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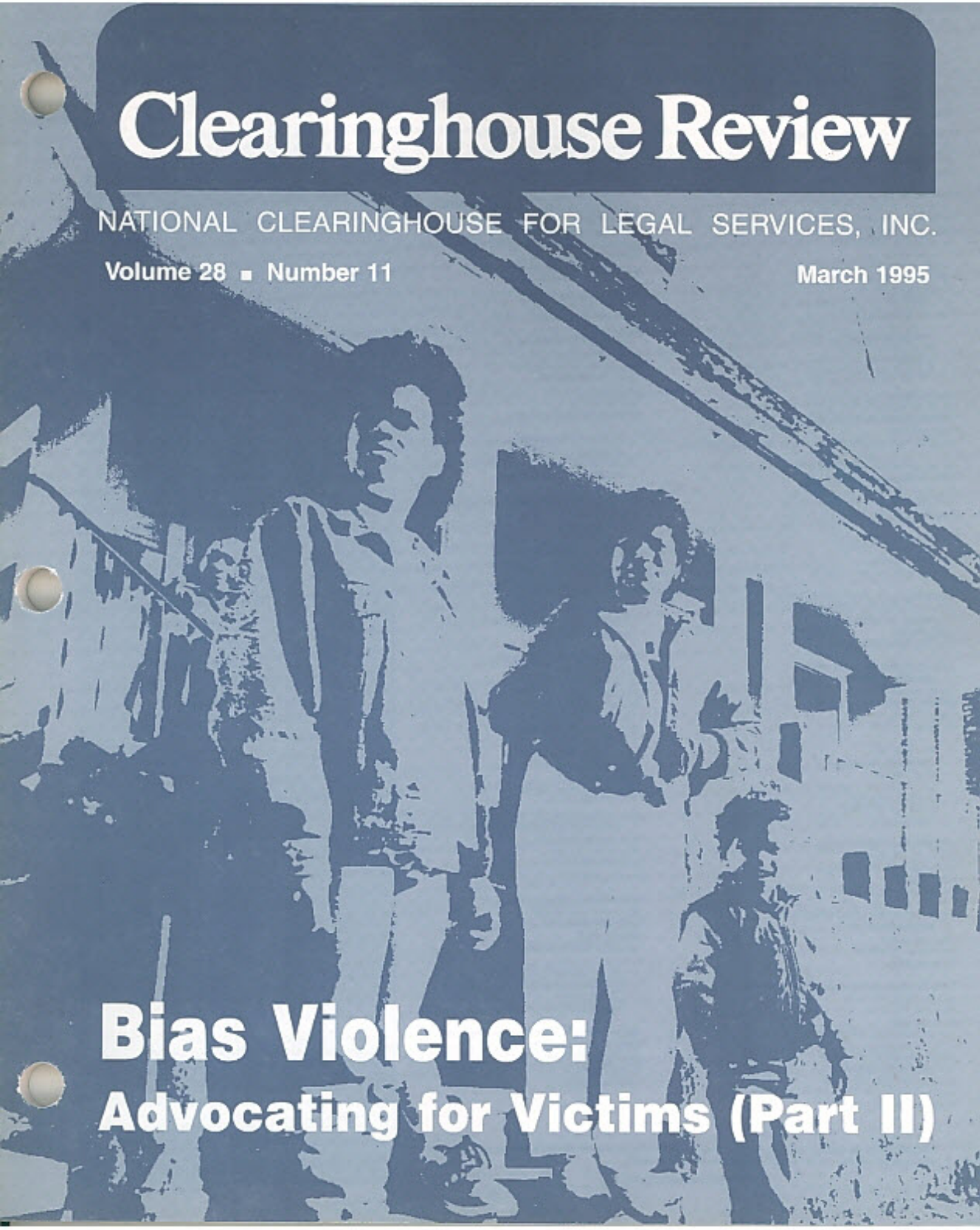

Bias Violence:
Advocating for Victims (Part II)

EPSDT and Managed Care: Do Plans Know What They Are Getting Into?

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I. Introduction

Managed care is rapidly becoming the predominant method of delivering and financing health care services for low-income people, and children in particular. This article discusses the relationship of Medicaid managed care and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the pediatric benefit package under Medicaid. After briefly describing managed care and EPSDT, the article summarizes the literature to date on the delivery of services using managed care to poor children. Specific problems with EPSDT coverage are discussed. Finally, the article suggests steps that can be taken to assure the delivery of EPSDT in managed care settings.

II. Background of Managed Care

Increasing numbers of Medicaid recipients are enrolled in managed care arrangements. In the past year, enrollment rose to 7.8 million recipients, or 23 percent of the Medicaid population. /1/ Over half of all AFDC recipients are enrolled in managed care. /2/

The goals of managed care are to reduce the provision of unneeded or unnecessarily costly services, to contain Medicaid spending, and to improve access to care. Managed care links recipients to a single health care provider, often called the "gatekeeper," who is responsible for providing or arranging for the recipient's nonemergency primary and specialty care needs. Recipients are personally liable for health care received without the gatekeeper's approval.

There are three basic models of Medicaid managed care: (1) fee-for-service case management, under which a health care provider, usually a primary care doctor or clinic, receives a monthly case management fee per enrollee to perform gatekeeping and coordination of services; (2) fully capitated systems, under which a provider, usually a health maintenance organizations (HMO), is paid a preset, or "capitated," rate per enrollee and is at risk for excessive medical expenditures; or (3) partially capitated systems, under which a provider, usually a primary care physician or clinic, receives a capitated rate per enrollee and is at risk for a limited package of services. The trend is decidedly toward at-risk arrangements.

Recipients can voluntarily enroll in managed care plans, or the state can obtain a Medicaid "waiver" from HHS that allows it to make managed care enrollment mandatory. As of June l990,

about 900,000 recipients in 23 states were voluntarily enrolled in prepaid, managed care plans. /3/ Over the past decade, however, the majority of states have increasingly turned toward Medicaid waivers. States are obtaining waivers, at least in part, because evidence shows that voluntary enrollment does not necessarily save money. /4/ Moreover, without capitation and mandatory enrollment guaranteeing income, many mainstream HMOs avoid Medicaid because of low reimbursement rates, marketing problems, and the high turnover rate in Medicaid eligibility. /5/

Two types of Medicaid waivers allow mandatory enrollment in managed care: section 1915(b) program waivers and section 1115 demonstration project waivers. Section 1915(b) of the Social Security Act allows a state to mandate use of managed care by waiving certain Medicaid rules, typically those requiring statewide operation of the program, comparability of services, and free choice of provider. /6/ Participating providers must meet federal regulatory standards regarding access, quality, reporting, and utilization. /7/ Forty-four states and the District of Columbia currently operate at least one section 1915(b) program waiver. /8/

An increasing number of states are seeking section 1115 demonstration project waivers, which allow them broadly to restructure their Medicaid programs. /9/ These waivers are used to expand eligibility to uninsured populations, streamline eligibility determinations, and enroll all recipients in at-risk managed care plans. Significantly, many states seek permission to establish HMOs comprised only of Medicaid recipients; this is not authorized by section 1915(b). /10/ Moreover, these waivers present tradeoffs in Medicaid coverage for children. States already have the option to expand eligibility to children under section 1902(r)(2) of the Social Security Act, which places no upper limit on income eligibility. /11/ By contrast, states use section 1115 waivers to extend Medicaid to all persons, including single adults and childless couples, with incomes under a percentage of the federal poverty level. /12/

Notably, unless the federal protections are specifically waived, managed care does not alleviate the states' and managed care plans' obligations to comply with federal requirements mandating EPSDT for poor children under age 21. /13/ EPSDT's comprehensive benefits are set forth in the Medicaid Act and include periodic medical, dental, vision, and hearing screens; immunizations; laboratory tests; and health education. /14/ A broad package of institutional and home- and community-based diagnostic and treatment services is covered for both newly diagnosed conditions and conditions that existed prior to Medicaid eligibility (preexisting conditions). /15/ Moreover, the statute mandates aggressive outreach to notify children and their families of the importance of preventive care and the availability of EPSDT benefits. /16/ Congress has said that states must "not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit." /17/ Yet, as discussed below, children have encountered numerous problems obtaining EPSDT benefits from managed care plans.

III. Problems with Managed Care

In theory, managed care emphasizes cost-effective, preventive care over episodic, acute care. However, there is strong evidence that managed care arrangements can harm children's access to health services, including early and periodic checkups. The following examples illustrate:

- During a 1989 -- 90 measles outbreak in Wisconsin, 83 percent of the cases among children aged 1 -- 4 occurred in Medicaid recipients enrolled in HMOs. Sixty-seven percent of these cases were in children who had not been vaccinated, and 30 percent of the cases were in enrollees who stated they regularly used the emergency room for primary care. Some physicians "hesitated" or "declined" to vaccinate children out of fear of inadequate or excessively delayed reimbursement. /18/

- Aggressive marketing agents enrolled homeless women and children into a managed care plan in southern California that was less accessible to them than their clinic. The marketers did not tell the enrollees that they would need to travel to reach the plan's primary and emergency care sites and did not arrange transportation between the shelter and the medical facility. /19/

- A 17-year-old enrolled in the Tennessee managed care system suffers from Crohn's disease. Her pediatric specialist said she needed long-term care and a nutritional feeding tube. This doctor told the girl she would have to find another doctor because he was not being paid enough. The girl's gatekeeper found another specialist; however, she could not get an appointment for three months. Meanwhile, she went to the emergency room for tube assistance and pain shots and had constant diarrhea. /20/

- A managed care plan in New York refused continued coverage for home nursing services for a child. The mother, who has multiple sclerosis, contacted the state to appeal. The state informed her that the child had no rights to assistance pending appeal and that she had to use the plan's internal grievance procedure. The state said nothing about a state-sponsored fair hearing. /21/

These stories are reinforced by the research literature. /22/

A 1990 study looked at care received by women and children enrolled in HealthPASS, /23/ a Medicaid managed care plan in Philadelphia that earned over $16.6 million for its owners and directors during the first two and one-half years it operated. /24/ The study found that enrolled and nonenrolled recipients experienced the same low rates of access to prenatal care. /25/ Twenty percent of the newborns to both sets of recipients were born at low birth weight and required intensive care at birth. /26/ A l993 follow-up study found that the majority of children enrolled in the plan were not receiving timely preventive care required under EPSDT, partly because providers were not aware of the federal law. /27/

Similarly, an independent assessment of Minnesota's managed care program reported an overall lower level of compliance by the plans with standards of care related to prenatal, early and late childhood, and chemical dependency care. /28/ A 1992 study of ten HMOs participating in Medicaid demonstration projects concluded that serious risks of underservice result from inadequate Medicaid financing, and that neither the plans nor the states are doing a responsible job of monitoring for underservice. /29/

Moreover, a review of the literature that has evaluated access to prenatal care and preventive care for children in Medicaid managed care shows, overall, no improvement where access was already

inadequate. /30/ In some cases, access worsened. /31/ So far, managed care has meant little change in health outcomes. /32/

EPSDT involves numerous, and at times complex, activities: periodic medical, vision, hearing, and dental screening; treatment; referral and follow-up; case management; outreach and information provision; client education; and transportation and appointment scheduling assistance. These mandatory aspects of the EPSDT program can become especially complicated in managed care settings because responsibilities for the program may rest with a number of entities: federal, state, and county governments; managed care plans; third-party administrators; enrollment brokers; individual providers; and provider subcontractors. Unfortunately, the responsibility for assuring EPSDT is often not clearly defined in the managed care rules and contracts. /33/ As stated by HCFA's Office of Managed Care, "EPSDT is often not well integrated into Medicaid managed care programs." /34/ This is the most serious cause of EPSDT falling through the cracks in managed care.

There are other problems, as well. In a number of states, the full range of EPSDT services is not a mandatory part of the managed care contract. /35/ Thus, enrollees can be left by themselves to find providers for needed services. /36/ Similarly, some states' managed care contracts do not explicitly define the parameters of preventive care, particularly EPSDT. Providers, in turn, do not understand the extent of their obligations, and coverage decisions can vary from provider to provider. /37/ Managed care contracts can also fail to specify protocols for treatment and specialty referral, and overall quality-of-care and grievance standards.

Other problems arise when managed care plans do not have adequate numbers of participating primary and specialty care providers to meet the needs of children in a timely, appropriate manner. For instance, the plan may lack pediatric specialty providers who can make appropriate decisions on prior authorization requests for children's services. Or the plan may have an inadequate range of referral agreements with specialists. A preliminary analysis by the National Academy for State Health Policy has concluded that, in fact, few plans have made special efforts to assure the appropriate participation of pediatric specialists in their provider networks. /38/ Moreover, plans have failed to engage in needed care coordination to ensure that referral appointments to specialists are kept. /39/ Finally, there is often a failure to coordinate activities and responsibilities with other child-centered entities, such as early intervention, the Special Supplemental Food Program for Women, Infants, and Children (WIC), Healthy Start, and school-based programs. /40/

State capitation payment rates to Medicaid providers are also problematic. First, the rates are constrained by "upper payment limits" based on Medicaid fee-for-service rates, /41/ which have been historically low as compared with physicians' usual charges. Moreover, state capitation rates have failed to adjust for the increase in costs that would result from full implementation of EPSDT expansions mandated by the Omnibus Budget Reconciliation Act of 1989. /42/

States have also failed to implement adequate monitoring and tracking mechanisms to ensure that managed care contractors are delivering required preventive care and complying with EPSDT policies. /43/ A significant problem arises if capitated plans are not required to submit uniform, encounter-specific data regarding EPSDT services. /44/ The lack of such data obscures accurate

assessment of program effectiveness and leads to inaccurate summary data on the HCFA reporting forms. /45/

IV. Steps to Be Taken

It is important that child health advocates represent their clients in the development and implementation of Medicaid managed care. /46/ Clients can be represented in a number of ways. Copies of the standard and plan-specific contracts between the state and managed care plans should be reviewed for consistency with EPSDT. Audits and surveys of plans, disenrollment and utilization data, and any records of sanctions applied against plans should also be reviewed with respect to EPSDT. If necessary, advocates can assist clients with in-plan grievances and state fair hearings. Other complaints and requests for sanctions against plans should be recorded with the state Medicaid agency, the state's HMO licensing agency, and the HCFA Regional Office.

Regardless of the forum, client representation often will be centered upon relief designed to assure that contracts between the state and plans (and plan providers) clearly integrate the responsibilities for EPSDT and that plans are complying with these contract terms.

The HHS Office of Managed Care has, in fact, described the minimum provisions that should be included in state managed care contracts:

In order to formalize the designation of Medicaid managed care providers as the medical homes of their enrolled Medicaid beneficiaries under age 21, EPSDT requirements and expectations should be explicitly addressed in the provisions of State Medicaid contracts with managed care plans. These provisions should include, but not be limited to:

- Federally-defined EPSDT requirements.
- Additional services provided at State discretion.
- State periodicity schedules.
- EPSDT-specific payment policies, as appropriate.
- Data reporting requirements.
- Coordination of EPSDT with other State or local programs or initiatives, as appropriate.
- State-defined EPSDT performance standards, as appropriate.
- Inclusion of EPSDT performance as a topic of State periodic medical audits or external quality reviews, as appropriate. /47/

These requirements should be spelled out in the managed care contracts between the state and plans and in place before plans begin enrolling children and their families. /48/ Moreover, it should be

made clear that the state Medicaid agency will maintain legal responsibility for assuring that plans adhere to their contracts.

The following are specific recommendations for the different components of EPSDT. /49/

A. Outreach and Provision of Information

Contracts should specify the plan's and the state agency's respective responsibilities for conducting EPSDT outreach and information provision. /50/ Specifically, contracts should require managed care plans to conduct minimum EPSDT outreach activities within 60 days of enrollment and annually thereafter that include:

- providing information to each recipient in written form and face-to-face about the importance of and need for preventive care and EPSDT and how to access pediatric services and providers; /51/
- educating beneficiaries, orally and in writing, about the managed care plan and use of the gatekeeper; /52/
- providing of information to children and their families about services available in the plan and how to obtain out-of-plan services;
- offering recipients assistance in scheduling appointments and obtaining transportation prior to the date of each periodic examination;
- documenting declined services (but deeming rejection of a service as specific to the particular service so that outreach and education for other EPSDT services persists);
- keeping records of the efforts taken to assure that missed screens are corrected;
- targeting outreach to high-risk groups (e.g., pregnant women and adolescents, foster parents and children, first-time eligibles, and recipients who have not used services recently); and
- using written, oral, and other appropriate means to communicate in a manner that is culturally and linguistically appropriate for all enrollees, including those who do not speak or read English, who are hearing impaired, or who are blind.

B. Screening Services

Early and periodic screens are the foundation of the EPSDT program. By law, states must "provide or arrange for" four separate types of screens: medical, vision, hearing, and dental. /53/ To this end, managed care contracts should:

- delineate each screening requirement (e.g., screening components and periodicity schedules) and allocate responsibility for each requirement; /54/
- require an initial medical screen within 15 days after enrollment in the managed care plan; /55/
- specify a time period of 24 to 48 hours for urgent screening visits;
- provide for comprehensive screens for children in out-of-home placement within 30 days after enrollment; /56/
- specify separate periodicity schedules for medical screens and for vision, hearing, and dental screens (and necessary follow-up if a screen cannot be completed in a single visit);
- specify the immunization schedule in accordance with the Centers for Disease Control's Advisory Committee on Immunization Practices; /57/
- specify for adolescents a separate screening schedule that includes screening for sexually transmitted diseases, pap smears, and pelvic examinations for sexually active teens;
- carry out health education activities and anticipatory guidance according to standards of recognized medical and dental organizations;
- adopt U.S. Preventive Services Task Force health education recommendations specific to age, gender, and health status of patients;
- specifically target adolescents, pregnant adolescents, and high-risk children and families (e.g., children at risk for lead poisoning, children with chronic conditions) for health education;
- provide clear standards that comply with federal EPSDT requirements for interperiodic screens; /58/
- prohibit plans from imposing prior authorization on either periodic or interperiodic screens; and
- require plans making referrals for screening components to conduct follow-up, assure the timely receipt of services, and maintain health records for all screening components (e.g., dental or blood-lead screens).

C. Diagnosis and Treatment

EPSDT covers "necessary diagnostic and treatment services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screen" if they are among those listed in 42 U.S.C. Sec. 1396d(a), "whether or not such services are covered under the State [Medicaid] plan." /59/ This definition of medical necessity assures children of a broad range of treatment services. /60/ To ensure that plans comply with EPSDT diagnostic and treatment

requirements, the state agency should list all of the services listed under 42 U.S.C. Sec. 1396d(a) in the contract, specifying:

- services that the plans are expected to provide and for which the plan is expected to pay and
- services for which the state maintains responsibility, and the state's and the managed care plan's respective responsibilities to assist children in obtaining access to and to maintain health records of those services.

The contract should also specify that plans must adopt the EPSDT definition of medical necessity to cover services needed to correct or ameliorate illnesses and conditions and/or have a preventive, therapeutic, or remedial outcome in children. /61/ Plans should be prohibited from imposing arbitrary, absolute-amount, duration and scope limitations (e.g., eight physical therapy visits per year or rehabilitation only to the extent that significant improvement can be shown). Finally, the contract should articulate reasonable and timely (e.g., within 10 days, or less if urgent or an emergency) prior authorization mechanisms to obtain needed services beyond "tentative" amount, duration, and scope limitations.

D. Case Management

Case management is a mandatory EPSDT service that includes informing individuals of EPSDT and providing appointment and transportation assistance. /62/ When medically necessary, case management includes services that will assist individuals in gaining access to needed medical, social, educational, and other services. /63/ To ensure that children in managed care have access to "proactive" case management, contracts should specify that the plan is responsible for assisting a child in obtaining access to any needed medical, educational, social, or other service. The plan's responsibility for ensuring access should include performing activities such as making referrals, monitoring, maintaining medical records, and making appointments. /64/ Where plans have contracted to provide more limited case management, the contract should specify that the plan must make referrals to appropriate case managers, whom the state is responsible for reimbursing and monitoring separately.

E. Transportation

EPSDT entitles children to nonemergency transportation services necessary to obtain primary and preventive care and treatment. /65/ Transportation assistance can be particularly important to children because, under Medicaid, it includes "related travel expenses," such as the cost of meals and lodging en route to and from care and the cost of an attendant to accompany the recipient, if necessary. /66/

The state agency must ensure that children enrolled in managed care have access to nonemergency transportation services. To accomplish this, contracts should

- require plans either themselves or through an agreement with another provider (such as the local Maternal and Child Health program) to provide nonemergency transportation (merely making a referral would not be sufficient to comply with the contractual obligation) and

- reflect transportation (and other related expenses) in the plans' capitated rates.

- In the case of plans that exclude nonemergency transportation services in their contracts, the contract should outline protocols that the plan must follow to make referrals to a Medicaid-enrolled transportation provider and follow-up to ensure that transportation is provided.

F. Emergency Services

Emergency services are mandatory under the Medicaid program for both children and adults. /67/ Where managed care plans contract to provide emergency services, federal law requires all contracts, at a minimum, to specify that emergency services will be provided

- 24 hours a day and seven days a week;

- when services are needed immediately because of an injury or sudden illness; and

- if the time to reach the plan's (or subcontractor's) facilities would risk permanent damage to the recipient's health. /68/

G. Coordination with Other Child-Oriented Programs

States must coordinate with other programs in the provision of EPSDT services. /69/ In particular, EPSDT services are to be coordinated with state vocational rehabilitation agencies; Title V grantees; other public health, mental health, and education programs (including the Individuals with Disabilities Education Act); Head Start; social service programs under Title XX; housing programs; and WIC. /70/ In addition, EPSDT should be integrated with school-based health services, which increasingly have become a means to improve access to health care for school-aged children. /71/

It is important that coordination with child-oriented programs continue within managed care. The effectiveness and financial viability of these various programs may suffer if, through design or confusion, they are cut off from Medicaid recipients and reimbursement. Thus, the state agency should

- require plans to make referrals to WIC and Title V and, in the case of early intervention programs, participate in "Child Find" /72/ as part of their case-management responsibilities; /73/

- in the case of children who would be made ineligible for managed care by qualifying for special programs, allow the children and families to remain in managed care if they so choose for primary and preventive services (and for services not pertaining to a child's disability);

- have procedures delineated in the contract for disenrollment for special programs;

- establish payment procedures and amounts for Medicaid-reimbursable services provided by other agencies (e.g., evaluation and assessments for children in part B and part H of the Individuals with Disabilities Education Act). /74/

- require plans to subcontract with school-based health providers and require payment for those services; /75/

- require school clinics to counsel and inform recipients that medical records will be forwarded to their health plans;

- require that medical records be kept confidential, except with the express permission of the patient (in the case of adolescents); and

- have plan hours of operation that are convenient for adolescents.

H. Family Planning

Family planning services and supplies are mandatory under Medicaid, even though federal law grants states discretion to define the scope of family planning services. /76/ Recipients have the right to select the provider of their choice for family planning services, whether or not enrolled in a managed care plan and whether or not the state has obtained a freedom-of-choice waiver. /77/ Thus, the state agency should

- require plans to notify members, upon enrollment and annually thereafter, that they can access family planning services either from within or outside of the plan;

- notify members orally and in writing of the family planning services offered by the plan;

- exclude family planning from the capitated rate and pay for these services on a fee-for-service basis;

- require plans to pay family planning clinics directly or specify that the state agency will continue directly to reimburse clinics on a fee-for-service basis;

- require family planning clinics and managed care plans to coordinate the use of medical records in order to give records a medical home;

- require that family planning clinics counsel and inform recipients that medical records will be forwarded to their health plans; and

- impose confidentiality protections on medical records and restrict plan use of these records to billing and treatment.

I. Data Reporting

The Medicaid Act requires reporting of EPSDT eligibility and utilization. /78/ Because managed care plans are paid on a capitated, rather than claim, basis, reporting of recipients' health care encounters is at risk of being lost in managed care. To avoid this, managed care contracts should:

- require plans to report uniform, encounter-specific data, by the gender and race/ethnicity of the recipient;
- require plans to report data in a way consistent with the HCFA-416 form;
- prohibit plans from reporting a child as having received an EPSDT screen if the medical visit has not, in fact, included the comprehensive screen required by EPSDT law; /79/ and
- require "continuing care providers" -- providers that have signed an agreement with the state promising to ensure that children enrolled with them receive the full range of EPSDT services -- also to report on EPSDT screens. /80/

J. Provider Participation

The Medicaid Act requires that Medicaid payments be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." /81/ The Act specifically requires adequate reimbursement to assure pediatric and obstetrical provider participation. /82/ Furthermore, pediatric and family nurse practitioners and nurse midwives must also be included as Medicaid providers. /83/ Arguably, these requirements continue under a managed care system. /84/

Any plan that cannot demonstrate access to appropriate pediatric and obstetric providers should not be awarded a managed care contract. Primary care providers must be able to perform gatekeeping and case-management activities effectively and treat children (including children with chronic illnesses) and high-risk adolescents and pregnant women. All plans also should have pediatric specialists (e.g., pediatric cardiologists) in their networks.

To assure adequate provider participation, states should require all plans to

- provide quarterly reporting to the state and enrollees showing the number, location, and current availability of pediatric and obstetrical providers contracting and subcontracting with the plan; /85/
- assign children to gatekeepers who are either pediatric providers or family or general practitioners demonstrating significant pediatric training and experience (e.g., 50 percent of the provider's current practice); /86/

- designate pediatricians as primary care providers;
- demonstrate their capacity to provide the full range of EPSDT services by having the appropriate pediatric specialists in their network;
- assign women recipients who so request to gatekeepers who are gynecological providers or providers with significant gynecological training and experience;
- demonstrate their capacity to provide gynecological, prenatal, and obstetric services to high-risk adolescents, women, and pregnant women with the appropriate providers in their network;
- automatically assign high-risk pregnant women to obstetricians for case management; and
- allow beneficiaries to change providers, without cause, within the plan.

K. Monitoring Quality and Access

Quality of care and access are the essential ingredients of successful managed care. States should

- require plans to use HCFA's "A Health Care Quality Improvement System for Medicaid Managed Care" to conduct internal quality review; /87/
- require all managed care plans to meet the accreditation Standards of the National Committee for Quality Assurance; /88/
- conduct annual medical audits as required by federal law; /89/
- require annual independent external review of the quality of services provided by managed care plans;
- collect data and information on the ownership and control of contracting managed care plans, on licensure actions taken against providers within plan networks, and on submission of claims by all physicians participating in managed care plans;
- notify HCFA whenever a plan or a plan's provider is sanctioned under the state's Medicaid program;
- require plans to collect race-based data and information "sufficient to permit effective enforcement of Title VI;" /90/
- report to HCFA any plan failing substantially to provide medically necessary services, imposing illegal premiums on enrollees, discriminating in enrollment, disenrollment, or reenrollment, misrepresenting or falsifying information during marketing, or failing to comply with requirements related to physician incentive plans;

- require plans to implement corrective action where deficiencies are found;

- sanction plans that fail to correct deficiencies or that exhibit a pattern or practice of deficiencies;

- require plans to publish information on the health status of child enrollees, including "input" measures (e.g., comprehensive medical screening rates, immunization rates) and "output" measures (e.g., childhood disease outbreaks, pediatric asthma and other ambulatory-sensitive hospital admissions, accidental poisoning rates, teen pregnancy rates); /91/ and

- require plans to show "measured improvement" in the health status of children as a condition of participation in the state's managed care program.

L. Due Process

Due process requires an adequate prior notice and an impartial fair hearing before the state agency for "any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." /92/ Recipients also must be notified of their right to "aid paid pending;" that is, where there are reductions or terminations in services, the right to continue receiving services as long as the request is made not more than ten days after the date of action. /93/ In addition, if the hearing involves medical issues, and if the hearing officer considers it necessary to have a medical assessment other than that involved in the original decision, a medical assessment must be obtained at agency expense and made part of the record. /94/ Significantly, these rights to a fair, impartial hearing apply to managed care. /95/

Moreover, grievance procedures that are administered by plans cannot substitute for fair hearings, and recipients should not be required to exhaust such grievance procedures before obtaining a fair hearing before the state. /96/ Federal law requires that all contracts between state Medicaid agencies and managed care plans provide for internal grievance procedures that (1) are approved in writing by the state agency; (2) provide for prompt resolution; and (3) assure the participation of individuals with authority to require corrective action. /97/ In addition, state Medicaid agencies must have procedures to ensure the proper implementation of such grievance procedures. /98/

To assure due process rights, managed care contracts should specify

- that plans must notify the recipient of any denial, reduction, or termination of services, including by the treating physician or primary care provider;

- that plans notify recipients of their right to a state fair hearing, without exhaustion of internal grievance procedures, and how to request such a hearing;

- that the plan and/or the state inform the recipient of any rights to obtain second opinions;

- that plans inform recipients of the right to aid paid pending;

- that plans inform recipients of their right to file a grievance and give the recipient the phone number and name of the person(s) responsible for receiving and logging such complaints;

- that plans record and report every complaint (including those made orally) and indicate the date, the names of the persons making and receiving the complaints, and the resolution of such complaints; and

- that all information be given in a language understandable to the recipient.

V. Conclusion

Child health can be protected and assured in the managed care setting. However, it is crucial that managed care plans know what they are getting into when they agree to enroll Medicaid recipients. In the coming months, the National Health Law Program will make available additional resources for use in the representation of child and managed care clients. /99/

Footnotes

/1/ U.S. Dep't of Health and Human Servs., Press Release (Dec. 9, 1994). This represents a 62.5-percent jump from the year before. Id. The states with the largest Medicaid managed care programs are California, Massachusetts, Arizona, Michigan, Florida, Kentucky, Maryland, Pennsylvania, New York, Ohio, Colorado, Illinois, and Wisconsin. Deborah Freund, An Overview of Medicaid Managed Care: 1982 to 1993 and Beyond, Presentation at Medicaid Managed Care Conference, Scottsdale, Arizona (Sept. 27, 1994).

/2/ Kaiser Comm'n on the Future of Medicaid, Medicaid and Managed Care: Lessons from the Literature (forthcoming).

/3/ Mark Merliss, Medicaid Source Book: Background Data and Analysis app. G at 7 (Nov. 16, 1992).

/4/ Medicaid Managed Care Options Have Mixed Results, Says Rand Study, 46 Medicine & Health 2 (Nov. 16, 1992) (Rand study concluded that Florida, which attracted sicker recipients, cut expenditures, while New York, with healthier enrollees, spent more than it would had it maintained fee-for-service).

/5/ U.S. General Accounting Office, Medicaid: States Turn to Managed Care to Improve Access and Control Costs 23 -- 26 (Mar. l993) (GAO/HRD-93-46).

/6/ 42 U.S.C. Sec. 1396n(b).

/7/ Id.; 42 C.F.R. Secs. 431.55 and 434.1 et seq.

/8/ Office of Managed Care, U.S. Dep't of Health & Human Servs., Waiver Directory (July l994).

/9/ 42 U.S.C. Sec. 1315 (section 1115 of the Social Security Act). Six states have obtained section 1115 waivers: Arizona, Florida, Hawaii, Oregon, Rhode Island, and Tennessee. South Carolina's Palmetto Health Initiative was conditionally approved by HHS in November 1994. Applications are pending from Delaware, Georgia, Illinois, Massachusetts, Minnesota, Missouri, New Hampshire, and Ohio. States such as Kansas, Louisiana, Nebraska, New Jersey, New York, Oklahoma, Texas, Utah, Vermont, and Washington are developing waivers. For a more thorough discussion, see Jane Perkins & Michele Melden, Section 1115 Medicaid Waivers: An Advocate's Primer (Oct. 1994); National Health Law Program (NHeLP), Biweekly Updates on Medicaid 1115 (available on HandsNet and from NHeLP).

/10/ 42 U.S.C. Sec. 1396b(m) (requiring at least 25-percent nonpublic assistance enrollees). For a more thorough discussion of section 1915(b), see Michael Parks, An Advocate's Guide to Medicaid Case Management Systems (Dec. 1988).

/11/ 42 U.S.C. Sec. 1396a(r)(2) (Social Security Act Sec. 1902(r)(2)). E.g., Vermont has used the option to extend coverage to all children under age 18 up to 255 percent of the federal poverty level.

/12/ E.g., the state might choose to cover all persons with incomes under 100 percent of the federal poverty level. Children with family incomes exceeding this level would not qualify for Medicaid.

/13/ See 42 U.S.C. Secs. 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). Notably, one state, Oregon, has obtained a waiver of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements as part of its section 1115 project. Florida has obtained a waiver of EPSDT for expansion populations but will continue EPSDT for "traditional" Medicaid recipients, and New Hampshire seeks to do the same. Meanwhile, Minnesota seeks to waive EPSDT outreach and information provision requirements so that it can blend EPSDT with provision of information about managed care. In National Ass'n of Community Health Centers v. Shalala, No. 1:94CV01238 (D.D.C. filed June 6, 1994) (Clearinghouse No. 50,038), amici curiae, represented by NHeLP and the Mental Health Legal Advisors Committee, argue that EPSDT is part of the "common law" of the Medicaid program that cannot be waived under section 1115.

/14/ 42 U.S.C. Sec. 1396d(r). For a more thorough discussion of EPSDT rules, see Jane Perkins, An Advocate's Medicaid EPSDT Reference Manual (Nov. 1993).

/15/ 42 U.S.C. Sec. 1396d(r).

/16/ 42 U.S.C. Sec. 1396a(a)(43).

/17/ H.R. Rep. No. 101-M, 101st Cong., 1st Sess. 70 (1989).

/18/ Schlenker & Fessler, Measles in Milwaukee, Wis. Med. J., July 1990, at 403, 405.

/19/ Michele Melden, NHeLP, and Michael Keys, San Francisco Neighborhood Legal Services, Testimony Before the U.S. House of Representatives Subcommittee on Health and the Environment (Apr. 20, 1993).

/20/ Stan Dorn and Jane Perkins, NHeLP, Testimony Before the Physician Payment Review Commission 6 (Nov. 21, 1994).

/21/ Interview with Michele Melden, NHeLP (Dec. 5, 1994) (discussing a Nov. 1994 request for assistance).

/22/ But see U.S. General Accounting Office, Medicaid: States Turn to Managed Care to Improve Access and Control Costs 29 -- 42 (Mar. l993) (GAO/HRD-93-46) (discussing the limitations and inexact nature of selected managed care studies).

/23/ Neil I. Goldfarb et al., Impact of a Mandatory Medicaid Case Management Program on Prenatal Care and Birth Outcomes, 29 Med. Care 64 (Jan. 1991).

/24/ IG Questions PA Medicaid Plan's High Profits, 46 Medicine & Health 1 (Feb. 17, 1992) (Office of Inspector General describes HealthPASS as a "cash cow").

/25/ Goldfarb, supra note 23 (39 percent had inadequate access, exceeding the national rate of inadequate access for Medicaid beneficiaries of 30 percent).

/26/ Id.

/27/ U.S. General Accounting Office, HealthPASS: An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (May 1993) (GAO-HRD-93-67).

/28/ HealthPro, State of Minnesota Prepaid Health Plan's Review of Quality Health Care (Feb. 15, 1992).

/29/ Jean L. Buchanan et al., HMOs for Medicaid: The Road to Financial Independence is Often Poorly Paved, 17 J. Health Pol., Pol'y & L. 71 (Spring 1992). See also U.S. General Accounting Office, Medicaid Prenatal Care: States Improve Access and Enhance Servs., But Face New Challenges (May 1994) (GAO/HEHS-94-152BR) (if states want to improve infant heath, they must focus on making managed care plans accountable for improving the health of enrolled population); U.S. General Accounting Office, Medicaid: Oversight of Health Maintenance Organization in the Chicago Area (Aug. 1990) (GAO/HRD-90-81) (discussing failure of state oversight). See also, e.g., U.S. Dep't of Health & Human Servs., Office of Inspector General, Concerns Pertaining to Safeguards over Medicaid Managed Care Program, reprinted in [New Developments] Medicare & Medicaid Guide (CCH) Para. 41,752 (Aug. 1993) (report on state monitoring of plan solvency); U.S. Dep't of Health & Human Servs., Office of Inspector General, Quality Assurance in Medicaid HMOs (Draft Report), reprinted in [New Developments] Medicare & Medicaid Guide (CCH) Para. 40,082 (Mar. 1992) (25-state review concluding that state quality assurance relies too heavily on HMO self-reporting and self-assessment); U.S. Dep't of Health & Human Servs., Health Care Fin. Admin., Review of California's Administration of Its Managed Care Program 39 -- 48 (1993)

(criticizing failure to ensure that children are provided preventive care). See also Legal Aid Soc'y of Dayton et al., With Their Eyes Closed -- The State of Ohio's Monitoring of the Mandatory Medicaid HMO Program in Montgomery County, Ohio 5 -- 6 (Mar. 1992). The three HMOs in the Medicaid Dayton Area Health Plan used different methodologies to compute EPSDT utilization, resulting in data that could not be compared. The HMOs also overreported well-child checkups. Id.

/30/ Deborah Freund & Eugene Lewitt, Managed Care for Children and Pregnant Women: Promises and Pitfalls, in The Future of Children 92, 93 -- 95 (1993).

/31/ Id.

/32/ Dana Hughes, Children Now, Testimony Before the Subcommittee on Health and the Environment House Committee on Energy and Commerce Regarding Medicaid Managed Care: The California Proposal (Apr. 20, 1993).

/33/ E.g. Health Care Fin. Admin., Region IX Review of California's Administration of Its Medicaid Managed Care Program (1993).

/34/ U.S. Dep't of Health & Human Servs., Office of Managed Care, Integrating EPSDT and Medicaid Managed Care -- Strategies for States and Plans 8 (discussion draft July 13, 1994) ("State Medicaid managed care contracts do not always clearly identify EPSDT expectations and responsibilities, and do not always facilitate the integration of EPSDT with general Medicaid benefit packages.").

/35/ Jane Perkins, Presentation to Children First, Tallahassee, Fla. (Feb. 5, 1993) (available from NHeLP) (noting experiences of NHeLP with managed care contract review); National Academy for State Health Policy, Preliminary Analysis of Issues and Options in Serving Children with Chronic Conditions Through Medicaid Managed Care Plans 3 (Summer 1994) (Medicaid HMOs often do not contract to provide the full range of regular Medicaid or expanded EPSDT benefits).

/36/ This problem can arise during the EPSDT screening when, for example, the managed care plan does not provide lead-blood-level assessments. It can also arise during treatment when the plan does not cover the range of services needed by the recipient.

/37/ See U.S. Dep't of Health & Human Servs., Office of Managed Care, Integrating EPSDT and Medicaid Managed Care -- Strategies for States and Plans 8 (discussion draft July 13, 1994).

/38/ National Academy of State Health Policy, supra note 35 at 3 (noting cardiology as an exception). See also Jenifer D.C. Cartland & Beth K. Yudkowsky, Barriers to Pediatric Referral in Managed Care Systems, 89 Pediatrics 183 (Feb. 1992).

/39/ Id.

/40/ Id. at 4.

/41/ 42 C.F.R. Sec. 447.361 -- .362.

/42/ See 42 U.S.C. Sec. 1396d(r)(5); U.S. Dep't of Health & Human Servs., Office of Managed Care, Integrating EPSDT and Medicaid Managed Care -- Strategies for States and Plans 8 (discussion draft July 13, 1994).

/43/ Id. See also supra note 29.

/44/ Federally and state-qualified HMOs are required to maintain patient-encounter data. 42 U.S.C. Sec. 1396b(m)(2)(A)(xi). However, most states do not use such entities to deliver care; rather, they use less-regulated prepaid health plans and primary care case management systems.

/45/ E.g. HCFA-Form 416 (EPSDT) and HCFA-Form 2082 (eligibles, services, payments).

/46/ The advocacy described in this article should be undertaken to be consistent with 45 C.F.R. pt. 1612.

/47/ U.S. Dep't of Health & Human Servs., Office of Managed Care, Integrating EPSDT and Medicaid Managed Care -- Strategies for States and Plans 9 -- 14 (discussion draft July 13, 1994). For additional discussion of the provisions needed to integrate EPSDT and managed care, see Jane Perkins & Michele Melden, Potential Medicaid Managed Care Protections and Enforcement (May 17, 1993); Ass'n of Maternal & Child Health Programs, Managed Care for Women, Children, Adolescents & Their Families: Concerns and Recommendations for Assuring Improved Health Outcomes and Roles for State MCH Programs (Mar. 1993); Children's Defense Fund, Testimony Before the Senate Subcommittee on Health for Families and the Uninsured, Finance Committee -- Medicaid Managed Care (Apr. 10, 1992).

/48/ U.S. General Accounting Office, Medicaid: States Turn to Managed Care to Improve Access and Control Costs 23 (Mar. 1993) (GAO/HRD-93-46) (discussing problems with improper planning for managed care).

/49/ For a more extensive discussion of EPSDT, see Jane Perkins, An Advocate's Medicaid EPSDT Reference Manual (Nov. 1993).

/50/ 42 U.S.C. Sec. 1396a(a)(43); 42 C.F.R. Sec. 441.56; Health Care Fin. Admin., State Medicaid Manual Secs. 5010 et seq. See also 58 Fed. Reg. 51288 (Oct. 1, 1993) (proposed EPSDT regulations).

/51/ Some plans engage in some exemplary outreach and information provision activities. Minnesota-based Medica Foundation is a nonprofit HMO that conducts ongoing consumer satisfaction surveys of its Medicaid enrollees and holds separate focus group discussions with white, African American, and Vietnamese Medica members. Interview with Connie Brown, Medica Foundation (Dec. 6, 1994).

/52/ U.S. General Accounting Office, Medicaid: States Turn to Managed Care to Improve Access and Control Costs 27 (Mar. 1993) (GAO/HRD-93-46) (describing importance and nature of six states' beneficiary education programs).

/53/ 42 U.S.C. Sec. 1396d(r). See, e.g., Health Care Fin. Admin., State Medicaid Manual Secs. 5123 et seq.; 58 Fed. Reg. 51288, 51296 (Oct. 1, 1993) (proposing amended 42 C.F.R. Sec. 441.57).

/54/ See 42 U.S.C. Sec. 1396d(r).

/55/ Beginning in December 1994, every new Medicaid enrollee in the Minnesota-based Medica Foundation is questioned about such things as primary care use, pregnancy, breathing difficulties, and immunization. A Health Profiles Coordinator is to follow up with persons who need care management to direct and coordinate appropriate preventive care. Interview with Connie Brown, Medica Foundation (Dec. 6, 1994).

/56/ See West Virginia Dep't of Health & Human Resources' Plan to Ensure All Children in the Temporary or Permanent Legal Custody of the Department Who Are Medicaid Eligible Receive Full Early and Periodic Screening, Diagnosis and Treatment Services (Oct. 21, 1994). This plan was drafted to comply with the court's order in Sanders v. Lewis, No. 2:92-0353 (W.D. W. Va. Aug. 16, 1993) (Clearinghouse No. 48,638).

/57/ See 42 U.S.C. Secs. 1396a(a)(62), 1396d(r)(1)(B)(iii), and 1396s(e).

/58/ Proposed regulations would deem "any encounter with a health professional . . . [to] be considered . . . a screen and any ensuing medically necessary health care, diagnosis, and treatment would be considered to have been discovered by a screen." 58 Fed. Reg. 51288, 51291 (Oct. 1, 1993). Any person (such as an educator, parent, or health professional) who suspects a problem can refer a child for an EPSDT screen. See 42 U.S.C. Sec. 1396d(r) and Health Care Fin. Admin., State Medicaid Manual Sec. 5140(B) (July 1990).

/59/ 42 U.S.C. Sec. 1396d(r)(5).

/60/ See 42 U.S.C. Sec. 1396d(a).

/61/ 42 U.S.C. Sec. 1396d(r)(5). Otherwise, the managed care plan may apply its own medical necessity limits and protocols, which may be more restrictive than those allowed by the Medicaid Act.

/62/ See, e.g., Health Care Fin. Admin., State Medicaid Manual Secs. 4302, 5310(D).

/63/ 42 U.S.C. Secs. 1396d(r)(5), 1396d(a)(19), 1396n(g)(2).

/64/ Id. See also Health Care Fin. Admin., State Medicaid Manual Sec. 5310(D).

/65/ See 42 U.S.C. Sec. 1396d(a)(25) (listing any other medical or remedial care recognized under state law and specified by the Secretary of HHS as a Medicaid-reimbursable service); 42 C.F.R. Sec. 440.170 (specifying transportation services that are necessary to secure medical examinations and treatment); Health Care Fin. Admin., State Medicaid Manual Sec. 5150 (requiring the state

agency to offer both transportation and scheduling assistance prior to each due date of a child's periodic examination).

/66/ 42 C.F.R. Sec. 440.170(a).

/67/ 42 U.S.C. Sec. 1396d(a)(25); 42 C.F.R. Sec. 440.170(e) (defining emergency services as "services that are necessary to prevent the death or serious impairment of the health of a recipient").

/68/ 42 C.F.R. Sec. 434.40 (applying standards to both federally qualified health maintenance organization (FQHMO) and Prepaid Health Plan (PHP) contracts and further requiring FQHMO and PHP contracts to specify that either the managed care plan or the state will provide reimbursement for medically necessary emergency services furnished by nonplan providers); 42 U.S.C. Sec. 1396b(m)(2)(A)(vii) (requiring that state and federally qualified HMO contracts specify that either the plan or the state agency will provide reimbursement for emergency services).

/69/ See 42 C.F.R. Sec. 441.61. These regulations were not changed by proposed EPSDT regulations, 58 Fed. Reg. 51288 (Oct. 1, 1993). See also Health Care Fin. Admin., State Medicaid Manual Sec. 5230; 42 U.S.C. Sec. 1396a(a)(11) (coordination with Title V) and Sec.1396a(a)(53) (coordination with the Special Supplemental Food Program for Women, Infants, and Children).

/70/ Health Care Fin. Admin., State Medicaid Manual Sec. 5230.

/71/ John J. Schlitt et al., State Initiatives to Support School-Based Health Centers: A National Survey (Oct. 1994).

/72/ "Child Find" is the Early Intervention Program's outreach and referral system, which requires coordination with EPSDT. 20 C.F.R. Sec. 1476(b)(5); 34 C.F.R. Sec. 303.321.

/73/ Plan providers should be trained to identify and refer children to the appropriate agencies.

/74/ 42 U.S.C. Sec. 1396b(c) requires that Medicaid pay for Medicaid-reimbursable services included in a Medicaid-enrolled child's treatment plan developed under part B or part H of the Individuals with Disabilities Education Act.

/75/ If there is no contract, then the state agency should establish a formal agreement with school-health providers to conduct surveys of recipients seeking out-of-plan services. This can serve to monitor access and quality of managed care plans.

/76/ 42 U.S.C. Sec. 1396d(a)(4)(C); 42 C.F.R. Secs. 440.40(c), 441.20; Health Care Fin. Admin., State Medicaid Manual Secs. 2088.5, 4270.

/77/ 42 U.S.C. Sec. 1396a(a)(23); 42 C.F.R. Sec. 431.51(a)(3); Health Care Fin. Admin., State Medicaid Manual Sec. 2088.5.

/78/ 42 U.S.C. Secs. 1396a(a)(43)(D), 1396d(r)(5); Health Care Fin. Admin., State Medicaid Manual Secs. 2700.4, 5320,, 5360.

/79/ E.g., if a lead-blood test is not administered by the plan, then the plan has not completed a periodic screen. A referral for the lead-blood test is insufficient, unless the plan has documentation ensuring that the screening component was actually completed. See Health Care Fin. Admin., State Medicaid Manual Sec. 5360(D).

/80/ 42 C.F.R. Sec. 441.60; Health Care Fin. Admin., State Medicaid Manual Sec. 5240. Unless a managed care plan has signed a separate agreement with the state designating the plan a continuing care provider, the plan must follow the same EPSDT reporting procedures as any other provider. Id. Until October 1990, HCFA had been deeming children enrolled with continuing care providers as screened. Recognizing the shortcomings of this assumption, HCFA now requires states to show separately the number of children enrolled with continuing care providers on the HCFA-416 form. Health Care Fin. Admin., State Medicaid Manual Sec. 2700.4, l. 16. These children may not be included in the total number of children receiving initial and periodic screens unless documentation is available to show that full and complete screens were provided. Health Care Fin. Admin., State Medicaid Manual Sec. 2700.4 ll. 7, 10, and 16. See also 58 Fed. Reg. 51288, 51292 -- 3 (Oct. 1, 1993) (proposing 42 C.F.R. Sec. 441.60 strengthening states' obligation to ensure that continuing care providers are providing EPSDT services, but still not imposing any obligation on states to obtain any particular reporting data from these providers).

/81/ 42 U.S.C. Sec. 1396a(a)(30)(A).

/82/ 42 U.S.C. Sec. 1396r-7.

/83/ 42 U.S.C. Sec. 1396d(a)(21); Health Care Fin. Admin., State Medicaid Manual Sec. 4415.

/84/ See, e.g., K. v. Dillenberg, 836 F. Supp. 694 (D. Ariz. 1993) (Clearinghouse No. 49,988) (holding that a Medicaid managed care plan provider of mental health services to children was carrying out "state action," and therefore subject to the same due process requirements). See also Clark v. Belshe, 1994 WL 720217 (E.D. Cal. modified order filed Dec. 14, 1994), in which the court refused to modify an order issued pursuant to Clark v. Kizer, 758 F. Supp. 572 (E.D. Cal. 1990) (Clearinghouse No. 43,105), requiring the state to comply with federal equal access, comparability of services, timeliness, and statewideness in the provision of dental services for a class of fee-for-service dental care Medicaid recipients. The state sought a modification to allow it to require members of the protected class to enroll in dental managed care plans. The court refused the modification where the state offered no reliable evidence showing that the proposed plan would meet requirements under federal law and under the court's order.

/85/ This will allow the state to measure beneficiary access directly rather than through proxy measures that, e.g., assess provider and recipient satisfaction with the plan.

/86/ Some states, such as Kentucky, are considering allowing specialty care providers to be gatekeepers for SSI-linked disabled children who have chronic, ongoing medical needs.

/87/ Health Care Fin. Admin., A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for Status (July 6, 1993).

/88/ National Comm. for Quality Assurance, Standards for the Accreditation of Managed Care Organizations (1994).

/89/ 42 C.F.R. Sec. 434.53.

/90/ 28 C.F.R. Sec. 42.406(a). But see Madison-Hughes v. Shalala, No. 3:93-0048 (M.D. Tenn. Sept. 19, 1994) (Clearinghouse No. 49,119) (no subject matter jurisdiction to review HHS's discretion over data collection).

/91/ All children enrolled in the plan during the reporting period should be included. Currently, some managed care plans are using "report cards" that, e.g., show immunization rates only for those children enrolled for two or more years. This can exclude large numbers of Medicaid children from the calculation due to the high turnover rate in eligibility.

/92/ The hearing right can arise, e.g., when there is a denial, termination, or reduction in service, a delay, or a failure to process a disenrollment.

/93/ 42 C.F.R. Secs. 431.230 -- .231. If the recipient loses, the state can recoup costs. Id.

/94/ Id. Sec. 431.240(b).

/95/ See Dillenberg, 836 F. Supp. 694.

/96/ See, e.g., Schweiker v. McClure, 456 U.S. 188, 196 -- 99 (1982) (Clearinghouse No. 26,303) (impartial hearing officer necessary prerequisite to due process rights); Isaacs v. Bowen, 865 F.2d 468 (2d Cir. 1989) (Clearinghouse No. 43,930) (delay caused by Medicare Part B appeals procedure does not violate due process as long as the appeals procedure is consistent with due process).

/97/ 42 C.F.R. Sec. 434.32.

/98/ Id. Sec. 434.63(b).

/99/ In particular, NHeLP will publish a Medicaid managed care guide. An Advocate's Guide to Medi-Cal Managed Care for California is now available. In addition, along with Texas Rural Legal Aid, NHeLP will publish a comprehensive guide to children's preventive care services.