Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID MANAGED CARE AND EPSDT

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

This inspection examines the extent to which Medicaid managed care providers deliver Early and Periodic, Diagnostic, Screening and Treatment (EPSDT) to Medicaid children.

BACKGROUND

Under EPSDT, State Medicaid agencies must provide eligible children services that include comprehensive, periodic health assessments beginning at birth and continuing through age 20. All medically appropriate immunizations are required. Age appropriate assessments must be provided at intervals following defined periodicity schedules.

State Medicaid agencies have turned to managed care to rein in escalating health care costs, difficult to do in a fee-for-service environment, while ensuring health care access for Medicaid enrollees. Medicaid managed care has grown exponentially. Between 1983 and 1995, Medicaid managed care enrollment increased from 750,000 to 9.8 million and now includes over 400 managed care plans.

FINDINGS

Fewer than one in three Medicaid children enrolled in managed care plans receive timely EPSDT services. Six of ten receive none at all.

Based on our review, we estimate that only 28 percent of Medicaid managed care children receive all of the EPSDT screens called for by the periodicity schedule used in their State. Sixty percent of Medicaid managed care children do not receive any EPSDT services called for in the States' periodicity schedules. Older adolescents receive significantly fewer required EPSDT services than other children. We find no significant differences in EPSDT performance between health maintenance organizations and primary care case management plans, or between large or small managed care plans. We find there is no difference in EPSDT performance if a break in managed care enrollment occurred.

Most of the visits Medicaid children make to managed care plans are sick visits. In our review of medical records, when children made sick visits to managed care providers, only the symptoms that generated the sick visit were treated, with very few exceptions. There were few visits treating conditions discovered as a result of a previous EPSDT screen.

Children receive significantly more EPSDT services from Medicaid managed care plans when states inform the managed care plans which children are due for EPSDT.

A comparison of the EPSDT results in Michigan and Nevada to the others in our sample

shows that there is a very strong statistical difference in managed care plan performance. These States identify children currently due for EPSDT screens to their managed care plans and closely monitor EPSDT performance by managed care plans for these children. In our sample, 54 percent of the Medicaid children enrolled in these plans received all of their EPSDT services compared to 19 percent of those enrolled in other managed care plans.

RECOMMENDATIONS

The Health Care Financing Administration should revise their EPSDT reporting requirements and data collection to emphasize the number of children who receive all of their EPSDT screens in a timely fashion.

Current EPSDT reporting methods obscure the low EPSDT rates we found, especially for adolescents. The Health Care Financing Administration (HCFA) should revise their EPSDT data collection so States identify children of different ages who receive all of the required EPSDT screens. The HCFA and the States should monitor the age groups to determine where progress is being made and where additional efforts are required. This revision will improve EPSDT data collection for both fee-for-service and managed care programs.

The Health Care Financing Administration should encourage States to actively notify managed care plans of enrollees due for EPSDT exams and to follow up if EPSDT services are not rendered shortly thereafter.

Our study dramatically demonstrates the value added to EPSDT performance when States continue to track and monitor plan performance at the individual patient level.

The Health Care Financing Administration should work with States to ensure timely managed care EPSDT reporting.

Current State EPSDT reports to HCFA do not distinguish services rendered by managed care plans. The HCFA collects combined managed care EPSDT and fee-for-service EPSDT information from States annually. In 1994, HCFA surveyed the States and discovered that States collect EPSDT data from managed care plans in inconsistent ways.

All managed care plans should report EPSDT services to States in a timely and uniform manner. At present, managed care plans subcontract with numerous individual providers. Consequently, reporting of EPSDT services is inconsistent, not always timely, and underreporting may occur. Without consistent reporting of EPSDT data, determining whether States meet participation goals becomes problematic.

The Health Care Financing Administration should emphasize to States the need to define and clarify EPSDT requirements in their Medicaid contracts with managed care plans.

Our study confirms the findings of earlier studies pointing out the lack of contractual specificity regarding EPSDT in States' Medicaid contracts with managed care plans.

AGENCY COMMENTS

We received comments from HCFA and the Acting Assistant Secretary for Health. Their comments are included in Appendices B and C respectively. Both fully agree with the recommendations. The Acting Assistant Secretary for Health suggested additional recommendations. These additional suggestions are quite consistent with the recommendations in our report. We suggest that HCFA consider them in developing their implementation plan.

We made appropriate revisions to the report based on their technical comments.

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INTRODUCTION

PURPOSE

This inspection examines the extent to which Medicaid managed care providers deliver Early and Periodic, Diagnostic, Screening and Treatment (EPSDT) to Medicaid children.

BACKGROUND

EPSDT

Congress created the EPSDT program in 1967 to provide initial and periodic examinations and medically necessary follow-up care for Medicaid-eligible children.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) expanded EPSDT to cover most Medicaid-eligible children under age 21. In July 1990, the Health Care Financing Administration (HCFA) established participation goals for EPSDT requiring that States screen 80 percent of eligible children by 1995. Medicaid provides health care coverage for more than 20 million children. In 1992, the Assistant Secretary for Planning and Evaluation estimated that less than half of Medicaid eligible children receive any Medicaid reimbursed services in a given year.

Under EPSDT, State Medicaid agencies must provide eligible children services that include comprehensive, periodic health assessments beginning at birth and continuing through age 20. All medically appropriate immunizations are required. Age appropriate assessments, known as "screens,"[1] must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever anyone suspects the child may have a health problem. Medicaid also covers treatment for all medically necessary services discovered during EPSDT screening. Preventive, restorative and emergency dental care is also covered by EPSDT.

Medicaid Expenditures for Children

Poor children and their parents comprise 73 percent of the Medicaid population, but account for only a third of Medicaid expenditures. The balance is spent on the aged and disabled. Overall, the younger Medicaid patients require less care and less costly services than the aged and disabled, and very little long-term care.

State Medicaid agencies have turned to managed care to rein in escalating health care costs, difficult to do in a fee-for-service environment, while ensuring health care access

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[1] *States must provide for medical, vision, hearing and dental screens. An EPSDT medical screen must include: a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical; appropriate immunizations; laboratory tests, including lead blood level assessment appropriate for age and risk factors, and; health education, including anticipatory guidance.*

for Medicaid enrollees. The Federal Government encourages the switch to managed care by approving Medicaid experiments in some States that require Medicaid recipients enroll in managed care plans.

Medicaid Managed Care

Medicaid managed care has grown exponentially. Between 1983 and 1995, Medicaid managed care enrollment increased from 750,000 to 9.8 million. In 1983, less than one percent of Medicaid enrollees were covered by managed care programs. By 1995, Medicaid managed care covered nearly 1 in 3 Medicaid recipients. Between 1993 and 1994, an additional 3 million Medicaid recipients joined managed care programs, a 1 year rise of 63 percent, and in 1995 almost 4 million more Medicaid enrollees had managed care health care coverage. By June 1995, 44 States, Puerto Rico and the District of Columbia had contracted with 403 Medicaid managed care plans to serve almost 10 million recipients.

Managed care aims to reduce unnecessary services, lower health care costs, increase access to services and monitor the quality of medical care provided to its beneficiaries. At one type of managed care plan - a health maintenance organization (HMO), "gatekeepers" direct patients to needed care, usually within the managed care plan.[2] The HMOs receive a contracted amount from the State, a fixed capitated rate per member, to provide for the health care of its Medicaid members. The HMOs do not submit individual claims for payment for services rendered to the State. Roughly 75 percent of Medicaid recipients in managed care belong to HMO-type plans.

A second type of managed care program, Primary Care Case Management (PCCM), also uses a gatekeeper to refer patients for necessary services. The PCCMs are reimbursed a fixed amount for case management services only. Individual medical services are billed on a fee-for-service basis by the individual provider of services.

Although some basic tenets of managed care - to provide preventive medical services and education - mirror those of the EPSDT program, some factors work against Medicaid managed care plans delivering EPSDT services to Medicaid children. Managed care plans receiving a capitated rate have a financial incentive to deliver fewer services. Since EPSDT candidates are generally healthy, not providing required preventive and/or educational services can represent a short term way for managed care plans to avoid expenses at minimum risk. To discourage these tendencies, some States build EPSDT performance measures into their contracts with managed care plans. In addition, Federal, State and managed care plan quality assurance activities work to ensure that managed care plans and providers fulfill their contractual obligations to deliver appropriate medical services.

The on-again, off-again nature of welfare and Medicaid entitlement is at odds with

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[2] *Other types of managed care plans - Prepaid Health Plans and Health Insurance Organizations - are similar to HMOs. For the purpose of this evaluation, we treat these types of managed care organizations like HMOs.*

managed health care delivery. Some patients are enrolled for very short periods of time and do not receive any services from their managed care plan. Some managed care plans or Medicaid patients may not see any benefit in establishing a medical relationship that will be short-lived. Likewise, many Medicaid patients use the emergency care system for their health care needs and are unfamiliar with preventive approaches that managed care plans use.

Documenting EPSDT Services in a Managed Care Setting

In 1991, the Office of Inspector General issued a report entitled "Early and Periodic Screening, Diagnosis, and Treatment - Performance Measurement" OEI-07-90-00130, that found, among other EPSDT reporting problems, that children enrolled in Medicaid managed care plans were considered to have received their EPSDT services strictly on the basis of their enrollment. Since that time, HCFA changed their policy and now requires that States report specific EPSDT encounter data for children covered by managed care plans as well as fee-for-service.

In 1994, HCFA reported that States capture EPSDT data from its capitated plans in different ways. Some States require HMOs submit "dummy" claims which their systems would process for tally purposes. Two States require different reporting standards depending on the capabilities of the HMO to provide data. Massachusetts reconciles HMO reported amounts by auditing a sample of medical records. States rely on PCCMs to report EPSDT services accurately to ensure prompt payment for services.

Annually, HCFA collects combined managed care EPSDT and fee-for-service EPSDT information from States on Form HCFA-416. This report emphasizes the ratio of EPSDT encounters to the total EPSDT eligible population. The HCFA-416 does not capture the number of Medicaid managed care children who received all of the EPSDT visits required by the State for that year. Also, since States report combined managed care EPSDT and fee-for-service EPSDT information to HCFA, no definitive comparisons of EPSDT performed by fee-for-service providers and managed care programs exist.

EPSDT and Managed Care Contracts

State contracts with managed care plans often do not specify EPSDT requirements. A 1995 Children's Defense Fund study of 100 Medicaid 1991 managed care contracts found that less than half delineated EPSDT responsibilities. In September 1996, HCFA issued *Integrating EPSDT and Medicaid Managed Care*, which also indicates that some State contracts with managed care plans do not adequately spell out what EPSDT services are required. This HCFA report cites the managed care contract with States as the blueprint for patient care, and recommends that States define and specify EPSDT program requirements. By mandating managed care plan performance in the State contract, managed care plans would be more likely to specify similar EPSDT details when contracting with individual providers.

Managed care plans who contract with individual providers must rely on those providers

for accurate data. A University of North Carolina study of EPSDT services in North Carolina indicated many problems with providers' inaccurate reporting of services. A managed care plan in Wisconsin reported to us that 1 of 5 providers they audited had EPSDT documentation problems.

SCOPE AND METHODOLOGY

This inspection analyzes how well Medicaid managed care plans deliver timely EPSDT services to children. We did not examine managed care services to children with special health care needs. There are several studies of this area already proposed or underway. Likewise, we did not focus on specific EPSDT requirements like immunizations, which has been studied extensively.[3] We make no comparisons of the individual managed care plans sampled in this inspection.

Data Gathering

We base our findings on data we collected from several sources, including interviews with State and managed care officials, and a review of a national sample of medical records for children enrolled in managed care programs. We used SAS and SUDAAN quantitative software plans to assist in our analysis and projections.

We interviewed State personnel and Medicaid managed care plan managers for the plans chosen in our sample. These interviews focused on access and barriers to providing EPSDT, including outreach and transportation activities, EPSDT contractual arrangements, and reporting and verifying services.

Sampling Procedures

We examined medical records for a national sample of children covered by Medicaid managed care plans.

To draw the sample, we first stratified managed care plans treating Medicaid-enrolled children as of January 1, 1994 into two groups - PCCM model and HMO model. These two strata then were further stratified into two more strata - Medicaid enrollees of 50,000 or more, and less than 50,000 Medicaid enrollees. We compiled our stratified list using HCFA data published in the "Medicaid Managed Care Enrollment Report" as of June 30, 1994.

We then randomly selected six plans from the large HMO strata, and two from the small HMO strata. Two large PCCM plans and two small PCCM plans were also randomly selected for a total of twelve plans from all strata. This sampling methodology ensured that we have accurate representation from both large and small plans, as well as

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[3] *An April, 1996 Office of Inspector General report, "Children's Dental Services Under Medicaid: Access and Utilization" (OEI-09-93-00240) focused on EPSDT dental services.*

adequate representation from PCCM-type models for comparison purposes. The 12 managed care plans in the sample represent 10 different States.

The 12 plans selected in the sample provided us with the names of all children in their plans who met the criteria of being in Medicaid and under age 21, and who were enrolled in their plan for any period of time between January 1, 1994 and December 31, 1995. From each plan, we randomly selected 30 names, a total sample of 360 children. Twenty-two children were subsequently dropped from the sample when we found they had less than 4 months of managed care enrollment and had received no EPSDT services. Final projections were based on the remaining 338 children in the sample.

To account for the sampling plan and provide results that accurately reflect the distribution of cases in the population studied, all percentages in the report reflect the proper weighting of the data. This will also be true of the totals presented. When we present sample based results, we identify them.

Reviewing the Medical Records

To examine the extent of EPSDT services actually being performed, we reviewed the medical records for this sample to see if EPSDT was reported accurately, whether EPSDT services were provided in line with periodicity schedules, and to make a national projection of EPSDT services rendered. We did not address issues of quality of care. In instances where rendering of EPSDT services was in doubt based on the medical records, we credited the services as having been rendered. We credited EPSDT as being performed whenever screens were performed or if subsequent treatment resulting from EPSDT screens took place.

We reviewed the managed care medical records and the State's fee-for-service data for each child for at least 6 months prior to and after the study period. In this way, if the EPSDT services fell outside of our study timeframe, we would credit them as being performed. By reviewing the fee-for-service billings, we were able to credit any EPSDT services rendered out of plan.

During the study timeframe of 1994 and 1995, children might require multiple EPSDT services depending on their age and the State's periodicity schedule. For example, an infant requires six EPSDT screens the first year of life in most States. But a 17 year old may require an EPSDT visit annually or less frequently, depending on the State. Our analysis accounted for these variables. In determining the age of the child, we used the age as of January 1, 1995. If not enrolled on that date, we used the age at the period of coverage.

Other Data Gathered

We also conducted interviews with 27 physicians randomly chosen from the plans' directories. We limited these interviews to pediatricians, family practitioners and internists since these providers would most likely be the primary physicians for children

receiving EPSDT. The physician discussions covered contractual arrangements with the managed care plan and knowledge of the EPSDT (or by its local name) program.

We contacted all States to obtain copies of any standard contract they use with Medicaid managed care providers. We analyzed these contracts to determine the extent of EPSDT-specific requirements.

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Fewer than one in three Medicaid children enrolled in managed care plans receive timely EPSDT services. Six of ten receive none at all.

Based on our review, we estimate that only 28 percent of Medicaid managed care children receive all of the EPSDT screens called for by the periodicity schedule used in their State. Another 12 percent of children enrolled in managed care receive some, but not all of the EPSDT services they should. Sixty percent of Medicaid managed care children do not receive any EPSDT services called for in the States' periodicity schedules.

When we separate these data into age cohorts, we estimate older adolescents enrolled in Medicaid managed care receive significantly fewer required EPSDT services than other children.

Age of Child	Receive all EPSDT	Receive some EPSDT	Receive no EPSDT
Birth - age 5	30%	22%	48%
ages 6 - 14	32%	1%	67%
ages 15 - 20	14%	0	86%
all ages	28%	12%	60%

Our results approximate those recently found by the Oregon Medical Professional Review Organization (OMPRO) in a review of Washington Medicaid managed care EPSDT performance. The OMPRO used the Medicaid Health Plan Employer Data and Information Set (HEDIS), a voluntary standardized performance measurement tool for managed care plans, to review immunizations in infants, and EPSDT screens for 4-6 years old and 12-21 years old. They found that 26 percent of the 4-6 year old children and 16 percent of the adolescents received EPSDT services in a 12 month period.

We tested for other variables that might affect delivery of EPSDT services. We find no significant differences between HMO and PCCM plans or between large or small managed care plans. We find there is no difference in EPSDT performance if a break in managed care enrollment occurred. Besides the age of the child discussed above, the only variable that is significant is the State's EPSDT monitoring, which is discussed in the next finding.

The mean age of the children in the sample is 7 years. The sample averaged 16 months enrollment in Medicaid managed care. The children averaged 2.75 visits (including .8

EPSDT services) to the managed care plan during the study period.

Medical Record Reviews

Most of the visits Medicaid children make to managed care plans are sick visits, based on our review of medical records. In a few exceptions, we found these visits were expanded to become full EPSDT services. But in most cases, only the symptoms that generated the sick visit were treated. Likewise, we found few visits treating conditions discovered as a result of a previous EPSDT screen.

As could be expected, documentation of EPSDT services varied greatly between States, managed care plans, and providers. Frequently, we found more complete EPSDT documentation when providers used preprinted forms that detail the appropriate services for a child at a given age. These forms correspond to the State's periodicity schedule and are usually provided by the managed care plan to individual providers. One plan color-coded the forms to make each age cohort distinctive in order to alert the provider that different services, tests, guidance and observations are required for each age group.

However, many medical records failed to detail all of the EPSDT components. Lead testing was absent from many records. Frequently, vision and dental examinations do not appear to be performed, although in some States, dental services are not part of the managed care contracts. If health education, growth and development and anticipatory guidance for the child to the responsible adult were provided, they were seldom part of the medical record. One managed care plan said that in a capitated environment, there are few incentives for providers to provide the full range of services. Another managed care plan pointed out that with capitated payments, there was little incentive to report EPSDT services timely.

The philosophy of some States and managed care plans may work against EPSDT services being provided. One managed care plan explained it is the parent's responsibility to ensure their children receive all the necessary screens. In that plan, individual physicians do not know what families have chosen them as their primary care provider until that family makes an appointment for services. One State said that using primary care physicians as gatekeepers is a way to ease the physician community into accepting managed care.

State Contracts

As stated in our background, studies show that States vary widely in emphasizing EPSDT in their managed care contracts. Our survey tends to confirm these earlier findings. Forty-one States responded to our request for contract information. Nine of these States do not contract with any managed care plans for services to Medicaid children. We found 13 States spell out managed care EPSDT responsibilities in detail in their contracts with managed care plans, and Oregon does the same without mentioning EPSDT by name. Three States are in the process of revising their managed care contracts. The other States' managed care contracts mention the EPSDT requirement without providing

specific detail.

Efforts to Promote EPSDT

Medicaid providers face many obstacles in attracting Medicaid patients for non-emergency health care. Barriers include the on-again, off-again nature of Medicaid coverage, transient addresses and phone numbers, the high number of "no-show" appointments, and convincing parents of the need for preventive care for healthy children. Some States specifically require managed care plans to provide transportation to patients and conduct outreach activities to overcome some of these barriers.

In addition to sending reminder postcards and phone calls to parents and providing needed transportation to EPSDT exams, managed care plans and individual providers have taken many innovative steps to foster EPSDT screens and treatments. One Nevada physician distributes coupons for McDonald's "Happy Meals" to every parent who brings in a child for an EPSDT screen. He reports buying more than 500 coupons this year. The restaurant sells the coupons to him at a bulk discount rate. Another physician provides drug store discount coupons for those receiving their EPSDT exams. One managed care plan held a lottery to win a "big wheel" bicycle. Chances to win this prominently displayed prize were distributed when children came for their EPSDT screens.

Providers routinely distribute promotional material including EPSDT refrigerator magnets, coloring books, and coupons for baby shoes and diapers. Managed care plans may send a nurse for a personal home visit to newborns. While most of these attractions are aimed at infants and small children, one managed care plan is starting a teen health plan.

Managed care plans and school-based health centers are beginning to work together. Some States require or encourage coordination between managed care plans and school-based health centers, community health centers and local health departments in an attempt to bring health care services to hard-to-reach populations.

Children receive significantly more EPSDT services from Medicaid managed care plans when States inform the managed care plans which children are due for EPSDT

Two States in our sample, Michigan and Nevada, identify children who are currently due for EPSDT screens to their managed care plans. Michigan notifies their plans by an electronic file transfer listing all of the children due that month. The State requires each plan to respond for each child by electronic file transfer by month's end.

For children enrolled in Nevada's PCCM, the State sends a listing of children due for EPSDT screens to the PCCM, who sends notices to the responsible adult for the child advising of the need for EPSDT testing. They follow up as appropriate. If the State has not received a bill for EPSDT services within 3 months, phone calls to the responsible

adult are made.

A comparison of the EPSDT results in these States to the others in our sample shows that there is a very strong statistical difference in managed care plan performance.

Managed Care State	received all EPSDT	received some, not all EPSDT	received no EPSDT
Michigan/Nevada	54%	7%	38%
All Others	19%	13%	68%

Administratively, a large State and a small State, have adapted EPSDT monitoring to their State's environment. Michigan's monitoring affects capitated managed care plans, while Nevada's tracks PCCM performance. The approaches they take, while basically the same, vary in terms of the number of children to be monitored and the systems sophistication of the States and managed care plans.

RECOMMENDATIONS

The managed care philosophy stressing preventive services now to avoid costly expenses later for medical care complements EPSDT program objectives. Medicaid managed care plans are potentially very conducive to delivering EPSDT services. Managed care plans serve as a medical home and as gatekeeper to medical care and emphasize prevention and wellness for millions of children. Capitated plans especially feature many advantages over individual providers in being able to provide outreach and transportation to clients. They benefit from economies of scale and a steady funding stream. However, many of our findings indicate that managed care plans have not yet realized their full potential in providing EPSDT services.

The Health Care Financing Administration should revise their EPSDT reporting requirements and data collection to emphasize the number of children who receive all of their EPSDT screens in a timely fashion.

Current EPSDT reporting methods obscure the low EPSDT rates we found, especially for adolescents. The HCFA should revise their EPSDT data collection so States identify children of different ages who receive all of the required EPSDT screens. This revision will improve EPSDT data collection for both fee-for-service and managed care programs. The HCFA and the States should monitor the age groups to determine where progress is being made and where additional efforts are required.

States currently report only the number of children receiving at least one screen during the defined time period. Since the EPSDT requirements vary with State and age, revised reporting data should identify not only the number of children who receive an EPSDT screen, but also the number of EPSDT screens those children should be receiving. Presently, EPSDT reporting presents data in a way to suggest that most children receive EPSDT services. One State advised us that reporting HCFA-416 data "always shows us over 100 percent. We've been stuck at 52 percent forever." This anomaly occurs because current reporting overemphasizes the greater number of required medical services provided to very young children.

We support States using Medicaid HEDIS as a measurement tool to evaluate the nature of EPSDT services performed in managed care settings. States should be encouraged to evaluate both HMO and PCCM type plans. Our study shows that more than half the children enrolled in Medicaid managed care plans receive no EPSDT services, regardless of plan type.

The HCFA should encourage States to actively notify managed care plans of enrollees due for EPSDT exams and to follow up if EPSDT services are not rendered shortly thereafter.

Our study dramatically demonstrates the value added to EPSDT performance when States continue to track and monitor plan performance at the individual patient level. In some States, this responsibility may belong at the County level, but regardless, the technique should be emulated. The techniques used in Michigan and Nevada could serve as models for States to identify the children due for, and receiving timely EPSDT screens. Beginning in 1997, Virginia's Medicaid Management Information System will notify PCCMs twice annually of children due for EPSDT exams.

The HCFA should work with States to ensure timely managed care EPSDT reporting.

The breakout of managed care EPSDT services from fee-for-service is important. The HCFA needs specific data to determine whether managed care is living up to its promise of access and care to children, who represent more than half the total Medicaid population.

Current State EPSDT reports to HCFA do not distinguish services rendered by managed care plans. The HCFA collects combined managed care EPSDT and fee-for-service EPSDT information from States annually. Immunization records may lag behind as well. In 1994, HCFA discovered that States collect EPSDT data from managed care plans in inconsistent ways.

All managed care plans should report EPSDT services to States in a timely and uniform manner. At present, managed care plans subcontract with numerous individual providers. Consequently, reporting of EPSDT services is inconsistent, not always timely, and underreporting may occur. Without consistent reporting of EPSDT data, determining whether States meet participation goals becomes problematic.

The HCFA should emphasize to States the need to define and clarify EPSDT requirements in their Medicaid contracts with managed care plans.

Our study confirms the findings of earlier studies, including HCFA's, pointing out the lack of contractual specificity regarding EPSDT when States contract with managed care plans to provide Medicaid services. In omitting EPSDT programmatic details from managed care contracts, States have less leverage in persuading managed care plans to deliver timely EPSDT services and fewer ways to evaluate individual plan performance. The HCFA needs to continue working with States to provide examples of effective contracts.

AGENCY COMMENTS

We received comments from HCFA and the Acting Assistant Secretary for Health. Their comments are included in Appendices B and C respectively. Both fully agree with the recommendations. The Acting Assistant Secretary for Health suggested additional recommendations. These additional suggestions are quite consistent with the recommendations in our report. We suggest that HCFA consider them in developing their implementation plan.

We made appropriate revisions to the report based on their technical comments.

APPENDIX A

VARIANCE TABLE

VARIANCE AND ESTIMATED CONFIDENCE INTERVALS

	Estimate	Standard Error	95% Confidence Interval	
			Lower Limit	Upper Limit
Medicaid managed care children who receive all required EPSDT services	28.10%	8.30%	11.83%	44.37%
Medicaid managed care children who receive some required EPSDT services	11.52%	1.79%	8.01%	15.03%
Medicaid managed care children who receive no required EPSDT services	60.38%	13.37%	47.01%	73.75%

APPENDIX B

HCFA COMMENTS ON DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: APR 29 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Managed Care and EPSDT," (OEI-05-93-00290)

We reviewed the above-referenced report that examined the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services Medicaid children enrolled in managed care plans receive.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG)
Draft Report: "Medicaid Managed Care and EPSDT,"
(OEI-05-93-00290)

OIG Recommendation

HCFA should revise its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) reporting requirements and data collection to emphasize the number of children who receive all of their EPSDT screens in a timely fashion.

HCFA Response

We concur. HCFA convened a workgroup of representatives from the public and private sectors to assess and recommend changes to the current EPSDT reporting and data collection tool, the HCFA-416. The workgroup will focus on, among other issues: (1) developing an instrument that will collect more consistent, meaningful data from states regarding the furnishing of EPSDT services, especially services provided under managed care arrangements; (2) reviewing the effectiveness of periodicity schedules that vary by state to determine if there is a better way to measure each state's participation goal against the actual periodicity requirement in the state; and (3) determining if Health Plan Employer Data and Information Set (HEDIS) measures will be a useful tool in measuring EPSDT services in managed care settings.

It should be noted the current HCFA-416 collects data that identifies children of different ages. It also uses the periodicity schedule of the American Academy of Pediatrics to measure the number of screens children should be receiving in order to adjust the figure (i.e., 6 screens for the less than 1 year old, 50 screens for the 15-20 years old who should receive one every other year).

OIG Recommendation

HCFA should encourage states to actively notify managed care plans of enrollees due for EPSDT exams and follow-up if EPSDT services are not rendered shortly thereafter.

HCFA Response

We concur. We will address this as part of the follow-up activities resulting from George Washington University's recently released study of Medicaid managed care contracts, or as part of the Medicaid Managed Care Team's outreach efforts.

OIG Recommendation

HCFA should work with states to ensure timely managed care EPSDT reporting.

HCFA Response

We concur. This issue has been an ongoing concern of HCFA and will be addressed by the workgroup mentioned above.

OIG Recommendation

HCFA should emphasize to states the need to define and clarify EPSDT requirements in their Medicaid contracts with managed care plans.

HCFA Response

We concur. In addition to encouraging states through ongoing technical assistance, HCFA will continue to encourage states through its review and approval of new and existing waivers to include specific EPSDT programmatic requirements in their contracts with managed care programs.

Technical Comments

Page 2, Paragraph 1 - The enrollment figures published in the (1995) Medicaid Managed Care Enrollment Report contain double counts. The figures have been revised to estimate unduplicated figures. As a result, total Medicaid managed care enrollment as of June 30, 1995, is estimated to be 9.8 million, or 29.4 percent of the total Medicaid population. This 9.8 million figure represents a growth of about 2 million beneficiaries from the previous year.

HCFA recently published the 1996 enrollment figures. The total Medicaid managed care enrollment as of June 30, 1996, is reported to be 13.3 million (see HCFA's Home Page on the World Wide Web for the full report).

The reference to managed care plans to which people are being enrolled should be changed to managed care programs. The term programs more accurately describes the variety of systems into which people are enrolling. Of the 403 Medicaid managed care arrangements in 1995, 48 are primary care management programs and 355 are some form of managed care organization.

Page 2, Paragraph 2, first sentence - We suggest the following to replace the first sentence: "Managed care aims to reduce the utilization of services that are not medically necessary, lower health care costs, increase access to services, and provide a vehicle to better monitor the quality of care provided to beneficiaries."

Page 2, Paragraph 3 - Managed care plan is more accurately managed care program.

Page 2, Paragraph 4 - Quality assurance activities at the Federal, state government, and plan levels are designed to ensure Medicaid beneficiaries are provided access to the services to which they are entitled and that providers and managed care organizations are fulfilling their contractual obligations. This point should be made more clearly in the discussion of fraudulent activities.

Page 3, Paragraph 1 - Mention should be made that the contracts discussed in the 1995 Children's Defense Fund study were from 1991. Since that time, increased attention has been focused on child health, which is likely reflected in newer contracts. In the second sentence, please change showed to indicated, since no contract language was provided in Integrating EPSDT and Medicaid Managed Care.

Page 4, Paragraph 2 - Managed care plan is more accurately managed care program.

Page 7, Paragraph 3 - The Medicaid HEDIS was issued by the National Committee for Quality Assurance, not HCFA.

Page 9, Paragraph 4 - Federally Qualified Health Centers (FQHCs) have protections not realized by school-based health centers, community health centers, and local health departments. States are required to provide Medicaid beneficiaries with access to FQHCs, which is not the case for the other entities. Either this distinction should be clear, or FQHCs should be removed from this provider list.

Page 9, Last Paragraph - Nevada has a Health Maintenance Organization program, which means the state pays managed care organizations a capitated fee to provide a defined set of services to the Medicaid beneficiaries enrolled in the plans. In the description of Nevada's approach, mention is made of bills not being received by the state. In a capitated situation, bills are never received by the state. Please clarify Nevada's approach.

It would be useful if the OIG report indicates what age groupings would provide more useful information than those currently used.

It would be more accurate if the report used managed care program rather than managed care plan.

APPENDIX C

ASSISTANT SECRETARY FOR HEALTH COMMENTS ON DRAFT REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Assistant Secretary for Health
Office of Public Health and Science
Washington D.C. 20201

MAR 27 1997

TO: June Gibbs Brown
Inspector General

FROM: Acting Assistant Secretary for Health

SUBJECT: OIG Draft Report: "Medicaid Managed Care and EPSDT"
OEI-05-93-00290

Thank you for the opportunity to review and comment on the initial draft inspection report: "Medicaid Managed Care and EPSDT", OEI-05-93-00290. The study makes an important contribution to the evolving knowledge of the use of managed care plans in providing necessary preventive and treatment services to Medicaid recipients.

I have limited my comments to two specific areas: (1) Report Findings; and (2) Additional Recommendations. Overall, I agree fully with your recommendations and have included several clarifications and additional recommendations for your consideration. I look forward to your final report.

Report Findings

1. Under the EPSDT benefit, a State must provide general screening, vision, hearing, and dental services at intervals which meet recognized standards of medical and dental practice, and at other intervals, as necessary, to determine the existence of certain physical or mental health conditions. Screening services include: comprehensive health (physical and mental) and developmental history; a comprehensive physical exam; appropriate immunizations; laboratory testing; and health education and anticipatory guidance.

   The OIG study did not report on differences between managed care (HMO) primary care case manager (PCCM) beneficiaries within the above mentioned EPSDT categories. It would be useful to further stratify the data into distinct categories within the report, such as general health, vision, dental, and hearing, in order to assist policy makers in distinguishing areas of least compliance or greatest improvement.

2. The study was basically an evaluation of a beneficiary's clinical medical record. In this case, there exist several limitations:

   First, it is not clear to what extent the States separated the items and services in the EPSDT package and allowed for providers of partial screens.

Was the study limited to managed care or PCCM providers that were under contract, or otherwise expected, to provide the full array of EPSDT services? If not, what procedures were used to determine additional services acquired by beneficiaries outside of the designated provider or plan?

Second, various preventive screenings are not well documented and are difficult to identify in the medical record. For example, health education and counseling are commonly not documented in the medical record during clinic visits, especially for sensitive or illegal activities. This does not, however, indicate a total absence of these services. The recommendation of collecting future data on a standardized EPSDT reporting form, including areas of health education, counseling, and anticipatory guidance, for all Medicaid beneficiaries (under 21) would solve this reporting problem.

3. Interestingly, no statistical differences were observed between managed care and PCCM beneficiaries. I would have hypothesized that PCCM providers had a higher rate of success due to the financial and treatment incentives inherent in the fee-for-service reimbursement system. This finding raises issues related to the effect/s of the State or the individual in the acquisition of such services. The managed care plan and State bear direct responsibility in providing many of these enabling services.

As part of your evaluation of efforts used by providers to increase patient compliance, were you able to evaluate the use of transportation services, location of provider, or accessibility of services that may adversely effect access to services?

Additionally, it is our understanding that each State Medicaid program is required to inform eligible individuals and their families (including foster families) of the availability of EPSDT services within 60 days of Medicaid eligibility determination and annually thereafter. This communication is to be given on what and where EPSDT services are available, and how to obtain them. Were you able to determine the State's compliance with sending beneficiary information to EPSDT eligible participants?

4. The States selected for the study are far below the EPSDT participation goal set by the Secretary, as directed by OBRA 1989. The goal set for each State, by 1995, was to provide 80 percent of the annual screening services recommended for each age group (under 1, 1-5, 6-14, and 15-20) by the American Academy of Pediatrics.

Given the study findings, what are we to conclude about the State's ability to use managed care programs (HMO or PCCM) for the provision of preventive services among high risk populations? Does HCFA need to hold the State in greater compliance with EPSDT services, when enrolling Medicaid beneficiaries into managed care programs, as a condition of federal waiver approval?

Additional Recommendations

1. The advantages of managed care, as part of the introductory paragraph of the Recommendation's section, have yet to be realized or demonstrated; specifically, outreach programs, transportation services, and stressing preventive services to avoid "costly expenses later" for medical care. I recommend revisions based on our current state of knowledge on these issues.

2. In Recommendation #1, require additional data reporting within specific categories of EPSDT services for each age group. These categories include: complete physical exam; vision and hearing; dental; developmental and behavioral screening; procedures (laboratory and immunizations); and health education and anticipatory guidance.

3. In Recommendation #2, the State must continue to notify beneficiaries of the availability of EPSDT services, how to obtain them, and transportation and scheduling assistance. Additionally, if the State contracts services to partial providers, they must develop a mechanism to collect EPSDT data from all sources of care; thus, demonstrating compliance with providing the full range of EPSDT services.

4. In Recommendation #3, the development and implementation of a standardized reporting form is vital to the State's and HCFA's efforts in monitoring participation goals. The lack of meaningful health information is further complicated by the loss of Medicaid reimbursement claims files through the use of capitated payment programs. This form should include the broad range of services available to eligible beneficiaries, as discussed above. Implementation of such a form should be linked to HCFA's 1915(b) or 1115 Demonstration waivers.

5. In Recommendation #4, in addition to requiring the use of well-defined, enforceable EPSDT contract language, managed care providers need to demonstrate linkages with other EPSDT providers if they are not providing the full range of EPSDT services. These linkages, or referral sites, need to be included in the benefits and educational information distributed to beneficiaries during plan enrollment.

6. As demonstrated by this study, the failure of managed care plans and PCCM providers to provide mandatory EPSDT services requires increased review and monitoring by HCFA, especially among States with mandatory Medicaid managed care enrollment via 1915(b) or 1115 waivers. These States should be held at previously established 80 percent participation goals as part of the terms and conditions of initial and ongoing waiver approval. States must be able to demonstrate the capacity to develop and implement data collection mechanisms that report on EPSDT services among a range of provider sites.

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