REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REPORT ON EARLY INTERVENTION SERVICES FOR INFANTS AND TODDLERS WITH DISABILITIES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 40

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COMMONWEALTH of VIRGINIA

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To: The Members of the General Assembly

The report contained herein is provided pursuant to House Joint Resolution 724 of the 1999 General Assembly. The report includes "(i) efforts to enhance and expand training on the availability of, access to, and use of Early and Periodic Screening Diagnosis and Treatment (EPSDT) and (ii) contracts between Managed Care Organizations (MCOs) and DMAS to evaluate Part C provider participation in the network in order to meet access standards and to allow recipients greater choice."

The Department of Medicaid Assistance Services incurred a total of $12,850 in administrative cost in preparing this study, consisting of 360 staff hours.

Respectfully submitted,

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House Joint Resolution 724 of the 1999 Virginia General Assembly requested the Department of Medical Assistance Services (DMAS) to report on early intervention services for infants and toddlers with disabilities. Specifically, the Virginia General Assembly requested that the report include (i) efforts to enhance and expand training on the availability of, access to and use of Early and Periodic Screening Diagnosis and Treatment (EPSDT) and (ii) contracts between Managed Care Organizations (MCOs) and DMAS to evaluate Part C provider participation in the network in order to meet access standards and to allow recipients greater choice. The Virginia General Assembly also requested that the report include an analysis of reimbursement rates across MCOs to ensure the rates are sufficient to attract providers to the MCO networks.

EXECUTIVE SUMMARY

DMAS is pleased to report that in the area of efforts to enhance and expand training on the availability of, access to and use of EPSDT, DMAS has:

- conducted state-wide physician training sessions in cooperation with the Virginia Department of Health (VDH),
- improved access to EPSDT training materials, tutorials, and provider manuals by making them available on the DMAS web site. The DMAS web site address is www.cns.state.va.us/DMAS,
- planned targeted quality assurance audits of MEDALLION providers,
- updated the EPSDT section of the Medicaid Physician's Manual,
- conducted training for school-based clinics in cooperation with the Department of Education (DOE),
- given specific training to Part C/IDEA Council Coordinators,
- contractually required increased performance standards for Medicaid providers,
- begun analysis and review of encounter data from all Medallion II providers for compliance with the EPSDT program,
- contracted with independent groups to monitor immunization status, access to care and satisfaction with services received, and
- held a one-time Early Intervention training on September 21, 1999, to discuss the Exception Process for Medallion II recipients. The training also included a brief segment on EPSDT and how the Denver II may be used for early detection of developmental delay. DMAS may hold additional trainings as necessary.

To ensure that Part C recipients have access to needed early intervention services (physical therapy, occupational therapy and speech-language pathology services), House Bill 2617 was introduced to mandate a carve out of children enrolled in Part C. This has allowed Part C recipients to disenroll from MCOs if certain criteria were met in order to obtain the needed services.

The rates reimbursed to Part C providers by the MCOs are sufficient to attract providers to the MCO networks. This is evident by the increase in the number of providers in the

Medallion II region since the implementation of the Medallion II program. In 1996 with the implementation of Medallion II in Tidewater, the MCOs were reimbursing the Part C providers below their commercial rates. After the providers voiced their concerns to DMAS and the MCOs, reimbursement was increased in 1997-98 across most plans to equal their commercial rates. This has resulted in an increase in providers, which has resulted in better access and more recipient choice of providers. A table of the MCO reimbursement rates for the most frequent early intervention services is included as a part of this report.

Contracts between DMAS and Medicaid MCOs contain specific language and requirements relating to the number and types of providers to be included in the network, access and availability standards, qualifications of participating providers, and the scope of medical services to be provided by MCOs to Medicaid recipients. Adherence to these requirements and the degree of recipient satisfaction with the MCOs are monitored monthly, quarterly, and annually by DMAS.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT

Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program of outreach and comprehensive health care screening and follow up services for all Medicaid eligible individuals under the age of 21. Through the use of the Periodicity Schedule (Exhibit A), all children, including children enrolled in the early intervention program, should receive certain health assessments according to their age. The services that states participating in the Medicaid program are required to provide under the EPSDT program are stipulated in the Social Security Act and the 1989 amendments to the Act. Screening services are the core of EPSDT and include the following five elements:

- Comprehensive health and developmental history, including assessment of both physical and mental health development,
- Comprehensive unclothed physical examination,
- Appropriate immunizations according to the Advisory Committee on Immunization Practice (ACIP) schedule,
- Laboratory tests, including blood level lead assessment, and
- Health education, including anticipatory guidance.

In addition to these services, the Federal Health Care Financing Administration (HCFA) has also mandated very proscriptive EPSDT outreach and education requirements. Federal regulations stipulate that states must ensure that all eligible Medicaid enrollees are adequately informed of EPSDT services. These requirements include:

- Providing a combination of written and oral methods designed to effectively inform all EPSDT eligible individuals (or their families) about the EPSDT program,

- Using clear and non-technical language, providing information about the following:
  - The benefits of preventive health care,
  - The services available under the EPSDT program and where and how to obtain those services,
- Ensuring that EPSDT eligible individuals understand that EPSDT services are without cost to eligible individuals under 18 years of age, and if the agency chooses, up to age 21,
- Ensuring that necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request,
- Effectively informing those individuals who are blind or deaf, or cannot read or understand the English language,
- Providing assurance to HCFA that processes are in place to effectively inform individuals as required under this paragraph, generally within 60 days of the individual's initial Medicaid eligibility determination, and in the case of families which have not utilized EPSDT services, annually thereafter.

DMAS makes every effort to meet these Federal EPSDT screening and client informing obligations through a variety of marketing methods and through the use of its agency partners, provider networks, existing contracts, regional training, and targeted mass mailings.

DMAS EFFORTS TO ENHANCE AND EXPAND EPSDT TRAINING

DMAS has expanded and enhanced its existing EPSDT training methods for Medicaid enrolled EPSDT providers, EPSDT related advocacy groups, Medicaid managed care contractors and related programs. This has been accomplished by implementing annual statewide EPSDT training sessions in cooperation with the Virginia Department of Health (VDH), granting greater access to EPSDT training materials, tutorials and the EPSDT section of the Medicaid Physician's Manual by having these materials readily available on the internet, and planning for the future implementation of targeted quality assurance audits of Medicaid primary care providers (PCPs).

In addition, DMAS carries out ongoing provider relations activities with our contracted Medicaid PCPs and Medicaid MCOs. These Medicaid PCPs are often the gateway to EPSDT for Part C/IDEA recipients who need health services related to their disability.

Provider Training for EPSDT

DMAS recognized a need for training for all Medicaid PCPs and not just the early intervention providers. As a result, DMAS developed provider training sessions which are offered annually throughout the Commonwealth for Medicaid PCPs, in addition to one-on-one visits by Medicaid provider relations staff. This training focuses primarily on EPSDT, as well as managed care specific program requirements. The statewide training provided during the summer of 1999 was a cooperative effort with VDH and focused on the following clinical aspects of EPSDT:

- The Periodicity Schedule
- The Unclothed Physical
- Hearing and Vision
- Lead Screenings
- Vaccines for Children
- Developmental/Behavioral Assessment
- Dental Referral
- Documentation
- Related Programs
- Comprehensive Health and Developmental/Behavioral History

These training sessions were offered to our Medicaid PCPs and Medicaid contracted MCOs and other EPSDT providers, including local health departments, Head Starts, early intervention program providers and School-Based Clinics, in eight regional areas of the state. Four (4) hour sessions were offered in Lynchburg, Fairfax, Williamsburg, Richmond, Abingdon, Roanoke, Weyers Cave, and Fredericksburg from June 23 through August 25, 1999. Over 500 Medicaid enrolled providers attended these sessions and offered feedback through written evaluations of the training provided by DMAS staff.

A primary focus of EPSDT training is the importance of the "diagnosis" and "treatment" components and the importance of carrying out an assessment of developmental and behavioral status. DMAS clearly defines both "diagnosis" and "treatment" in the EPSDT section of the Medicaid Physician's Manual. Each definition is clearly labeled on the first page of the EPSDT section of this manual and helps explain the concept behind the EPSDT program. The terms are defined as follows:

> Diagnosis: The determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental, and psychological examination, and laboratory tests and x-rays. Physicians who do EPSDT screenings may diagnose and treat health problems discovered during the screening, or they may refer the child to other appropriate sources for such care.
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> Treatment: Any medically necessary treatment service required to correct or ameliorate defects and physical and mental illnesses and conditions discovered

during a screening examination. Any treatment service that is not otherwise covered under the Virginia State Plan for Medical Assistance (SPMA) can be covered through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS as medically necessary.

As stated in the Medicaid Physician's Manual and MCO contract and reinforced during all of the agency's EPSDT training sessions, when an EPSDT screening indicates the need for diagnosis or treatment for a suspected condition or abnormality, the child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment. The PCP is instructed to follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and documents the results in the child's medical record.

The Omnibus Budget Reconciliation Act of 1989 requires states to reimburse for medically necessary services not otherwise covered under the SPMA for Medicaid eligible children up to the age of 21 when such services are needed to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services, as long as the services are allowable under the Social Security Act. Services not included in the SPMA must be preauthorized by DMAS. Some non-state plan services are available to children up to the age of 21 under Community Based Care Waivers. Medicaid recipients enrolled in Part C/IDEA may also be eligible for non-state plan or State Plan Option services if these services are medically necessary. This language is covered in the Medicaid PCP agreement and the MCO contract.

Additionally, Federal regulations require EPSDT programs to coordinate services with Title V Maternal and Child Health programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) offered through VDH and the DMAS Baby Care Program. Coordination requirements also include child health initiatives with other related programs such as, but not limited to, Head Start, Healthy Start, school-related health programs, and Part C early intervention programs. The services of each program are explained in detail in the Medicaid Physician's Manual and the MCO contract and is reinforced in all DMAS training sessions, along with information on how to contact the program's coordinators. DMAS strives to develop linkages to these programs and uses training and provider relations activities as a platform for these linkages.

The developmental/behavioral assessment component of EPSDT is clearly connected with early intervention services for infants and toddlers with disabilities and discussed in detail during training. The EPSDT section of the Medicaid Physician's Manual and the MCO contract state that a child younger than three (3) who exhibits developmental delay or a diagnosed condition that may result in developmental delay is to be referred to the "Babies Can't Wait" program for a comprehensive developmental evaluation. The "Babies Can't Wait" program is Virginia's early intervention program, administered by

the Department of Mental Health, Mental Retardation, Substance Abuse Services (DMHMRSAS).

The EPSDT section of the Medicaid Physician's Manual suggests the use of the Denver II test (a nationally recognized developmental evaluation tool) to determine if a developmental delay exists. DMAS requires that any developmental assessment include a range of activities to determine whether or not the child has reached an appropriate level of development using criteria for specific age groups described in the latest edition of the American Academy of Pediatric's (AAP) Guidelines for Health Supervision III. AAP Guidelines for developmental assessment are included in the manual as a reference for the EPSDT Provider.

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 amended section 1903(c) of the Social Security Act permits Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP), if it is a Medicaid coverable service. Examples of some of these services include physical therapy, speech language pathology services, occupational therapy, psychological services, and medical screening and assessment services. Medicaid PCPs, who act as medical Case Managers for patients who may be receiving Part C/IDEA services, are encouraged to develop relationships with local school districts and local Part C/IDEA councils to ensure that health care services identified in the IEP and the IFSP are provided as required by Federal law under IDEA.

In addition to the mandatory referral requirement to the "Babies Can't Wait" program for children under age three (3), a child three (3) years or older must be referred to the local school system's special education department for a developmental/psychological evaluation if he or she meets criteria for referral as defined by an objective test or if the child exhibits one or more of the following behaviors:

- Developmental delays
- History of poor school performance
- Poor social adjustment
- Emotional or behavioral problems

In addition to these EPSDT training sessions, DMAS carries out an additional yearly training session for school-based clinics and other health care providers in cooperation with the Department of Education that focuses on school-based services, Medicaid covered therapy, and EPSDT.

DMAS has held numerous workshops and training sessions over the last two years with MCOs, early intervention providers and advocates in cooperation with the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), and will continue to do so. These sessions are designed to ease the transition of early intervention clients from fee for service to managed care and help providers and

advocates understand managed care policies and procedures. Representatives from all Medicaid MCOs are asked to discuss their plan's early intervention strategies and each organizational representative has the opportunity to address their particular issues and concerns in these sessions.

Two of these training sessions were held last year in response to House Joint Resolution 581 from the 1998 General Assembly session. These sessions entitled "Enhancing and Integrating Medicaid Coverage of Part C of IDEA Services for Infants and Toddlers" were devoted to providing an extensive overview of the Medicaid services and EPSDT as they apply to Part C/IDEA. All local interagency coordinating councils were invited to attend as were local community services boards.

DMAS managed care staff held a specific training session for Part C Service Coordinators, Part C Council Coordinators and MCO Case Managers on September 21, 1999, in Williamsburg. This training session was designed to explain the relationship between EPSDT, Part C/IDEA and managed care, as well as to explain the coverage benefits of Medicaid enrolled children who participate in Part C/IDEA.

This Medallion II, Exception for Part C Recipients training was attended by forty-seven (47) participants with representation from DMHMRSAS (including the State Coordinator of the "Babies Can't Wait" program), Case Managers from all seven (7) MCOs, and Part C providers, including Early Intervention Service Coordinators, Early Intervention Council Coordinators, Social Workers, Case Management Supervisors and Outreach Coordinators. Trainers and operations staff from the Division of Program Operations were in attendance from DMAS. Topics presented during this training included: the specific EPSDT requirement to perform a Denver II assessment, Medallion II Scope of Services, PCP/Medical Home, and the Exception Process. (The Exception Process is a mechanism to disenroll certain early intervention children from MCOs if the MCO is unable to provide all the services to a child within their network). Also, participants were informed about training provided to primary care providers to refer children under age three (3) with developmental or suspected developmental delay to the "Virginia Babies Can't Wait" program. After the Medallion II, Exception for Part C Recipients presentation was completed, DMAS facilitated a guided discussion with participants to identify and resolve concerns. The majority of the discussion focused on the administrative process and accountability issues.

Administrative concerns raised during this training pertained to the Individual Family Service Plan (IFSP). Many providers asked what was required on the IFSP. MCOs require IFSPs to include objective evaluation results to determine medical necessity and monitor outcomes. Often MCOs receive incomplete plans delaying determination pending the receipt of additional information. DMHMRSAS agreed to take the lead to develop a uniform IFSP format for the State of Virginia.

Inconsistency was detected on the Exception Process Flow Chart between calendar day and workday requirements to complete the steps. A compromise was achieved for

requirements needing less than a week for completion to have a "workday" suspense. Requirements needing more than a week for completion will have a calendar day suspense. Clarification for the provision of care while awaiting finalization of the IFSP and MCO authorization approval was requested by Part C providers. The Part C providers were directed to initiate treatment or therapy if clinically appropriate and providers will be reimbursed through Part C funds.

DMAS will maintain an Exception Process Log indicating the number of exceptions initiated and their outcomes. This log is a deliverable report to the Health Care Financing Administration (HCFA).

The Role of Medicaid PCP Provider Relations Activities and EPSDT

MEDALLION is a Medicaid managed care program that includes a requirement that eligible enrollees select a PCP to provide primary care services and coordinate some specialty services in selected localities. The MEDALLION Primary Care Case Management Program is a mandatory, statewide managed care health program for Temporary Assistance for Needy Families (TANF) and the Aged, Blind and Disabled (ABD) Medicaid enrollees.

Medicaid enrolled providers are reimbursed on a fee for service basis, with Medicaid PCPs receiving an additional $3 per enrollee per month for enrollees assigned to their panel of patients. Access to some specialty services, inpatient hospital admissions and other health care services require a referral from the enrollee's PCP. As of June 1999, there were approximately 142,000 MEDALLION enrollees, of which, 67 percent were under the age of 21 and eligible to receive EPSDT services.

Provider relations staff at DMAS communicate program policies and procedures on an ongoing basis with Medicaid PCPs. In particular, DMAS provider relations staff focus their training and education efforts on the Medicaid PCPs' understanding and compliance with their contract with DMAS and the appendix to that contract.

The appendix to the Medicaid participation agreement requires Medicaid PCPs to carry out the following EPSDT and EPSDT related services:

- Provide all routine preventive and treatment services to MEDALLION patients assigned to the PCP's practice. This will include EPSDT services and the maintenance of a comprehensive medical record for each patient assigned to the PCP's MEDALLION panel,

- Enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VFC) program if the PCP has patients who are under age 21 assigned to their MEDALLION panel, and

- Provide case management, primary care and health education to enrollees that fosters continuity of care and improved provider/patient relationships.

The EPSDT screening is a comprehensive examination in which the required screening components are to be completed according to the time frames on the Periodicity Schedule. This screening consists of the following required components: an unclothed physical, physical/mental evaluation, growth and nutrition assessment, developmental assessment, vision assessment, hearing assessment, dental assessment, laboratory procedures, immunizations, and anticipatory guidance.

Because of the nature of the relationship between the PCP and the enrollee, the PCP's role is crucial to ensure that clients receive EPSDT screenings, diagnosis and follow up treatment. The vast majority of EPSDT eligible Medicaid enrollees are managed care eligible and as a result are assigned to a Medicaid PCP who is contractually responsible to provide primary and preventive care and make any needed referrals for specialty care. EPSDT is an important required component of the PCP's contractual responsibility as a Case Manager for EPSDT eligible Medicaid enrollees. Therefore, it is extremely important that the Part C staff work closely with the PCP in order to access EPSDT services.

DMAS will begin closely monitoring each PCP's EPSDT screening rate for patients assigned to their panel using the current EPSDT Periodicity Schedule. Utilizing claims and enrollment data obtained from the Department's Medicaid Management Information System (MMIS), utilization review analysts will review each PCP's EPSDT compliance rates as a part of an overall quality assurance review. Medicaid PCPs who do not meet the agency's screening targets are counseled on ways to increase screening compliance, such as provider generated mailings and phone calls and using alternative EPSDT providers, such as local health departments and school based clinics. Medicaid PCPs who continually fail to meet EPSDT compliance targets after repeated counseling may have their panel of patients limited or eliminated all together.

The Monitoring of EPSDT Compliance with DMAS contracted MCOs

More than 50 percent of EPSDT eligible enrollees in Virginia are now enrolled with DMAS contracted MCOs through the Medallion II program. As of May 1999, there were 150,067 Medicaid clients enrolled in MCOs. Approximately 70 percent of these enrollees are children eligible to receive EPSDT services and as a result, these MCOs play a vital role in providing these services. In the Medallion II program, access to primary care and pediatric providers have increased by 40 percent.

Medicaid contracted MCOs must also follow the DMAS EPSDT Periodicity Schedule, which is routinely updated, based on the recommendations of the American Academy of Pediatric's Guidelines for Health Supervision III. MCO network providers are also required to follow the same diagnosis, treatment, developmental and behavioral assessment requirements mentioned earlier for DMAS' fee for service EPSDT providers.

Under the terms of the Medallion II contract, MCOs are explicitly required to provide EPSDT services to all of their enrollees under the age of 21 and have designated performance standards. EPSDT age appropriate screenings must be completed for at least 80 percent of the eligible enrolled recipients, immunizations must be completed by age two (2) for 85 percent of the eligible enrolled recipients, and Neonatal Intensive Care Unit (NICU) days must be reduced by 5 percent. Each plan is monitored against these standards each year. In addition, the MCOs must follow all applicable Federal and State EPSDT laws, which includes informing clients about the benefits of EPSDT, training their provider networks about how to carry out an EPSDT screening and making appropriate specialty referrals.

Although DMAS delegates the provision of medical services to MCOs in the Medallion II program, DMAS retains the ultimate responsibility for the recipients enrolled in Medallion II. One process recently established by DMAS to review the enrollment needs of Part C recipients is through the exception program handled by DMAS' Managed Care Clinical Coordinator. This Coordinator works with the MCOs on Part C provider issues. To help facilitate this, each MCO has designated a Case Manager to handle Part C provider issues. The Managed Care Clinical Coordinator also conducts quarterly statewide informational/discussion sessions with all MCO Case Managers and special needs groups. All Community Services Boards and early intervention providers are invited to these sessions.

DMAS also performs monitoring and oversight activities to ensure compliance with contract and EPSDT requirements. The primary method for determining the number and completeness of EPSDT screenings being carried out by the MCOs is through the evaluation of encounter data. DMAS requires each MCO participating in the Virginia Medallion II program to submit encounter data in a standardized format that details each health service given to all of their Medicaid enrollees. DMAS has been working with the contracted MCOs for over a year to refine the encounter data submission process. After submission, this data is analyzed for each MCO in relation to the number of EPSDT screenings, which should have been performed based on the DMAS EPSDT Periodicity Schedule (Exhibit A) and the assigned Medicaid recipients.

In addition, DMAS closely monitors health service utilization, member satisfaction and quality through its contracted independent peer review organization (Keystone Peer Review Organization, Inc. (KeyPRO)) and contracted university studies through Virginia Commonwealth University and George Mason University. Parents/guardians and adult recipients are asked about access and satisfaction with their MCO providers for themselves and their children. George Mason University has been retained to evaluate the immunization status of Medicaid recipients under the age of two (2). Comparisons will be made for each MCO and Medicaid Plan. They will include recommendations for actions to be taken to increase the rate of immunizations. DMAS also carries out ongoing reviews of each MCO's provider sub-contracts, marketing and recipient education material.

DMAS also has a Special Needs Liaison who works directly with the early intervention providers and councils in addressing family issues. The Special Needs Liaison attends monthly interagency council meetings as the Director's representative and is involved in the management and oversight of the program.

Ongoing DMAS Initiatives to Enhance EPSDT Training and Program Compliance

Staff at DMAS are continuing to find inventive ways to effectively inform clients about the benefits of EPSDT and re-evaluating the effectiveness of current training, informing and service provision methods. These efforts will include Part C staff, providers and families. The agency's new Medicaid Management Information System (MMIS), scheduled for implementation in 2001, will have a significant impact on the Agency's ability to expand it's EPSDT informing, training, and screening compliance. Of particular importance, will be its capability to report and track EPSDT screening, immunization and referral data at the MCO plan and PCP level, the identification by plan and PCP of children eligible for EPSDT services, and the ability to report past due screenings and future screenings of individual EPSDT eligible recipients by MCO plan and PCP. DMAS will have the capability to not only track screenings, but referrals that resulted from these screenings. These new system enhancements will allow DMAS quality assurance analysts to determine if referrals made as a result of an EPSDT screening were appropriate based on the diagnosis, whether or not the service was actually performed, and whether or not the appropriate provider carried out the service.

The implementation by DMAS of ongoing quality assurance reviews of all of our Medicaid PCPs with large panels of patients should also have a dramatic effect on the Agency's overall screening compliance rate, as well as the rate of appropriate referrals. These audits will also significantly increase the level of knowledge of our EPSDT providers about the program. One of the primary goals of quality assurance reviews will be the training of our Medicaid PCPs on the importance of EPSDT, the importance of educating their patients about preventive care, how EPSDT screenings are carried out by the provider, how the patient's medical record should be documented, and how appropriate referrals are made.

The MCOs also have targeted audits and medical record reviews for EPSDT and immunization as part of their National Committee for Quality Assurance (NCQA) and Health Plan Employer Data Information Set (HEDIS) measures. The NCQA is a private, not for profit organization dedicated to assessing and reporting on the quality of managed care plans. The Board of Directors includes employers, consumer and labor representatives, health plans, quality experts, policy makers, and providers. HEDIS, which is a part of NCQA, is a set of standardized performance measures, designed to allow for the reliable comparison of the performance of managed health care plans. The MCOs also have elaborate informational compliance measures including outreach calls, tracking systems, post-cards, outreach visits and provider incentives based on EPSDT compliance. EPSDT is part of MCO PCP contracts and evaluation. These measures demonstrate the MCOs' commitment to identifying and reaching these children.

Administration and labor costs associated with these measures are not included in the capitation rate.

Brochures, letters, notices on Medicaid cards, and other mass marketing methods will continue to be evaluated in terms of their effectiveness through the use of targeted surveys of MEDALLION, fee for service and MCO clients eligible for EPSDT. DMAS understands the importance of the EPSDT program on the health and well-being of Virginia's children who are eligible to receive EPSDT services and is committed to fully complying with Federal and State EPSDT requirements. Information on the EPSDT program is included in member newsletters, annual notices and member handbooks.

DMAS training staff are also developing multimedia training presentations in Microsoft PowerPoint that includes voice-over narration. These sessions will include on-line tutorials. These presentations will be available on the DMAS' web site, allowing anyone to download the presentation, review it at their leisure, complete a tutorial and return it to DMAS training staff with questions or suggestions. These presentations are scheduled to be completed by July of 2000. In addition, the EPSDT section of the Medicaid Physician's Manual, which is mailed to all Medicaid enrolled EPSDT providers, will be available "on-line" for easy viewing and downloading. These initiatives will make available to Part C staff, providers and parents detailed information regarding EPSDT.

CONTRACTS BETWEEN THE MANAGED CARE ORGANIZATIONS AND DMAS

Medallion II is the mandatory managed care program that requires enrollment in a contracted Managed Care Organization for certain groups of Medicaid recipients. This program began in 1996 and currently has seven (7) MCOs who administer services to approximately 160,000 Medicaid recipients. The MCOs must, by contract, offer the same services provided to recipients under fee for service Medicaid to the extent as these services are noted in the State Plan of Virginia. Individuals who are exempt from Medallion II include those individuals that have other comprehensive insurance coverage, individuals who reside in nursing homes or other skilled care facilities, and participants of Federal waiver programs.

To become a contractor for DMAS, each MCO must be licensed by the Virginia Bureau of Insurance (BOI). BOI requirements for all MCOs operating in Virginia include proof of financial stability, BOI approved complaint systems, processes in place to pay provider claims accurately and timely, adequate arrangements for availability and accessibility to health services, and a sufficient network for the enrolled population. DMAS builds on the BOI requirements by also requiring MCOs to secure and retain accreditation by a nationally recognized accrediting agency such as the National Committee for Quality Assurance (NCQA). Half of the MCOs in the nation, covering three-quarters of all MCO enrollees, are currently involved in the NCQA Accreditation process. During the accreditation process, plans are reviewed against more than 60 different standards

including a member satisfaction survey. The standards fall into the following five broad categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness. One of the criterion of the NCQA is that each MCO must have enough providers in their networks and take into consideration the health care needs of their specific populations when contracting with providers. For MCOs contracting with Medicaid, this means that there must be an emphasis on providers specializing in early childhood and youth services. Each MCO is also required under NCQA to achieve clinical results which are demonstrated by successfully meeting standards on several items including childhood immunization status.

NCQA also requires a rigorous and on-going credentialing process for all providers and facilities contracting with a MCO. A MCO may not contract with a non-credentialed provider and retain NCQA accreditation. The NCQA standard ensures that all providers have met a national standard for education and training, licensure, and office practice.

Each MCO must guarantee to DMAS that all DMAS covered services are included in the services they provide. This includes enrolling early childhood specialists in their networks or otherwise arranging care by these providers. These early childhood specialist providers, in addition to the Part C providers, are necessary to render the needed services to all Part C enrolled children. The MCOs are responsible for arranging for and administering covered services to enrollees and for ensuring that it provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. The MCOs must also cover services furnished in facilities or by practitioners outside the MCOs' networks if the needed medical services or necessary supplementary resources are not available in the MCOs' networks. This provides the MCOs with greater access than under traditional Medicaid as Medicaid can only reimburse within its network, thereby excluding some commercial only providers. MCOs must develop and maintain a list of referral sources which includes community agencies, state agencies, "safety net" providers (i.e., free clinics, school-based services, community health centers, public hospital clinics, federally qualified health centers, rural health clinics, maternal and child public health services), teaching institutions and facilities that are needed to ensure that the enrollees are able to access and receive the services required.

12 VAC 30-50-410 and 12 VAC 30-50-280 mandate comprehensive services to pregnant women, postpartum women, and infants and toddlers up to the age of two (2). All contracted MCOs are to comply with these regulations. They must annually submit a plan to DMAS that fully describes the services they will provide, how the services will meet the program goals and how the MCO will measure and monitor program health care outcomes. The program services must include case management services to minimize fragmentation of care, reduce barriers, and link recipients with appropriate services. Assessments to determine recipient's psychosocial, nutrition and medical needs are to be performed. The implementation of the DMAS approved plan helps ensure identification of infants with developmental needs. Care coordination for those infants and toddlers can then occur. It should be noted that two (2) of the MCOs that contract with DMAS have won national recognition awards for their maternal infant programs.

MCOs must also establish referral mechanisms to link enrollees with providers and programs not covered through Medallion II or Medicaid; maintain a current list of providers, agencies, and programs; and provide the list to enrollees who have needs for those programs. Each PCP must have a list of all referral sources. The MCOs must refer enrollees who are potentially eligible for or qualify for Early Intervention Services to local interagency councils. They should also maintain a listing of local interagency councils and make that listing available to all qualified enrollees.

Disputes between the MCO and enrollees about medical necessity and the scope of services provided may be appealed to DMAS by the enrollee. DMAS' determination will be based on whether Medicaid would have covered that service on a fee for service basis or whether the service meets the criteria for an additional service as provided under the contract.

DMAS provides monitoring to ensure access to services and to ensure adequate provider networks. These monitoring activities are carried out by DMAS and the DMAS contractor, Birch & Davis Health Management Corporation (BDHMC). MCOs are audited through reports and encounter data. Activities include monthly meetings, on-site reviews, submission of reports, and analysis of complaint/grievance data. The MCOs' complaints have been consistently low (e.g. 5 per 1000 recipients).

The MCO must submit to DMAS their provider file thirty (30) days prior to the effective date of their contract and quarterly thereafter. Any changes to the network must be reported to DMAS to ensure that network provider participation remains adequate.

The DMAS contract with the MCOs require that the MCOs must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid enrollees, and there must be one (1) FTE PCP with pediatric training and/or experience for every 2,500 enrollees under the age of eighteen (18). The MCOs exceed this standard. In Tidewater, PCP enrollment has increased by 44 percent and in Central Virginia, PCP enrollment has increased by 56 percent, since DMAS contracted with the MCOs. The MCOs must maintain in their networks and in their referral listing a number of specialists which is adequate to provide covered services to its Medallion II enrollees, and include a Pediatric Physical Medicine and Rehabilitation specialist. For an enrollee who is a member of a special needs population, the MCO must have in place a primary care system of care delivery which includes a comprehensive plan of care and which uses a coordinated and continuous case management approach, involving the enrollee and, as appropriate, the enrollee's family, guardian, or caregiver in all aspects of care.

MCOs must meet travel time and distance requirements as well. The MCOs must ensure that each enrollee will have a choice of at least two (2) PCPs located within no more that thirty (30) minutes travel time from any enrollee in urban areas and within no more than sixty (60) minutes travel time from any enrollee in rural areas. Travel time shall be based on driving during normal traffic conditions (i.e., not during commuting hours). The

MCOs must also ensure that each enrollee will have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and within no more than a thirty (30) mile radius in rural areas.

The MCOs must have in place a system to monitor its provider network to ensure that the access standards set forth in the contract are met and must be prepared to demonstrate to DMAS that these access standards have been met. DMAS reviews each MCO annually to ensure that these access standards are met and that the MCO continues to meet the requirements as outlined in the contract. Member satisfaction surveys are conducted by an independent contractor and the results are reported to DMAS. Satisfaction with providers and access are stressed in the survey. There has been high satisfaction with Medallion II based on an independently conducted Household Survey. Results of the last survey reported that more than 90 percent of the Medicaid Medallion II respondents were satisfied with the medical care and treatment they received and 92 percent reported having no problem in accessing specialty care.

Complaint Tracking System

One mechanism which is used to determine if Part C recipients are not receiving adequate services is through the complaint tracking system. Managed care inquiries, complaints, grievances and appeals are obtained from the following three sources: the enrollment broker (Benova), DMAS Helplines, and the MCOs. Benova maintains a toll free Managed Care Helpline for DMAS. All calls received are logged in on a database and all calls that are classified as complaints are documented on a Complaint Report. This report is forwarded to the DMAS Enrollment Broker Liaison on a weekly basis. The Enrollment Broker Liaison reviews the Complaint Report and routes copies of complaints to the appropriate DMAS staff in the Medallion Unit or MCO Unit for resolution.

DMAS currently maintains two internal Helplines, one for providers and one for recipients. The Provider and Recipient Helplines receive and handle both managed care and fee for service calls. The Helpline staff responds to all inquiries received for which sufficient information is available to provide a response. If the Helpline is unable to respond to an inquiry, the caller will be referred to the MCO, Benova, or the MCO Unit at DMAS for a response.

The MCOs routinely receive inquiry, complaint and grievance type communications either by telephone or in writing. The process for handling inquiries, complaints and grievances varies from MCO to MCO but must be approved by DMAS. Each MCO has its own system for documenting and tracking calls. In addition, each MCO must use the DMAS classification system for classifying complaints received and the MCOs must submit a monthly report to DMAS. For MCOs the complaints and grievances are classified by the following categories which are identified in the contract: (1) Access to Health Care Services, (2) Utilization and Medical Management, (3) Providers Care and Treatment, (4) Payment and Reimbursement Issues, and (5) Administrative Issues. The information that must be included for the DMAS database includes the name of the

enrollee, provider type, complaint code, description of complaint, resolution date, if it appears to be a trend, action taken and if follow up is needed.

Any formal grievance decision or adverse action by a MCO may be appealed by the enrollee to DMAS in accordance with the Client Appeals regulations. Medallion II enrollees may also appeal adverse decisions by the PCP or DMAS to deny, terminate or reduce services. Managed care enrollees receive written notice of their right to file a grievance and request a fair hearing at enrollment at least ten days before a proposed adverse action is implemented. The Appeals Division only accepts written requests for a fair hearing. DMAS will grant a hearing to any enrollee who requests one within thirty days from the date of the notice.

Process for Part C Recipients to Disenroll from a MCO

Over the past two General Assembly sessions, DMAS worked closely with the early intervention providers in regards to their transitional issues with managed care. A workgroup was formed, as a result of House Joint Resolution 581 from the 1998 General Assembly session, in which the early intervention providers and MCOs received extensive training.

In the 1999 session, House Bill 2617 was introduced to mandate a carve out of children enrolled in Part C. DMAS, MCO staff and Part C staff agreed upon a compromise which provided a mechanism to disenroll certain early intervention children from MCOs if the MCO is unable to provide all the services to a child within their network. This process was unique as it fostered a cohesiveness between the providers, MCOs and DMAS. DMAS took this commitment seriously and began workgroup meetings the first week of March. The workgroup consisted of local council representatives, representatives from DMAS, and DMHMRSAS representatives. Emergency Regulations were created and HCFA approval sought. DMAS is pleased to announce that we were able to complete both processes three months earlier than expected, thereby, implementing the process by October 1, 1999. The approved process and sample letters are included as Exhibit B. The process is as follows:

(1) Recipient must be a certified Part C child,
(2) There must be a comprehensive Individualized Family Service Plan (IFSP) signed by the team working on the IFSP, including the primary care physician. The IFSP must indicate all services needed by the child and the name of the provider of all services,
(3) Request for exception must come from the Council Coordinator not the Service Coordinator and the parent/caregiver must sign this request,
(4) They must have gone through the first two steps of the process prior to making this request, and
(5) They must have followed the MCO's requirements for preauthorization, participation, etc. for all required services. This is not a process to circumvent those requirements.

The information required by DMAS for this process includes:

(1) Comprehensive IFSP (if it is not comprehensive, DMAS will return for completion). In order to be considered comprehensive, an IFSP must include the following:
   - information about the child's status
   - family information
   - outcomes expected to be achieved
   - statement of the specific early intervention services necessary to meet the needs of the child and the family to achieve the outcomes
   - other services the child needs as well as the funding sources for these services
   - the projected dates for initiation of the services and the duration for the services
   - name of the service coordinator, and
   - the steps to be taken to support the transition of the child to preschool services or other services

(2) Statement signed by the PCP indicating agreement with the IFSP, or the PCP's signature on the IFSP. The PCP referral can be substituted for the signed IFSP or statement until it is obtained,

(3) Log or documentation of communication between Part C representatives and the MCO. This must include dates and names of contacts with the MCO. (Each MCO has a designated Case Manager to handle Part C provider issues), and

(4) Any clinical documentation that is pertinent to the problems identified.

There are time frames in place to ensure the timely response to complaints and issues. The exception process that must be followed is:

- The Part C Service Coordinator will report to the Part C Council Coordinator if the MCO has failed to respond or resolve an identified issue within four (4) working days (the one (1) working day acknowledgement time and the three (3) working days response time). If the Part C Council Coordinator finds the issue cannot be resolved, a written request for exception for participation in Medallion II will be sent to the DMAS Managed Care Clinical Coordinator or designee on behalf of the family.

- The Part C Council Coordinator must submit both a written request for exception and the required information needed by DMAS. Required information includes the comprehensive Individualized Family Service Plan (IFSP), documentation of PCP agreement with the IFSP, log of communication of Part C representatives and the MCO, and pertinent clinical documentation. The Managed Care Clinical Coordinator or designee will, within three (3) working days of receipt, review the submitted documentation.

- If the Managed Care Clinical Coordinator or designee determines that the services are not covered under Medicaid, a letter will be addressed to the family/guardian with that determination stated.

- If the Managed Care Clinical Coordinator or designee determines that the services are covered under fee for service Medicaid, contact with the MCO will be made to attempt a resolution to the issue. If the MCO resolves the issue with a temporary solution within two (2) working days and a permanent solution is found within fifteen (15) calendar days, the recipient will remain with the MCO. If the MCO believes they have made a satisfactory resolution; however, the Part C Council Coordinator does not accept the resolution, final determination will be made by DMAS' Director of the Division of Program Operations. The Managed Care Clinical Coordinator or designee will send a letter to the parent/responsible party and the Part C Council Coordinator to inform them that the child has not been excepted from participation in Medallion II and appeal rights will be given.

- If the issue cannot be resolved within the prescribed time limits stated above, the request for exception shall be approved. The Managed Care Clinical Coordinator or designee will send a letter to the parent/responsible party and the Part C Service Coordinator. The letter will state that the exception is only until the recipient reaches their third birthday and then they will return to participate in Medallion II. Since the child will no longer be in Medallion II, the Service Coordinator is responsible for the case management of this child to ensure that he/she has a PCP that accepts Medicaid. A validation of the medical home for this individual must be given to the Managed Care Clinical Coordinator or designee within thirty (30) calendar days.

- If the exact situation reoccurs for the same recipient, the Council Coordinator may contact the Managed Care Clinical Coordinator or designee directly, skipping the other steps.

- When the recipient reaches his/her third (3rd) birthday or if the circumstances for this exception change, the child will no longer be eligible to receive services through the Part C program and will lose the exception for participation in Medallion II. The recipient will be entered into the current preassignment process which determines Medallion II enrollment. Individuals not meeting criteria for exclusion must participate in Medallion II.

NOTE: If the recipient picks or is assigned a MCO that does not have their regular PCP or specialist in network, the recipient has the option to change to another MCO who has the specialist or PCP in the network. The recipient may have to choose which is more important, PCP or specialist, if all are not in the same MCO network. This is not a reason to request an exception. DMAS will maintain a record of all exception requests, exceptions granted, exception reason and MCO.

ANALYSIS OF REIMBURSEMENT RATES

The MCOs receive a capitation rate from DMAS based on age, sex, eligibility designation and region. The capitation rate is based on dollars spent for fee for service providers for an annual period less 5 percent. The capitation rate is for all contracted services, excluding administrative costs. As the MCOs are at full risk for all services, the plans have the discretion in reimbursing and contracting with providers. DMAS ensures that all contracted services are provided by the MCOs.

The following are the average DMAS rates for the most common early intervention services (physical therapy, occupational therapy, and speech-language pathology services) for calendar year 1998. Final rates are determined after the cost settlement process.

Physical Therapy	Evaluation	Individual Visit	Group Visit
	$ 125.20	$ 99.83	Not Available

Occupational Therapy	Evaluation	Individual Visit	Group Visit
	$ 126.63	$ 100.87	$ 99.40

Speech-Language Pathology	Evaluation	Individual Visit	Group Visit
	$ 145.35	$ 92.65	$ 69.64

Outpatient rehabilitation agencies enrolled in the Virginia Medicaid Program are reimbursed on a cost based methodology as opposed to individual outpatient rehabilitation providers who are reimbursed, by most commercial third party carriers, on a fee for service basis. Medicaid rates of payment are determined from annual cost reports filed by the individual provider. These reports are reviewed for allowable costs reported by the provider in accordance with the principles of reimbursement set by Medicare, unless modified by Medicaid as stated in the State Plan of Virginia. Commercial plans do not utilize this system.

The Medicaid rate of payment is set at a percentage of charges billed by the providers. This percent is determined from the ratio of total charges for all services reported by the provider to the total allowable costs for these services after review of the cost report filed. The interim rate of payment during the year is subject to settlement at the end of the current cost reporting period. At year end, a new rate is set for the next reporting period. Because these rates are clinic services and include administrative costs they are significantly higher than commercial MCO rates.

In 1996 with the implementation of Medallion II in Tidewater, the MCOs were reimbursing the Part C providers below their commercial rates. The providers voiced their concerns to DMAS and the plans. As a result, reimbursement was increased in 1997-98 across most plans to their commercial rates. One plan increased their rate by

100 percent. Another increased both their commercial and Medicaid rates for the services.

Under House Bill 2715 the commercial MCOs were mandated to cover medically necessary early intervention services in their commercial plans. This was consistent with the Federal mandate under Part C/IDEA that early intervention providers contract and utilize commercial carriers. Most providers also contract with the MCOs in the commercial line of business and understand the negotiation and contracting processes. Under the commercial plans, early intervention therapy services are reimbursed on a procedure code basis. The commercial plans contract with individual early intervention providers, whereas Medicaid contracts with agencies (i.e., a rehabilitation agency).

Most of the MCOs consider their reimbursement rates to providers to be proprietary information since the recruitment and retention of qualified providers in their networks is competitive. The MCOs reimburse Part C providers based on a fee for service schedule.

The table below identifies the MCO reimbursement for the most frequent services provided by both Medicaid and commercial plans.

Procedure Code	Types of Service	MCO A	MCO B	MCO C	MCO D	MCO E
	Physical Therapy (PT)					$49.50*
97001	Evaluation	$48.53	$33.80	$64.86	$57.17	
97002	Re-evaluation	$19.01	$13.05	$18.36	$22.39	
97110	Therapeutic Exercises	$17.83	$13.50	$25.70	$20.66	
97116	Gait Training	$15.95	$11.55	$20.71	$17.91	
	Occupational Therapy (OT)					$49.50*
97003	Evaluation	$48.53	$44.10	$64.86	$57.17	
97110	Therapeutic Exercises	$17.83	$13.50	$25.70	$20.66	
97112	Neuro-muscular Re-education	$17.53	$15.14	$23.53	$20.32	
97530	Therapeutic Activities	$19.03	$14.00	$21.70	$30.24	
	Speech Therapy (ST)					$49.50*
92507	Speech, Language, Voice, etc. individual treatment	$26.16	$22.59	$22.50	$29.98	
92508	Speech, language, voice, etc. Group treatment	$13.67	$12.43	$13.57	$15.67	

This fee for service method of reimbursement is quite different from the cost methodology employed by DMAS, and therefore, it is difficult to compare the DMAS and the MCO reimbursement rates for Part C Providers.

* This MCO reimburses providers for their PT, OT, and ST services on a global type basis per day. That is, for any type of PT service or combination of PT services on a given day, the reimbursement amount is $49.50, regardless of the number of PT procedure codes submitted for reimbursement. The same method is used for OT and ST service(s) reimbursement. If any two of PT, OT, or ST services are performed on the same day, then reimbursement is $99.00 (2 x $49.50.)

Access and Reimbursement

There has been a 15 percent increase in pediatric and developmental rehabilitation providers in the Medallion II region since the implementation of MCOs. Prior to the implementation of MCOs in the Tidewater and Central Virginia areas, our records indicate there were approximately fifty-five (55) designated Part C providers. Under managed care the number of rehabilitation providers has increased resulting in better access and more recipient choice of providers.

The Medicaid MCOs currently contracting with DMAS have at least 64 providers who identify themselves as providers of pediatric rehabilitation and developmental services. This number not only includes at least thirty (30) designated Part C providers but also includes approximately thirty-four (34) additional providers who are qualified to perform pediatric rehabilitation and developmental services.

If, however, the current contracted Part C providers do not make themselves available for network participation, the Medicaid MCOs would seek out other providers that are sufficiently qualified to perform these services to participate in their networks and, if needed, contract with providers to render these services out of network. The MCOs are required by Medicaid's Medallion II contract, as well as NCQA standards, to ensure sufficient numbers of potential network providers for all Medicaid covered medically necessary services.

CONCLUSION

DMAS has enhanced and expanded training on the availability of, access to and use of EPSDT by conducting training sessions for physicians, school-based clinics, Part C/IDEA staff and MCO staff. DMAS has also improved access to EPSDT training materials and provider manuals by making them available on the DMAS web site. In order to ensure that Part C recipients have access to needed early intervention services, DMAS, MCO staff and Part C staff developed a mechanism to disenroll certain early intervention children from MCOs if the MCO is unable to provide all the services to a child within their network. The MCOs must cover services furnished in facilities or by practitioners outside the MCOs' networks if the needed medical services are not available in the MCOs' networks. This provides the MCOs with greater access than under traditional Medicaid as Medicaid can only reimburse within its network, thereby excluding some commercial only providers. It has been determined that the rates reimbursed to Part C providers by the MCOs are sufficient to attract providers to the MCO networks.

EXHIBIT A

APPENDIX 1
Virginia EPSDT Periodicity Schedule

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				ADOLESCENCE				
AGE[1]	By1m	2m	4m	6m	9m	12m	15m	18m	24m	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY																				
Initial/interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																				
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•											
Blood Pressure										•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																				
Vision[2]	s	s	s	s	s	s	s	s	s	o[2]	o	o	s	s	o	o	s	s	o	s
Hearing[2]	s	s	s	s	s	s	s	s	s	o[2]	o	o	s	s	o	o	s	s	o	s
DEVEL/BEHAVIORAL ASSESSMENT[3]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES GENERAL																				
Hereditary /Metabolic Screening[5]	<---•																			
Immunization[6]	<---•	•	•	•		<---•--->					<---•--->					---•--->				
Lead Screening					<---•				•											
Hematocrit or Hemglobin[7]	<---•--->															<---•[7]--->				
Urinalysis[8]												•				<---•[8]--->				
PROCEDURES-PATIENTS AT RISK																				
Tuberculin Test[9]						*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening[10]									*	*	*	*	*	*	*	*	*	*	*	*
STD Screening																s	s	s	s	s
Pelvic Exam[11]																*	*	*	<-*--->	*
ANTICIPATORY GUIDANCE[12]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[13]						<---•--->														

[1] If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
[2] If the patient is uncooperative, rescreen within six months.
[3] By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
[4] At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
[5] Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to State law.
[6] Schedule(s) per the Committee on Infectious Diseases, published periodically in Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations
[7] All menstruating adolescents should be screened.
[8] Conduct dipstick urinalysis for leukocytes for male and female adolescents.
[9] TB testing per AAP statement "Screening for Tuberculosis in Infant and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.
[10] Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
[11] A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between ages of 18 and 21 years.
[12] Appropriate discussion and counseling should be an integral part of each visit for care.
[13] Earlier initial dental evaluation may be appropriate for some children. Subsequent semi-annual examinations by a dentist

Key: • = to be performed * = to be performed for patients at risk s = subjective, by history o = objective, by standard testing method
<----------> = the range during which a service may be provided, with the dot indicating the preferred age.

EXHIBIT B

DMAS Process for Medallion II Exception for Part C Recipients

Any communication, either by phone or letter with the Managed Care Clinical Coordinator or designee regarding PT, OT or Speech therapies for a child under the age of three will result in the initiation of a letter requesting an Exceptional Needs Care Coordinator from the HMO. (see attachment 1). NOTE: This is not part of the Exception process but serves as a primary tool to alert the HMO Case Manager to potential Part C recipients and their special needs.

DMAS Process for Medallion II Exception for Part C Recipients

1. The Part C Service Coordinator will report to the Part C Council Coordinator if the HMO has failed to respond or resolve an identified issue within four working days (the 1 working day acknowledgement time and the 3 working days response time). If the Part C Council Coordinator finds the issue cannot be resolved, a written request for exception for participation in Medallion II will be sent to the DMAS Managed Care Clinical Coordinator or designee on behalf of the family.

2. The Part C Council Coordinator must submit both a written request for exception and the required information needed by DMAS. Required information includes the Comprehensive IFSP, documentation of PCP agreement with the IFSP, log of communication of Part C representatives and the HMO, and pertinent clinical documentation. The Managed Care Clinical Coordinator or designee will, within three (3) working days of receipt, review the submitted documentation. Note: incomplete or illegible documents will result in a denial for exception. (see attachment 2)

3. If the Managed Care Clinical Coordinator or designee determines that the services are not covered under Medicaid, a letter will be addressed to the family/guardian with that determination stated. (see attachment 3)

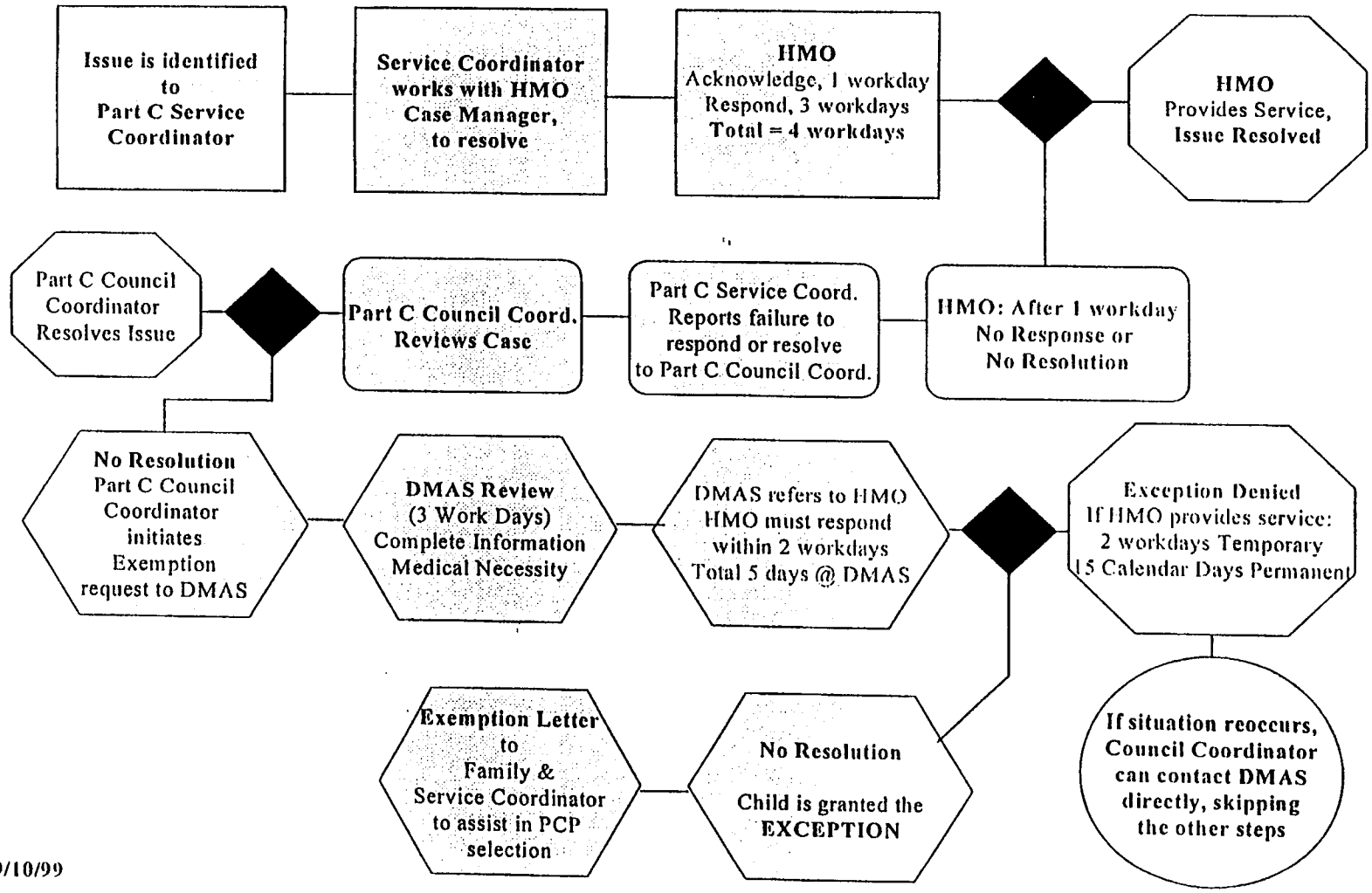
4. If the Managed Care Clinical Coordinator or designee determines that the services are covered under fee for service Medicaid, contact with the HMO will be made to attempt a resolution to the issue. If the HMO resolves the issue with a temporary solution within two (2) working days and a permanent solution is found within fifteen (15) calendar days, the recipient will remain with the HMO. If the HMO believes they have made a satisfactory resolution but the Part C Council Coordinator does not accept the resolution, final determination will be made by DMAS' Division Director. The Managed Care Clinical Coordinator or designee will send a letter to the parent/responsible party and the Part C Council Coordinator to inform them that the child has not been excepted from participation in Medallion II and appeal rights will be given. (see attachment 4)

5. If the issue cannot be resolve within the prescribed time limits stated above, the request for exception shall be approved. The Managed Care Clinical Coordinator or designee will send a letter to the parent/responsible party and the Part C Service Coordinator. The letter will state that the exception is only until the recipient reaches their third birthday and then they will return to participate in Medallion II. Since the child will no longer be in Medallion II, the Service Coordinator is responsible for the case management of this child to ensure that he/she has a PCP that accepts Medicaid. A validation of the medical home for this individual must be given to the Managed Care Clinical Coordinator or designee within thirty (30) days. (see attachment 5)

6. If the exact situation reoccurs for the same recipient, the Council Coordinator may contact the Managed Care Clinical Coordinator or designee directly, skipping the other steps.

7. When the recipient reaches his/her third (3rd) birthday or if the circumstances for this exception change, the child will no longer be eligible to receive services through the Part C program and will lose the exception for participation in Medallion II. The recipient will be entered into the current preassignment process which determines Medallion II enrollment. Individuals not meeting criteria for exclusion must participate in Medallion II. (see attachment 6)

Medallion II-Part C Exception Flow Chart



9/10/99

QUALIFICATIONS TO REQUEST EXEMPTIONS

- Must be a certified Part C child.
- Must have a comprehensive IFSP signed by the team working on the IFSP, including the primary care physician. The IFSP must indicate all services needed by the child and the name of the provider of all services. This should have been sent to the HMO earlier in the process.
- Request for exemption must come from the Council Coordinator not the Service Coordinator; parent/caretaker must sign the request.
- Must have gone through the first 2 steps of the process prior to making this request.
- Must have followed the HMOs requirements for preauthorization, participation, etc. for all required services. This is not a process to circumvent those requirements.

INFORMATION NEEDED BY DMAS

- Comprehensive IFSP (if not comprehensive, DMAS will return for completion). In order to be considered comprehensive, an IFSP must include the following information about the child's status: family information, outcomes expected to be achieved, statement of the specific early intervention services necessary to meet the needs of the child and the family to achieve the outcomes, other services the child needs as well as the funding sources for these services, the projected dates for initiation of the services and the duration for the services, name of the service coordinator and the steps to be taken to support the transition of the child to preschool services or other services.
- A statement signed by the PCP indicating agreement with the IFSP, or the PCP's signature on the IFSP. The PCP referral can be substituted for the signed IFSP or statement until it is obtained.
- Log or documentation of communication between Part C representatives and the HMO. Must include dates and names of contacts with the HMO.
- Any clinical documentation that is pertinent to the problems encountered.

PLEASE NOTE

If recipient picks or is assigned an HMO that does not have their regular PCP or specialist in network, recipient has the option to change to another HMO who has the specialist or PCP in the network (recipient may have to choose which is more important, PCP or specialists if all are not in the same HMO network). This is not a reason to request an exemption.

Services that have been reduced or denied by the HMO must be dealt with through the HMO grievance and appeals process. Change of HMO is available through the Managed Care Helpline.

Follow up must be done and documentation must include: results, who the involved parties were, and what was discussed or shared with the HMO. In the event that either the designated HMO Case Manager, DMAS representative, or the Part C Service our Council Coordinator is not available, there must be someone assigned as their back up who is able to handle the cases as they come in.

DMAS will maintain a record of all exemption requests, exemptions granted, reason and HMO.

ATTACHMENT 1

<date>

((HMO_NAME))
((HMO_ADD1))
((HMO_ADD2))
((CITY_ST_ZIP))

RE: ((CLIENT_NAME))
((CLIENT_ID))

We have learned from ((our Managed Care Helpline)) that the above referenced client has complex health care needs (<CONDITION>) and has experienced difficulty navigating through the Managed Care system. While the medical condition does not warrant exemption from Medallion II, this client would benefit from the one-on-one services of an Exceptional Needs Coordinator within your HMO.

It is unknown how long this recipient will require monitoring and guidance through the Managed Care System. Nonetheless, we are confident that the case management team at ((HMO_NAME)) will be responsive to this member's needs.

We look forward to hearing progress reports as soon as new information is available.

Sincerely yours,

DMAS
Managed Care Clinical Coordinator

/krr
cc: Benova

ATTACHMENT 2

Date

Part C Council Coordinator
Name
Address
City, VA zip

Dear <name>:

The request for exception from participation in Medallion was received on <date> for the Part C recipient <name>.

The request for exception from participation in Medallion II is denied due to illegible/incomplete required information necessary for evaluation and review.

If the parent or guardian disagrees with this decision, the parent or guardian may appeal. An appeal must be presented in writing within thirty (30) days of receipt of this letter. Send the written appeal to Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Sincerely,

Kathleen Dickerson, RN
Managed Care Clinical Coordinator

CC: <recipient>
<HMO>

ATTACHMENT 3

Date

<parent/responsible party>
<address>
<city>

Dear <name>:

The request for exception from participation in Medallion II along with the required documentation was received on <date> for the Part C recipient <name>.

The review of the information received was evaluated based on standards applicable to the Health Maintenance Organizations' (HMOs) contractual agreement with the Department of Medical Assistance Services (DMAS) and other state and federal requirements. This review gives us an opportunity to ensure the HMO and their subcontractors provide all medically necessary services.

Based upon the submitted documentation, it was determined that the service requested is not a covered benefit under Medicaid.

The request for exception from participation in Medallion II is denied. The recipient's enrollment in <HMO> is continued.

If you disagree with this decision, you may appeal. An appeal must be presented in writing within thirty (30) days of receipt of this letter. Send the written appeal to Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Sincerely,

Kathleen Dickerson, RN
Managed Care Clinical Coordinator

CC: <Part C Council Coordinator>
<HMO>

ATTACHMENT 4

<Date>

<parent>
<address>
<city, VA zip>

Dear M. <parent>:

The request for exception from participation in Medallion II along with the required documentation was received on <date> for the Part C recipient <child's name>. The request for exception was submitted by your Part C Council Coordinator <name>.

The review of the information received was evaluated based on standards applicable to the Health Maintenance Organizations' (HMOs) contractual agreement with the Department of Medical Assistance Services (DMAS) and other state and federal requirements. This kind of review gives us an opportunity to ensure the HMO and their subcontractors provide all medically necessary services.

By working with your child's HMO <name HMO> it was determined that the services and issues surrounding these services have been resolved. Therefore, the request for exception from participation in Medallion II is denied. <child's name> enrollment in <HMO> is continued.

If you disagree with this decision, you may appeal. An appeal must be presented in writing within thirty (30) days of receipt of this letter. Send the written appeal to Division of Client Appeals, Department of medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Sincerely,

Kathleen Dickerson, RN
Managed Care Clinical Coordinator

CC: <Part C Council Coordinator
<HMO>

ATTACHMENT 5

<date>

<responsible party/parent>
<address>
<city, VA zip>

Dear M. <name>:

The request for exception from participating in Medallion II was received on <date> for the Part C recipient <child's name>.

The review of the information received was evaluated based on standards applicable to the Health Maintenance Organizations' (HMOs) contractual agreement with the Department of Medical Assistance Services (DMAS) and other state and federal requirements.

It has been determined that a resolution to the disputed issue has not been agreed upon by all the parties involved. Therefore, the request for exception from participation in Medallion II is approved. The limits of this exception for Part C individuals extend only until the third birthday of the recipient or until the circumstances for this exception change. The Agency reserves the right to monitor the need for this exception. At the time of <child's name> third birthday, unless other exclusion criteria are met, participation in Medallion II will be mandatory.

Because <child's name> is no longer in Medicaid managed care program, it will be the responsibility of the Part C Service Coordinator to coordinate the care of <child's name> to ensure that he/she has a Medicaid Primary Care Provider (PCP).

<child's name> will receive a Medicaid care effective <date>.

If you disagree with this decision, you may appeal. An appeal must be presented in writing within thirty (30) days of receipt of this letter. Send the written appeal to Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Sincerely,

Kathleen Dickerson, RN
Managed Care Clinical Coordinator

CC: <Part C Council Coordinator

ATTACHMENT 6

June 25, 1999

HMO SELECTION LETTER

Dear

A Health Maintenance Organization (HMO) will soon provide health care coverage for the family members listed on the back of this letter. This means your doctors, hospitals, drugs and specialists will be provided through an HMO. HMOs give the same services as the Department of Medical Assistance Services (DMAS). Some HMOs offer even more services.

Enclosed are a pamphlet and a chart listing the HMOs and the extra services each HMO offers. Please read this material carefully. Call our Managed Care HelpLine to:

- Find out which HMO your family doctor (PCP) belongs to. Then pick the HMO that's best for you and your family.
- Tell the HelpLine which HMO and family doctor (PCP) you want.

If you do not call by August 9, 1999, you and/or the family members listed will be assigned to the HMO(s) listed.

If you wish to be enrolled in the HMO listed, you do not need to call the HelpLine.

In about two months, we will notify you of your HMO enrollment. Once your HMO enrollment is effective, you will receive an HMO membership card instead of a card from the Department of Medical Assistance Services.

If you have questions about this letter or any of the HMOs, call the Managed Care HelpLine.

Sincerely,

Managed Care Operations

1-800 MGD-CARE (1-800-643-2273)
TDD #1-800-817-6608
Monday-Friday 7:00 am. – 7:00 p.m.
(Translation Services Available)

MEDICAID HMO EARLY INTERVENTION

HMO	Address	Customer Service Number	Early Intervention Case Manager	Telephone/Fax
CareNet: Southern Health Services	9881 Mayland Drive Richmond, VA 23233	1-800-279-1878 1-800-967-9186	Janie Clark	1-804-747-3700 ext. 1155 1-804-935-0265 (fax)
Optimum Choice, Inc.	3951 Westerre Parkway Suite 200 Richmond, VA 23233	1-800-343-8205	Linda Gilson	1-301-545-5743 1-804-270-6479 (fax)
Sentara Family Care	4417 Corporation Lane Virginia Beach, VA 23462	1-800-SENTARA 1-757-552-8888	Carol Swanson	1-757-552-7280 1-757-552-7249 (Fax)
Trigon HealthKeepers Plus HealthKeepers, Inc.	2015 Staples Mill Road Richmond, VA 23230	1-800-758-7066 1-757-591-5260	Debbie Foard	1-804-354-2571 1-804-354-3882 (Fax)
Trigon HealthKeepers Plus Peninsula Health Care, Inc.	334 Main Street Newport News, VA 23601	1-800-758-7066 1-757-591-5260	Julia Kiriazidis	1-757-875-5790 1-757-875-5160 (Fax)
Trigon HealthKeepers Plus Priority Health Care, Inc.	621 Lynnhaven Parkway Suite 450 Virginia Beach, VA 23452	1-800-901-0200 1-757-431-5090	Jeanne Fink	1-757-431-5765 1-757-340-2329 (Fax)
Virginia Chartered Health Plan	P.O. Box 5307 Richmond, VA 23220-0307 600 E. Broad Street Suite 400 Richmond, VA 23219-1800	1-800-289-1970 1-800-828-7953	Constance Goodman Tidewater Kate Pevsner Richmond	1-800-828-7989 1-757-166-1133 (Fax) 1-804-819-5151 ext. 5208 1-804-819-5187/6 (Fax)