for-Service	Provisions for Special-Needs Children to Receive Services Outside of the HMO
Alabama	Prenatal, well-baby, SNF, and ICF services; some mental health, physician, vision, and transplant services	Additional hospital days	—
Arizona	—	—	Eligible children referred to CSHN for specialty care; HMO pays
California	Dental and some SNF services	Health education and preventive care for adults	—
Colorado	Dental, vision, long-term care, hearing, and abortion services; some mental health and physical therapy services; and prescription drugs		
District of Columbia	—	—	—
Florida	SNF, ICF, and family planning services	Adult dental care	—
Hawaii	Dental, inpatient psychiatric, and abortion services	—	—
Illinois	Vision and dental services	Preventive care for adults	—
Indiana	—	—	—
Iowa	Case management for the mentally ill and developmentally disabled	—	—
Maryland	SNF, ICF, and medical day care services	Emergency adult dental care	—
Massachusetts	Dental, podiatry, and long-term ancillary therapy services; and eyeglasses	—	Case-by-case approval for persons with mental health problems to receive service outside the plan; Medicaid pays
Michigan	Dental, most outpatient mental health, and EPSDT screening services	Preventive care for adults and additional prescription drug coverage	—
Minnesota	—	—	—
Missouri	Dental, ambulance, and family planning services, and prescription drugs	Health education for adults and transportation services	—

See footnotes at end of table.

Table 2—Continued

Health Maintenance Organization (HMO) Benefit Policies for Medicaid Recipients, by State: 1989[1]

State	Medicaid Services Offered Under Fee for Service but Excluded from HMO Contracts[2]	Additional Services Provided by HMO that are not Provided Under Fee-for-Service	Provisions for Special-Needs Children to Receive Services Outside of the HMO
New Hampshire	Dental and ICF services, prescription drugs, durable medical equipment and eyeglasses	Health education for adults and inpatient psychiatric services	—
New Jersey	Dental and transportation services and some SNF and ICF services	—	—
New York	Some SNF, ICF, and home health services	Health education for adults	—
North Carolina	Dental services	Additional physician visits and prescription drugs	—
Ohio	SNF and ICF services	Additional physician visits, over-the-counter drugs, and transportation services	—
Oregon	Dental and SNF services, medical equipment and supplies	Additional hospital days and over-the-counter drugs	—
Pennsylvania	Dental services	Health education for adults, dental and hotline services, additional vitamins and eyeglasses	—
Rhode Island	Dental services and eyeglasses	—	—
Tennessee	All but physician, inpatient and outpatient hospital, and laboratory and X-ray services	Additional physician visits and over-the-counter drugs	—
Utah	All mental health, dental and some transplant services	Health education for adults, and smoking cessation and weight-loss classes	Eligible children referred to CSHN for specialty care; Medicaid pays
Washington	Dental, chiropractic, and some vision services	Preventive care for adults	Special-needs children obtain specialty services as necessary from outside or HMO providers; Medicaid pay
Wisconsin	Dental services	Health education for adults	—

[1]As of August 31, 1989.
[2]In States with more than one HMO contract, excluded services may vary between contracts. A service was included in the table if it was excluded from at least one HMO contract.

NOTES: SNF is skilled nursing facility. ICF is intermediate care facility. CSHN is children with special health care needs. EPSDT is early and periodic screening, diagnosis, and treatment.

SOURCE: Telephone interviews conducted by Fox Health Policy Consultants with State Medicaid agency staff: July/August, 1989.

State, New York, limits HMO liability for home health services. Four States limit it for mental health services: Hawaii excludes inpatient psychiatric care and Alabama, Colorado, and Michigan exclude long-term outpatient mental health care.

Several other States structure arrangements for children and others with special health needs to receive specialized services outside the HMO plan. Both Arizona and Utah, for example, enroll children eligible for the State's CSHN program in HMOs, but mandate that they be referred to CSHN providers for specialty care. In Arizona, the Medicaid agency reimburses the CSHN program directly, but charges the child's HMO for specialty service costs. In Utah, the Medicaid program reimburses CSHN on an FFS basis, removing the HMO's financial responsibility for the CSHN services and, at the same time, giving the plan a strong incentive to refer children with complex conditions to well-qualified CSHN providers.

Massachusetts is another State that has made arrangements for a special-needs population to receive services outside of the HMO plan. The State includes Medicaid mental health services in its HMO contracts, but allows enrollees to use outside mental health providers upon request, on an FFS basis.

Washington has adopted the broadest policy for meeting special needs of HMO-enrolled individuals. It allows all enrollees needing specialty services not included in the contracts to receive them from either the HMO or an outside provider on an FFS basis.

Although there are some services additional to those in a State's basic Medicaid benefit package that HMOs typically furnish Medicaid enrollees, these essentially are preventive and health education services. Such services may hold special attractions for adult Medicaid recipients, but offer Medicaid children in managed-care arrangements few special advantages. Unlike adults, children covered by Medicaid already are required to receive routine preventive care and health education services as part of their EPSDT benefit.

Financial Risk Issues

Most States reported that HMOs are willing to serve Medicaid recipients only if some protection against extraordinary costs is guaranteed. The approaches States have taken to providing this protection include paying higher premiums for disabled SSI recipients enrolled in HMOs, providing stop-loss insurance to protect against unusually high costs for a given patient, and entering into risk-sharing arrangements to minimize the impact of unexpected adverse selection on the HMOs.

The 27 States that use HMOs to serve Medicaid recipients typically set different premium rates based on the eligibility category, age, gender, and geographical location of Medicaid enrollees but are less apt to vary premium amounts based on actual health status. Among the 12 States that allow or require disabled SSI recipients to enroll in a managed care plan, 9 pay higher premiums for them—usually about 4 times the amount paid for AFDC recipients. California, which pays a higher premium for enrollees with AIDS, is the only State that recognizes the higher costs associated with a specific health condition.

Reinsurance is the dominant strategy States use to protect HMOs against ex-

traordinary health care costs for any single plan enrollee. Reinsurance provided by States takes two forms: stop-loss protection and risk-sharing arrangements. With stop-loss protection, the State Medicaid agency agrees to pay 100 percent of the costs of serving an enrollee whose total costs in a contract year exceed a specified amount. With risk-sharing arrangements, the State Medicaid agency agrees to pay a certain proportion of costs incurred by the HMO for an enrollee after a specified level of cost has been reached.

Eleven of the States contracting with HMOs offer stop-loss protection, beginning at levels ranging from $20,000 to $50,000 (Table 3). Six States (including one that also provides stop-loss protection) have risk-sharing arrangements under which the Medicaid agency pays 80 to 85 percent of costs that exceed the established level. Medicaid staff in a few States noted that when the reinsurance takes effect, the State Medicaid program will pay for services at its usual rate. If hospitals or other providers used by the HMO are unwilling to accept the level of Medicaid reimbursement, the prepaid plan may be compelled to pay the difference.

State Medicaid Agency Experiences

Our survey found that State Medicaid agency staff in the 27 States having HMO contracts are generally satisfied with the overall performance of the HMOs serving Medicaid recipients and that few problems have been reported regarding the quality of care provided to children with disabilities or chronic conditions. Respondents' comments were qualified, however, by the fact that there are relatively few special-needs children enrolled in HMOs and that they have little reliable information on the quality of care provided to these children. In the opinion of slightly more than one-half of the 27 respondents (16), the quality of care provided by HMOs is at least as good or better than care provided in the FFS system.[9] They cited as particular advantages of prepaid plans for Medicaid recipients the availability of a usual source of primary care, improved access to specialists, and the provision of care coordination. Interestingly, a higher proportion of respondents in States with mandatory enrollment programs than those in States with voluntary enrollment perceived HMO care to be at least as good as FFS care. Several noted, however, that this is because the quality of the FFS system is very poor and not because HMO care is outstanding.

Medicaid staff from eight States had no strong views about the quality of care provided by HMOs, reporting that services seem adequate and that the Medicaid program has not received any complaints.[10] Seven respondents are from States with only voluntary enrollment policies, however, and a few noted that dissatisfaction among Medicaid recipients might be masked by the fact that, for the most part, they are able to disenroll at any time. These respondents suspected that families would be more likely to choose to leave the HMO than complain. Respondents in the remaining three States lacked sufficient information about the quality of care provided to HMO-enrolled special-needs children to form an opinion.[11]

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[9]These States are Alabama, Arizona, Colorado, the District of Columbia, Florida, Iowa, Missouri, North Carolina, New Hampshire, New York, Ohio, Oregon, Tennessee, Utah, Washington, and Wisconsin.

[10]These States are California, Hawaii, Indiana, Iowa, Massachusetts, Michigan, Minnesota, and New Jersey.

[11]These States are Maryland, Pennsylvania, and Rhode Island.

Table 3

Health Maintenance Organization (HMO) Financial Policies for Medicaid Recipients, by State: 1989[1]

State	Higher Premium Paid for Special-Needs Children	Reinsurance Provided in HMO Contract	Risk-Sharing Provided in HMO Contract
Alabama	—	—	—
Arizona	For children receiving SSI	Stop-loss amount varies with contract	Risk-sharing amount varies with contract
California	For children receiving SSI and children with AIDS	Stop loss at $25,000	—
Colorado	—	—	—
District of Columbia	—	—	80 percent after $15,000 in expenses incurred
Florida	For children receiving SSI	—	—
Hawaii	—	Stop loss at $35,000	—
Illinois	—	—	—
Indiana	—	Stop loss at $50,000	—
Iowa	—	—	80 percent after $30,000 in expenses incurred
Maryland	For children receiving SSI	Stop-loss amount varies with contract	—
Massachusetts	For children receiving SSI	—	—
Michigan	For children receiving SSI	—	—
Minnesota	—	—	80 percent after $15,000 in expenses incurred
Missouri	—	Stop loss at $20,000	—
New Hampshire	—	—	—
New Jersey	—	—	—
New York	For children receiving SSI	Stop-loss amount varies with contract	—
North Carolina	—	Stop loss at $25,000	—
Ohio	—	—	85 percent after $20,000 in expenses incurred
Oregon	—	—	—
Pennsylvania	For children receiving SSI	Stop-loss amount varies with contract	—
Rhode Island	—	—	—
Tennessee	—	—	—
Utah	For children receiving SSI	—	Risk-sharing amount varies with contract
Washington	—	Stop loss at $20,000	—
Wisconsin	—	Stop-loss amount varies with contract	—

[1]As of August 31, 1989.

NOTES: SSI is Supplemental Security Income. AIDS is acquired immunodeficiency syndrome.

SOURCE: Telephone interviews conducted by Fox Health Policy Consultants with State Medicaid agency staff: July/August, 1989.

When asked whether children with certain types of medical problems or conditions would not be adequately served by HMOs, only two State respondents (both of whom viewed HMO care as generally adequate) reported specific problems documented by families of special-needs children. In one of the States, there were two cases of children being denied necessary mental health services; in both instances the complaint was resolved satisfactorily after intervention from State agency staff. In the other State, HMOs had been, and continue to be, resistant to providing necessary speech therapy and occupational therapy services for Medicaid children with disabilities.

Some respondents also commented that although they were unaware of specific instances in which special-needs

children had experienced problems in HMOs, enrolling in an HMO would probably not be in the best interest of some children with highly specialized needs. Children with severe mental health problems and children with chronic illness or disability were cited as examples of such a situation, particularly if they would be compelled to interrupt an existing provider relationship.

DISCUSSION

Our survey results indicate that in the majority of the 27 States using HMOs to serve Medicaid recipients, special-needs children are not required to join. Only about one-third of the States require that Medicaid recipients enroll in an HMO or other form of managed care, and most of these provide some type of protection for at least some special-needs children. These include exemptions from enrollment, arrangements for providing out-of-plan care, and exclusion of services from HMO contracts.

Although there is a need for policies to protect special-needs children under all Medicaid managed-care arrangements, it is most critical in mandatory enrollment States. Three-quarters of the States that mandate HMO enrollment, in fact, do protect the small number of most severely disabled children by excluding SSI recipients from HMO participation. Most of them, with several other States that permit enrollment by disabled individuals, exclude from HMO contracts some services that could be particularly important for special-needs children. Even though the exclusion of these services, for the most part, does not result from efforts to protect disabled or chronically ill children in HMOs, these policies may serve to improve special-needs children's chances of receiving care from the best qualified providers.

In most cases, though, the steps that States have taken to protect special-needs children do not affect all chronically ill and disabled children and may not be effective in ensuring that these children receive adequate care. Exemptions from enrollment and special arrangements for out-of-plan care generally are limited to small groups.

Risk-sharing arrangements and other financial strategies also affect few children and probably do little to influence HMO incentives. Because reinsurance policies do not go into effect until relatively high costs have been incurred, they do little to encourage HMOs to provide sufficient amounts of relatively low-cost services that may be crucial to the care of many special-needs children. Data from the National Medical Care Utilization and Expenditure Study reveal that only about 10 percent of disabled children, defined as those with an activity-limiting chronic condition, had annual health care expenditures exceeding $2,000 (Newacheck and McManus, 1988)—an amount far below the level at which stop-loss and risk-sharing provisions typically take effect.

An obvious approach to addressing the potential problems associated with HMO enrollment of special-needs children receiving Medicaid benefits would be to discourage or exclude them from enrolling in the plans. Given the trend toward increasing enrollment in HMOs and other managed-care systems for Medicaid-covered populations, however, this is probably not a realistic or even desirable goal. The challenge for families and advocates, HMOs, and State Medicaid agen-

cies, then, is to determine what types of changes can be made within the current framework of HMO benefits and operations to assure appropriate care for Medicaid-enrolled special-needs children.

State Medicaid agencies have assumed broad financing responsibility for the health care needs of child recipients, in most States stretching beyond coverage of traditional medical interventions and into the myriad of ancillary health and psychosocial support services that special-needs children require in various home and community-based settings. States turning to HMOs as the provider of services to children may want to consider the use of objective contracting criteria that address specifically the health care and developmental outcomes expected for children and the linkages to specialty care providers in the community that would be required to achieve them.

With recent statutory revisions to the EPSDT benefit, the scope of services that Medicaid agencies must provide children has become even broader. States now are required to cover any federally allowable service that is medically necessary to diagnose or treat a physical or mental health problem detected during a screening examination. Many States are requiring the HMO providers with which they contract to furnish at least some of the services now covered as a result of the new EPSDT mandate. Others are expecting their HMO providers to take on the important role of referring children to out-of-plan specialists for previously unreimbursed services (Fox and Wicks, 1991). Regardless of the approach States use, a careful consideration of HMOs' responsibility for working cooperatively with other programs and providers serving special-needs children will become even more desirable.

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Reprint requests: Harriette B. Fox, Fox Health Policy Consultants, 1747 Pennsylvania Avenue, NW., Suite 1200, Washington, DC 20006.