Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Protecting and Promoting Medicaid's Guaranteed Benefits for Children: EPSDT and Managed Care
Iowa Case Study

With support from the Georgetown University Center for Children and Families under a Robert Wood Johnson Foundation grant, the Child and Family Policy Center (CFPC, also referred to as the Center) engaged in activities in 2017 to protect and strengthen Medicaid's critical pediatric benefit in the context of Iowa's managed care rollout. CFPC welcomed this opportunity because during the state's rapid transition to Medicaid managed care, children's issues were largely put on the back burner. Facing more pressing issues, neither the state, MCOs, nor providers prioritized promoting and protecting EPSDT. This project allowed the Center to not only promote the EPSDT benefit specifically but also elevate the importance of children's health care needs within Medicaid more generally and give children a "seat at the table" with key stakeholders.

It also gave the Center the chance to engage in positive, proactive work to improve the quality of care for Iowa kids, a welcome shift from the more defensive stance the Center has recently taken to protect access to health care. Protecting access and improving quality are complimentary efforts because access to health coverage is only as good as the quality of care that such coverage makes available.

Background

In January 2015, then-Governor Terry Branstad announced that Iowa would convert its $4 billion Medicaid program from a fee-for-service model to a managed care model delivered through for-profit managed care organizations (MCOs). The Governor's office projected the state would save over $100 million during the first year of managed care and set an ambitious implementation start date of January 1, 2016.

Gov. Branstad's announcement came as a surprise to many in the state legislature, and members of both parties expressed concerns with the managed care model itself and/or the rapid timeline. At the time, the only exceptions to fee-for-service in Iowa were the "Iowa Plan" (managed care program for mental health and substance abuse services) and a geographically limited pilot program. Concerns fell on deaf ears within the administration, however, and in August 2015, the state awarded contracts to four MCOs: Amerigroup Iowa, UnitedHealthcare Plan of the River Valley, WellCare of Iowa, and AmeriHealth Caritas Iowa.

Four months later—and only two weeks before the targeted implementation date—after conducting a readiness assessment, CMS announced that "we do not believe Iowa is ready to make this transition Jan. 1," and pushed the start date back to March 1, 2016. One day later, the director of the Iowa Department of Administrative Services announced that the

state would terminate its contract with WellCare for failing to disclose relevant information during the procurement process.

At the end of February, Iowa finally received federal approval to implement managed care but again pushed back the start date, this time to April 1, 2016. That date held, and 15 months after the Governor announced his intent to adopt managed care, virtually all of Iowa's 500,000 Medicaid members began receiving services through one of three MCOs.

Nearly two years down the road, the transition to Medicaid managed care in Iowa remains rocky. Instead of realizing the $100 million in savings the Governor projected, MCOs reported "catastrophic losses" of over $400 million in the first year of implementation. After less than two years of operation, AmeriHealth Caritas gave only a one-month notice before exiting the Iowa market on December 1, 2017. Citing limited capacity at Amerigroup, one of two remaining MCOs, the state temporarily suspended member choice until May 2018. The impact on providers and enrollees is significant as providers report substantial delays in payments from MCOs and members struggle to get access to necessary services.

Overall Strategy

In order to protect and strengthen EPSDT in Iowa, the Center organized its efforts into three strategic areas:

- Launch an education and awareness campaign targeting payers, enrollees, and fellow advocates.
- Build a collaborative relationship with the state Medicaid agency and the three MCOs.
- Gather, analyze, and disseminate outcome data to identify trends in access and quality.

Education and awareness campaign
Recognizing the complex nature of the EPSDT benefit, CFPC developed training and informational materials to educate various stakeholders involved in the delivery, management and utilization of the benefit. After hearing confusion from providers about the type of services covered under EPSDT, the Center focused its efforts on equipping health care providers with information to help them understand the full scope of benefits to which their Medicaid pediatric patients are guaranteed.

In order to maximize its reach, the Center conducted trainings with the state's two largest health systems and largest public hospital. One of the trainings was held during a monthly pediatric conference, another was held during a special event targeting pediatric residents and the third was a 'lunch and learn' event for pediatric clinical staff. The Center gave an overview of the EPSDT benefit, key provisions providers should know, challenges providers face in providing this benefit, and resources that would be helpful in addressing barriers.

Understanding that the delivery of the EPSDT benefit often extends beyond the health care field, CFPC also conducted a training for early-childhood professionals, including those in the early care and education and family support systems. While almost all of the children served by these early-childhood programs are enrolled in Medicaid, most of the early childhood professionals were not familiar with the full range of services and protections provided by EPSDT.

Collaboration with state Medicaid agency and MCOs
The Center's next strategy focused on building collaborative relationships with the state Medicaid agency (Iowa Medicaid Enterprise or IME) and three MCOs. A first step was to bring key partners together on a regular basis for open discussion, brainstorming, and troubleshooting. CFPC worked with a small group of other advocates to convene the Medicaid Modernization Strategic Planning Group (MMSPG). The planning group brought together providers (from hospitals systems, private practices and community-based organizations), high-level representatives from each MCO, state Medicaid representatives, and advocates for biweekly meetings.

During these meetings the group identified and addressed individual problems, "connected the dots" to tackle these problems systemically, and revisited previously addressed issues to ensure policy changes were actually implemented at the practice level. Group leaders intentionally adopted a solutions orientation to create a positive, trusting relationship among stakeholders. By helping facilitate these regular meetings, the Center built collaborative relationships with both IME and the MCOs to work on specific issues related to EPSDT.

The MMSPG worked with IME to clarify the scope of services provided by the MCOs and ensure that protections written into the state's contract with the MCOs were fully implemented. For example, the contract specifically states that EPSDT screening services do not require prior authorization or referral. Providers participating in the biweekly meetings reported that not only were the MCOs requiring prior authorization for these services, these services were at times not being approved or paid. This issue was brought to the attention of IME and the MCOs and as a result, IME issued a policy clarification letter to the MCOs providing formal guidance regarding payment for these services.

The group identified other EPSDT provisions that were written into the state's contracts with MCOs but were not being followed in practice, including ensuring that 19- and 20-year-olds in Iowa's Medicaid adult expansion population received the full EPSDT benefit, as required federally. Another issue was assuring that providers were promptly paid for preventive services covered through EPSDT. While plans must avoid costs by coordinating the payment of services that should be paid by a third party (i.e., an employer plan covering the child), the MCO contracts clearly outline exceptions for pediatric preventive services. These "pay and chase" provisions are intended to ensure that access to preventive services is not harmed by a lack of timely reimbursement. The MMSPG served as a useful forum to address these and other concerns by bringing together the MCOs representatives overseeing implementation of the policies and IME staff responsible for enforcing policies

with providers who could provide on-the-ground experience and examples and advocates to help connect the dots.

CFPC also built on the collaborative relationships established at these meetings to work with MCOs on three additional actions: adopting a single standardized health risk assessment (HRA); integrating risk factors associated with social determinants of health (housing, food, etc.); and extending EPSDT benefits to Iowa's CHIP population. The MCOs are required to complete HRAs for their members, but each one uses a different tool—asking different questions to identify a different range of health needs. CFPC's first goal was to encourage the MCOs to standardize their assessment. Using a standardized HRA across the three MCOs would allow for richer data collection and analysis on health status at the population level. Standardized risk assessments would also allow consistency of information as Medicaid members transfer from one MCO to another. Unfortunately, after meeting with the MCOs, it became apparent it would not be feasible to implement a standardized HRA, at least in the near future. Each MCO was committed to using its own assessment tool so it could compare results across the states in which it operates. Although there was not traction with standardization, CFPC was able to see progress among the MCOs in their interest in including social determinants of health in their health risk assessments. For example, one of the MCOs includes questions about food security and housing needs as part of their HRA. Both MCOs are now participating in a social determinants of health planning group that is working to collect and analyze data on social determinants of health.

CFPC also hoped to encourage AmeriGroup and United to follow the example of AmeriHealth Caritas and cover EPSDT benefits for CHIP members as a value-added service for its members. Unfortunately, AmeriHealth's sudden departure from the Iowa market made it more difficult to pressure the other two MCOs to offer this service.

Gather, analyze and disseminate outcome data
The Center has worked to track and evaluate outcome data (well-child visit rates, immunization rates, percent of eligible and enrolled children, etc.) leading up to, during and after the start of managed care. The heightened awareness of EPSDT in the context of the move to Medicaid managed care resulted in legislative interest in requiring the MCOs to uniformly report EPSDT data. Although the measure fell short of specificity on EPSDT, it did require the MCOs to report children's health outcomes.

CFPC is also working to collect and analyze data from the MCO quarterly reports, CMS Child Core Quality Measures and the federally-requirement EPSDT reporting form (CMS 416) While too early to evaluate trends since the start of manage care (the recently released child core measure data set only includes six months of managed care data), this information will provide a helpful baseline for outcome data and help advocates identify opportunities for improvement and targeted action down the road.

Challenges and Pivots

Nearly two years in, Medicaid managed care still faces many challenges making it difficult to draw attention to quality improvement initiatives like strengthening EPSDT. The state, MCOs and providers have limited bandwidth—and they are consumed with addressing core implementation issues (paying claims, maintaining network adequacy, negotiating contracts, etc.). The Center hopes that the work it has done to build and maintain relationships with these key stakeholders will pay dividends in the future as implementation challenges decrease.

Iowa's fast implementation timeline, limited legislative buy-in and overly optimistic cost-savings projections have led to the politicization of managed care. These struggles have made it a challenge to protect and promote Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which guarantees comprehensive and preventive health care services for children under age 21.

Successes and Surprises

Throughout this project, CFPC's largest success was in building and maintaining collaborative relationships with the state, the MCOs, providers and other advocates as part of the Medicaid Modernization Strategic Planning Group. The success of this group was two-fold— it created the means and space to foster positive, productive relationships among key stakeholders and it allowed for the identification and resolution of key issues and challenges.

One of the best examples relates to coverage for newborns. Since the start of managed care, newborns whose mothers have Medicaid benefits have been auto-assigned to their mother's MCO at birth. Before the newborn could be assigned an ID number through their MCO, they had to receive a State ID number. They were not able to get a State ID number until the hospital reported the birth and the mother verified the delivery with IME. The estimated time it took for all of these events to occur was 13 to 15 days. This two-week period when the baby was not yet assigned to the MCO caused delays in getting the newborn needed care. The MMSPG identified this as a problem, brought it to the attention of both the MCOs and the state, and implemented a solution: a standardized fax form (approved by the state and all MCOs) to notify the state about the child's birth and expedite assignment of state and member IDs.

Next Steps

The Center plans to build on the collaborative efforts of 2017 by continuing to conduct outreach and awareness trainings in 2018. MCOs representatives have expressed interest in trainings on the EPSDT benefit and the Center also hopes to provide more targeted training to families with children enrolled in Medicaid on the full scope of benefits they are entitled to.

In partnership with the Iowa Chapter of the American Academy of Pediatrics, CFPC also intends to identify opportunities for quality improvement projects focused on EPSDT. As

the state moves from process measures (timely claims processing) to utilization measures (well-child visit rates) as part of its pay-for-performance program, there will be greater attention on improving quality measures associated with ESPDT. Improving well-child visits in the third, fourth, fifth, and sixth years of life is also one of the state-mandated Performance Improvement Projects.

CFPC hopes that these quality improvement initiatives will create the opportunity for ongoing collaboration with the state, the MCOs and providers to strengthen EPSDT in Iowa.

Lessons Learned and Advice to Advocates

Child health advocates have a key role to play in helping their states strengthen delivery and management of the EPSDT benefit. The benefit is complex and can be difficult to monitor. By positioning themselves as resources, advocates can become valuable partners to providers, plans, state Medicaid agencies and members and help these key players unpack their responsibilities for implementing EPSDT.

Forming a small task force or advisory group with representation from providers (e.g. American Academy of Pediatrics), MCOs, the state Medicaid agency and members can help inform advocates on the unique needs, questions and information gaps of each stakeholder group. In turn, this information can be used to develop resources, toolkits, and trainings to educate key stakeholders involved in the delivery and utilization of the EPSDT benefit.

Moving to managed care is a complex undertaking that is resource and time intensive. Advocates should sound the alarm when a state moves too quickly with overly optimistic expectations in terms of costs, cost savings, and transition challenges. A more thoughtful approach is to phase in managed care by groups, geography or other factors to ensure that problems and issues can be easily identified and addressed.

Providers, state Medicaid agencies, members and managed care organizations have a shared interest in ensuring that all eligible children receive the full range of services guaranteed by the EPSDT benefit. Child health advocates are uniquely positioned to help other stakeholders recognize and act on this shared interest—and ultimately ensure that children and youth receive the comprehensive array of services they need to thrive.

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