



MEDICAID MANAGED CARE COVID-19 ADVOCACY ACTION GUIDE

For Pediatricians, Other Primary Care Practitioners, and Child Health Advocates

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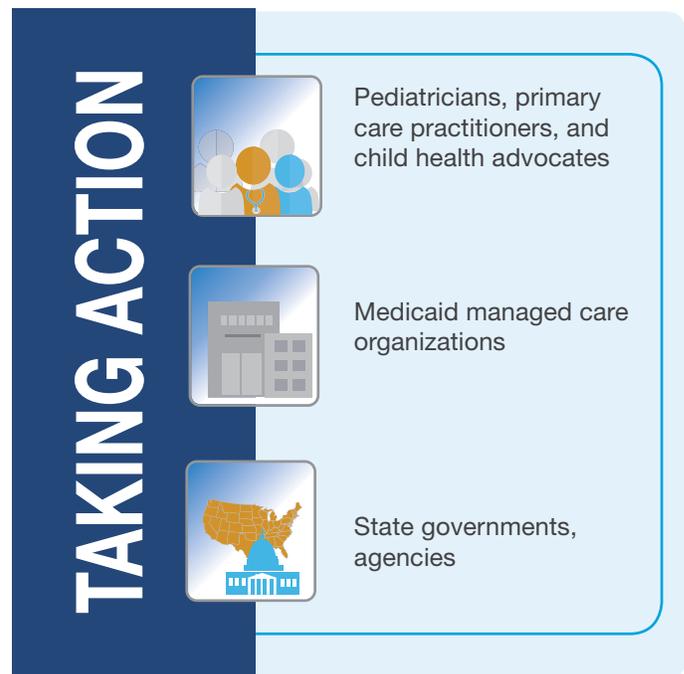
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This guide is jointly produced by the American Academy of Pediatrics (AAP) and the Georgetown University Center for Children and Families (CCF) as part of [“Keeping Kids Connected to Care During COVID-19 and Beyond,”](#) a project supported by the David and Lucile Packard Foundation and the Annie E. Casey Foundation. The goal of the project is to protect and improve children’s access to comprehensive care through Medicaid and the Children’s Health Insurance Program (CHIP) during and after the COVID-19 pandemic by strengthening the capacity for collaborative initiatives between AAP chapters, state child advocates, and health policy experts. This guide supplements [“Medicaid Managed Care Payment Policies to Support Pediatric Providers,”](#) a webinar presented on December 7, 2020 by Manatt Health, CCF, Family Voices, and AAP.

OVERVIEW

- Pediatricians and other primary care practitioners who care for children covered by Medicaid and are paid on a per visit basis have experienced large declines in patient encounters during the COVID-19 pandemic despite the increase in use of telehealth.
- The decline in utilization has led to a decline in revenues, undermining the financial stability of these practices, which in turn threatens to compromise beneficiary access to needed care.
- In the case of practitioners who participate in the provider networks of Medicaid managed care organizations (MCOs), there are steps that both the state Medicaid agency and individual MCOs can take to offset practitioner revenue shortfalls.
- This guide outlines advocacy actions that pediatricians, other primary care practitioners, and child health advocates can take to improve MCO support for primary care practices during the COVID-19 pandemic and the accompanying economic downturn.



WHY DOES THIS MATTER?

Medicaid is the nation's largest health insurer for children, covering over 30 million children. In 39 states and DC, most children covered by Medicaid are enrolled in managed care organizations (MCOs). MCOs may be for-profit, not-for-profit, or public.

States that use MCOs to manage the delivery of Medicaid services to children pay those MCOs a fixed amount each month for each enrolled child whether or not the child visits a practitioner and receives a service. This is known as a capitation, or per member per month (PMPM), payment.

Many MCOs pay their practitioners on a fee-for-service basis. The decline in patient visits during the pandemic has reduced the amount that MCOs pay those providers but not the capitation rates that state Medicaid agencies use in making payments to the MCOs. In many states, Medicaid

enrollment has increased and consequently aggregate capitation payments to MCOs have increased. As a result, many MCOs have experienced excess revenues.

MCOs are responsible for organizing and maintaining networks of providers that are adequate to furnish needed services to enrollees. Because of this network adequacy requirement, MCOs and the state Medicaid agencies with which they contract both have an interest in ensuring that practitioners caring for enrolled children remain financially stable.

Achieving this goal is particularly challenging in the midst of a pandemic and the economic dislocation it has caused, but strategies are available to pediatric practitioners, child health advocates and state Medicaid agencies to improve MCO support for primary care providers.

THE CONTEXT FOR MEDICAID MANAGED CARE ADVOCACY IN 2021

Advocacy for MCO support for pediatric providers in 2021 will be state-specific. One checklist will not fit all states because the public health, economic, budgetary, and Medicaid situations will vary from state to state. That said, there are some general trends common to many, but not all, Medicaid managed care states:

- Coronavirus infection rates are surging, as are hospitalizations and deaths.
- This pandemic surge, and the state and local public health measures in response, will likely continue to reduce use of primary care and other non-emergency services until enough of the population is vaccinated to allow a safe re-opening of the economy.
- The economic downturn caused by the pandemic has resulted in a drop in state and local tax revenues at the same time that demands on state budgets are increasing due to increased unemployment and a growth in Medicaid enrollment.
- The \$175 billion federal Provider Relief Fund enacted in March 2020 has not effectively reached community-based providers like pediatric practices nor other pediatric providers.
- Most states expect revenue reductions of 10 percent to 25 percent in state fiscal year (SFY) 2021, but no federal fiscal relief has been enacted to help states address this shortfall.
- Most states are currently in the middle of SFY 2021 and in January 2021 many state legislatures will begin debating budgets for SFY 2022, which will begin on July 1, 2021.
- In many states, Medicaid MCOs are among the few sectors that have achieved [steady revenue gains](#) since the economy began to close down due to the pandemic in March 2020.



STATE STRATEGIES FOR SUPPORTING PEDIATRIC AND PRIMARY CARE PROVIDERS IN MEDICAID MCO NETWORKS

There are a number of actions state Medicaid agencies and state legislatures can take to require or encourage MCOs to support pediatric and primary care providers. These include: (1) state “directed” payments to providers by MCOs and (2) financial incentives for MCOs to increase payments to providers. This guide focuses on the first and highlights the successful advocacy strategy of Virginia pediatricians.

Note that in the spring of 2021 many state legislatures will be in session to consider their SFY 2022 budgets (which begin on July 1) or revisions to their SFY 2021 budgets (which end on June 30). In most cases, states will be trying to identify spending cuts or revenue increases, or both, to balance their budgets. Because Medicaid is one of the largest components of every state’s spending

and revenues (from federal Medicaid matching funds), and because states that accept additional federal matching funds (as all states do) are prohibited from disenrolling program beneficiaries during the coronavirus public health emergency, state budget officials in managed care states will be examining options for reducing (or limiting the growth in) spending on MCOs.

These [options could include](#) reducing capitation rates, which would reduce state spending; requiring remittances of excess payments from MCOs, which would return state funds to the state treasury; and imposing taxes on net MCO revenues, which would raise new revenues for the state. Any of these options compete with efforts to improve MCO support for pediatric and other primary care providers.

MEDICAID MANAGED CARE BASICS

State Medicaid Programs Operate within Federal Rules

- Medicaid is a federal-state program. The federal government on average pays about 65 percent of the cost of the program. States administer the program within federal rules; the regulations that apply to Medicaid managed care are in Appendix A. The Centers for Medicare & Medicaid Services (CMS) is responsible for applying those regulations.
- State Medicaid programs have choices in how they pay for covered services for eligible children and parents. They can pay providers directly on a fee-for-service (FFS) basis; they can contract with MCOs on a risk basis; or they can mix and match, using FFS for some populations or services and MCOs for others.
- Currently, [39 states and the District of Columbia](#) contract with two or more MCOs on a risk basis—that is, the MCO assumes the financial risk of providing Medicaid services to eligible children and other enrollees. In these states, the Medicaid agency pays the MCO a fixed amount each month for each child enrolled, whether or not the child uses services in that month. This is referred to as a capitation payment.
- In exchange for the monthly capitation payment, the MCO agrees to arrange for the provision of covered services to its enrollees (in the case of children, this would include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit unless certain services are expressly “carved out” or excluded from the contract). (Appendix B)
- The federal government will match a state’s capitation payments to an MCO (at 50 percent to 90 percent, depending on the state and the population enrolled), but only if the risk contract between the state and the MCO, as well as the capitation rates paid to the MCO, meet certain requirements. To ensure that they are met, the risk contract and capitation rates must be approved by CMS.

- Among those requirements is that the MCO’s provider network be [adequate](#) to make covered services available and accessible to its enrollees. Provider participation in an MCO network is voluntary; however, providers who do not participate in an MCO’s network generally cannot be paid for treating the MCO’s Medicaid enrollees.
- Federal regulations do not prescribe the amount of payment the MCO makes to a network provider or the method by which the MCO makes that payment. State Medicaid agencies, in their risk contracts with MCOs, can allow MCOs and network providers to negotiate payment rates and arrangements, or they can require the MCOs to use minimum fee schedules (such as FFS Medicaid or Medicare rates) and specific billing codes. Like other risk contract provisions, these are subject to CMS approval.
- State Medicaid programs generally contract with MCOs for a multi-year period, commonly three to five years. At the conclusion of that period, the state will allow both the incumbent MCOs and potential new entrants to compete for the contracts for the next multi-year period. This [procurement process](#) is conducted under state, not federal, rules.

How MCO Capitation Rates are Set

- Federal regulations (Appendix A) require that the capitation rates paid by the state Medicaid agency to each MCO be “actuarially sound”—that is, sufficient for “all reasonable, appropriate, and attainable costs required under the terms of the contract and for the operation of the MCO.”
- Capitation rates must be certified by an actuary and approved by CMS every 12 months. The actuary must follow the [rate development guides](#) that CMS updates every year and uses in determining whether capitation rates for the 12-month rating period are “actuarially sound.”

- Capitation rates vary depending on the expected use of covered services by the population group (“rate cell”) to which the payment applies. For example, in South Carolina for state FY 2020, the capitation payment for infants from 0-2 months was \$2,356.71; for infants 3-12 months, \$260.04; and for children age 1-6, \$141.96 (See Table 1 for more details on rate cells).
- Capitation rates are calculated based in part on historical utilization of services. The rates in effect during the period beginning in March when the pandemic arrived were based on pre-pandemic utilization patterns. Claims payments by MCOs, however, fell sharply, with steep drops in non-emergency visits reflecting pandemic utilization patterns.
- States have a number of [options for adjusting capitation rates](#) and risk mitigation strategies to account for changes in utilization as well as uncertainties about future costs of testing, treatment, and vaccines.
- The current CMS [Rate Development Guide](#) covers rating periods starting between July 1, 2020 and June 30, 2021. The guide does not address the treatment of utilization during the pandemic, because it bases historical experience on the three most recent and complete years prior to the beginning of the rating period for which utilization data are available, almost all of which will be pre-pandemic.

Table 1. South Carolina Example of Medicaid Managed Care Rate Cells

Rate Cell	Projected Membership	SFY 2019 Rate*	SFY 2020 Rate*	Increase or (Decrease)
TANF: 0-2 months old (AH3)	82,856	\$2,167.32	\$2,356.71	8.7%
TANF: 3-12 months old (AI3)	354,132	254.97	260.04	2.0%
TANF: Age 1-6 (AB3)	2,194,860	136.94	141.96	3.7%
TANF: Age 7-13 (AC3)	2,621,148	146.40	151.38	3.4%
TANF: Age 14-18, Male (AD1)	734,040	154.08	164.10	6.5%
TANF: Age 14-18, Female (AD2)	749,856	184.59	201.73	9.3%
TANF: Age 19-44, Male (AE1)	273,000	239.59	240.38	0.3%
TANF: Age 19-44, Female (AE2)	1,382,364	330.15	339.69	2.9%
TANF: Age 45+ (AF3)	234,168	555.40	582.64	4.9%
SSI - Children (SO3)	139,932	654.70	682.56	4.3%
SSI - Adults (SP3)	605,052	1,231.22	1,329.85	8.0%
OCWI (WG2)	163,464	348.62	382.32	9.7%
DUAL	–	155.37	165.49	6.5%
Foster Care - Children (FG3)	58,740	933.29	872.55	(6.5%)
KICK (MG2/NG2)	26,556	6,715.22	6,807.22	1.4%
Composite	9,593,612	\$311.07	\$326.65	5.0%

* Including add-ons

Source: Presentation by Greg Barabell, MD | CPC, FAAP, “Ensuring Bright Futures in EPSDT: Payment Advocacy with your State Medicaid Program,” October 26, 2019.

How MCOs Spend Medicaid Capitation Payments

- One measure of an MCO's financial performance is the medical loss ratio (MLR). MLR gives an indication of the share of the capitation payments that an MCO receives from the state that is used to pay providers for services furnished to enrollees. The definition of MLR used in the Medicaid program is the ratio of (1) the MCO's incurred claims plus spending on health care quality and fraud reduction to (2) capitation revenues minus federal, state, and local taxes and fees (Appendix A).
- An MLR of 85 percent means that 15 percent of the capitation payments made by the state agency to the MCO (net of taxes) are used by the MCO for administration and margin (profit). The lower the MLR, the higher the share of capitation revenue retained by the MCO and the lower the share paid out to providers for serving enrollees and spent on quality assurance.
- State Medicaid agencies do not have to require that MCOs achieve a minimum MLR. If they do require that MCOs achieve a minimum MLR, that minimum cannot be lower than 85 percent.
- If states require MCOs to achieve a minimum MLR, they may (but are not required to) mandate that the MCO pay back the difference between the MCO's actual MLR and the minimum MLR established by the state. These repayments are called remittances. In 2019, 24 states [reported](#) always collecting remittances, and 6 states reported sometimes doing so.
- Whether or not a state Medicaid agency establishes a minimum MLR, it must require each MCO to calculate and report its MLR each year. The report is due no later than 12 months after the close of the reporting year. Among other things, the report must include information on capitation revenues, incurred claims for services, expenditures on quality improvement, and non-claims costs like administration and profit.
- Note that the definition of MLR commonly used by actuaries differs from that used by Medicaid. The actuaries' definition is the ratio of (1) total hospital and medical expenses plus increases in reserves in accident and health insurance contracts to (2) total revenue. According to a [Milliman research report](#), this definition of MLR produced lower average ratios (88.6 percent in 2019) than the CMS definition (92.5 percent). Thus, the CMS definition gives the appearance that MCOs are spending more on payments to providers for furnishing services than the actuaries' definition.

MCO Payments to Network Providers

- Federal regulations (Appendix A) do not prescribe how MCOs pay their network providers. In many cases, state Medicaid agencies, through their risk contracts with MCOs, allow MCOs and network providers to negotiate the amounts they will be paid and the methodologies used to make those payments (fee-for-service, subcapitation, or something in between).
- State Medicaid agencies may, however, specify through the risk contract with an MCO that it pay its network providers according to a minimum fee schedule (e.g., Medicaid fee-for-service rates or higher) or pay network providers a uniform dollar or percentage increase in their rates. The state Medicaid agency may also require MCOs to implement [value-based payment \(VBP\) arrangements with providers](#) (e.g., pay for performance, bundled payments).
- When a state agency directs the MCO to pay its network providers a certain amount in a certain way, it is known as a "directed payment" arrangement and must generally be approved by CMS.
- Depending on the terms of their risk contracts with the state Medicaid agency, MCOs may be able to use excess capitation payments to address shortfalls in network practitioner revenues without being directed to do so. A number of [MCOs have reported](#) taking such actions voluntarily.



DIRECTED PAYMENTS TO PROVIDERS DURING COVID-19: FEDERAL GUIDANCE



In March 2020, CMS gave state Medicaid agencies the opportunity to apply for [Disaster Relief SPAs](#) (State Plan Amendments) that allow them to increase fee-for-service payment rates during the COVID-19 public health emergency. The increases may be targeted to particular groups of providers and/or to providers in particular geographic areas. The state agency may increase rates by a uniform percentage, modify a published fee schedule, or increase Medicaid rates to align with Medicare rates. As of December 7, 2020, CMS has approved Disaster Relief SPAs for temporary provider rate increases in [34 states](#).

Once CMS has approved the temporary rate increases, states can require MCOs to use the temporarily increased fee schedule in paying their network providers. If the state's risk contract contains provisions requiring MCOs to pay rates at least as high as the state's fee schedule, any temporary rate increase should automatically be passed along to providers.

In May of 2020, CMS issued [guidance for state Medicaid agencies](#) that presents options for addressing the impact of declining utilization on the revenues of MCO network providers during the COVID-19 public health emergency. The guidance explains the circumstances under which states are allowed to direct MCOs to increase payments to network providers and, if capitation rate increases are involved, what rate certifications, contract amendments, and documentation are necessary. It gives as one example an “enhanced minimum fee schedule for pediatric primary care providers.”



Under the CMS guidance, practitioners and advocates can work directly with MCOs to increase payments to providers experiencing declines in utilization. For example, MCOs could adjust payments for current patient visits upward so that, in total, providers receive at least as much revenue as they received during a pre-pandemic period, before utilization declined. If this payment adjustment—think of it as a voluntary “stabilization” payment—does not affect the capitation rates the state pays the MCO (because the MCO is applying unused capitation revenues), no CMS approval would be required.



In the alternative, practitioners and advocates can work with their state Medicaid agency to encourage the MCOs to voluntarily address the declines in revenues for network primary care practitioners by adjusting payments for current visits upward. Again, as long as any payment adjustment the MCOs make does not result in an increase in capitation rates, no CMS approval is required. If the state offers the MCO a capitation rate increase as an incentive to increase provider payments, and if that [capitation rate increase is greater than 1.5 percent](#), CMS approval is required.

A recent [Kaiser Family Foundation survey](#) found that, among the states reporting, Massachusetts, Tennessee, and Virginia made “directed payments” to practitioners during state fiscal year 2020. The next section describes Virginia's approach.

REDIRECTING MCO GAINS TO OFFSET NETWORK PROVIDER LOSSES:

Virginia AAP'S Successful Advocacy Action

The Virginia Chapter of the AAP (VA AAP) has over 1,000 pediatrician and pediatric provider members. In June and July, the Chapter successfully advocated for an increase in MCO payments to members and other primary care practitioners. This is a summary of that successful action. For a full description see the presentation of Sandy Chung, MD, FAAP, FACHE in the December 7, 2020 webinar "[Medicaid Managed Care Policies to Support Pediatric Providers.](#)"

- Virginia contracts with six MCOs to deliver services to Medicaid and CHIP beneficiaries, including 703,000 children. As in other states, use of non-emergency services fell when the pandemic hit, reducing MCO payments to pediatric and primary care practitioners.
- The VA AAP first reached out to the state MCO association and was advised to work directly with the state Medicaid agency. In June the VA AAP met with the state agency. Due to lags in claims data, the agency did not have utilization data for the pandemic months and was not able to determine MCO or network provider financial experience.
- VA AAP collected data on Medicaid visit volume from 419 pediatric providers throughout the state. The data showed that Medicaid visit volume decreased over April and May to 67 percent and 62 percent of normal volumes respectively, and that Medicaid revenues to these providers fell over \$2.8 million from March to May.
- VA AAP made the data available to the state Medicaid agency, the Secretary of Health and Human Resources, and the Governor.
- On July 2, the state Medicaid agency directed each of the six MCOs to retroactively increase payments to network physicians and non-physician practitioners by 29 percent for certain services provided between March 1 and June 30 (the end of the state fiscal year). The increases were to be paid by October 31. The total amount of the transfer from the MCOs to providers was [estimated at \\$30 million.](#)
- Due to administrative difficulties in targeting specific provider types, the state agency directed the MCOs to target the increases on Evaluation and Management (E&M) services commonly billed by pediatric practices and other primary care providers through [CPT procedure codes 99200 through 99499.](#)
- This "directed payment" strategy worked. The MCOs made the payment increases as directed by October 31 to the benefit of pediatric and other primary care practitioners. The state was not required to spend any additional funds of its own to pay for these increases; instead, the funding came from excess capitation payments already being paid to the MCOs.
- Because the federal government matches Virginia's capitation payments to the MCOs, about \$16.9 million of the \$30 million in payment increases from excess MCO revenues are federal funds (the state's matching rate during the pandemic public health emergency is 56.2 percent). By directing the MCOs to make these payment increases, the federal funds stay in the state. If the state had required the MCOs to [remit their excess revenues to the state treasury](#), the state would have been required to return the \$16.9 million to the federal government.

ADVOCACY ACTIONS

In addition to “directed payment” to support pediatric practitioners, there are advocacy actions that state AAP chapters and child health advocates can take to improve the performance of MCOs for children and families during the pandemic and beyond. Below are actions that focus on improving the EPSDT benefit, improving the adequacy of MCO pediatric networks, understanding the financial performance of MCOs, and leveraging the state procurement process.

EPSDT

The risk contracts between state Medicaid agencies and MCOs specify the services that the MCO is obligated to arrange through its provider network. In the case of children, that benefit includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Practitioners and advocates can encourage their state Medicaid agency to ensure that the risk contract (or provider manual incorporated by reference into the risk contract) clearly sets forth the EPSDT benefit using [Bright Futures Periodicity Schedules](#), the full set of EPSDT-linked CPT/HCPCS Codes, and minimum payment rates for these codes is set at Medicare levels. (Appendix B)



Network Adequacy

MCOs are required to have provider networks that are “sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.” They must also document the adequacy of their networks at least annually. (This documentation is different than the Provider Directory that each MCO must make available on its website.) State Medicaid agencies are required to post documentation of the adequacy of each MCO’s provider network on their websites.



(Appendix A) Practitioners and advocates can review this documentation both to verify its accuracy and to identify opportunities for improvements in access to primary care and specialist services for children, including upgrades in provider payments where needed.

MCO Financial Performance

MCOs are required to file with the state Medicaid agency, on an annual basis, an audited financial statement, and a separate report documenting their Medical Loss Ratio (MLR). In addition, the state Medicaid agency is required to conduct or arrange for an independent audit, at least every three years, of the accuracy of the financial data submitted by the MCO. (Appendix A) Practitioners and advocates can request these submissions from the state Medicaid agency. The MLR reports will show, for the year in question, how much of an MCO’s Medicaid revenues were used to pay network (and out-of-network) providers for covered services and how much went to other expenses, such as quality assurance, administration, and profit. Practitioners and advocates can test these MLR reports with the MCO’s audited financial statement and the independent audit for consistency. They can also compare the MLRs of individual MCOs to identify which MCO is spending the highest percentage of its Medicaid revenues on administrative costs.



Procurement

In selecting the MCOs with which to contract, state Medicaid agencies go through a procurement. The procurement results in risk contracts that generally run for three to five years before another procurement. While state Medicaid agencies can negotiate amendments to risk contracts in mid-term, the procurement is the best opportunity for the agency to reset the coverage and payment policies reflected in its contracts, such as the definition of EPSDT benefits or payment rates



for pediatric practices. Procurement is also an important opportunity for providers, beneficiaries, and advocates to shape those policies and MCO actions going forward. In addition, if one or more the MCOs currently holding contracts with the state has been performing poorly, practitioners and advocates can [use the procurement to hold those MCOs to account](#).

APPENDIX A

Federal Medicaid Managed Care Regulations and Guidance

Federal regulations governing Medicaid managed care are at 42 Code of Federal Regulations (CFR) Part 438. Portions of Part 438 were recently [modified](#); the current version can be found [here](#). Agency guidance explaining these regulations is found [here](#). The sections of particular relevance to advocacy actions are:

CMS Approval Required

- Terms of contract between State agency and MCO: 42 CFR 438.3(a)
- Capitation rates paid by State agency: 42 CFR 438.4(b)

MCO Provider Networks and Payments

- Networks must be adequate: 42 CFR 438.68, 438.206
- MCOs must document network adequacy: 42 CFR 438.207
- State agencies may specify a minimum practitioner fee schedule: 42 CFR 438.6(c)(1)(iii)
- State agencies may require MCOs to implement value-based purchasing models for provider reimbursement: 42 CFR 438.6(c)(1)(i)

State Medicaid Agency capitation payments to MCOs

- Rates must be actuarially sound: 42 CFR 438.4
- Calculation of Medical Loss Ratios: 42 CFR 438.8
- Remittance if specific Medical Loss Ratio is not met: 42 CFR 438.8(j), 438.74

MCO Financial Performance

- MCOs must report Medical Loss Ratios annually: 42 CFR 438.8(k)
- MCOs must submit audited financial reports annually: 42 CFR 438.3(m)
- State agency must conduct or contract for independent audit of each MCO's financial data at least once every 3 years: 42 CFR 438.602(e)

Transparency Requirements

- State Medicaid agency must have a website: 42 CFR 438.10(c)(3)
- Risk contract between state agency and MCO must be posted: 42 CFR 438.602(g)(1)
- Documentation of provider network adequacy must be posted: 42 CFR 438.602(g)(2)

APPENDIX B

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

Every child enrolled in Medicaid is entitled to a comprehensive pediatric benefit of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. For this purpose, a child is any individual under age 21 (in OR and UT, the EPSDT entitlement has been [waived](#) for 19- and 20-year olds. The entitlement to EPSDT applies in states that contract with Medicaid managed care organizations as well as in states that administer fee-for-service Medicaid programs.

The CMS Guide to the EPSDT benefit for state Medicaid agencies is [here](#).

In 2018, AAP and CCF hosted a series of webinars on EPSDT. The topics were:

- [EPSDT Education for Providers and Advocates](#). This slide deck explains the preventive, diagnostic, and treatment elements of EPSDT.
- [Medical Necessity and EPSDT: Tools for Providers and Advocates](#). This slide deck explains the EPSDT medical necessity standard and how it varies among MCOs.
- [When to Engage the Legal Community](#). This slide deck explains how providers and medical-legal partnerships and legal services organizations can ensure that children receive the EPSDT services to which they are entitled.

States have the flexibility to use the [Bright Futures Periodicity Schedule](#) in implementing their EPSDT benefit.

Procedure codes are an essential element in the implementation of the EPSDT benefit. Dr. Greg Barabell of Clear Bell Solutions has identified the following CPT/HCPCS codes as integral to a high-performance EPSDT benefit:

EPSDT Billing Codes

Health Care Common Procedures Codes System (HCPCS)	Description
99496	Transition Care Management 7 Day Discharge
99491	Chronic Care Management Service (30 Min.)
99490	Chronic Care Management Service (20 Min.)
99484	Care Management Service Behavioral Health Condition
99406	Behavioral Change Smoking 3-10 Min.
99401	Preventive Counseling Individual
99188	Fluoride Varnish
99177	Ocular Instrument Screen
96161	Caregiver Health Risk Assessment
96160	Patient-Focused Health Risk Assessment
96127	Brief Emotional/Behavioral Assessment
96110	Developmental Screen with Score
92551	Pure Tone Hearing Test
90461	Immunization Administration, Each Additional

Source: Presentation by Greg Barabell, MD | CPC, FAAP, "Ensuring Bright Futures in EPSDT: Payment Advocacy with your State Medicaid Program, October 26, 2019.

APPENDIX C

SUMMARY OF ADVOCACY ACTIONS

The table below summarizes actions outlined in this guide that states, pediatricians, other primary care practitioners, and child health advocates can take to improve access to care during the pandemic and in the future.

Action	Actor
Specify through the MCO contract that MCOs pay network providers according to a minimum fee schedule	State Medicaid agencies and state legislatures
Specify through the MCO contract that MCOs pay network providers a uniform dollar or percentage increase in their rates	State Medicaid agencies and state legislatures
Temporarily increase rates or modify a published fee schedule during the public health emergency	State Medicaid agencies through Disaster Relief SPAs
Voluntarily use excess capitation payments to address shortfalls in network provider revenues	MCOs
Work directly with MCOs to increase payments to providers experiencing declines in utilization	Practitioners and advocates
Ensure that the risk contract clearly sets forth the EPSDT benefit using Bright Futures Periodicity Schedules, the full set of EPSDT-linked CPT/HCPCS Codes, and minimum payment rates for these codes set at Medicare levels	Practitioners and advocates
Review network adequacy documentation to verify its accuracy and identify opportunities for improvements in access to primary care and specialist services for children	Practitioners and advocates
Engage in the procurement process to shape the risk contracts and hold MCOs accountable for poor performance	Practitioners and advocates

ADDITIONAL RESOURCES

- American Academy of Pediatrics, “Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults,” <https://pediatrics.aappublications.org/content/132/5/e1452.full>.
- Medicaid.gov: Medicaid Managed Care, <https://www.medicaid.gov/medicaid/managed-care/index.html>.
- Medicaid and CHIP Payment and Access Commission (MACPAC): Managed Care, <https://www.macpac.gov/topics/managed-care/>.
- Kaiser Family Foundation: Medicaid Managed Care Market Tracker, <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>.
- Kaiser Family Foundation: “Options to Support Medicaid Providers in Response to COVID-19,” June 17, 2020, <https://www.kff.org/coronaviruscovid-19/issue-brief/options-to-support-medicaid-providers-in-response-to-covid-19/>.
- Kaiser Family Foundation: “State Medicaid Programs Respond to Meet COVID-19 Challenges: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2020 and 2021” (October 14, 2020), <https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-delivery-systems/>.
- State Health & Value Strategies: “Targeted Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis” (Updated August, 2020), <https://www.shvs.org/wp-content/uploads/2020/04/Targeted-Options-for-Increasing-Medicaid-Payments-to-Providers-During-COVID-19-Crisis-Revised-8.26.pdf>.

For Further Information

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