SUMMARY

Most state Medicaid agencies are turning to capitated prepayment to contain costs, to improve access to care, and to increase efficiency in the provision of services. However, many states have concerns about how the financial incentives that accompany prepaid care could affect services to chronically ill beneficiaries. Medicaid agencies are implementing a variety of prepayment strategies specifically for children with chronic conditions, often intended to reduce financial disincentives for providing adequate care. They range from excluding certain services, to allowing voluntary enrollment in prepaid health plans for some children while requiring others to enroll. Some have questioned how these different policies will affect provider behavior, and how this in turn will affect the care that a child receives.

California implemented a set of dramatic changes to the delivery of health care to Medicaid beneficiaries during the 1990's. Much of the policy debate over access to services focused on how to preserve specialty care access for children with complex medical diagnoses while also improving access to primary care to the general population. As California's ambitious plan to expand managed care unfolded in its largest counties, a legislative effort preserved the traditional role of the Social Security Act, Title V Children with Special Health Care Needs program in authorizing services under the traditional fee-for-service system. Child Medicaid beneficiaries who are eligible for Title V are those with complex medical diagnoses.

This legislation created new relationships between physicians, health plans, and county Title V programs (called California Children Services, or CCS) as well as new financial incentives that encouraged referral of potentially eligible children to CCS. When providers are placed at financial risk for medical care with specific services "carved out" from their risk, a financial incentive to shift costs to the excluded services is created. Theoretically such a policy creates a financial incentive for the provider to refer children to the entity responsible for the carve-out services whenever eligibility is suspected. It also creates an incentive for identifying services as related to the qualifying diagnosis. Thus the CCS carve-out policy may affect both the volume of CCS participants and the volume of services identified as CCS-related. This study highlights the impact of such a "carve-out" approach on children's participation in CCS.

Purpose of the Research

The specific aims of this study are:

1. To determine whether the financial incentives of a carve-out policy increase "case-finding" of children with Title V-eligible conditions, and composition of the CCS caseload; and

2. To determine how "carving-out" specialty services during a managed care expansion affects total CCS expenditures.
Policy Relevance

How providers respond to capitated prepayment for services to chronically ill and disabled children is a significant consideration for children and their families, for the outcome of Medicaid managed care expansions, and for policy-makers who expect prepayment policies to control costs. There also are policy implications from a public health perspective, because Medicaid and other State-administered public health programs have outreach and related program participation goals designed to promote population health. Because State Medicaid programs are a traditional "safety net" for low income and chronically ill individuals—especially for children, who are the largest group of beneficiaries—they have a particularly vital policy interest in the effects of new financial incentives. States also continue to have public health responsibilities for policy development, assessment, and assurance, as well as a mandate within their state-operated Medicaid programs to assure health care access for many low-income and chronically ill beneficiaries. At the same time, state programs continue to operate under the federal Title V mandate to assure a comprehensive system of care for children with costly, complex medical diagnoses. In some states, both the medical care delivery system and Medicaid funds are handed to the commercial managed care sector while the Medicaid program adopts an oversight role. Thus the expanded use of managed medical care systems challenges these state agencies to oversee how care is provided and to focus on system outcomes and system improvement.

Despite the new incentives that are evolving, and the policy questions that result, state agencies are not always well equipped to monitor the effects of new payment systems. The first reason that effects of Medicaid managed care on chronically ill children are not well understood is that relatively few children have intensive health care needs and thus have not been the initial focus of managed care studies. Moreover, some states initially excluded children with specific medical diagnoses from Medicaid managed care expansions, or excluded children's specialty care from these new prepayment systems. Second, it is difficult for states to identify policy effects because of difficulties in the following: (1) identifying appropriate comparison groups; (2) studying a representative group of beneficiaries; and (3) discerning the impact of other trends. The result is that states currently have few data that can guide how they develop, implement, and evaluate payment policies. State Medicaid agencies benefit from understanding how payment policies affect service use and costs. There is additional value in examples of how new payment policies affect public health care case-finding objectives and how these policies can change public program roles from service provision to a combination of service delivery, policy development, and advocacy.

Study Design and Methods

This study uses data from California—a state that implemented Medicaid managed care earlier and more extensively than most other states—to understand the financial incentives of a "carve-out" payment system for children, and to understand the impact on (and response of) public health care agencies. In the 1990's, California initiated a phase-in of mandatory Medicaid managed care—on a staged county-by-county basis—for most children, including those eligible for Title V Children with Special Health Care Needs (with diagnoses such as spina bifida, congenital anomalies, and cerebral
Children required to participate in managed care included those receiving welfare benefits or meeting general low-income Medicaid eligibility requirements. Following special legislation, Medicaid services relating to a CCS eligible medical diagnosis\(^1\) were excluded from managed care contracts and reimbursed on a traditional fee-for-service basis. The difficulty in determining whether specific services are required exclusively for a particular diagnosis suggests that this mixed reimbursement policy could motivate cost-shifting from capitated care to the carved-out services.

The CCS carve-out design not only creates financial incentives but also introduces a new participant—the prepaid health plans—into the CCS referral process. On the provider side, response to the carve-out policy is driven by physicians, hospitals, and the prepaid health plans. Perceived costs and benefits of CCS referrals are expected to influence their CCS referral practices both prior to and following implementation of the carve-out policy. The fiscal agents include the Medi-Cal field offices that authorize services for fee-for-service (FFS) Medicaid beneficiaries, and the local CCS programs that administer the carve-out. State policies and procedures, local variation in authorization practices and outreach, and any local responses to the carve-out are expected to influence any public agency contributions to post carve-out changes. Any combination of referral and authorization practice patterns on the part of these different institutions could contribute to carve-out impact.

This study seeks answers to several questions. Does the volume of CCS program participants increase with the carve-out? Does the composition of the CCS caseload change as greater numbers of "marginally eligible" children, and requests for "marginally CCS-related" services, are referred to CCS? Do total CCS expenditures increase? Do per claimant CCS expenditures change as the caseload expands to include more children with low or moderate cost needs? Do per claimant expenditures increase as more services for each participating child are handled by CCS?

It is possible to study the impact of the carve-out policy using several comparison groups. The comparison groups including the following: (1) beneficiaries in the managed care expansion counties prior to and following the carve-out; (2) children with CCS eligible diagnoses who are in specific Medicaid eligibility categories (such as disability-linked Medicaid) that are exempted from the managed care requirement; and (3) counties that are not implementing Medicaid managed care. This study analyzes 1994-1997 Medicaid claims, covering the pre and post carve-out periods, to examine how the “carve-out” policy affects program participation and total costs of care. A difference-in-differences model employs a pre-post design with a control group to capture policy-related as well as other secular program participation and cost trends. Specifications that measure carve-out impact as a function of the level of managed care participation also are evaluated. Results from the quantitative analyses were supplemented with qualitative findings from interviews with several CCS program administrators.

\(^1\) The specific exclusion refers to specialty services provided to children with Title V eligible medical diagnoses. These are diagnoses recognized in state Maternal and Child Health Block Grants as entitling children to case management and supplemental medical services. The administering program in California is called "California Children Services", or CCS. Details are provided in Chapter 3.
Findings for Identification of Program Eligibles

*The carve-out policy caused CCS claimant volume to increase.*

It appears that the "case-finding" incentives of the carve-out policy caused more children to be identified as CCS eligible. In general, the carve-out implementation was associated with increased participation in the CCS program within the managed care expansion counties. This occurred in counties that implemented California's "Two Plan" model with competing health plans in a county, as well as in new, delegated county-run health plans ("County Organized Health Systems", or COHS). The effect of increased managed care participation was evaluated for the group of children required to enroll in managed care in Two Plan counties, controlling for Medi-Cal enrollment and time trend.

Combining the expansion and selected non-expansion comparison counties, claimant volume increased with the rate of managed care participation. This occurred for both mandatory and non-mandatory groups. A further analysis of the initial months of carve-out implementation, and the later months of implementation when the carve-out was fully operational, shows that the carve-out effect was concentrated in the full implementation period. Low managed care participation rates in the initial months after implementation is a likely explanation. Moreover, managed care participation was technically voluntary during these months, termed “pre default”, when one of the two plans was not yet operating and beneficiaries who did not select a plan were not assigned a plan by default.

There was variation in carve-out impact on claimant volume across the expansion counties. Total claimant volume increased most substantially in the COHS counties and in several Two Plan counties that did not have a history of Medi-Cal managed care.

*Carve-out impact among those in aid categories that were mandated to participate in some, but not all expansion counties, appeared to be greater with mandated than with voluntary participant groups.*

Using several large Medi-Cal aid categories, it was possible to compare post carve-out trends among expansion counties that had different managed care requirements for those aid categories. This also was done due to the heterogeneity within the mandatory and non-mandatory groups; each included a large number of distinct eligibility aid categories, and different time trends could affect claimant volume across the aid categories. One aid category included children receiving public cash assistance. It was of special interest because of a decline in total enrollment by approximately 15 percent over the study period. Another aid category included children not receiving cash assistance but eligible for Medi-Cal due to low family income, and had more stable enrollment. Overall, CCS claimant volume increased for the largest cash assistance aid category and for the largest non-cash assistance aid category. The effect was most substantial in the COHS counties. Findings for the Supplemental Security Income (SSI) group that was mandatory in COHS counties and voluntary in Two Plan counties diverged somewhat. Using a set of pre and post carve-out indicators, there was no increase in claimant volume for SSI beneficiaries in expansion counties where managed care was voluntary for these beneficiaries. In contrast, in the two COHS counties where managed care was mandatory for these beneficiaries, SSI claimant volume did increase.
Increased claimant volume was evident across diagnosis categories, indicating that the carve-out increased CCS authorization for many different types of claimants. Evaluation of claimant volume by diagnosis category showed significant carve-out impact across most diagnosis categories, controlling for covariates and in comparison to non-expansion counties. The impact of managed care participation increase for the mandatory group was not constant across the diagnosis categories and was particularly significant for claimants with an endocrine/metabolic/nutritional diagnosis. One possible explanation is physician referral and health plan referral practices that caused more CCS-authorized services per child, somewhat independent of diagnosis. Changes to CCS program authorization practices in response to the carve-out could have affected services authorized for CCS eligible children across diagnostic groups. Some of the increase across diagnosis categories could be an artifact of the expansion/carve-out that is not a caseload increase. Greater variability in claim coding with respect to diagnosis could contribute.

CCS program administrators attributed increased CCS case-finding to changed provider referral practices, health plan involvement, and Medicaid and CCS program responses to the carve-out/managed care incentives. Health plans and physicians alike had a clear financial incentive to identify and refer CCS eligible children to the CCS program. Health plans were a new participant in the identification and referral process. The health plans provided infrastructure for case-finding and referral in addition to having the financial incentive for referral, given their financial risk for certain specialty and inpatient services. Results from interviews with several county CCS administrators indicate that the perceived changes taking place in provider referral practices seemed to encompass all potentially CCS eligible children, whether they were in a mandatory managed care group or a non-mandatory managed care group. While some of this change can likely be attributed to the financial incentives for physicians and health plans, there are other explanations for the increased participation. According to CCS administrators in several managed care expansion counties, California's carve-out of CCS services increased the visibility of the CCS program not only to the provider community but also to the local Medi-Cal offices that are one source of CCS referrals. Overall, the findings indicate that the carve-out policy stimulated a combination of practice changes that led to increased CCS program participation.

Findings for CCS Expenditures

The carve-out did not cause a significant increase in total CCS-authorized expenditures in most managed care expansion counties. Despite increases in monthly claimant volume, the carve-out generally was not associated with increased monthly CCS-authorized expenditures. Increased CCS expenditures during the study period were found in COHS counties but not in all Two Plan counties. When compared with non-expansion comparison counties, however, no overall increase in expenditures was found for the Two Plan or the COHS counties. COHS results were sensitive to the group of non-expansion counties used as a comparison group, however, and showed a significant increase when compared to eight counties with independent CCS programs but not when compared to these counties in addition to several other metropolitan non-expansion counties. While findings at the aid category level were
sensitive to the type of specification used, there was some indication of increased expenditures within the SSI aid category only, in the Two Plan and the COHS counties. No increases were found for the larger cash assistance and medically needy aid categories.

The carve-out was associated with a decline in expected monthly costs per CCS claimant, but a statewide trend toward lower per individual expenditures appeared to dominate the trend. Monthly expenditures for a child having a CCS claim declined in COHS counties with a trend toward decline in Two Plan counties. Median and 75th percentile claimant expenditures for the mandatory group in Two Plan counties appeared to be lower after the carve-out. Per claimant CCS expenditures are skewed; for example, for the mandatory group in Two Plan counties, the post carve-out median monthly claimant expenditure was $254 while the mean was $4,188. This finding was consistent with the expectation that higher volume post-carve-out claimants in the lower tails of the cost distribution would lower the claimant cost at the median and upper tails of the distribution. However, this finding could also be explained by an independent time trend of declining per claimant expenditure.

The carve-out was associated with an increase in monthly claimants receiving CCS-authorized ambulatory services, such as physician services in office and outpatient settings, and hospital-based outpatient services, and an increase in claimants receiving pharmaceutical authorizations. The number of children with claims for ambulatory physician and for hospital outpatient services increased with the carve-out. In contrast, and as expected, there was no change to the monthly number of children receiving inpatient hospital services. Hospital inpatient stays were expected to be less sensitive to carve-out incentives. It was not hypothesized that the volume of newly identified children with cost-intensive, medically complex diagnoses would increase significantly with the carve-out. Findings were consistent with this expectation given the lack of significant expenditure increase for inpatient hospital services. Among those claimants mandated to participate in post carve-out managed care, monthly expenditures for physician office services, and hospital outpatient services, declined per recipient of those services. This suggested lower intensity service per recipient, which is consistent with a carve-out effect of increasing CCS program participation among "marginally eligible" children with lower expected CCS costs. For the non-mandated group, expenditures per recipient of the service declined for pharmaceuticals, hospital outpatient, and rehabilitation hospital services, though not for ambulatory physician services. Results tended to show that rather than increasing total expenditures, the carve-out tended to increase the number of low average expenditure claimants.

It is also possible that the expansion/carve-out caused systemic changes with effects not limited to those formally "exposed" to the carve-out effects. While this argument is plausible and is consistent with the observations of those CCS program administrators interviewed, this remains only a hypothesis.
Findings for Carve-out Impact on the CCS Program

The carve-out appeared to broaden the CCS role in authorizing services for which the program would not have been involved prior to the carve-out. Organizational changes were stimulated by the managed care expansion and CCS carve-out. Extensive contact between the local prepaid health plans and the CCS program took place along with expanded outreach and community education regarding CCS program eligibility. When the carve-out was adopted, the CCS program implemented a defined time window within which CCS medical eligibility would be determined. The carve-out also facilitated CCS enforcement of provider paneling standards for a larger proportion of CCS eligible Medi-Cal beneficiaries. Some CCS administrators who were interviewed as part of the study noted that the CCS program was increasingly known for its case management functions, and that the CCS program role could eventually evolve into a role of quality assurance and oversight for children with special health care needs. Some CCS administrators indicated that prepaid health plans potentially offered more flexibility for adopting policies and procedures in response to the carve-out. In several of the expansion counties, one or more administrators expressed the observation that the program had moved away from an initial somewhat "adversarial" relationship between one or more of the health plans and the CCS program. Some administrators reported that the combination of a carve-out with the entry of commercial health plans with a statewide presence was resulting in greater program standardization across the counties, in terms of medical eligibility and in terms of authorization for specific services. Finally, while beyond the scope of this study, CCS program administrators reported new, evolving challenges for the CCS program. Broader issues than the "case-finding" and expenditure effects are evident, such as the sustainability of specialty provider networks given low Medi-Cal payment rates and specialty care restrictions in the non-Medi-Cal commercial health care sector for children with special health care needs.

Policy Implications

For children in low-income families, there are many public programs for which case-finding and access to health care are important objectives. The evolution of Medicaid and Title V programs, among others, creates divided responsibility across public programs for meeting the medical care needs of children with special health care needs. The conversion of fee-for-service state Medicaid programs to managed care systems can affect the roles and responsibilities of each of these interdependent programs. Whether implemented for financial or access to care objectives, service carve-outs provide a potential mechanism for referring vulnerable children to the appropriate public program or service sector.

These findings indicate a substantial effect on case-finding where responsibility for services is divided across programs. In this study, new financial incentives for health plans and providers, and greater visibility of CCS eligibility in the provider community and even within some Medi-Cal field offices, appeared to increase referral to CCS and expand monthly claimant volume. Health plans and physicians alike were given a clear financial incentive to identify and refer CCS eligible children to the CCS program. Findings suggest that some children in the pre carve-out period who were CCS eligible were not referred or were not found to be eligible. While some of the change can likely be
attributed to the financial incentives for physicians and health plans, there are other explanations for the increased participation. Some services for CCS eligible children may have bypassed CCS and been authorized by Medi-Cal. There is some evidence that the managed care expansion and the CCS carve-out thereby stimulated statewide effects that extended to the non-expansion counties.

Increased case-finding may change the composition of program participants. If this occurs, then caseload projections and expectations of per child expenditure based on pre-intervention data many not reflect actual post-intervention experience. In this study, monthly expenditures per claimant fell across the post carve-out period. While there was a time trend of declining per child expenditures over the study period, it appeared that the carve-out increased monthly volume of children with lower expenditures. It suggests that the tightening of the authorization process with respect to CCS involvement brought lower intensity claimants into the system and also increased overall services authorized for known eligible. It appears that on average, these were lower intensity services.

It is important to note that California's carve-out policy did not directly impose a different delivery system for CCS services. Instead, it created a financial incentive for referral and for adherence to CCS program standards. This is in contrast to other carve-out arrangements that introduce a new health care management system (contractor) into the delivery system. It is not known whether children who were not referred to CCS prior to the carve-out saw providers and/or received care that met CCS program standards of care. To the extent that the provider or location of care changed for a child as a function of the carve-out, the primary mechanism was greater enforcement of pre-existing CCS standards. Participation of children in the new Medi-Cal managed care delivery system could have changed the primary care provider and the specialists that were accessible for the child beyond the CCS diagnosis and CCS involvement, for better or for worse. Prior to referral to CCS, only the contracted primary care and specialty providers within a given health plan's provider network are accessible to a child. Such access questions comprise an important area for future research but remain outside the scope of this study.

Whether quality of care was enhanced by the carve-out policy is not known. This study did not evaluate how service access and volume may have changed for children. The only finding that relates directly to quality stems from increased referral to CCS. Greater referral rates to CCS may increase children's access to appropriately trained providers in the most optimal settings available (as defined by CCS standards). Prior to the CCS carve-out, findings suggest that some eligible children were not referred to CCS, and CCS was unable to play a referral and case management role for such children. Of course, it is important to keep in mind that without the carve-out, health plans would have been responsible for authorizing and reimbursing CCS services. Thus a complete carve-out evaluation would need to account for how CCS services might have been delivered within a fully capitated system.

Another important policy finding is that the carve-out effects may have extended beyond the targeted group of beneficiaries. The carve-out appeared to enhance case-finding and CCS authorization roles for those child Medicaid beneficiaries who were not required to participate in managed care.
California's carve-out of CCS services from prepaid care increased the visibility of the CCS program to the provider community as well as within the Medi-Cal program. The carve-out enabled the CCS program to more fully identify their target population, and to become more involved in monitoring the health care received by eligible children. The fact that the carve-out policy preserved an independent authorization process that was external to the health plans also was reported as a positive outcome of the carve-out policy. Greater recognition of the CCS role in case management was reported by some program administrators to demonstrate the program's value for children with special health needs. The increased and regular contact between the prepaid health plans and the CCS program may also offer future opportunities for system improvement that extend beyond Medi-Cal managed care beneficiaries to commercially insured children with special health needs. Future oversight and quality assurance roles of the Title V program may be more productive under a carve-out than under a fully capitated system, to the extent that more eligible children are identified.

While California's carve-out policy and pre-carve-out case-finding patterns may not be replicated exactly in other states, features of the policy and its impact are relevant to Title V programs in other states and potentially to other publicly funded health programs for children. It is possible that in other states as well, some eligible children are not referred to the Title V program. Even though California requires such referral, this study suggests that a greater number of children—and/or a greater volume of services they received—were part of the CCS program after the carve-out incentive was put in place. There are a number of publicly funded health programs for children that are independent but require coordination with other programs—such as Medicaid and EPSDT, Title V, developmental services, and mental health—and these findings may be relevant to those programs. Such health programs also in many cases require coordination with commercial insurers and the medical care system for certain groups of children. These findings are directly applicable to non-CCS programs such as mental health that involve similar financial and organizational relationships. For example, California's carve-out of behavioral health services from prepaid health plan contracts requires coordination between the health plans and the public department that manages the carved-out services, with potential lack of clarity regarding responsibility for diagnoses that involve ambulatory services. Thus the interface along with the case-finding and cost-shifting incentives of California's CCS carve-out provide important findings for other programs and other states.