Accountability in Medicaid Managed Care: *Implications for Pediatric Health Care Quality*[a]

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Introduction

U.S policymakers increasingly focus their attention on the challenge of health care quality. The intersection of health care quality and public policy is not new, but the desire to find more effective and prospective interventions against substandard care is much more pronounced than a generation ago. For centuries, the legal system has employed a measurement system known as the "professional standard of care" to determine legal liability for medical negligence and this standard has become more rigorous over the past several decades.[1] Furthermore, tools such as professional education and training, as well as licensure and accreditation, are longstanding in U.S. policy.

But the rapid escalation in health costs that began in the early 1970s, accompanied by documented and inexplicable variations in health care quality as well as a movement toward greater openness in the relationship between patients and physicians, has led researchers into an increasingly critical examination of health care quality and toward the development of evidence-based measures for assessing quality.[2] These measures, which are then used to examine distinct sub-populations, payer systems, and diagnostic conditions, extend beyond an intellectual interest in health care quality. Payers have exhibited a marked interest in using these population-based measures to gauge the value and quality of the services they purchase.[3] This interest in turn has spurred quality improvement activities sponsored by the managed care industry, national accreditation organizations, and professional societies.[4] Reporting systems now permit health care consumers to compare health systems on a variety of measures and indicators,[5] and a number of studies and reports focus specifically on the quality of pediatric care.[6]

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[1] Rosenbaum, S. (March 26, 2003). The Impact of United States Law on Medicine As a Profession. *JAMA* 289(12), http://jama.ama-assn.org/cgi/reprint/289/12/1546.pdf.

[2] See Adams, K. and Corrigan, JM., Eds. (2003). *Committee on Identifying Priority Areas for Quality Improvement, Priority Areas for National Action: Transforming Health Care Quality*. Washington, DC: National Academy Press; Institute of Medicine (1999). *To Err is Human: Building a Safer Health System*. Washington, DC: IOM, http://www.iom.edu/includes/dbfile.asp?id=4117; Institute of Medicine (2000). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: IOM, http://www.iom.edu/includes/dbfile.asp?id=4124.

[3] See Centers for Medicare and Medicaid Services, http://www.cms.gov; For a collection of materials and tools on purchasing quality health care, see http://www.facct.org/facct/site; for a sample of Leapfrog's performance expectations, see http://www.leapfroggroup.org/toolkit/GMPatientSafetyPerf.pdf; See also Partridge, L. (2001). *The APHSA Medicaid HEDIS Database Project: Report for the Third Project Year* (Data for 1999), Washington, DC: The Commonwealth Fund, December, http://www.cmwf.org/programs/quality/partridge_aphsa_hedis_1999.pdf (or Partridge, L. and Ingalls Szlyuk, C. (February, 2000). *National Medicaid HEDIS Database/Benchmark Project*. Washington, DC: The Commonwealth Fund, http://www.cmwf.org/programs/quality/partridge_hedis_366.asp.

[4] For information about NCQA's Quality Compass, see http://www.ncqa.org/Info/QualityCompass/index.htm;
For information about JCAHO's program in Performance Measurement in Health Care, see http://www.jcaho.org/pms/index.htm; See also, Leatherman, S. and McCarthy, D. (April, 2002). *Quality of Health Care in the United States: A Chartbook*. Washington, DC: The Commonwealth Fund, http://www.cmwf.org/programs/pub_highlight.asp?id=736&pubid=520&CategoryID=3.

[5] See NCQA's Health Choices at http://www.healthchoices.org/.

[6] March, A. (April, 2003). *The Business Case for Clinical Pathways and Outcomes Management: A Case Study of Children's Hospital and Health Center of San Diego*. Washington, DC: The Commonwealth Fund, http://www.cmwf.org/programs/quality/march_physicianorderentry_609.pdf; Bethell, C. et al. (September, 2002) *Partnering with Parents to Promote the Healthy Development of Young Children*

Quality improvement activities extend beyond the realm of informal activities by purchasers and health systems. Error reduction legislation designed to prospectively improve performance while shielding the medical care industry against excessive liability for negligence, has been enacted at the state level of government.[7] Purchasers also have sought legally enforceable contractual approaches to quality that permit a level of legal accountability for health care quality that simply did not exist outside of the tort system a generation ago.

This study, undertaken for the David and Lucile Packard Foundation, examines the structure and operation of Medicaid and State Children's Health Insurance Program (SCHIP) health care access and quality monitoring systems for children enrolled in comprehensive managed care arrangements. As the single largest purchasers of pediatric health care in the U.S., Medicaid and SCHIP agencies play a potentially powerful role in pediatric health policy. How these agencies approach, design, and carry out health quality monitoring activities has the potential to have a major impact not only for poor and low-income children, but for the entire pediatric health system. Even when these systems are developed exclusively for publicly insured children, their influence can extend beyond the "four corners" of a specific contractual arrangement, since participating health professionals, health care institutions and businesses typically are not exclusive to these arrangements, and the devolutionary influence of one purchaser's expectations thus can travel beyond the scope of the agreement.

This analysis opens with an overview of enforcement of health care access and quality standards at both the individual and purchaser level, providing both a brief overview of the safeguards and protections available to individual children and families, as well as applicable federal standards concerning agency enforcement action. It then turns to the question of structure: what types of tools do public agencies maintain to assess—and more importantly enforce—expectations of health care quality? Finally, it reports on the experiences of state agencies with the enforcement of standards. The study concludes with a discussion of relevant policy implications.

The Medicaid and SCHIP Health Quality Enforcement Framework: A Multi-Based Rationale for Focusing on Pediatric Health Quality

For a number of reasons, the quality of care for low-income children insured through public insurance programs is of particular concern. First, lower-income

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Enrolled in Medicaid. Washington, DC: The Commonwealth Fund, http://www.cmwf.org/publist/publist2.asp?CategoryID=2.

[7] Patient Safety and Quality Improvement Act (Reported in House)[H.R.663.RH]; Flowers, L. (February, 2002). *State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals*. Washington, DC: National Academy for State Health Policy, http://www.nashp.org/_docdisp_page.cfm?LID=05607042-4CAC-11D6-BCEE00A0CC558925; Rosenthal, J. and Booth, M. (March, 2003). *Defining Reportable Adverse Events: A Guide for States Tracking Medical Error*. Washington, DC: National Academy for State Health Policy.

children are at elevated risk for a wide range of physical, developmental, and mental health conditions and disorders. This is true even in the case of children who enter public insurance through eligibility pathways other than disability (i.e., children whose connection to Medicaid and SCHIP is based on income alone).[8] As Figure 1 shows, conditions requiring additional monitoring and preventive interventions are generally prevalent among lower income children.

Figure 1. Four States' Top Ten Diagnoses of Chronic or Disabling Conditions among Child Medicaid Beneficiaries

Diagnosis	Number of states (of 4) in which this Condition is a "Top Ten" Diagnosis for Child Medicaid beneficiaries
Asthma	4
Attention Deficit Disorder	4
Congenital Anomalies (e.g., cleft palate, Downs Syndrome)	4
Chronic Depression	4
Intestinal Infectious Diseases (e.g., giardia)	4
Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (e.g., acquired deformities of limbs, osteomyelitis)	4
Burns	4
Other Disorders of the Central Nervous System (e.g., multiple sclerosis, epilepsy)	4
Psychoses (e.g., schizophrenia, affective psychosis)	2
Neurotic Disorders (e.g., obsessive-compulsive disorders, agoraphobia)	2
Other Diseases of the Respiratory System (e.g., tracheostomy complication, abscess of lung)	1
Hernia of Abdominal Cavity	1

Source: Brodsky *et al.*, 2003[9]

A second reason for focusing on pediatric health policy relates to both the dominance of children in public insurance and the intermittent nature of their coverage, which triggers a need to maximize health quality during periods of coverage. Children comprise some 50 percent of all Medicaid beneficiaries and nearly all SCHIP enrollees. The quality of pediatric care thus would be expected to be a dominant theme in health quality measurement. Children's eligibility patterns further propel the need for monitoring the quality of pediatric care. Studies suggest that periods of Medicaid and SCHIP eligibility for a significant portion of enrollees may be, on average, no longer than 11 to 12 months, and children enrolled in Medicaid and SCHIP incur long periods

[8] Brodsky, K.L., Cuccia, L., Kelleher, A. *et al* (Eds) (March, 2003). *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities*. Washington DC: The Center for Health Care Strategies, http://www.chcs.org/publications/cfm-view.html.
[9] *Ibid.*

without any coverage.[10] The intermittent nature of children's insurance coverage promotes a sense that health care should be optimized during periods of enrollment.[11] To that end, the managed care arrangements in which Medicaid and SCHIP agencies enroll most children may offer especially important protections, since the obligation of managed care contractors is not merely to cover necessary services that fall within the contract but to actually make care available.[12]

A third rationale for the high interest in pediatric health quality is that the actual receipt of care, not mere coverage, is a distinct goal of U.S. pediatric health policy. Health promotion, along with early intervention to avert disability, represent major objectives of both Medicaid (as embodied in its special benefit known as "Early and Periodic Screening, Diagnostic, and Treatment" services (EPSDT)[13] and SCHIP.[14] Furthermore, the concern over health quality extends beyond the programmatic boundaries of Medicaid and SCHIP themselves. Other important children's programs such as HeadStart, the Supplemental Feeding Program for Women, Infants and Children (WIC), child welfare programs, and basic and special education programs all depend to at least some degree on access to health care among low-income children as part of their ability to achieve their own objectives. For example, assuring access to preventive health services is a basic function of HeadStart programs; similarly, inclusion of necessary medical care is a specific aspect of the individualized education plans written for children who participate in the Individuals with Disabilities Education Act (IDEA). Yet neither HeadStart nor the IDEA maintains health funds of its own; each depends instead on Medicaid and SCHIP to finance health care. Indeed, the IDEA specifically references Medicaid. Medicaid, in turn, contains statutory references to the IDEA, WIC, and other programs serving children.

Finally, health quality has evolved as a focus of large health insurance purchasers in conjunction with the evolution of the entire insurance system. Twenty years ago, Medicaid agencies, like private insurers, paid bills as Medicaid participating providers interacted with their patients. Undeniably, Medicaid agencies historically have had a statutory obligation to focus on pediatric access under EPSDT, as well as a duty to focus on provider selection and health quality.[15] But fundamentally, Medicaid

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[10] Dick, A., Allison, A., Haber, S. *et al*. (Spring 2002)Consequences of States' Policies for SCHIP Disenrollment. *Health Care Financing Review* 23(3): 65-88; Allison, A., Andrew, A., Shenkman, E. (June 27, 2003) Pathways Through SCHIP: A Longitudinal Analysis of Enrollment and Coverage Patterns. Presentation at *20th Annual Research Meeting of AcademyHealth*, Nashville, TN; Austein Casnoff, C. (June 26, 2003) The State Children's Health Insurance Program (SCHIP)—

Five Years of Progress. Presentation at *Fifth Annual Child Health Services Research Meeting: What Works in Child Health Services Research*, Nashville, TN.

[11] Kaiser Commission on Medicaid and the Uninsured (Mary 31, 2002). Children's Health—Why Health Insurance Matters. *Fact Sheet*, Washington, DC: KFF, http://www.kff.org/content/2002/4055/4055.pdf.

[12] Rosenbaum, S. (February 19, 2003). Managed Care and Patients Rights (Editorial) *Journal of the American Medical Association* 289 (7): 906-907, http://jama.ama-assn.org/cgi/content/full/289/7/906.

[13] Rosenbaum, S. and Sonosky, C. (December, 2000) *Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts*. http://www.gwhealthpolicy.org/medicaid_publications_epsdt.htm

[14] Rosenbaum, S., and Sonosky, C. (2001) Medicaid Reforms and SCHIP: Health Care Coverage and the Changing Policy Environment in DeVita, C., and Mosher-Williams, R., Eds. *Who Speaks for America's Children: The Role of Child Advocates in Public Policy*. Washington, DC: The Urban Institute.

[15] §1902(a)(8) of the Social Security Act, 42 U.S.C. §1396a(a)(8); §1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(30)(A); §1902(a)(43) of the Social Security Act, 42 U.S.C. §1396a(a)(43); 42

agencies functioned similarly to private indemnity arrangements in their relatively distant relationship with actual provider performance. Provider participation contracts contained no performance measures or treatment duties but instead were limited to the business elements of the relationship (e.g., payment terms, licensure and accreditation status, and term and termination). Today Medicaid and SCHIP agencies, like private purchasers, purchase "hybrid" health coverage arrangements that specifically and contractually merge coverage and care. As the United States Supreme Court has observed, these arrangements "wear two hats" and obligate contractors not only to the management of insurance resources but also to the management of health care itself.[16] This fundamental shift in the nature of insurance coverage compels purchasers to extend their focus beyond simple claims payment and into the realm of access and quality. Figure 2 shows the numerous "domains" covered by these contracts;[17] together, these domains reflect the underlying dimensions of classic quality assessment: structure, process of care, health care outcomes, and consumer interaction with the health system.

Figure 2. Managed Care Contracting Domains

Key Domains
Enrollment
Coverage and Benefits
Service Duties
Public Health and Social Service Agency Relationships
Quality Assurance, Data, and Reporting
Business Terms and Relationships
Payment

Source: Rosenbaum *et al.*, *Negotiating the New Health System,* www.gwhealthpolicy.org

C.F.R. §441.56; §1915(b) of the Social Security Act, 42 U.S.C. §1396n(b); §1932(b)(5) and §1932(c) of the Social Security Act, 42 U.S.C. §1396u-2(b)(5) and (c); §42 C.F.R. 431.55

[16] *Pegram v. Herdrich*, 530 U.S. 211.

[17] See Rosenbaum, S. *et al.*, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 1st-4th editions (1997-2001), Washington, DC: GWU-CHSRP, http://www.gwhealthpolicy.org/managed_care.htm.

Part I: Pathways to Accountability

A. Individual Enforcement of Health Care Access and Quality Standards

In some cases, federal and state laws offer children and their families means for enforcing the legal obligations undertaken by managed care contractors on their behalf. But as important as they are, individual legal enforcement tools are quite constrained, inaccessible, and not particularly effective in structuring systemic improvements in quality. These limitations grow out of the nature of law and legal enforcement, the difficulties in securing legal representation, and practical considerations in litigation.

Table 1 sets out a taxonomy of individual legal enforcement mechanisms, as well as their application and limitations. As Table 1 shows, in the context of this study, individual enforcement can be categorized into four major categories: a) health care quality litigation involving medical liability; b) litigation to enforce federal rights; c) litigation to enforce state law rights, particularly rights created by the large purchasing agreements; and d) grievances and appeals. Each tool has distinct applications and limitations.

Table 1. Individual Enforcement Mechanisms: Legal Basis, Application, and Limitations

MECHANISM	LEGAL BASIS	APPLICATION	LIMITATIONS
a) Malpractice litigation	State law (common law and statutory rights)	Against individual health professionals Against health care corporations including managed care organizations for both corporate and vicarious liability	Complex elements of proof Limited availability in the case of low-income children Available only after serious injury has occurred
b) Enforcement of federal legal rights	Federal statutes	Can be used in those cases in which federal law is determined to create *both* enforceable individual expectations among persons served by a program and the legal right to bring an individual enforcement action	The narrow nature of what courts will recognize as a "legal" right The imminence of the injury that must be present The complexity of systemic class-wide litigation and the difficulty of fashioning and monitoring workable legal remedies, particularly where the legal issues are access and quality
c) Enforcement of	State constitutions,	Can be used to	3 states *specifically*

MECHANISM	LEGAL BASIS	APPLICATION	LIMITATIONS
contractual rights created by managed care state contracts	statutes, and regulations; state "common law"	enforce quality-related rights that are created by contracts between state agencies and managed care organizations.	*preclude* third party enforcement actions by Medicaid and SCHIP enrollees Injury must be actual or imminent Size and complexity of actions; suits typically limited to named individuals only; remedies difficult to devise and monitor
d) Grievances, appeals, and fair hearings	Federal law, state contracts, state rules and statutes	Individual cases where care has been or may be denied	Single claims and non-systemic in nature. Injuries must be actual or imminent

Source: GW CHSRP, 2003.

a. Medical malpractice litigation

Medical malpractice cases can be brought not only against health professionals but against health care corporations,[18] including litigation against managed care organizations for both vicarious[19] and corporate[20] liability. But bringing malpractice actions is difficult, costly, and time consuming and the number of cases is very small in relation to the total number of possible negligence events.[21] Poor children may be at particular risk of under-representation, because of financial disincentives in their representation. Unless there exists the type of negligent conduct that would be considered egregious under state law and thus would qualify for noneconomic damages (e.g., willful or wanton disregard for human life), pediatric cases are worth little other than the families' out-of-pocket medical care costs because in the case of children, lost earnings would not be an issue.

b. Federal rights enforcement

Medicaid (and SCHIP when it is administered as part of the Medicaid plan) creates certain federal legal rights in children. Federal law establishes certain legal rights to coverage and benefits, and children have the right to seek recourse in court when these rights are allegedly violated.[22] But these rights are narrow; indeed, many of the

[18] Rosenblatt, R.., Rosenbaum, S., and Frankford, D. (1997, 2002-2002 Supp) *Law and the American Health Care System, Chapter 3,* New York, NY: Foundation Press.
[19] *Boyd v. Albert Einstein Medical Center*, 547 A2nd 1229 (Pa. Super 1988); *Shannon v. McNulty* 718 A2nd 828 (Pa. Super. 1988); and *Petrovitch v. Share Health Plan* 719 NE 2nd 756.
[20] *Moscovitch v. Danbury Hospital* 25 F. Supp 2d 74 (D.Ct. 1998); In re US Healthcare; *Lazorka v. Penn Hospital* 237 F3d 242 (3rd Circuit, 2000).
[21] See, e.g., Roan Gresenz, C., Hensler, D, Studdert, D. *et al.* (1999) A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries. *Health RAND Law Issue Paper,* http://www.rand.org/publications/IP/IP184/
[22] 42 U.S.C. §1983.

most important general legal duties of states and their contractors under managed care may not create individually enforceable rights at all but may instead be capable of enforcement only by the Secretary of Department of Health and Human Services (HHS).

c. Third party beneficiary enforcement

Traditionally, state courts have recognized a "common law" (i.e., judicially created) right on the part of insured persons to enforce the terms of their contracts.[23] This right is known as "third party beneficiary enforcement," and is embodied for the most part in modern state insurance laws, as well as federal laws related to insurance and health plans.

Third party enforcement does not appear to apply to Medicaid and SCHIP, however. Evidence from other studies suggests that these contracts may be exempt from state insurance laws either entirely or in part with a separate and legally distinct body of regulation.[24] Our own review of state Medicaid and SCHIP contracts suggests considerable ambiguity regarding the application of state insurance law. Indeed, of the contracts we analyzed,[25] only five contain provisions relating to third party beneficiary enforcement; of these, two (Minnesota and North Carolina) contain language expressly declaring that Medicaid beneficiaries are intended third party beneficiaries to the contract between the state and the managed care organization; the remaining three direct that beneficiaries are *not* to be considered third party beneficiaries.[26] No similar provisions were found in the separate SCHIP managed care contracts.

State Medicaid and SCHIP agencies could give beneficiaries the right to enforce at least certain contractual terms directly through third party beneficiary actions but few do so. Although a state agency has the legal power to broadly define a range of contractual injuries that are capable of legal enforcement by enrollees, practical and market considerations obviously preclude this. What company would be willing to do business with a state agency that made it easy for enrollees to sue the contractor for general complaints about health care quality?

With respect to all forms of judicial remedies, it is important to note that the very power of both state and federal courts causes them (and legislatures) to be strict about who can gain access to judicial relief and under what circumstances. To the layperson, it may appear that there is a deluge of cases. But in fact, very few claims of legal injury are ever litigated in court because of strict jurisprudential rules related to who can bring cases and under what circumstances, as well as numerous federal and state laws that not only make the process of litigation difficult but also curb the size of recoveries.[27]

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[23] See Calamari and Perillo, *Contracts 3rd Ed.* 1987, §§17-4, 17-7.
[24] See, e.g., Kaye, N. (June 2001) *Medicaid Managed Care: A Guide for States, 5th Edition* Portland, ME: National Academy of State Health Policy; Perkins, J, Hitov, S. (September 2003) *Enforcing the Bargain: An Overview of Third Party Beneficiary Claims in Medicaid Cases*. http://www.healthlaw.org/pubs/200310.issuebrief.htm
[25] A total of 50 Medicaid managed care contracts and 15 separate SCHIP contracts were reviewed.
[26] No contract included a third party beneficiary provision in specifications concerning an enrollee's rights and responsibilities. Rhode Island is the only state that defines the term "party," making clear that the state and the MCO are the *only* contracting parties to the contractual agreement. *Negotiating the New Health System*, 2001.
[27] *Moscovitch v. Danbury Hospital* 25 F. Supp 2d 74 (D.Ct. 1998); In re US Healthcare; *Lazorka v. Penn Hospital* 237 F3d 242 (3rd Circuit, 2000).

Most fundamentally perhaps, courts insist on real individual injury before they intervene (known as the law of "standing"), as opposed to generalized complaints about how a system is working. This means that even if a remedy is available, a legal representative can be found, and the process is accessible, children cannot use their individual enforcement tools unless they have been injured or face an imminent risk of injury.

d. Individual enforcement through administrative complaints

Federal law accords Medicaid and SCHIP enrolled children the right to appeal managed care denials and delays in coverage and care and guarantees the right to an external and impartial review of claims. Figure 3 summarizes the key elements of federal law related to Medicaid and SCHIP external grievances and appeals. But a grievance and appeal also involves injuries that either have occurred or that are imminent. Furthermore, appeals are by their nature individualized, non-precedential, and thus not a means of making systemic change. Studies of grievance and appeals systems suggest that they are seldom used in relation to the incidence of injury.[28] Thus, as important as the legal right to appeal and external review may be, it is not a substitute for systemic monitoring and enforcement.

Figure 3. Key Elements of Medicaid and SCHIP External Grievances and Appeals

KEY ELEMENTS	MEDICAID	SCHIP
General requirement	• States must provide for an opportunity for a "fair hearing" process when benefits are denied and follow specific time frames for hearing decisions. They may allow enrollees direct access to a fair hearing (i.e., enrollees do not need to exhaust an MCO's internal grievances and appeals system before they appeal to the state). They must ensure that their hearing system meets the minimum, federally-specified requirements (see below).	• States must provide an opportunity for an independent, external review process when benefits are denied and set specific time frames for the review. They have flexibility in how they design the process: they can either meet the minimum requirements set in federal regulations (see below) or, if a state's consumer protection law meets or exceeds these requirements, they can rely on state law and choose to require providers to comply with state-specific grievance and appeals requirements currently in effect for health insurers in the state. States may elect to use the Medicaid "fair hearing" process.
Core elements of the process	• The hearing system must allow for either a hearing before the state agency or an evidentiary hearing at the local level with a right to appeal to the state level. The hearing system must follow due	• Reviews must be conducted by an impartial person or entity, review decisions must be timely and written, and enrollees must have an opportunity to represent themselves or use a representative of their

[28] See, e.g., Pollitz, K., Crowley, J., Lucia, K., Bangit, E. (May 2002) *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation,* Washington, DC: Kaiser Family Foundation, http://www.kff.org/content/2002/3221/externalreviewpart2rev.pdf; Studdert, D., Roan Gresenz, C. (February 19, 2003) Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations *Journal of the American Medical Association* 289 (7): 864-870, http://jama.ama-assn.org/cgi/content/full/289/7/864

KEY ELEMENTS	MEDICAID	SCHIP
	process standards. Hearings must be conducted by an impartial individual. Decisions must be timely and written. Enrollees must have an opportunity to represent themselves or use a representative of their choice, review their files and other relevant information, fully participate in the hearing process, and receive continued enrollment.	choice, review their files and other relevant information, fully participate in the review process, and receive continued enrollment.
Matters subject to review	• Eligibility or enrollment, both initial and subsequent decisions regarding eligibility. • Health services, including changes in the type or amount of services.	• Eligibility or enrollment, including denial of eligibility, failure to make a timely eligibility determination and suspension or termination of enrollment, including disenrollment for failure to pay cost-sharing contributions. • Health services, including delay, denial, reduction, suspension or termination of health services, including the determination about the type or level of services, and failure to approve, furnish or provide payment for health services in a timely manner.
Impartial review	• Hearings must be conducted by one or more impartial officials or other individuals not directly involved in the matter under review.	• Independent, external review must be conducted by the state or a contractor other than the contractor responsible for the health services matter subject to external review.
Time frames	• Final administrative actions must be taken within 90 days from the date the enrollee filed an appeal or from the date an enrollee filed for direct access to a state fair hearing, if the state permits direct access. Expedited timeframes, applicable when the enrollee's health condition requires, consist of 3 working days from the time the agency receives the case file from the MCO or from the time the agency receives a request directly from an MCO enrollee.	• Reviews must be completed in accordance with the medical needs of the patient. A standard timeframe (applicable when medical needs do not dictate a shorter time frame) consists of 90 calendar days from the date an enrollee requests an internal or external review. An expedited timeframe (applicable when medical needs dictate a shorter time frame) consists of 72 hours from the time an enrollee requests an external review and can be extended to 14 calendar days at the request of the enrollee.
Continuation of enrollment	• Coverage continues during an appeal that is requested in a timely manner.	• Coverage continues until the review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost-sharing, is completed.
Notice	• States must give at least 10 days advance written notice of their intention to terminate, suspend or reduce eligibility or covered services, provide the reasons for the action, and inform enrollees of their appeal rights.	• States must provide timely written notice of any determination subject to review, which includes: reasons for the determination; an explanation of applicable rights to review that determination; the standard and expedited times frames for review; the manner in which a review can be requested; and the circumstances under which

KEY ELEMENTS	MEDICAID	SCHIP
		enrollment may continue pending review.

Source: GW CHSRP, 2003.

B. State Agency Obligations to Monitor and Enforce Quality Standards

Federal law requires Medicaid and SCHIP agencies to engage in various types of activities aimed at ensuring health care quality. These obligations, summarized in Figure 4 begin with the development of a contract itself and continue throughout a monitoring and enforcement phase.

Figure 4. Federal Medicaid and SCHIP Health Care Quality Requirements

FEDERAL REQUIREMENTS	MEDICAID	SCHIP
Development of contract	States must use contracts for coverage or other services that comply with federal procurement requirements, which include: (1) states must provide for administrative, contractual, and legal remedies for breaches of the contract, including termination; (2) states must grant access to books, documents, papers, and records for audit and examination purposes; (3) states must monitor and report on program performance; (4) states must evaluate contractors' performance and document whether they meet the terms, conditions, and specifications of the contract. In addition, the contract must specify the following: (1) the population covered by the contract; (2) enrollment and reenrollment procedures; (3) amount, duration and scope of services; (4) evaluation of quality, appropriateness and timeliness of services delivered under the contract; (5) procedures and criteria for termination of the contract; (6) appropriate record system; (7) confidentiality protections; (8) third party liability activities; (9) subcontract requirements.	States must use contracts for coverage or other services that comply with federal procurement requirements, which include: (1) states must provide for administrative, contractual, and legal remedies for breaches of the contract, including termination; (2) states must grant access to books, documents, papers, and records for audit and examination purposes; (3) states must monitor and report on program performance; (4) states must evaluate contractors' performance and document whether they meet the terms, conditions, and specifications of the contract.
Contractual standards	States must include standards on access, structure and operations, and measurement and improvement in their contracts with MCOs. Access standards include: (1) availability of	States must abide by the contractual standards described above.

FEDERAL REQUIREMENTS	MEDICAID	SCHIP
	services by providing access to an adequate provider network, timely access to services, and culturally competent services; (2) coordinated care and continuity of care; (3) coverage and authorization of services. Structure and operation standards include: (1) provider selection; (2) enrollee information; (3) confidentiality; (4) enrollment and disenrollment; (5) internal grievance systems; (6) subcontracts. Measurement and improvement standards include: (1) practice guidelines; (2) quality assessment and performance improvement program. Performance measures and improvement projects are not defined, but can be federally determined; states are not required to establish minimum performance levels; and evaluations can be plan-conducted or state-conducted or both.	
Agency's monitoring and enforcement of contract and contractual standards	States must implement a quality assessment and performance improvement program, which they must use to monitor and evaluate compliance with, at a minimum, standards of access to care, structure and operations, and quality measurement and improvement. The program must include an annual, external independent review of quality outcomes, timeliness of services, and access to care. It must also provide for intermediate sanctions.	States must ensure quality and appropriateness of care. They also must establish and implement procedures to investigate and resolve cases of fraud and abuse.

Source: GW CHSRP, 2003.

In virtually all states, children, including those who are publicly insured, have basic legal rights to sue for injuries caused by medical negligence.[29]

Children enrolled in managed care arrangements do have certain grievance and appeals rights in the event that care is denied or delayed. These appeals systems offer some opportunity for external oversight of health plan conduct, but as with other individual legal tools, the grievance and appeals system tends to operate at a late stage in the health system, when allegedly necessary care already has been delayed or denied. Although federal law provides protections to ensure rapid reviews in certain emergency situations, the potential for injury must be imminent in order to invoke a

[29] Rosenblatt *et al., op.cit.*

fast-track response. Furthermore, it is unclear what impact disparate individual legal actions have on large systemic quality challenges. An isolated case can take on enormous significance when the negligence is clear, the case is publicized, and the award is enormous, but these types of cases are rare. A good quality management system would consider patterns of complaints and grievances when examining overall operations but pronounced patterns would be important in such cases.[30]

In sum, the role of purchasers in fostering the quality of care is key, given the lack of active federal oversight or individual legal remedies that are effective at the systemic level. This study examines efforts by state Medicaid and SCHIP agencies to use their power as the largest purchasers of pediatric health care in the nation to ensure pediatric health care quality in comprehensive managed care settings. In 2002, approximately 36 percent of all children were covered by the two programs,[31] making them the most significant purchasers of pediatric care, with the theoretical ability to influence overall system quality through their expectations and their active enforcement of these expectations through quality measurement. Medicaid and SCHIP interventions are particularly important in the case of comprehensive managed care because of the nature of the managed care systems in which children are enrolled. Because of the budgetary constraints under which they operate and within which their families live, Medicaid and SCHIP agencies contract for tightly managed arrangements that permit only the most limited out-of-network coverage and employ strict forms of utilization management. The consequences of tight management relative to a population with elevated health risks can be seen in the broad and detailed contracts that Medicaid and SCHIP agencies write for their contractors. In earlier studies, we have found that Medicaid managed care contracts are relatively comprehensive in the areas of health care access, network capacity and competence, and the general service duties of managed care organizations toward enrollees.[32] The question thus becomes how these detailed expectations are measured and enforced.

C. State Contracting Practices and their Enforcement

As previously noted, contracts are a federal requirement when Medicaid and SCHIP managed care arrangements are used. This requirement of a written agreement with providers and subcontractors rests not only on the provisions of the two benefits laws but on general federal grants management rules related to the administration of federal programs.

In keeping with the broad discretion granted states, the federal government does not design basic Medicaid and SCHIP managed care contracts for states to use. As a result, each state develops its own basic agreements that incorporate both federal standards as well as its own specifications based on local conditions and priorities. These specifications also reflect state laws related to contracts with private companies, which can be quite extensive.

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[30] See, e.g., the National Committee on Quality Assurance, www.ncqa.org
[31] www.kff.org
[32] See Rosenbaum, S. *et al.*, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 1st-4th editions (1997-2001), Washington, DC: GWU-CHSRP, http://www.gwhealthpolicy.org/managed_care.htm.

a. Summary of previous findings

For nearly a decade, the Center for Health Services Research and Policy at The George Washington University has studied Medicaid and SCHIP managed care contracts and analyzed and reported on their contents.[33] Findings, which have been widely disseminated over the years, can be summarized as follows: First, in the case of children, the contracts are comprehensive and reflect not only the coverage standards of federal law but additional standards of performance that states expect. Second, the contracts vary tremendously in what they emphasize and prioritize, although less so in the case of children, perhaps because the federal pediatric standards are themselves uniform and comprehensive. For example, a state with a high incidence of childhood lead poisoning may amplify the lead screening provisions of the Medicaid EPSDT program and set forth very detailed expectations regarding when, how, and where the screen should occur, the protocols that should be used, and how the data should be reported. Another state with a limited lead poisoning problem may barely mention lead screening beyond the minimum requirements.

Third, in the case of Medicaid only (which is far broader than SCHIP in its coverage requirements) many states contract for less than all required benefits under federal law, leaving certain types of benefits and coverage either entirely or partially in the residual Medicaid program. For example, some states may omit certain prescription drugs from their contracts, or specify levels of nursing home and home health benefits that are less than the full coverage available to beneficiaries under Medicaid amount, duration and scope standards.

Fourth, in state Medicaid programs that use multiple "prime contractors" (e.g., a comprehensive managed care organization and a managed behavioral health organization), there may be coverage "pockets" or "gaps" between the contracts. These

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[33] Rosenbaum, S., *et al*. (1997-2001), *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, Editions 1-4, op cit.;* Kamoie, B., Rosenbaum, S., Stange, P., (2003). Implementation and Management of Public Health Programs in a Managed-Care Legal Framework. *Law in Public Health Practice* (R. Goodman, *et al*., Eds) New York, NY: Oxford University Press; Rosenbaum, S., Skivington, S., Praeger, S. (2002). Public Health Emergencies and the Public Health/Managed Care Challenge. *The Journal of Law, Medicine and Ethics*, 30(3)(supp.): 63-69; Rosenbaum, S., Mauery, R., Blake, S., Wehr, E. (2000). *Public Health in a Changing Health Care System: Linkages Between Public Health Agencies and Managed Care Organizations in the Treatment and Prevention of Sexually Transmitted Diseases*. Washington, DC: Henry J. Kaiser Family Foundation; Rosenbaum, S. (1999). Approaches for Assuring Access to Quality Health Care Through State Contracts with Managed Care Plans. *Access to Health Care*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured; Blake, S., Wehr, E. (1999). Asthma and Managed Care: A Focused Study of Asthma-Related Medicaid Managed Care Contract Provisions. *Report to the Centers for Disease Control and Prevention*; Mauery, R., Rosenbaum, S., Woolley, Wehr, E., Sofaer, S. (1998). *An Evaluation of Emerging Relationships Through Memoranda of Understanding Between Managed Care Organizations and Public Health Agencies: Implications for Population-Based Communicable Disease Prevention and Control Programs and Public Health Policy*. Washington, DC: GWU Center for Health Services Research and Policy; Rosenbaum, S., (1998). Negotiating the New Health System: Purchasing Publicly Accountable Managed Care. *American Journal of Preventative Medicine*, 14:3S; Blake, S., Rosenbaum, S., Wehr, E. (1997). *Contract Specifications for Sexually Transmitted Disease (STD) Services in Medicaid Managed Care Plans. A Focused Study*. Atlanta, GA: Centers for Disease Control and Prevention; Rosenbaum, S., Richards, T. (Summer 1996). Medicaid Managed Care and Public Health Policy. *Journal Public Health Management Practice* 2(3): 76-82.

also can exist when a single comprehensive contract contains certain ambiguities and must be interpreted against the residual coverage under the state plan. These gaps – which tend to be an inevitable problem when the less-than-precise art of contract drafting meets the complexity of federal law – are of obvious importance to all parties to the agreement as well as those on whose behalf the agreement is written or who are paid through the agreement. Ambiguities in drafting can lead to ambiguities regarding who is at financial risk for costly services. Contractors may be unclear as to where their service duties begin and end. Providers may be unclear regarding who will pay them for their services, the state or a contractor. Comprehensive and behavioral contractors may disagree over the point at which the former company's mental health service duties end and the specialty system's begin, with resulting dilemmas for providers in the two systems. And finally of course, the beneficiaries of these agreements may confront a situation in which everyone – the state, the contractors, and the network providers – disavows responsibility to manage and pay for particular conditions. This type of confusion may be most evident in the case of children with complex and co-occurring mental and physical conditions, whose management is challenging to begin with and whose families must navigate several distinct systems – their comprehensive health plan coverage, their behavioral health plan coverage in the case of states that use behavioral providers,[34] and the state plan.

Our previous analysis found that because coverage is narrower and predicated on a commercial insurance model, SCHIP programs tend to buy all services from single contractors, thereby removing this layer of complexity that is part of Medicaid managed care.[35] However, the same problem of drafting ambiguities can still be decisively present. Since state SCHIP agencies are at risk for coverage and payment of all services enumerated in their state plans (unless and until a service is removed) a state SCHIP agency and its contractors can find themselves in similar coverage disputes. States and their contractors similarly can find themselves in disagreement over the meaning of non-coverage provisions of SCHIP agreements, such as provisions related to access and quality.

Because Medicaid and SCHIP contracts are comprehensive and because, as discussed in the previous section, the primary role in contracts and their enforcement is assigned to state agencies, it is important to understand both the powers that state agencies have to pursue contract enforcement as well as the process of enforcement itself. The importance of state activities in this area is magnified by the limited enforcement capabilities that children have on their own, as well as by the outright prohibition against third party contract enforcement imposed by many states and by the limitations described above on individual enforcement inherent in the federal law of individual rights.

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[34] See Rosenbaum, S., Mauery, D.R., Teitelbaum, J. (August 2001). *Issue Brief 14: An Overview of Legal Developments in Managed Care Caselaw and Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services*, Washington, DC: GWU Center for Health Services Research and Policy, http://www.gwhealthpolicy.org/downloads/behavioral_health/bhib-14.pdf.

[35] Rosenbaum *et al., Negotiating the New Health System, op.cit.*; Rosenbaum, S., Shaw, K., Sonosky, C. (December 2001) Managed Care Purchasing under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts *SCHIP Policy Brief #3*, Washington, DC: GWU Center for Health Services Research and Policy, http://www.gwhealthpolicy.org/downloads/SCHIP_brief3.pdf

b. Contract design and enforcement

Drawing on a unique database maintained by the George Washington University Center for Health Services Research and Policy (CHSRP)[36], we reviewed the mechanisms for enforcing compliance with pediatric performance standards that are internal to the risk contracts between Medicaid and SCHIP purchasers and MCOs. The analysis focused on contracts in effect as of March 31, 2000 in 16 states: Arizona, California, Colorado, Florida, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Ohio, South Carolina, Texas, Washington, Wisconsin. Twelve of these states are also the focus of the Urban Institute's *Assessing the New Federalism* project.[37] The remaining four are among the states that have communities being tracked by the Center for the Study of Health Systems Change.[38] Together, these states represent 58 percent of all Medicaid beneficiaries and 53 percent of Medicaid beneficiaries enrolled in MCOs in 2001. Similarly, they represent over 90 percent of the 3.25 million SCHIP beneficiaries enrolled in MCOS in 2001.[39] This analysis focuses on remedies and enforcement involving comprehensive MCOs and does not examine enforcement against individual practitioners. In addition, we focused on enforcement rather than incentivization in this review, since our goal was to determine the remedies that exist where a state concludes that perhaps in spite of incentivization,[40] non-compliance is a problem that must be addressed.

The analysis focused on contractual remedies, however states have other tools that can be used to enforce contract standards. These include state licensure laws aimed at assuring that only health plans with certain capabilities are eligible to bid for state-financed managed care contracts, anti-fraud statutes aimed at both civil and criminal conduct, and other general laws relevant to consumer protection. These laws are extremely important and act as an overarching legal framework for the Medicaid managed care agreement itself.

For purposes of this review, we identified remedies typically used in Medicaid and SCHIP contracts in conjunction with a pediatric performance standard based on the requirement under Medicaid statute and regulation that children receive appropriate immunizations according to the schedule recommended by the CDC Advisory Committee on Immunization Practices.[41] Our prior reviews of Medicaid and SCHIP contracts[42] revealed 11 basic types of remedies that one or more state Medicaid and or

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[36] The CHSRP contract database, assembled with support from the David and Lucille Packard Foundation,
contains Medicaid and SCHIP contracts in effect on March 31, 2000, *Negotiating the New Health System*, 4th Edition, www.gwhealthpolicy.org/managed_care.htm.

[37] The Urban Institute's *Assessing the New Federalism* study covers 13 states (AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, WI and DC), http://www.urban.org. Because Alabama did not enter into any risk contracts with MCOs during 2000, it is not included in this analysis.

[38] The Center for the Study of Health Systems Change is studying 12 communities, including Phoenix, AZ; Indianapolis, IN; Cleveland, OH; and Greenville, SC. http://www.hschange.org/.

[39] http://www.cms.gov/medicaid/managedcare/mcsten02.pdf Data as of June 30, 2002.; http://www.cms.gov/schip/ and Austein Casnoff, *op.cit.*

[40] See Bailit Health Purchasing, LLC (March, 2002) *Recommended Health Care Markets for Provider Incentive Demonstrations*, http://www.nhcpi.net/pdf/incentives.pdf, regarding the use of incentives in Medicaid managed care.

[41] Section 1905(r)(1)(B)(iii); 42 C.F.R. 441.56(c)(3).

[42] GW Center for Health Services Research and Policy, *Negotiating the New Health System: State Children's Health Insurance Programs, Fourth Edition,* Washington, DC: The George Washington University, Center

SCHIP agencies have incorporated into their contracts with MCOs in order to enforce compliance with the requirements of the contract.[43] These remedies are set forth below.

Figure 5. Managed Care Contractual Remedies

Types of Remedies in State Medicaid and SCHIP Risk Contracts with MCOs
Corrective action plans
Liquidated/exemplary damages
Suspension of new enrollment
Disenrollment of current enrollees
Withholding from capitation payments
MCO payment for out-of-plan care
State payment to out-of-plan provider
Adjusting capitation payment rates
Receivership by state Medicaid agency
Termination or non-renewal of contract

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

There is a dramatic difference between contract termination and any of the other remedies listed above. Termination represents the end of the business relationship between the state purchaser and the MCO; if the MCO does not have a significant enrollment of individuals who are not Medicaid or SCHIP beneficiaries, then termination also represents the commercial demise of the MCO. Because termination is such a harsh remedy, it is not commonly invoked; instead, purchasers rely on the imposition (or the threat of imposition) of intermediate sanctions to deter noncompliance with contract requirements and, when noncompliance occurs, to cure it.

The use of intermediate sanctions has particular logic in the case of pediatric performance standards, for example the CDC Advisory Committee's childhood immunization specifications. This performance standard is an important marker of the extent to which an MCO is complying with Medicaid program requirements as well as the quality of pediatric care the MCO offers. However, this performance standard does not measure the range of the MCO's responsibilities vis-à-vis its child enrollees, and an MCO that does not meet the immunization performance standard could be performing most of its other pediatric care responsibilities adequately. In such circumstances, contract termination would serve no useful purpose. The imposition of one or more intermediate remedies that target and are proportionate to the performance standard and the degree of noncompliance is likely to be much more effective at inducing compliance by the MCO.

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for Health Services Research and Policy, http://www.gwu.edu/~chsrp/Fourth_Edition/CHIP/schiptoc.html.

[43] *Ibid*., Table 6.4.

A similar review of contracts in effect in 2000 between state SCHIP agencies and MCOs found that these contracts contained 9 of the 11 types of remedies present in the Medicaid risk contracts. In this prior review, we identified two notable remedies available to Medicaid purchasers but not incorporated into SCHIP contracts that exist independent of the Medicaid agreement under separately administered SCHIP programs. These two remedies involve situations in which a company's network is unable to furnish contractual care, a problem that is by no means unique to Medicaid (indeed, access to out-of-network providers is a major focus of state managed care oversight generally).[44] The remedies permit an agency to either require the MCO to pay for contractual care that it cannot furnish through its own network or to pay for the out-of-network care and recoup from the contractor. The potential for network failure apparently was less of a concern to state SCHIP agencies, since these remedies did not appear in the SCHIP contracts.

[44] Butler, P. (August, 2001). *Comparison of State Managed Care Liability Laws*. Washington, DC: Kaiser Family Foundation, http://www.kff.org/content/2001/3155/MCOReport.pdf.

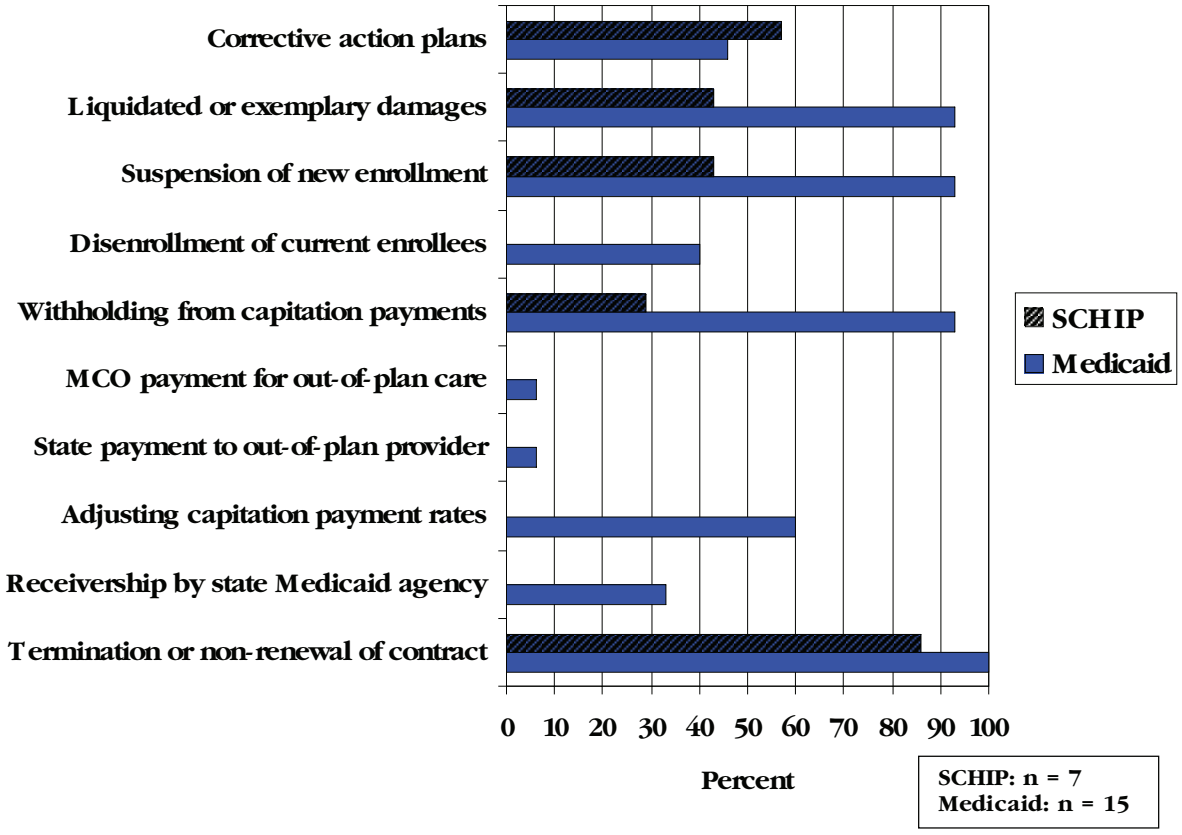
c. Sanctions in Medicaid and SCHIP Managed Care Contracts, 2000

In our review of the 16 focus states in this study, we examined contracts in effect during the 2000 time period. Figure 6 illustrates the frequency of contractual recourse to seven specified remedies for ten SCHIP states and 15 Medicaid states. Tables A.I through A.IV below provide details on the various intermediate sanctions that appear in the two groups of contracts and compare Medicaid and SCHIP agency approaches. A discussion of the remedies and the tables follow. Additional tables are in Appendix I.

Overview

Type of remedy by frequency. The most frequently described remedy for noncompliance in both the SCHIP and Medicaid contracts is termination or non-renewal of the contract. Unlike Medicaid, however, withholding from capitation payments was the remedy least frequently described in SCHIP managed care contracts. The majority of SCHIP contracts cited recourse to corrective action plans; this was the second most frequently cited sanction in SCHIP contracts and the sixth for Medicaid. Three of the seven SCHIP contracts and 14 of the 15 Medicaid contracts also included suspension of new enrollment and liquidated or exemplary damages as remedies for noncompliance.

Figure 6. Percent of States with Contractual Recourse to Specified Remedies in Medicaid and SCHIP Contracts



State payments to out-of-plan providers recouped from plans and mandatory MCO payment for out-of-plan care were the remedies least frequently described in Medicaid managed care contracts and neither is cited by any of the SCHIP contracts analyzed. SCHIP contracts did not contain the following remedies: receivership, adjustment of capitation rates, state payment to out-of-plan provider recouped from MCO, MCO payment for out-of-plan care, and disenrollment of current enrollees. Like Medicaid, a general and nonspecific failure to comply with the contract was systematically one of the top reasons for employing the remedy.

Total number of remedies by state. Massachusetts Medicaid included the most number of available remedies in the contract, while California and Michigan were the states with the lowest number of remedies available. The California SCHIP contract, however, contained the highest number of remedies of all the SCHIP contracts analyzed. Similar to Medicaid, Michigan was one of two states with the lowest number of remedies included in the separate SCHIP contract.

Individual Remedies and the Uppermost Reasons for Imposing Them

Corrective action plans. Seven Medicaid contracts included language for imposing corrective action plans. The most frequently cited reasons for requesting such plans included failure to comply with the contract and failure to provide quality care. Four SCHIP contracts authorized the use of corrective action plans, most frequently in response to a failure to comply with the contract. Other reasons for the use of corrective action plans identified in SCHIP contracts were knowledge that representations or warranties regarding a participating provider may be untrue or incorrect, hindrance of enrollee access to covered services due to inability of providers within the plan to accept additional enrollees as patients, and a deficiency or event causing an assessment of a liquidated damage.

Liquidated or exemplary damages. The majority of Medicaid states and three SCHIP states included provisions in their Medicaid contracts on liquidated or exemplary damages to sanction a variety of MCO behaviors. The most frequently described basis for imposing this type of remedy in Medicaid contracts was MCO failure to comply with the contract, followed closely by MCO failure to submit data, medical records, or other information or to submit them in the required form or format by a specified deadline, and MCO failure to comply with federal laws and regulations. For SCHIP, the most frequently cited basis for instituting this remedy was failure to comply with objective performance standards monitored by the state.

Suspension of new enrollment. The majority of Medicaid and three SCHIP states gave the Medicaid or SCHIP agency the contractual authority to suspend new enrollment. Principal reasons for suspending enrollment were failure to comply with the contract (Medicaid and SCHIP); and, failure to comply with marketing guidelines and failure to comply with state laws and regulations (Medicaid only).

Disenrollment of current enrollees. Six states used disenrollment of current enrollees as a remedy against participating MCOs. The most frequently cited reasons for imposing this remedy were failure to comply with the contract and the failure to provide

services, followed by failure to comply with federal laws and regulations and failure to maintain or provide records. None of the SCHIP contracts included this remedy.

Withholding from capitation payments. While the majority of Medicaid states included withholding from capitation payments as a sanction under certain circumstances, only two SCHIP states included such a remedy in their contracts. Most often, Medicaid contracts cited failure to comply with the contract, failure to provide medically necessary services, discrimination in employment, and termination as reasons for withholding from capitation payments. Other reasons included failure to comply with federal laws and regulations, failure to comply with state laws and regulations, failure to comply with financial soundness requirements, failure to comply with reporting requirements, misrepresentation or falsification of information, and failure to comply with physician incentive plan requirements. The two SCHIP states included failure to comply with the contract and failure to make payments to the Consumer Assessment of Health Plans (CAHPS) vendor for reasons for employing this sanction.

MCO payment for out-of-plan care. Only one Medicaid contract required MCOs to pay for out-of-plan care when they failed to comply with the contract or failed to comply with laws and regulations.

Recoupment of state payment to out-of-plan providers. Only one Medicaid contract had the contractual authority to recoup from MCOs state payments to out-of-plan providers for failure to reimburse covered services after receiving a monthly prepayment to provide these services and when an enrollee has moved outside of the MCO's service area.

Adjustment of capitation rates. Nine Medicaid contracts included the option to adjust capitation rates as a remedy against plan violations, most frequently in response to a failure to comply with the contract or a failure to submit data. None of the SCHIP contracts analyzed described this remedy.

Receivership. Five Medicaid contracts described receivership as one option against specified MCO behavior, such as failure to comply with the contract, failure to comply with federal laws and regulations, MCO action amounting to egregious behavior, and MCO action posing a substantial risk to the health of enrollees.

Termination. All Medicaid states and all but one SCHIP state included termination clauses in their contracts both for contractor violations and other reasons independent of contractor behavior. In the long list of contractor violations, failure to comply with the contract, failure to maintain financial viability or meet financial soundness requirements, loss of qualification for licensure, certificate of authority, or certification, failure to comply with federal laws and regulations, and unremedied breach within a specified time period topped the list for Medicaid. The protection of enrollees from injury, the best interest of the state, and the protection of state or federal funds or property were the top three other reasons enabling states to terminate the contract. Top contractor violations in SCHIP contracts included failure to comply with the contract, failure to meet statutory financial requirements or to comply with solvency requirements, and assignment for the benefit of creditors, appointment of receiver, or

bankruptcy proceedings. Lack of funding or appropriated funds was the leading other reason enabling states to terminate the contract.

State Law Remedies External to Contract

Contracts between state Medicaid or SCHIP purchasers and MCOs are governed primarily by state and federal Medicaid and SCHIP laws. These laws may be expressly referenced in the contracts or may be covered in a broad reference to "all applicable state and federal laws and regulations." Other state laws also apply to these arrangements or to the MCO doing business with the state Medicaid agency. For example, most states have laws requiring MCOs doing business in the state to obtain a license, and some states have enacted legislation prohibiting the submission of false claims by Medicaid providers. These other laws, in turn, contain remedies for noncompliance with their requirements. These remedies, however, are not tools that will realistically enable state purchasing agencies, other state regulatory officials, or the state courts to hold MCO contractors accountable for compliance with pediatric performance standards.

Medicaid Law

States that contract on a risk basis with MCOs are required under federal law to "establish" intermediate sanctions in connection with certain specific offenses.[45] Federal law is silent as to whether the intermediate sanctions are contained in statute, regulation, or in the risk contract itself. At a minimum, the state Medicaid agency must have available to it the following two intermediate sanctions: appointment of temporary management; and permitting enrollees to disenroll without cause and notifying the enrollees of their right to do so.[46] The state may also adopt one or more of the following intermediate sanctions: civil money penalties; suspension of new enrollment (including default enrollment); and suspension of capitation payments until the reason for the sanction no longer exists and is not likely to re-occur.[47] States may establish additional sanctions at their discretion.[48] States are not required to impose intermediate sanctions except in one circumstance: if the state finds that an MCO "has repeatedly failed to meet" federal statutory requirements.[49]

[45] Section 1932(e)(1)(A) of the Social Security Act, as implemented by 42 CFR 438.700. States must be in compliance by June 13, 2003, 67 Fed. Reg. 40989 (June 14, 2002).
[46] 67 Fed. Reg. 41067; 42 CFR 483.706(b). States must be in compliance by June 13, 2003, 67 Fed. Reg. 40989 (June 14, 2002).
[47] 42 CFR 438.702(a). States must be in compliance by June 13, 2003, 67 Fed. Reg. 40989 (June 14, 2002).
[48] 42 CFR 438.702(b).
[49] Section 1932(e)(3) of the Social Security Act, as implemented by 42 CFR 438.706(b). States must be in compliance by June 13, 2003, 67 Fed. Reg. 40989 (June 14, 2002).

Part II. State Experiences with Monitoring Contract Enforcement

Considerable attention has been paid to the development of clinical performance measurement and initiatives aimed at upgrading the clinical quality of care around key health problems (e.g., under-immunization, pediatric asthma). But far less attention has been devoted to the study of how these quality improvement efforts become integrated with the elements of contractor accountability: specification, compensation, and performance oversight, including direct access to patient protections.

Studies on monitoring and enforcement of Medicaid managed care are sparse as are studies of monitoring SCHIP contractor performance (this is not surprising, given the recent nature of the SCHIP program). One GAO study focused on four states' general efforts in monitoring Medicaid managed care programs and ensuring plan compliance with the access and data collection requirements of the contracts. [50] That study, however, did not focus on pediatric health care. A second, more recent GAO study examined efforts to implement Medicaid EPSDT services in five states.[51] This second study did not examine contractual enforcement, although it theorized certain managed care-related contractual enforcement strategies as a means of improving access and quality. Other recent studies have focused on specific components of managed care performance monitoring, such as the use of performance incentives, early warning systems, and data reporting.[52] Again, these studies are not specific to pediatric health care and do not tie these approaches to contracting practices. At the same time, the small body of research that does exist suggests that compliance monitoring matters and that noncompliance is a problem.

This phase of our analysis attempts to fill this gap by examining state contractual monitoring practices under Medicaid and SCHIP by combining an analysis of contractual provisions with interviews with state officials regarding their experiences in monitoring and enforcing two specific pediatric health standards.

A. Study Design

This phase of the study explores: 1) the logic behind a state's selection of certain conditions to emphasize in its contractual specifications; 2) similarities and differences in how states with comparable areas of child health emphasis approach enforcement; 3) the extent to which the contracts were written to reflect existing standards, or modify or replace current standards; and 4) how states developed their expectations regarding contractor performance and monitored actual performance against those expectations.

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[50] General Accounting Office, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort* (GAO/HEHS-97-86, 1997), http://www.gao.gov.
[51] General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services* (GAO-01-749, 2001), http://www.gao.gov.
[52] See, e.g., Dyer, M.B., Bailit, M., and Kokenyesi, C. (2002). *Are Incentives Effective in Improving the Performance of Managed Care Plans?* Washington, DC: Center for Health Care Strategies, http://www.chcs.org/publications/pdf/ips/bailitperformance.pdf; Dichter, H, M.D., (2002). *Monitoring Medicaid Managed Care via an Early Warning Program.* Washington, DC: Center for Health Care Strategies, http://www.chcs.org/publications/pdf/ips/earlywarning.pdf.

Because of the sheer breadth of managed care contracts, as well as our desire to delve beyond generalized assertions regarding enforcement and to examine enforcement experiences in the context of actual childhood health conditions, we selected two pediatric health condition "markers" for analysis. Following consultation with pediatric experts, examination of the contracts themselves, and a review of literature on child health, we selected markers of child health that are tied to both high prevalence and low prevalence child health conditions, and represented in Medicaid and SCHIP managed care contracts in terms of reasonably clear contractual specifications, thereby lending themselves to an exploration of state oversight experiences. Our assumption was that if a state was sufficiently concerned with a particular child health condition to address it with some specificity in the contract, the condition presumably would be one that a state intended to focus on as part of its oversight efforts.

We selected conditions that not only were representative of both high and low prevalence problems but that also, in their comprehensiveness as reflected in the contracts, suggested a state's desire to move beyond what a contractor might be expected to do as a matter of professional industry custom. In any Medicaid managed care contract, one would expect that managed care contractors would adhere to professional health practice in the provision of both low and high prevalence pediatric care. The fact that states choose to emphasize certain services at length suggests that they wish to maintain a special and elevated focus on a particular child health problem above and beyond what professional custom alone might produce.

The study design was qualitative and combined document analyses of state managed care contracts and other legal documents with semi-structured telephone interviews with officials from Medicaid and SCHIP agencies, as well as other agencies involved in contract oversight, when appropriate.

Pediatric standards of care and performance standards related to these standards of care were selected to represent standards common to all pediatric managed care arrangements and to reflect both high and low prevalence childhood conditions. The two conditions that we selected were oral disease and childhood lead poisoning. Figure 7 describes the prevalences and the potential sequelae of oral disease and lead poisoning.

Figure 7. Comparison of the Prevalence of Oral Disease and Lead Poisoning[53]

Prevalence of oral disease **(high prevalence condition)**	Oral diseases and conditions can have serious short-term and long-term consequences for a child's growth, function, ability to learn, self-image, and employability. Today, tooth decay is the single most common chronic childhood disease, affecting approximately 20% of preschoolers, 50% of 6-8 year olds, and 75% of 15 year olds. The prevalence of dental caries is higher for low-income children. Analyses of data from a nationally representative sample of children show that the amount of tooth decay in children is

[53] Sources: Children's Dental Health Project (2003). *At-a-Glance Pediatric Oral Health & Oral Health Disparities; At-a-Glance Medicaid & SCHIP Dental Programs*, http://www.childent.org; American Dental Association (2003). *Fact Sheet—Children's Dental Disease,* http://www.ada.org; Centers for Disease Control and Prevention. (2000). *Blood Lead Levels in Young Children—United States and Selected States, 1996-1999,* http:/www.cdc.gov/mmwr/preview/mmwrhtml/mm4950a3.htm.

	inversely related to income level, suggesting that Medicaid children have a higher prevalence of dental caries than SCHIP children, who in turn have a higher prevalence of dental caries than higher income children not enrolled in SCHIP. Data by state are not readily available. ***The Healthy People 2010 Objective 21-1 is to reduce the proportion of children and adolescents who experience dental caries in their primary or permanent teeth.
Prevalence of lead poisoning **(low prevalence condition)**	Lead poisoning has the potential to damage a child's central nervous system, kidneys, and reproductive system. At high levels, it is associated with decreased intelligence, impaired neurobehavioral development and hearing acuity, decreased stature and growth, and sometimes, death. Today, lead poisoning is a low prevalence condition. Blood lead levels are highest for younger children and for children who are poor (i.e., with family incomes below 100% of the federal poverty level). In 1999-2000, 300,000 children ages 1-5, or approximately 2% of children in that age group, had elevated blood lead levels, representing a 2.4% drop since 1991-1994. In 1991-1994, the prevalence of lead poisoning among Medicaid-covered children ages 1-5 was 9%, compared to 3% among children not covered by Medicaid. Aggregate SCHIP data are not available, but presumably would show a prevalence among SCHIP-covered children lower than that for Medicaid yet higher than for the general population. The estimated prevalence of elevated blood lead levels across seven of the nine study states ranges from a low of 3.8% to a high of 16%, with a midpoint estimate of 7.4% (the rate for the two remaining states is unknown). Within states, the prevalence rate varies considerably as well. For example, in one state, where the statewide prevalence rate is approximately 13%, the proportion of children with elevated blood lead levels ranges from a low of 1.3% to a high of 27.3%, depending on the county. ***The Healthy People 2010 Objective 8-11 is to eliminate elevated blood lead levels in children.

Oral disease represents one of the most prevalent and disparate conditions affecting low income children, with both short-term and long-term consequences.[54] There is an extensive body of literature on the problem,[55] as well as practice guidelines that define accepted interventions at preventive, acute, long term and emergency care stages.[56] Oral health improvement has been a specific quality improvement target among federal and state Medicaid agencies and many managed care plans have been involved in oral health improvement efforts.[57] Oral health also is a specific service mentioned in 39 of the 42 comprehensive physical health Medicaid contracts and 13 of the 15 SCHIP contracts in our contracts database.[58]

The second condition selected was blood lead levels sufficiently elevated to require treatment. This condition was selected because of its public health importance,[59] its long-term effects on children,[60] its recognized severity as a condition requiring immediate treatment,[61] and the intensity of focus that has been given to the

[54] Nolan, L., Kamoie, B., Harvey, J., Vaquerano, L., Blake, S., Chawla, S., Levi, J., and Rosenbaum, S. (January, 2003). *The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children*, http://www.gwhealthpolicy.org/downloads/Oral_Health.pdf.
[55] *Ibid*.
[56] *Ibid*.
[57] *Ibid*.
[58] *Negotiating the New Health System, op cit*., http://www.gwu.edu/%7Echsrp/Fourth_Edition/.
[59] Farmer, C. (2003). *Lead Screening for Children Enrolled in Medicaid: State Approaches*. Washington, DC: National Conference of State Legislatures Promising Practices Issue Brief. See also GW Center for Health Services Research and Policy, (1998) Medicaid Managed Care Contracting for Childhood Lead Poisoning Prevention Services.
[60] *Ibid*.
[61] *Ibid*.

threat of lead poisoning in low-income communities at both the federal and state levels over the years.[62]

Sixteen states encompassing 27 Medicaid managed care and separate SCHIP programs with full-risk managed care contracts in existence (whether these contracts are separate from each other or integrated with each other) were included for potential participation in the study: Arizona, California, Colorado, Florida, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, South Carolina, Texas, Ohio, Washington, and Wisconsin. These states mirror those studied by the previously mentioned Urban Institute and Center for Studying Health Systems Change in their ongoing studies of federalism and market change. They also comprise more than half of the nation's population, and a broad range of fiscal capacity, child well-being, managed care markets, and approaches to government programs.

A total of nine states and 15 programs (eight Medicaid managed care programs and seven separate SCHIP programs) chose to participate in the study, representing a response rate of 56 percent. The remaining seven states declined to participate for various reasons.[63]

B. Data Collection and Methods

Data were collected and analyzed according to a theoretical framework developed from a combination of sources, including the literature on policy implementation and the available research on oversight in a Medicaid managed care context. The theoretical framework delineates the key components of an effective state monitoring plan and incorporates ten elements that have been identified by implementation theorists as important to successful implementation (see Figure 8). It is important to note that this framework was not prescriptive but rather a guide for conducting the study and developing the research questions (see interview guide, attached).

Figure 8. Key Components of an Effective State Monitoring Plan[64]

Formal Plan with Clear Goals, Assignments, Measurements, and	Policy goals have been clearly stated (element one); precise standards for measuring compliance with policy goals have been specified (element two); agency for implementing and enforcing the policy has been set up

[62] *Ibid*.

[63] Reasons given for declining to participate included: the legislative session and the demands it imposed on the agency; current fiscal pressures; shortage of staff; structure of the program, which did not lend itself to what was perceived as a useful contribution to the study; absence of focus of the quality improvement plan on lead poisoning and oral health or the beginning of the development of a plan on lead poisoning and oral health; low levels of managed care participation in the program; a belief in improving quality through other means than the contract; or the perceived lack of utility of research such as this for an individual state.

[64] Bullock, C. and Lamb, C. (1984). A Search for Variables Important in Policy Implementation. *in* Bullock, C. and Lamb, C. [Eds] *Implementation of Civil Rights Policy* New York, NY: Brooks Cole; General Accounting Office. *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort* (GAO/HEHS-97-86, 1997); National Medicaid Fraud and Abuse Initiative. *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* (Department of Health and Human Services, Baltimore, MD, 2000).

Milestones	(element four); multi-faceted support exists toward the policy goals, i.e., the personnel responsible for implementation are committed to promoting the policy goals (element five), those enforcing the policy enjoy the support of their superiors (element six), and the policy beneficiaries are organized and cohesively support implementation of the policy goals (element seven).
Prevention Strategies	Strategies to prevent implementation problems, including specifying contract requirements in the following areas: service components and service periodicity schedule; adequacy of provider network, travel distances, and waiting times; and adequacy of medical care provided and beneficiary satisfaction.
Coordination Strategies	The various agencies responsible for achieving the policy goals administratively coordinate their efforts (element eight).
Detection Strategies	A mechanism for monitoring compliance has been created (element three); quantifiable standards have been developed to measure performance and information is collected to measure plan compliance with standard; analysis and investigation are independently conducted by the state or other external organization rather than plan-conducted.
Enforcement Strategies	General approach is proactive, systematic, ongoing rather than reactive, periodic; incentives and penalties favor compliance (element nine).
Reporting Strategies	Federal government is an active participant on behalf of those protected by the policy (element ten); state reports back to the federal government for additional sanctions beyond the purview of the state.

Data were collected from two main sources of information. First, service and enforcement provisions found in Medicaid and SCHIP managed care contracts collected for CHSRP's ongoing study entitled "Negotiating the New Health Care System,"[65] as well as federal and state laws, including federal and state Medicaid statutes and regulations, federal and state SCHIP statutes and regulations, federal and state HMO acts, and federal and state procurement laws, when appropriate.

The second source of information consisted of telephone interviews with state government officials that were used to complete, corroborate, and clarify the documentary evidence. In these interviews, we discussed specific contract requirements, state oversight activities, and state actions available or taken as a result of monitoring.[66] A wide range of officials were included, including both Medicaid and SCHIP agency staff.[67] We sought information about contract enforcement issues state officials faced as well as information on the extent to which contract drafting created additional problems in enforcement. This last point was of particular interest; since we began the contracts project nearly a decade ago, we have given specific focus to noting potential ramifications of vague language from an enforcement viewpoint.

Data were analyzed across states to describe the logic of Medicaid and SCHIP contract performance standards selection and the similarities and differences in state

[65] *Negotiating the New Health System* [4th Ed.], *op. cit.*

[66] To protect the privacy of interviewees, all interviews with state officials were treated as confidential, informed consent procedures were followed, and only written notes were taken. No individual information that personally identifies an individual by name is published in this paper. This research project was reviewed for human subject protections by the George Washington University Medical Center Institutional Review Board and received approval on July 20, 2002 (IRB# U080227ER).

[67] We also asked Medicaid and SCHIP interviewees to refer us to representatives from other agencies, e.g., Attorney General's offices, departments of insurance, as well as representatives from participating health plans whom they felt were appropriate for some follow-up questioning. Because of the low level of responses and the lack of representativeness obtained through this request, we decided to postpone this component of this study to a later date.

monitoring plans by degree of managed care penetration, type of program design, and prevalence of the condition targeted by the contractual performance standard.

C. Analysis of Contract and Interview Findings

a. Medicaid and SCHIP Contract Performance Standards Selection

In this part, we analyze how state contracts reinforce existing professional standards and industry norms and develop new standards of care that attempt to raise the bar in health care quality for children.

1. Dental Care

Typically, in the private sector, dental services are not included in the contractual obligations of managed care organizations. Rather, they are optional and furnished through alternate systems of care. In contrast, in the Medicaid program, at least in the case of children, states must cover EPSDT services, which include oral screenings and referrals to dentists as part of the physical examination required under the program. In addition, other necessary care (i.e., diagnosis, treatment) discovered by the screen should be covered. At a minimum, other dental care should include emergency, preventive and therapeutic services, as defined in law, to relieve pain and infections, restore teeth, and maintain dental health.

States must provide dental services at intervals that meet reasonable standards of medical and dental practice and should consult with recognized medical and dental organizations involved in children's health care in setting these standards. However, there are differences of opinion among these professional associations on what the periodicity schedule should look like. The American Dental Association (ADA), American Academy of Pediatrics (AAP),[68] and American Academy of Family Physicians (AAFP) recommend a direct referral to a dentist at age 3 or earlier if medically necessary and greater frequency of dental visits than physical examinations for older children (a practice also supported, albeit no longer required, by the Centers for Medicare and Medicaid Services (CMS)). The American Academy of Pediatric Dentistry (AAPD), on the other hand, recommends a dental visit within six months of the eruption of the first tooth and no later than a child's first birthday, and subsequently a minimum of two visits per year.

Generally speaking, separate SCHIP programs have more flexibility to determine which benefits they will cover. SCHIP requires states to provide benefits that are actuarially-equivalent to a benchmark benefit package (e.g., state employee benefit plan) for basic services, which must include well-baby and well-child care. Unlike Medicaid, dental care is not specifically listed as a component of well-baby and well-child care in the SCHIP program.

We asked state Medicaid and SCHIP officials why they set the oral health standards as they had in the contract. The most striking difference came from the fact that Medicaid programs, including SCHIP Medicaid expansion programs, and separate SCHIP programs are governed by two separate sets of rules.

Medicaid officials almost uniformly cited the federal ESPDT requirements as the driving force for their oral health standards. While the majority of these officials believed that, or did not venture a guess as to whether, their standards reflected current federal requirements, professional standards, and industry norms, officials in two states thought theirs went a step further because they had "beefed up" the existing preventive guidelines with additional requirements. In the first state, officials added two requirements: 1) that primary care physicians perform oral screens at each well-child

[68] Since this research took place, the AAP changed its policy and joined the AAPD in recommending the establishment of a dental home by referring a child for an oral health examination by a dentist 6months after the first tooth erupts or by 12 months of age.

visit and refer children to dental services when necessary, and 2) that managed care organizations guarantee open access or self-referral to oral health services for children and notify families when the annual visit is due.

In the second state, officials further defined what the examination of the oral cavity should entail, by requiring that medical providers "look at the teeth" not just the tonsils, perform various educational activities, and refer to dental providers using "First Tooth, First Birthday, First Dental Visit" as a guide for the age of referral, an approach similar to the one recommended by the AAPD. The state still faces difficulties with the referral component because the AMA, ADA, and AAPD differ on the age of referral (e.g., one says age three, the other with the sighting of the disease) and because providers remain confused as to which standard applies.

SCHIP officials, on the other hand, pointed to the flexibility of the SCHIP statute and regulations, which do not set federal standards in the area of oral health. The three separate SCHIP programs represented in this study all covered dental care and explicitly listed components of that care in their contracts. Two of these three programs also referred in their contracts to a specific periodicity schedule for providers to follow, the AAP schedule in the first case and the AAPD schedule in the second case. The third contract was silent on this issue, but the state official representing the program explained that the dental care component was based in large part on the Medicaid managed care model, particularly in the area of oral health assessments, which requires plans to follow the AAP periodicity schedule. One state official believed that their dental care standards went beyond industry norms because they had used the state employee benefit plan as a benchmark for the SCHIP benefit package and augmented it with the AAP standard of "screen and refer at age three." State officials in the second state thought their standards reflected industry practice because the choice of the AAPD standard was based on the recommendations to the Commission set up to design the SCHIP program by a dentist. The state official in the third state was unsure whether theirs represented an advance beyond existing standards.

We asked state Medicaid and SCHIP officials how the pediatric oral health standards contained in their managed care contracts were arrived at and negotiated with contractors. There were basically two groups of states: those that made the pediatric oral health standards of their contracts nonnegotiable and those that negotiated them in some fashion. Half of the states fell into the first group and did not negotiate this aspect of the contract because it was in essence predetermined by the EPSDT requirements at the federal level or it was added to the RFP as a minimum, nonnegotiable requirement. The other half of the states took varied approaches to negotiation and involved health plans at different stages of the process, but they all underscored that it facilitated buy-in on the part of health plans and thus lessened the opposition of health plans to the oral health standards that resulted in the contract. Three states involved health plans early on in the development stage of the standards either through formal discussions where the state entity responsible for setting policy on oral health made the final decision or through informal discussions where group decisions were made based on the best dental practice in existence at the time. A fourth state involved health plans at the RFP stage, which, according to state officials, provided a forum for health plans to voice their concerns. In that state, during the RFP process, the state proposed a set of performance measures for dental and well-child

care and the plans suggested national Health Employer Data Information Set (HEDIS) measures instead. In the end, the state adopted a set of measures very similar to HEDIS.

Finally, we asked agency officials how important the capacity to measure the standard was and what was the anticipated approach to performance measurement. We found that although the majority of states expected health plans to show improvement from year to year, the level of sophistication of states' approaches to measuring health plan performance and compliance with the pediatric oral health standards of the contract varied widely from state to state (Table 1 in Appendix II). Eight programs had developed one or more clinical performance measures, and of those, three had made them specific to dental care, and five relied on the broader EPSDT well-child visit measure. In addition, half of those that did not have measures specific to dental care also used dental statistics to track the utilization rate of dental services. Two programs did not have any performance measures in place, but both used dental statistics to track the rate of dental services. State officials in the ninth state explained that, because of the very low level of managed care penetration in the state, they decided to focus on ensuring access to care and to address quality improvement later when it would be a more feasible proposition. To that end, they developed a quantifiable geographic access standard (e.g., 90 percent of children must have access to a pediatrician within 10 miles of their homes). Though specific to pediatric care, it does not address access to dental providers.

2. Lead Screening Services

Generally, the perception in the private sector—health plans and health professionals alike—is that the condition of childhood lead poisoning does not merit the investment of often scarce resources the federal government allocates in several of its public health and public insurance programs. This perception is reinforced by the low prevalence of the disease, which today affects only approximately two percent of children ages 1-5, and the current AAP guidelines, which recommend targeted blood lead level testing for children at ages 12 and 24 months based on the results of a health risk assessment indicating the potential for elevated blood lead levels.[69]

In contrast to the private sector, the detection and the treatment of childhood lead poisoning is an important priority in the public sector. The Healthy People 2010 Objective 8-11 is to eliminate elevated blood lead levels in children. To this end, the U.S. Centers for Disease Control and Prevention (CDC) has developed a strategic plan for the elimination of childhood lead poisoning, which includes an effort to build a national surveillance system for monitoring children's blood lead levels.[70] CDC recommends that states make public and private laboratories, including out-of-state laboratories performing tests for residents of other states, the basis of their surveillance system because, unlike oral disease, lead poisoning is usually a laboratory diagnosis that does not require clinical judgment.

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[69] Committee on Practice and Ambulatory Medicine, *Recommendations for Preventive Pediatric Health Care*, Washington, DC" American Academy of Pediatrics, http://www.aap.org.

[70] Centers for Disease Control and Prevention. (1991) *Strategic Plan for the Elimination of Childhood Lead Poisoning* Atlanta, GA: Department of Health and Human Services.

According to CDC data, the majority of states (58 percent) require reporting of blood lead levels in children (usually starting at birth), with two states mandating reporting of all blood lead test results and 18 states requiring reporting of elevated blood lead levels only.[71] The majority of states with reporting requirements required reporting from state laboratories (76 percent) and in-state private laboratories (83 percent); about half of those states (49 percent) required reporting from both in-state and out-of-state private laboratories.[72] The majority of states with reporting requirements also required reporting from physicians (79 percent).[73]

Following CDC's lead, CMS has made the detection and treatment of childhood lead poisoning a priority of the Medicaid program, which considers all children covered by the program at risk and thus needing universal blood lead level testing. This policy is in stark contrast with the AAP policy of performing a health risk assessment first before a blood test is even considered. Lead toxicity screening services are covered under EPSDT as part of the laboratory tests required under the program and must be provided according to the federally-specified periodicity schedule of the CDC Advisory Committee on Childhood Lead Poisoning Prevention. A blood lead test must be included. If a capillary specimen was used to perform the test and indicates elevated blood lead levels, it must be confirmed by a venous blood sample. Follow-up medical and public health services must also be provided.

In contrast to the Medicaid program, CMS has not made the detection and treatment of childhood lead poisoning a priority of the SCHIP program. As was the case for dental care, separate SCHIP programs have more flexibility to determine which benefits they will cover, although they must provide benefits that are actuarially-equivalent to the basic services provided under a benchmark benefit package (e.g., state employee benefit plan). Basic services explicitly include well-baby and well-child care, but do not specify lead screening as a component of well-baby and well-child care.

We asked state Medicaid and SCHIP officials why they had set the lead screening standards as they had in the contract. As was the case for dental care, the most striking difference came from the fact that Medicaid programs, including SCHIP Medicaid expansion programs, and separate SCHIP programs are governed by two separate sets of rules.

Medicaid officials almost uniformly cited the federal ESPDT requirements as the driving force for their lead screening standards. Because the EPSDT requirements incorporate the CDC guidelines on the detection and treatment of lead poisoning in Medicaid-covered children, which represent an expansion beyond the current industry norm and professional practice in this area, officials from all but one state with Medicaid programs and SCHIP Medicaid expansion programs or separate SCHIP programs administered under the same contract as Medicaid believed that their standards went beyond existing clinical guidelines.

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[71] Centers for Disease Control and Prevention. (1992) "Surveillance of Children's Blood Lead Levels—United States, 1991" *MMWR* 41(34): 620-622, http://http://ww.cdc.gov/epo/mmwr/preview/mmwrhtml/00017471.htm.

[72] *MMWR*, *op. cit.* Four study states required reporting from laboratories only, four additional states from both laboratories and physicians, and one state appeared not require either group of providers to report.

[73] *MMWR*, *op. cit.*

SCHIP officials representing the three separate SCHIP programs administered under a separate contract from Medicaid again pointed to the flexibility of the SCHIP statute and regulations, which do not set any federal standards in the area of lead screening. As a result, they were free to depart from the EPSDT standards and all of them did. In two states, the contract imposes a general requirement that, as part of periodic health examinations, laboratory tests be performed according to the AAP recommendations for preventive pediatric health care, which include a risk assessment prior to testing. SCHIP officials representing one of these states explained that they had elected the AAP standards pertaining to the well-child visit because, in their view, it was the best way to tie in lead screening services without explicitly mentioning them. They also believed that their choice reflected current industry practice. The SCHIP official representing the second state recognized the lack of specificity of the contract language and further noted that lead screening does not appear to be on the minds of the commercial plans participating in the program. In the third state, the contract is completely silent on the issue of laboratory tests, including blood lead level screens. However, the SCHIP official representing this state stated that participating plans are generally expected to follow the AAP standards and thus current industry practice.

We also asked state Medicaid and SCHIP officials how the pediatric lead screening standards contained in their managed care contracts were arrived at and negotiated with contractors. States took three main approaches to contract negotiation. Under the first approach, three states made pediatric lead screening standards a nonnegotiable component of the HMO contract either because they were predetermined by the EPSDT requirements at the federal level (two states) or because it was included in the RFP as a minimum, nonnegotiable requirement (one state). Under the second approach, four states, including all three separate SCHIP programs administered under a managed care contract independent from Medicaid and one state using a combined contractual document for its Medicaid and separate SCHIP programs, did not have to negotiate this aspect of the contract because the contract did not include any language specific to lead screening. Under the third approach, states (a minority in this study) negotiated the standards in some fashion. One state, which involves health plans at the RFP stage, used the RFP process to propose a set of performance measures for well-child care and the plans counter-proposed with national HEDIS measures instead. In the end, the state adopted a set of modified HEDIS measures.

Finally, we asked states how important was the capacity to measure the standard and what was the anticipated approach to performance measurement. Similar to our findings on oral health, we found extreme variations in state approaches to monitoring plan compliance with the pediatric lead screening standards of the contract, although the majority of state programs expected participating plans to provide some evidence of improvement in their performance (Table 2 in Appendix II). In addition, about half of the states that were more advanced in their monitoring efforts had also developed a closer collaboration with the public health agency in this area. At the opposite end of the spectrum, the two states that did not monitor compliance at all deferred all monitoring duties and responsibilities to the public health agency, which was seen as being the lead monitoring agency in this area.

3. Summary of Findings on Selection of Standards

Overall, our findings show that states with Medicaid and separate SCHIP programs faced different choices because of differing applicable federal law. For both dental and lead screening services, states with Medicaid programs and SCHIP Medicaid expansion programs or separate SCHIP programs administered by the Medicaid agency (hereafter, Medicaid states) followed the EPSDT requirements to set their standards, though, in the case of oral health, Medicaid states had a level of discretion in setting their standards not available for lead screening. In contrast, states with separate SCHIP programs had much greater flexibility in both areas.

The EPSDT standards on oral health essentially leave it up to states to select the periodicity schedule plans and providers must follow in the provision of oral health services, although they require states to consult with recognized medical and dental organizations involved in children's health care, which have not yet reached a consensus on what the standard of care should be. Despite this lack of consensus in the field, the majority of Medicaid states selected the AAP recommendations for preventive pediatric health care (i.e., screen and refer at age 3)[74] and believed that their choice reflected existing practice and thus did not exceed industry customs and norms in health care quality for children. Similarly, the majority of separate SCHIP plans chose to require participating health plans to follow the AAP standards on dental referrals. In at least two instances, states augmented the AAP guidelines with additional requirements on health plans, providers, or both and believed their choice went a step further than existing practice and thus attempted to raise the bar in health care quality for children.

The EPSDT standards on lead screening do not give states much flexibility in setting their own standards. In addition, they already represent an advance beyond existing professional and industry norms. As a result, the majority of Medicaid states incorporated the EPSDT standards into their own standards and believed that they went beyond existing norms. However, in what is perhaps indicative of what is to come as CDC and CMS are contemplating a possible change in lead screening policy, one Medicaid state, noting the current disagreement among CMS regional offices on the benefits of universal testing due to the very low prevalence of childhood lead poisoning in certain areas of the country, opted for a policy of targeted screening (which is reflected in the contract by a reference to current preventive guidelines), similar to that advocated by the industry, against current Medicaid policy, but with the understanding of its regional office. In contrast to the majority of Medicaid states but in step with the Medicaid state just described, all separate SCHIP programs selected the AAP standards on well-baby and well-child visits as a way to tie in lead screening services without having to explicitly mention them.

Taken together, these findings suggest that, unless the federal government specifies the content of coverage and the periodicity with which it should be furnished, states will be more likely to follow professional and industry practice and forego attempts to raise the bar in health care quality for children. They further suggest that the federal government will be more likely to specify the content of coverage and the periodicity with which it should be furnished in the case of low prevalence conditions

[74] See previous footnote about the change in AAP policy.

that are attached to public health concerns. If those federal specifications reflect an advance beyond current norms, as one can expect in the case of low prevalence conditions, states may run into serious implementation problems.

Our interviews indicate that it may be the case with childhood lead poisoning. Several states described a situation where plans and providers are uniformly opposed to universal screening and instead, favor targeted screening. In some states, the very low prevalence of the condition further reinforces the perception among medical directors and pediatricians that universal screening is a waste of resources. Except for one state, which decided against compliance with federal policy so that it could redirect its limited resources to addressing more pressing needs, states find themselves in a bind in trying to meet federal requirements. They either deal directly with provider resistance, as several states have done, investing resources in educating providers about the importance of universal screening (when changing provider behavior is known to be an extremely difficult task and when these resources could be put to other uses), or they do not do so directly but rather indirectly, relying solely on their monitoring and enforcement plan as a means to redress pervasive provider noncompliance (with the limitations of such an approach in addressing the root causes of the problem).

b. The Implementation of Medicaid and SCHIP Managed Care Monitoring and Enforcement Activities

In this section, we describe and compare state approaches to monitoring and enforcement of pediatric standards, by degree of managed care penetration (i.e., high vs. medium vs. low penetration), type of program design (i.e., Medicaid-administered program vs. separately-administered SCHIP plan), and prevalence of the condition targeted by the contractual performance standard (i.e., high vs. low prevalence condition).

1. State Approaches to Monitoring and Enforcement of Pediatric Standards by Degree of Managed Care Penetration

The nine participating states were categorized according to the level of managed care penetration in the general population. They were then divided into the following three groups for the purpose of analyzing interview responses: (1) states with high levels of managed care penetration, i.e., states with more than 20 percent of the general population enrolled in managed care (seven states); (2) states with medium levels of managed care penetration, i.e., states with 10 to 19.9 percent of the general population enrolled in managed care (one state); and (3) states with low levels of managed care penetration, i.e. states with less than 10 percent of the general population enrolled in managed care (one state). Because of the small sample size, our findings have to be interpreted with extreme caution. Nevertheless, we found that the level of MCO participation and competition in the state in general and in the Medicaid and SCHIP markets in particular appeared to matter. In the state with only one contractor, officials felt that pushing it too hard on compliance would result in the MCO pulling out. Table 3 in Appendix II describes each grouping in more detail, including the level of Medicaid and SCHIP managed care enrollment in the study states.

- **Formal monitoring and enforcement plan with clear goals, assignments, measurements, and milestones**

Under Medicaid, states are required to ensure that managed care organizations comply with federally-specified EPSDT and managed care requirements and standards established by the state in the area of quality assessment and performance improvement through regular monitoring and evaluation of their contract provisions, which by law they must establish when they buy managed care products. Under SCHIP, states that buy managed care products must also do so through contracts that adhere to federal and state contract and procurement requirements but they are not bound by similar requirements regarding coverage of benefits, managed care, and oversight of the quality of care furnished (although the option to follow Medicaid requirements is available).

In order to assess states' monitoring efforts, we asked whether they had a formal, written monitoring and enforcement plan for the provision of pediatric standards spelled out in their contracts, and if so, what its main goals were. We also asked them whether they had clearly stated their policy objectives regarding the monitoring and enforcement of the pediatric oral health and blood lead level screening standards included in their contracts, whether they had set up an agency responsible for implementing and enforcing these policy objectives, and whether there was multi-faceted support within the agency and among policy beneficiaries toward these objectives.

All states had a formal, written general monitoring and enforcement plan. All states responded that they had folded their general monitoring and enforcement plan into their contract, and that its general goal was to ensure access to quality care. Five states referenced federal Medicaid policy and state statutes, regulations, and policy manuals as additional documents embodying their monitoring and enforcement plan. Four states had also developed a separate, comprehensive quality improvement plan independent of the contract, and, of those, two had developed a dental quality improvement plan in addition to their comprehensive quality improvement plan. State officials explained that specific policy objectives regarding oral health and lead screening could be found in the same documents. The majority of respondents stated that they expected oral health services to be provided in accordance with the EPSDT requirements and AAP recommendations, and lead screening services in accordance with the EPSDT requirements and state laws. They also believed that they had clearly communicated these expectations, both orally and in writing.

Low levels of managed care penetration seemed to be a factor in explaining whether states had specified precise standards for measuring compliance with quality improvement goals in the areas of dental care and lead screening. While the degree of managed care penetration did not seem to be a factor in explaining whether states had a formal, written monitoring plan, it appeared to have some bearing on the extent to which states had specified precise standards for measuring compliance with their policy goals related to oral health and lead screening. In contrast to states with high and medium levels of managed care penetration, the majority of which had established clinical performance measures specific to well-child care (oftentimes replicating the federal requirement of a participation of 80 percent in the EPSDT visit), and in several cases specific to dental care and lead screening services, the one state with low levels of managed care penetration had not established any clinical performance measures. Because there is so little managed care in that state, program

officials explained, the program does not focus on quality improvement but on ensuring access to care instead. To that end, the program uses a quantifiable access standard, whereby plans must demonstrate that 90 percent of their enrolled children have access to a pediatrician within 10 miles. Although unique in the group of states studied, this state exemplifies the need for an underlying managed care market if states want to be successful in using managed care and quality improvement techniques in their public insurance programs.

All states had set up an agency for implementing and enforcing the policy objectives related to oral health and lead screening. Although all states had set up an agency for implementing and enforcing the policy objectives related to oral health and lead screening, in some states the responsibilities specifically linked to the oversight of managed care, dental carve-outs, and lead screening seemed to add layers of complexity to state program administration. It is not known whether states had plans outlining the lead agency's monitoring activities, key partners and stakeholders, and roles and responsibilities, but we found that states adopted differing approaches to program organization when setting up an agency for implementing and enforcing the policy objectives related to oral health and lead screening. Six states made the Medicaid agency the lead agency for setting contractual standards and the Medicaid managed care division the lead division for monitoring compliance with those standards. Two of those states also had a dental carve-out (one run under a fee-for-service system and the other under a managed care system) and had assigned oversight responsibilities specifically related to the provision of dental services to a division specializing in dental care (although the Medicaid managed care division retained oversight responsibility for the dental component of the EPSDT well-child visit). These two states also shared with the department of health or even had relinquished to the department of health significant oversight responsibility for lead screening services.

The seventh state integrated all Medicaid and SCHIP operations into one overarching agency and made that agency the lead oversight agency. The eighth state combined the Medicaid agency, the SCHIP agency, and the public health agency into one department. In the case of Medicaid, oversight over oral health and lead screening contractual duties were assigned to the Medicaid agency, and community awareness duties regarding lead screening to the public health agency. In the case of SCHIP, oversight duties were shared between the SCHIP agency (oral health) and the public health agency (lead screening).

The last two states, which happen to be separate SCHIP states, one located in a heavy managed care market and the other in an almost nonexistent managed care market, have their programs jointly administered by an independent health insurance board, which is responsible for setting standards for the program, and another entity. In the first state, this entity was the department of managed care, which was responsible for regulating all aspects of managed care operations and being the enforcer of state law. In the second state, the entity was the Medicaid agency, which was responsible for reporting and overall management of the program.

The level of support for the policy objectives regarding the monitoring and enforcement of oral health and lead screening varied across states, and the low degree of managed care penetration appeared to be a factor in one state. Three state programs enjoyed multi-faceted support toward their objectives on oral health and

lead screening. Personnel responsible for implementing the policy were committed to promoting the objectives, and they enjoyed the support of their superiors in doing so. Health plans cohesively supported implementation of the policy. In two additional state programs, interviewees described a general commitment from all sides to implementing important policies, particularly as they related to lead in the first state and to oral health in the second state, even though health plans appeared to raise issues around the lack of adequate resources for them to reach the stated objectives.

State and plan commitment to lead and oral health policy objectives seemed to rest heavily on a belief in the utility of such efforts. In one state, while the administration remained committed to promoting oral health and lead screening objectives, health plans and providers, while supportive of the oral health objectives, objected to the lead screening objectives because of the controversial issue of universal testing. In another state, while the administration was highly aware of the lead screening objectives but not very conscious of the oral health objectives, health plans and providers uniformly rejected the lead screening objectives and did not even focus on the oral health objectives.

In the one state with low levels of managed care penetration, program representatives explained that, while the state administration and the health plan were committed to promoting the oral health and lead screening goals, the health plan's loose managed care structure was not conducive to cohesiveness on the part of the providers and this lack of control over providers prevented the health plan from implementing strategies to reach those goals.

- **Prevention Strategies**

In our effort to assess the effectiveness of states' monitoring efforts, we also examined state strategies to prevent implementation problems, with a special emphasis on states' contract specifications in the following areas:

- service components and service periodicity schedule;
- adequacy of provider network, travel distances, and waiting times to provide the service according to the periodicity schedule;
- adequacy of medical care provided through the use of service specific utilization statistics, encounter data, clinical studies, and medical record audits; and
- adequacy of beneficiary satisfaction through the use of service specific satisfaction surveys and grievance reports.

We found that contractual specifications varied greatly across study states, a variation that did not seem related to the degree of managed care penetration in the state.

Specification of service components and periodicity schedule for dental care and lead screening services. State programs more often listed the service components of dental care and used the state's own periodicity schedule or referred to some professional organization's periodicity schedule for the provision of dental care. In contrast, they more often included a broad requirement to provide EPSDT or laboratory tests, or omitted altogether a requirement to provide lead screening services, and followed the EPSDT schedule or lacked specificity regarding the periodicity schedule for the provision of lead screening services.

Specification of minimum provider network requirements, waiting times, and travel distances. In general, state programs were more likely to omit specifications on one, two, or all three aspects of access to care (provider networks, waiting times, and travel distances) than to include provisions on all three aspects of access to care. Four state programs, including the separate SCHIP programs, lacked specificity on all three aspects of access to care; three programs lacked specificity on two of three aspects; and two programs lacked specificity on one of three. Only two state programs had specifications on all three aspects of access to care. In the area of dental care, they were as likely to specify minimums that were specific to the provision of dental services (e.g., network must include dentists who should be located within the specified travel distances and should see patients within the specified waiting times) as they were to specify general requirements for the adequacy of the provider network, waiting times and travel distances. In the area of lead screening services, on the other hand, they were much less likely to tailor their minimum requirements to the provision of lead screening services and more likely to impose general minima.

Specification of data requirements to monitor adequacy of medical care and beneficiary satisfaction. All but one state program included some data reporting requirements in their contracts. Only two state programs required managed care organizations to provide all sources of data, i.e., utilization statistics, encounter data, clinical studies, medical record audits, satisfaction surveys, and grievance reports. The remaining states required managed care organizations to provide one or more of these

sources of data, but in the aggregate each source of data was required in similar frequency. Additionally, except for two state programs (one contract specifically required utilization statistics and encounter data on dental services, while another contract specifically required clinical studies on lead screening services), requirements were not tailored to dental care and lead screening.

- **Coordination Strategies**

A third key component of a state monitoring plan consists of coordination among the various agencies responsible for achieving the policy objectives regarding oral health and lead screening. Do the Medicaid and SCHIP agencies and the various other agencies responsible for monitoring and enforcement (e.g., Attorney General's office, department of insurance) administratively coordinate their efforts? How do they coordinate their efforts? Do they share information and communicate on a regular basis? Again, we found great variation in the level of coordination across states, which did not appear related to the degree of managed care penetration in the state. Most states pursued strategies to coordinate their monitoring and enforcement efforts with other relevant agencies, such as allowing access to data on request (one state), being notified and notifying the appropriate agency when appeals indicate a potential problem (five states), disseminating or making available the results of internal audits to interested parties (four states), referring cases to the appropriate agency if monitoring reports show that they fall under some other entity's jurisdiction (one state), setting up regular channels of communication and information sharing, e.g., interagency meetings (one state).

Coordination with the Attorney General's office. Generally speaking, state programs did not appear to have close relationships with the Attorney General's office, which was perceived as having narrow responsibilities in the area of criminal activity (i.e., fraud and abuse) and thus as having little involvement in issues of quality of care, especially as it related to dental care and lead screening services. One state official also explained that the program currently lacked funding, staff, and need to pursue coordination efforts with the Attorney General's office. A few states described a more ongoing relationship between the two agencies, and of those, only one state had established a formal relationship with the other agency. Three state programs had no formal coordination with the Attorney General's office but did refer cases of fraud (e.g., enrollment fraud) detected through their own monitoring efforts. In addition, one of these programs held annual meetings with the Attorney General's fraud control unit staff, who come to the agency to make presentations to participating health plans. One state program had an interagency agreement with the Attorney General's office pertaining to cases of fraud.

Coordination with the department of insurance. Most state programs had some relationship with the department of insurance, which was chiefly responsible for issues of financial solvency. Several states described a close working relationship with the department. Working relationships with the department of insurance ranged from information sharing and regular communication to standing monthly or quarterly meetings to referrals of cases when warranted and permitted under state law. Other states described a more episodic kind of a relationship with the department, with no formal process in place. One state limited contact with the department to those cases

where there was a violation of insurance license or financial requirement; another to fraud and abuse issues. A third group of states had no relationship at all with the department, although they reported that they cooperated when necessary.

Coordination with the department of health. Coordination with the department of health was often cited as necessary needed in the area of lead screening oversight since it is a public health reportable condition, although there were gradients in the level of coordination across states. For example, we found that:

- one state shares a database on lead screening with the department;
- one state has a data sharing agreement with the department of health;
- one state has access to the department's surveillance data and does its own geographic analyses, and in addition, a nurse from the Medicaid managed care division is involved in the department's lead screening group;
- one state allows the department to access its Medicaid data on request;
- one state has regular communication and meetings with the department on lead screening issues and each agency's specific area of responsibility;
- one state has a close relationship with the department on the development of lead screening incentives;
- one state communicates with the public health agency on a regular basis through formal and informal meetings, which is facilitated by the fact that the two agencies are housed in the same department;
- one state (separate SCHIP program) is currently discussing future coordination efforts with the lead screening branch; and two states (separate SCHIP programs) have no formal collaboration with the department (though one program does collaborate on immunizations and quality improvement).

Much less often did states pursue coordination efforts with the department of health on oral health, with only two states mentioning that they also worked with the department on oral health issues (in addition to lead screening issues). Finally, two states also interacted with the department through formal and informal mechanisms on complaints and grievances.

Coordination between SCHIP and Medicaid agencies. All three separate SCHIP programs talked about their coordination efforts with the much larger and more experienced Medicaid programs. One state program works closely with Medicaid on quality monitoring and enforcement. The second state program works closely with Medicaid generally ("they share information on a regular basis and sit with them daily") and is currently holding regular meetings on encounter data where they are discussing the possibility of "piggy-backing" SCHIP's future data collection efforts on Medicaid current efforts. The third state program said that the two agencies have a close relationship and try to set common standards and share information on those.

- **Detection Strategies**

A fourth key component of a state monitoring plan consists of detection strategies or the creation of a mechanism to monitor compliance. What kind of mechanisms did the Medicaid and SCHIP agencies put in place to monitor the provision of dental care and lead screening services? Do they use quantifiable performance

standards and what types of information do they collect to verify plan compliance with the standards? The degree of managed care penetration did not seem to influence whether states had put in place mechanisms for monitoring compliance but, as stated previously, it seemed to influence whether states used quality performance indicators to measure compliance.

All states had created a mechanism for monitoring compliance, which was not specific to monitoring the provision of dental care and lead screening services but rather was applicable to the monitoring of plan performance in general. All states relied heavily on data collected at regular intervals (monthly, quarterly, annually) as a mechanism to monitor compliance. Specific sources of data included: comparative data analyses (e.g., EPSDT reports, HEDIS measures); routine reviews of specific problem areas (e.g., EPSDT, lead, dental, provider network); periodic site visits (e.g., operational and financial reviews, which can include a review of lead screening and dental care services); focused clinical studies/medical audits/medical record reviews (e.g., provision of dental, lead screening services); annual performance reviews/internal audits of performance; review of plan policies and procedures; regulatory reviews; review of plan-conducted quality improvement projects (e.g., dental care); satisfaction surveys; and use of oral feedback. One state also mentioned the department of health's lead screening data warehouse as an important source of data for monitoring plan compliance with lead screening requirements.

In addition, states usually relied on grievances and complaint calls as a source of data for monitoring compliance and also used them as an early warning system for detecting potential problems of substandard performance requiring follow-up on the part of the state. However, states explained, grievances and complaint calls rarely deal with denial of services, or if they do, they do not deal with preventive care services, such as oral health and lead screening, but rather with specialty care services.

Except for one state with a separate SCHIP program, where all of the analyses and investigations were plan-conducted, analyses of the various sources of data just described were performed by the state and/or an external organization and the plans, more often with than without outside validation.

As stated above, the degree of managed care penetration seemed to have some effect on the extent to which states had specified quantifiable quality standards for measuring compliance with their policy goals related to oral health and lead screening. In contrast to states with high and medium levels of managed care penetration, the majority of which had established clinical performance measures specific to well-child care (oftentimes replicating the federal requirement of a participation of 80 percent of enrolled children in the EPSDT visit), and in several cases specific to dental care and lead screening services, the one state with low levels of managed care penetration had not established any clinical performance measures. Because there is so little managed care in that state, program officials explained, the program does not focus on quality improvement but on ensuring access to care instead. To that end, the program uses a quantifiable access standard, instead of quality performance indicators.

- **Enforcement Strategies**

The fifth key component to a state monitoring plan consists of enforcement strategies. What is the state's general approach to enforcement? What kinds of penalty and incentive systems favor compliance? Are there any barriers in enforcing contract provisions related to lead screening and oral health?

All states characterized their general approach to enforcement as ongoing. The majority of states also characterized their general approach to enforcement as proactive and systematic in addition to ongoing. A few states added that in some aspects it is also reactive and periodic, citing complaints and grievances as a monitoring mechanism to which they react whenever providers and beneficiaries use it.

While several states with high levels of managed care penetration were uncomfortable with the term "enforcement," which invoked punishment, and preferred the terms "common quality improvement effort with plans," collaboration with plans, or partnership with plans, states with medium and low levels of managed care penetration related a real need to minimize their enforcement efforts if they wanted to keep plans in their programs. Even though monitoring and enforcement takes on a more collaborative tone in states with higher levels of managed care penetration because of external factors such as major access problems (e.g., undersupply of pediatric dentists), this was particularly true for states with lower levels of managed care penetration. In the state with medium levels of managed care penetration, the program witnessed a significant drop in the number of contracts signed with managed care organizations over a ten year period. Program officials attributed this drop to underlying systemic factors, such as provider shortages and low Medicaid reimbursement rates, which make it difficult for plans to attract providers willing to serve publicly-insured children. Under these circumstances, program representatives explained, it is difficult to "come down on HMOs," even though the contractual mechanisms exist to sanction them. These circumstances also encouraged the state to focus limited resources on "getting kids in" for care rather than "doing detailed analysis." Program officials use the rate of EPSDT well-child visits as a starting point to determine whether children receive dental services and they do not enforce the lead component of EPSDT not only because they feel that they would duplicate the extensive work of the department of health in this area and thus waste precious resources but also because they feel that they would not be the appropriate oversight agency in view of the department of health's jurisdiction over the entire state population.

State officials in the state with low levels of managed care penetration explained that, because there is so little managed care in general, there is also little enforcement other than in the case of criminal acts (e.g., fraud and abuse) or complaints. They stressed that they would lose their sole contractor if they started strict enforcement of plan performance. Instead, they work very closely with the contractor in order to retain its services.

The majority of states had specified sanctions in their contracts, and several states devised a graduated incentive and penalty system to encourage plan compliance but the actual use of sanctions varied across states. All but two state programs specified sanctions for plan noncompliance in their contracts, and in many cases also specified the basis for imposing each type of sanction. The number of contractually specified sanctions went from a low of one (i.e., termination, the ultimate

sanction) to a high of nine sanctions specified. Only four state programs tied sanctions to quality violations: liquidated damages in one state; corrective action plans in two states (one of which also tied sanctions to nonperformance on EPSDT, lead screening, and oral health services and termination to quality violations); and withholding of capitation in the fourth state.

At least five states developed a graduated incentive and penalty system. In all cases, states began with a corrective action plan, which is often, but not only, used to address quality violations, and then advanced to sanctions, when plans demonstrate sustained nonperformance. For example, in one state, sanctions start with the suspension of enrollment, followed by financial penalties, and end with termination. In another state, sanctions start with refundable fines, followed by nonrefundable fines, then by enrollment freezes, and end with termination.

States that have had to advance from corrective action plans to sanctions have found that this progression is the most effective way to ensure compliance. Overall, they have also found that the use of financial incentives rather than financial penalties works best. As one state official put it, "the carrot works as well as the stick, if not better." For example, one state gives plans additional dollars for each additional lead screen or uses withholds to encourage plans to meet the lead screening standards. Another state is currently considering using the HEDIS scores to determine default enrollment algorithms as an incentive to improve quality. Several states underscored that nonfinancial incentives, such as information sharing on the web and public reporting of unblinded information across plans, were also quite effective.

The actual use of incentives and penalties varied across states. Of those states with a graduated system, the majority did not have to go beyond the corrective action plan. However, at least two states have used the sanctions available to them beyond the corrective action plan, and one state used all of them but termination (although it did recommend it in one instance). Three states stated they never had to use sanctions, including the one state with medium levels of managed care penetration. This particular state explained it is difficult to sanction plans for systemic factors that are beyond the plans' control (as the state official put it, "it is hard to enforce the contract when there is nobody to do the service").

The majority of states did not report any barriers in enforcing the language of their contracts, although they did report significant challenges in both the area of oral health and lead screening related to the underlying health care system. States reported barriers and challenges not so much related to the language used in their contracts, though in two instances it did come up as an issue, but rather related to underlying systemic issues. As one state official put it, while there was an impetus for improving the contractual language on well-child care, especially lead screening, the contract was not seen as all encompassing on quality improvement because other work at the community level ultimately made a difference. The state official also noted that Medicaid, despite its reliance on contracts and payments, is not as effective as community standards to change medical practice. Or, as another state official put it, "we codify what we would like to see happen but have to deal with the reality of the delivery system."

Special challenges related to the provision of dental services included:

- access problems in rural areas;
- manpower and supply issues, such as the lack of dentists in general and the lack of dentists accepting Medicaid patients;
- low reimbursement rates;
- lack of awareness on the importance of oral health both among providers and beneficiaries (which prompted one state to increase attention to the issue by sending reminders to providers to do oral screens and stuffers to beneficiaries reminding them about the services to which they are entitled);
- the current practice of providers to bill for EPSDT in general, not specific oral components, which makes monitoring of dental care difficult, especially with encounter data;
- disagreement among professional organizations on the appropriate periodicity schedule; and
- lack of training (which prompted one state to develop a training program on pediatric dental care for both dentists and physicians, who are trained by dentists).

Special challenges related to the provision of lead screening services included:

- resistance to universal testing reinforced by the low prevalence of childhood lead poisoning and the perception that is it wrong to invest in this;
- poor reporting, poor data, lack of uniform measurement, lack of national protocols for collecting consistent information across plans and measuring performance across plans;
- lack of provider education (e.g., physicians do not do blood work in their offices, are not aware of other less common sources of exposure, are unaware of the differences between Medicaid policy and AAP recommendations); and
- reimbursement issues, including low provider reimbursement rates, unfunded mandates imposed on plans, reimbursement only for venipuncture not for capillary specimens.

- **Reporting strategies**

The sixth and final component of a state monitoring plan consists of reporting strategies to the federal government, which is a key actor in the implementation of Medicaid and SCHIP policy due to the federalist nature of the two programs.

The majority of states described an ongoing relationship with the federal government but the degree of involvement on the part of the federal government varied by state. Two states said the federal government was very involved in their programs in general. A third state stated that the federal government had an acute interest in its EPSDT program, especially in the area of lead screening. A fourth state described the federal government as an active purchaser articulating policy, not so much an active participant at the state level on behalf of children protected by Medicaid and SCHIP policy.

One separate SCHIP program described the federal government more as a silent partner, explaining that the well-child visit regulations were the only active involvement on the part of the federal government. In contrast, another separate SCHIP program said that the federal government was highly involved, at least in the beginning of the program, by exercising oversight over dental care because manpower and the ability to meet the needs of SCHIP children were significant issues for the state.

Although states can report back to the CMS and the Office of Inspector General for additional sanctions beyond the purview of the state, none had used this option. At least one state program explained that the contract reiterates some federal requirements that give CMS or the Office of Inspector General authority to impose sanctions, for example in the case of violations of the Civil Rights Act, and debarment of providers. However, states uniformly said they never had to use this option.

2. State Approaches to Monitoring and Enforcement of Pediatric Standards by Type of Program Design

As part of our study, we reviewed our discussions with state Medicaid and SCHIP agency representatives for differences and similarities in their approach to monitoring and enforcing their managed care contracts, particularly as it pertains to oral health and lead screening. We categorized our nine states according to program design and divided them into the following three groups for the purpose of analyzing interview responses: (1) states with Medicaid programs and SCHIP Medicaid expansion programs (two states); (2) states with Medicaid programs and separate SCHIP programs which use the same contractual document for both programs (four states); and (3) states with Medicaid programs and separate SCHIP programs which use separate contractual documents for each program (three states). Table 4 in Appendix II describes the federal requirements that apply to each grouping in more detail. Because officials representing states in the second group of states affirmed that SCHIP children were entitled to the same services as Medicaid children and managed care organizations were held to the same data collection and reporting obligations for both populations, we refer to the first and second group of states jointly as Medicaid states, unless specifically noted otherwise in this section.

SCHIP agencies' monitoring and enforcement plans tend to focus more on oral health than lead screening, whereas Medicaid agencies' plans focus more on lead screening than oral health. The differences in approaches to adopting, monitoring, and enforcing contractual provisions vis-à-vis lead screening and oral health are rooted chiefly within the respective federal and state laws and regulations that control the duties of the Medicaid and SCHIP agencies when contracting with managed care organizations.

Medicaid agencies operate within a more tightly regulated structure than their SCHIP counterparts. For instance, dental and lead screening services are federally required under EPSDT, and Medicaid programs must monitor the provision of these services. In addition, Medicaid law spells out a periodicity schedule for lead screening services in much more detail than it does for dental care services. SCHIP programs, on the other hand, have more flexibility in terms of the benefits they must provide and their responsibilities in measuring plan performance. Federal law only requires SCHIP programs to provide well-baby and well-child care services, and does not specifically list dental care and lead screening as a component of either. In neither case does it spell out a periodicity schedule. In addition, it does not impose any monitoring requirements similar to Medicaid.

For those states interviewed, all Medicaid and SCHIP contracts include or reference a formal, written plan for monitoring and enforcing the provision of pediatric services by managed care organizations. Most Medicaid contracts referred managed care organizations to pertinent policy guides, administrative rules and federal and state laws and regulations. A few Medicaid programs and one SCHIP program included a more detailed roadmap for monitoring plans in additional materials referenced by the contract, such as a quality improvement plan and provider manuals, which functioned as guidelines for monitoring the lead and dental provisions outlined in the contract.

The degree of specificity of contractual provisions for lead screening and dental care varied by contract, with no noticeable difference between Medicaid and SCHIP contracts other than references to EPSDT in Medicaid contracts which did not appear in SCHIP contracts. Medicaid agencies relied on EPSDT services to ensure the provision of lead screening and testing to their beneficiaries. In many cases, contracts simply referred to federal and state EPSDT standards. In contrast, Medicaid agencies were a little more specific in their contracts on the service components of oral health and the intervals with which they should be provided under EPSDT. Though physicians were required to perform an oral screen, most contracts did not more specifically denote what this screen should include. One Medicaid state "beefed up" such language by requiring doctors to "look at teeth" and also instituted training programs aimed at educating physicians and dentists in pediatric dental care. A second Medicaid program added requirements to ensure open access to dental care and had begun a statewide effort to educate families on their rights to seek such care.

Because there are no EPSDT-like mandates contained in federal law for the provision of well-child care services under SCHIP and because, one state official said, SCHIP children "look" more like private sector children and less like Medicaid children, health plan obligations regarding lead and dental services are less circumscribed in SCHIP contracts. SCHIP contract provisions were more specific regarding expectations for oral health but noticeably broader on the issue of lead screening. All three contracts listed specific service components of dental care whereas, for lead, two contracts included a broad requirement to provide laboratory tests and one contract omitted a requirement altogether. All three contracts required plans to follow the AAP guidelines for laboratory tests (two contracts) and oral health (one contract); one contract referred to the AAPD guidelines for oral health; and two contracts lacked specificity regarding the periodicity schedule for lead screening (one contract) and oral health (one contract).

There was not a significant difference between SCHIP and Medicaid in terms of interagency coordination with the state Attorney General's office and the department of insurance, but some differences were detected in their relationship with the department of health, particularly in the area of lead screening. Responsibilities and duties of the respective agencies seemed to be well laid out because the Attorney General's office and the department of insurance have very specific oversight authority over public health insurance programs on matters of fraud and abuse, and financial and other regulation, respectively. All agencies also had some type of process in place by which matters of concern were referred to the appropriate party.

Almost all of the Medicaid programs relied on some degree of coordination and communication with the department of health in regards to blood lead levels and high prevalence areas as well as lead abatement due to the department's surveillance activities in the area of childhood lead poisoning. Many of the Medicaid agency representatives expressed opposition to what they perceived as overly strict lead screening requirements imposed by the federal government. Many states felt that lead screening efforts were too broad and financially wasteful, and that more targeted screening efforts would be a more efficient use of limited funds.

In contrast, none of the SCHIP programs had a formal collaboration mechanism in place with the department of health, although one program had started discussions about future coordination efforts. One SCHIP representative noted that the SCHIP agency considered the issue more under the purview of department of health, and that when, issues of follow-up on high lead screening levels was necessary, the department of health worked directly with the state's only insurer and not with the SCHIP agency. SCHIP agencies also reported that they worked closely with their Medicaid counterparts.

Typically, an agency's ability to monitor the execution of contractual obligations relied heavily on data, but Medicaid agencies were generally more advanced than SCHIP agencies in this area due to differences in federal requirements and in program longevity. Medicaid agencies are legally required to collect certain types of data about their beneficiaries enrolled in managed care, including encounter and performance data, and data used evaluate the quality of services provided as well as beneficiary access to care. Managed care organizations participating in Medicaid programs are obligated to collect this data and report them to the state Medicaid agency as specified in their contracts. All Medicaid states and states using Medicaid contracts for both their SCHIP and Medicaid populations collected federally mandated encounter data and EPSDT data (Form 416). Several Medicaid program representatives noted that, although physicians are obligated to perform EPSDT services during well-child visits, it is difficult to unbundle EPSDT data to determine performance levels for oral health screens because they do not bill for those services separately. Additional sources of data, such as federally-required focused clinical studies, annual site visits, and other reports (e.g., complaints and grievances) helped agencies monitor health plan performance in regards to lead screening and oral health.

SCHIP programs, on the other hand, are not required to collect encounter data nor are they bound by EPSDT reporting requirements. In general, their contractual requirements and data collection techniques were not as evolved as their Medicaid counterparts. Most lacked dependable if any encounter data. State efforts to measure services provided to their SCHIP population tended to be more exploratory at this point, with the agencies struggling to find ways to measure and improve plan quality and performance, particularly for oral health, among other health issues. One agency representative noted that because their SCHIP program is relatively new, they were still in the process of "getting to know" the SCHIP population before determining contractual data reporting requirements. Another SCHIP agency reported that they relied on HEDIS reports and satisfaction surveys to monitor plans as they did not have the budget to include encounter data. Two states had not yet developed quantifiable standards for measuring oral health and lead screening quality; one of these relied solely on an access standard, which detects if children have access to a pediatrician. The third agency had developed a dental performance standard but not a lead performance standard. It had not yet developed a performance threshold for the dental standard, but had begun collecting data in order to "see what was happening out there."

Many Medicaid and SCHIP agencies also used HEDIS performance standards to monitor and enforce contract provisions and quality standards. HEDIS is limited, however, in that, while the National Medicaid HEDIS Database Project provides standardized performance information for managed Medicaid health plans to assist them in their evaluation of the quality of care provided to beneficiaries, including a

category for "annual dental visits," there are no formal national protocols in place for collecting information across plans specific to lead screening or testing. A few Medicaid states were piloting a HEDIS-like measure for lead screening.

SCHIP and Medicaid agencies did not exhibit significant differences in their enforcement strategies. The majority of those interviewed viewed the state's general approach to monitoring and enforcement of contractual obligations as ongoing, proactive, and systematic, as well as reactive at times. Penalties and incentives were documented in the contracts and states believed that they had the appropriate tools to enforce their contracts. The crosscutting concern expressed by all interviewees was the need to provide and monitor services under increasingly tight budgets. As federal and state budgets continue to shrink, states are faced with myriad challenges on how best to provide necessary services without financially overextending themselves. One interviewee from a low reimbursement state noted that budgetary constraints in some ways compelled states to try to form more cooperative relationships with managed care organizations. Other factors, such as the scarcity of health plans willing to serve Medicaid and SCHIP populations, the lack of dentists, and other underlying systemic problems, encouraged both Medicaid and SCHIP agencies to form patterns of two-way interaction and cooperation with participating plans, rather than top-down or heavy handed approaches.

Although contractual language generally gave agencies the ability to penalize, financially or otherwise, managed care organizations that did not meet certain performance, quality, or other contractual standards, the majority of states expressed reticence in using these measures, generally preferring the carrot to the stick. None of the three SCHIP programs had ever used the sanctions available to them, mostly because of the newness of the programs. But other reasons were invoked as well, such as the upfront selection process of plans as a guarantee for plans to be good business partners in one state, and the low level of managed care penetration in another state.

The direct involvement of the federal government varied across states, but several Medicaid agencies perceived the federal government as more involved in oversight than SCHIP agencies did. Several Medicaid and combination program interviewees viewed the federal government's role in lead screening and oral health as setting the standards by which the agencies designed their programs. The federal government, they noted, was particularly active in the area of lead screening oversight. SCHIP agencies, on the other hand, were given a lot more latitude in designing programs. One agency viewed the federal government more as a silent partner rather than an active participant; another agency noted that the federal government had been very involved, at least in the beginning of the program, in the area of oral health. This difference in federal involvement is most likely an inherent function of SCHIP program design and its size compared to Medicaid.

3. State Approaches to Monitoring and Enforcement of Pediatric Standards by Prevalence of the Condition Targeted by the Contractual Performance Standard

The assumption driving much of this research was that states would design more elaborate monitoring and enforcement plans of pediatric standards relating to low

prevalence conditions, presumably because these standards represent a level of care that goes beyond what contractors would already furnish as a matter of industry practice and, as such, require greater specificity in the contract language. Our assumption did not hold in the case of the nine study states and oral health and lead screening services; other important factors, such as program requirements and prevalence of the condition in the state, appeared to dictate states' approaches to monitoring the standards.

Contract specifications were not more detailed for lead screening services than for dental care services. In fact, our review of contract requirements indicates that contracts were more likely to be vague or silent on the components of lead screening services and the periodicity with which they should be furnished, less likely to tailor minimum provider network requirements, waiting times, and travel distances to the provision of lead screening services, and as likely to require data specific to lead screening services (which, in both cases, was a rare occurrence).

The majority of state programs did not design more elaborate monitoring and enforcement approaches for lead screening services than for dental care services. Rather, they either adopted approaches that focused more on the monitoring of dental care than lead screening or adopted the same monitoring approach for both types of services.

The first group of programs (four state programs) had more elaborate plans for monitoring the provision of dental care than lead screening. For example, one state program uses one performance measure specific to dental care (i.e., annual dental visit) with three levels of performance (i.e., minimums, goals, benchmarks). In contrast, that same state uses the federal participation goal for the EPSDT well-child visit without tailoring it to lead screening services. For this program, setting specific lead screening performance measures is less of a focus because of the very low prevalence of childhood lead poisoning in the state. Another state program uses performance measures specific to dental care, though with no performance minimums yet, but does not use any performance measures specific to lead screening. In this case, the program expects to set benchmarks for dental care at a later date once it knows "what is happening out there" and has an interest in developing measures specific to lead screening but it is currently less of a focus than dental care, partly because the program is seen as emulating the commercial market, where issues surrounding lead are not a priority. The last two programs are less advanced in their monitoring of dental services but nevertheless are more involved in monitoring dental services than they are in monitoring lead screening services. Indeed, neither program enforces the lead component of well-child services because both see monitoring and enforcement of lead screening as the responsibility of the department of health. In addition, one program underscored the low prevalence of childhood lead poisoning in the state and the other program the lack of federal requirements in this area as additional justifications for their lack of enforcement of lead standards.

The second group of programs (two state programs) had adopted the same monitoring approach for the provision of both dental care and lead screening. One program has performance measures specific to dental care and lead screening services, with performance minimums and goals, although it currently looks for an annual percentage increase in performance compared to the previous year. The other program

does not focus on quality improvement for either dental care or lead screening but rather on ensuring access to care through the use of a quantifiable access standard that applies to all pediatric services.

The third group of programs (five state programs) had more elaborate plans for monitoring the provision of lead screening than dental care, mostly driven by the fact that for these programs the federal requirements are more specific on lead screening than on dental care. One program has performance measures specific to the well-child visit, with an additional performance minimum for lead screening only. It uses several data sources to determine the rate of dental service and referral and EPSDT data to determine the rate of lead screenings. These rates then serve as a baseline for improvement on an annual basis and the program gives plans incentives to increase performance. Additionally, the program shares enrollment files with the department of health, which created a database on lead screening, and shares plan-specific data with plans. Three programs use minimum performance standards for the well-child visit, which are not specific to either dental care or lead screening, but also track the provision of lead screening services through data (two of these programs do not track dental utilization very closely). The first of these two programs uses plan-specific Form 416 data and an integrated data warehouse on lead screening. It also started collecting encounter data and generating plan-specific profiles with the long range goal of collecting and monitoring lead screening data on a quarterly basis. The second program requires submission of encounter data and is currently piloting a HEDIS-like measure to look at lead screening prevalence by plan. The third program not only uses EPSDT statistics but also has access to surveillance data from the department of health and performs geographic analyses to work with plans to do outreach. Finally, one program does not have performance measures for either dental care or lead screening. It tracks the provision of dental services through dental statistics, and uses the rate of lead screenings from the previous year as a baseline for improvement in the following year. It gives plans incentives to improve performance on lead screening and works closely with the department of health to set up the incentives.

4. Summary of Findings on Monitoring and Enforcement of Standards

Overall, our findings show that, in the aggregate, states in our sample had addressed each key component of a state monitoring plan, i.e., they had developed a formal plan with clear goals, assignments, measurements, and milestones, prevention strategies, coordination strategies, detection strategies, enforcement strategies, and reporting strategies. There was variation in the degree to which the ten elements that have been identified as important to effective implementation were fulfilled. More specifically, we found that:

- In the aggregate, states had clearly stated their policy goals related to the provision of oral health and lead screening services (element one).

- All states had some contract provisions on the coverage of oral health and lead screening services, and standards for measuring compliance with the contract provisions (element two). They varied in how specific those provisions were, however.

- All states had created a mechanism for monitoring compliance, which consisted of data collected at regular intervals and used to measure compliance of health plans with quantifiable standards. States varied greatly, however, in the extent to which they had established quantifiable quality performance standards (element three).

- All states had designated an agency responsible for implementing the policy goals related to pediatric services, including oral health and lead screening services (element four). However, in several states, the lead agency (Medicaid or SCHIP agency) shared roles and responsibilities with other agencies in the area of managed care, lead screening surveillance, and dental carve-outs that had the potential for adding layers of complexity to its oversight duties and raised issues of coordination among the various agencies concerned.

- The majority of respondents stated that the personnel responsible for implementation were committed to promoting the stated policy goals (element five) and enjoyed the support of their superiors in doing so (element six), both for oral health and lead screening. Policy beneficiaries, on the other hand, were described as demonstrating varying degrees of organization and cohesive support toward the implementation of policy goals related to oral health and lead screening (element seven). In three states, managed care organizations showed strong support for both oral health and lead screening goals; in two states, they showed support to both but questioned the adequacy of resources to achieve those goals; in two states, managed care organizations were unanimously opposed to the lead screening goals, and in one of these two states, they did not focus on oral health at all; and finally, in one state, while the health plan showed support to both goals, network providers did not, making it difficult for the plan to achieve the goals.

- The majority of states had undertaken efforts with the various agencies responsible for achieving the policy goals toward administrative coordination (element eight), but these efforts varied in their level of formality depending on the agency and the state. For all states, coordination efforts with the Attorney General's office did not entail any close relationship, but rather informal referrals when needed. In terms of coordination efforts with the department of insurance, several states described a close working relationship through, for example, regular meetings, but several other states only had an episodic relationship or no relationship at all with the department. As far as coordination efforts with the department of health, all Medicaid agencies had a relationship with the division in charge of lead surveillance, albeit in varying levels of formality, and none of the SCHIP agencies had such a relationship. In contrast, in the area of oral health, the majority of agencies, whether they were Medicaid or SCHIP agencies, did not have relationship at all with the department. Finally, all three SCHIP agencies described a close relationship with their sister Medicaid agency.

- Many states had designed a graduated system of incentives and penalties, which they believed favored compliance (element nine), but most states, even those with high levels of managed care penetration, approached enforcement more as a collaboration with plans, mostly because of the underlying health system's issues that are beyond the control of either the state or the plan.

- The direct involvement of the federal government varied by state (element ten), but it seemed to adopt a more active role on behalf of children protected by the policies on oral health and lead screening in its oversight of state Medicaid programs than in its oversight of state SCHIP programs, particularly in the area of lead screening.

Although our findings do not allow us to rank the ten elements in their order of importance in achieving successful implementation of the policy goals related to oral health and lead screening, these findings suggest that state monitoring and enforcement is strongly influenced by the conditions of the local markets in which the programs operate, and, as a consequence, may lose some of its leverage in ensuring that children have access to quality care. At the same time, the findings suggest that states adapt their strategies to those conditions in order to achieve the best possible outcomes for children under the circumstances.

We also found some noticeable differences in approaches to monitoring and enforcing pediatric contractual standards across states depending on the degree of managed care penetration and the type of program design in effect in the state. First, managed care penetration was a factor on whether a state had specified quality performance indicators and the extent to which it was able to garner support from managed care plans and providers for their quality goals, particularly as they related to lead screening. This suggests that, if states opt to use managed care to deliver pediatric services, they need a sufficiently strong managed care market upon which to build a system of care than can be truly monitored and enforced. However, our findings also suggest that, even in states that have high levels of managed care penetration, underlying problems of access to care and provider supply that disproportionately affect the population they serve impair states' ability to ensure plan compliance with their expectations regarding the provision of quality pediatric services.

Second, because of the differences in the federal law that regulates the monitoring and enforcement obligations of Medicaid and SCHIP agencies, Medicaid and SCHIP programs emphasized different areas for quality improvement. One of the major differences noted was the emphasis on oral health exhibited by those states with separate SCHIP programs in operation, whether or not the programs used the same service delivery system as Medicaid. In contrast, oral health disease, which is a high prevalence condition, was not as given as much emphasis as lead poisoning, a low prevalence condition, in Medicaid programs, including SCHIP Medicaid expansion programs. This is most likely because Medicaid agencies are subject to a variety of federal obligations, which put a particular stress on lead screening and poisoning issues. Oral health care is not as stringently prescribed in Medicaid law.

Finally, the evidence gathered in the context of this study did not support our assumption that states would design more elaborate monitoring and enforcement plans for the pediatric standard aimed at a low prevalence condition (here, childhood lead poisoning) than for the pediatric standard aimed at a high prevalence condition (here, oral disease). Rather, they either adopted approaches that focused more on the monitoring of dental care than lead screening or adopted the same monitoring approach for both types of services.

D. Conclusions

States play a significant role in ensuring health care quality and face a complex task because many different parties may be involved in monitoring and enforcement, some of whom may not have designed themselves the performance standards by which quality is measured. The Attorney General's office assumes the lead on fraud and abuse, the department of insurance on fiscal solvency and legitimate business practices, and Medicaid and SCHIP agencies on service delivery. The level of interaction between these various branches of government varies by state but generally speaking, each sees its area of jurisdiction as very delineated and as needing coordination only on a case-by-case basis. In their capacity as large purchasers of health care, Medicaid and SCHIP agencies are both distributors of information about managed care quality and regulators of contractual relationships between managed care organizations and the purchaser, and enrollees and providers. This study was intended to look at how Medicaid and SCHIP agencies perform both of these tasks. It examined not only why states included certain standards in their contracts but also how they ensured accountability or compliance with those standards. Thus, this study is the story of the "ideal world" states formulate in their contractual standards, and the reality states face in implementing these expectations in the "real world."

Our findings on the logic of Medicaid and SCHIP contract performance standard selection indicate that states do pay attention to the contract. Although the level of specificity varied across states, contractual provisions generally addressed the service components of oral health and lead screening as well as the periodicity with which they should be provided. Differences between Medicaid and SCHIP agencies in the specificity of the contractual provisions were typically driven by existing federal requirements related to benefits. These findings suggest that, unless the federal government specifies the content of coverage and the periodicity with which it should be furnished, states will be more likely to follow professional and industry practice and forego attempts to raise the bar in health care quality for children. They further suggest that the federal government will be more likely to specify the content of coverage and the periodicity with which it should be furnished in the case of low prevalence conditions that are attached to public health concerns. If those federal specifications reflect an advance beyond current norms, as one can expect in the case of low prevalence conditions, states may run into serious implementation problems, as our interviews seemed to indicate in the case of childhood lead poisoning.

Our findings on the implementation of Medicaid and SCHIP managed care monitoring and enforcement indicate that states generally perform some contract monitoring. State approaches were very idiosyncratic, a variation that can be explained by the local conditions that define the delivery system. Legislation is usually broad in that regard and probably should remain that way so that states can tailor their approaches to what is happening at the local level. This set of findings also revealed that states do not generally consider the contract as all encompassing on quality improvement because it cannot appropriately address systemic issues. These underlying delivery system problems mean that contractual language and contract enforcement lose

some of their power and that states must turn to other strategies, such as community awareness, to deal with these underlying issues.

Taken together, these two sets of findings have important policy implications. First, they have important implications for children's right to coverage under Medicaid and SCHIP, which is a crucial issue upon which the current debate on reforming Medicaid hinges. As stated earlier, because the contracts represent the sum total of the health care children will receive under either program, the pediatric standards that are specified in the contracts, as well as states' performance monitoring, contract enforcement, and access to patient protections become of the utmost importance. The fairly low level of monitoring described in this study and the limited direct access to patient protections for both coverage and quality issues described elsewhere brings into light the issue of a private right of enforcement by beneficiaries. Even though Medicaid is usually considered to be insurance, it is distinct in certain aspects and functions according to principles that do not prevail in the private insurance market. More specifically, the contract between states and managed care organizations may or may not constitute a contract of insurance, unless certain elements are fulfilled (e.g., the contract makes beneficiaries a party to the contract and requires insurers to obtain a license of insurance). Our research in this area indicates that two of the study states have third party beneficiary rights defined in their contract (one granting Medicaid beneficiaries third party beneficiary rights, the other explicitly denying those rights) and none require insurers to hold a license of insurance. This could lead courts to question the nature of the contract as a contract of insurance and the existence of a private right to enforce the contract. In the absence of such a right, the recognition of a mandatory federal individual entitlement as is the case with Medicaid becomes a key component in ensuring that children have access to the services they need.

Second, our findings have important implications for children with special health care needs. The higher prevalence of children with special health care needs in Medicaid and SCHIP than in the general population warrants particular efforts on the part of states to monitor the quality of care received by these children. While this research did not specifically focus on children with special needs, its findings on state monitoring of contractual standards targeting childhood lead poisoning suggest that, even when the federal government steps in to define with specificity benefits aimed at low prevalence childhood conditions and attempts to raise the bar in quality for children suffering from these conditions, states encounter problems in their monitoring efforts because of resistance at the local level to what is perceived as a waste of resources. This contradiction explains in part the fairly low level of monitoring described in this study. It also points to the need for approaches that are external to the contract, if states want to be successful in their monitoring of low prevalence childhood conditions.

TABLE A.I: Intermediate Remedies in Selected State Medicaid and SCHIP Risk Contracts, 2000

Type of Remedy	MEDICAID															SCHIP						
	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI	CA	CO	FL	MI	MS	NY	TX
Corrective action plan				X	X	X			X	X	X	X				X	X				X	X
Liquidated or exemplary damages	X[1]	X	X	X	X	X		X	X	X	X	X	X	X	X	X				X		X
Suspension of new enrollment	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X
Disenrollment of current enrollees					X	X			X			X	X		X							
Withholding from capitation payments	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
MCO payment for out-of-plan care				X																		
State payment to out-of-plan provider			X																			
Adjusting capitation payment rates	X	X				X[2]		X	X		X	X	X		X							
Receivership by state Medicaid agency						X[3]			X			X	X	X								
Termination or non-renewal of contract	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

[1] Provision in the general service agreement only.
[2] Provision in the behavioral health contract only.
[3] Provision in the general service agreement only.

TABLE A.II: Frequently Cited Causes of Corrective Action Plans, Medicaid & SCHIP Contracts (2000)

MEDICAID							
Cause	FL	IN	MA	NJ	NY	OH	SC
Failure to comply with contract	X[1]		X[3]			X	X
Failure to comply with state laws and regulations						X	
Failure to provide quality care				X			X
Failure to maintain efficient delivery system		X					
Failure to provide complete and accurate encounter data			X[4]				
Failure to comply with EPSDT screening rate	X[2]						
Failure to comply with the annual PCP turnover rate			X[5]				
Failure to comply with marketing guidelines					X		
Failure to meet financial stability						X	

SCHIP				
Cause	CA	CO	NY	TX
Failure to comply with access standards specified in contract			X	
Knowledge that representations or warranties regarding a participating provider may be untrue or incorrect	X			
Deficiency or event causing an assessment of a liquidated damage				X
Hindrance of enrollee access to covered services due to inability of providers within plan to accept additional enrollees as patients		X		

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision found in the behavioral health contract only.
2. Provision found in the behavioral health contract only.
3. Provision found in both the general service agreement and the behavioral health contract
4. Provision found in the general service agreement only.
5. Provision found in the general service agreement only.

TABLE A.III: Frequently Cited Causes of Liquidated or Exemplary Damages, Medicaid & SCHIP Contracts (2000)

Cause(*)	MEDICAID														*Cause*	SCHIP		
	AZ	CA	CO	FL	IN	MA	MN	NJ	NY	OH	SC	TX	WA	WI		CA	MS	TX
Failure to comply with contract	X[1]	X		X[3]	X	X[4]	X	X			X	X			Failure to comply with contract			X
Failure to provide medically necessary services								X							Failure to provide medically necessary services			X
Discrimination of enrollees on the basis of health status or need								X							Discrimination on the basis of health status or need			X
Misrepresentation or falsification or information								X							Misrepresentation or falsification of information			X
Failure to comply with federal laws and regulations	X[1]	X		X[3]							X	X			Failure to establish coverage and related administrative services		X	
Failure to comply with state laws and regulations	X[1]	X		X[3]											Failure to comply with objective performance standards monitored by state	X	X	
Failure to submit corrective action plan or meet requirements of corrective action plan	X[1]		X								X				Failure to cure default within specified time period			X
Failure to comply with marketing requirements					X			X	X						Imposition of premiums or charges in excess of allowable amount			X
Failure to submit data in specified format	X[2]		X		X	X[4]		X	X			X		X	Failure to file anti-lobbying certificate		X	

Source: Rosenbaum *et al.*, *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in general service agreement only; 2. Provision in behavioral health contract only; 3. Provision in general service agreement only; 4. Provision in behavioral health contract only

(*) Other less frequently causes under Medicaid included: failure to comply with network development and access to services requirements (IN, MA behavioral health); failure to comply with federal and state reporting requirements regarding abortions, hysterectomies and sterilizations (WI); failure to comply with quality improvement requirements (IN); failure to address cultural competency (IN); failure to comply with performance standards (MA behavioral health).

TABLE A.IV: Frequently Cited Causes of Termination, Medicaid & SCHIP Contracts (2000)

Cause	MEDICAID															*Cause*	SCHIP					
	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI		CA	CO	MI	MS	NY	TX
CONTRACTOR VIOLATIONS																						
Failure to comply with contract	X[1]		X	X[3]	X	X[4]					X	X	X		X	Failure to comply with contract	X	X	X			
Failure to comply with federal laws and regulations				X[3]		X[4]						X	X	X		Significant changes in network composition that negatively affect enrollee access to services					X	
Failure to comply with state laws and regulations				X[3]		X[4]					X		X			Enrollment procedures resulting in a pattern and practice of inappropriate enrollment					X	
Failure to provide medically necessary services						X[4]					X		X			Failure to meet licensing requirements				X		
Failure to maintain financial viability or meet financial soundness requirements					X	X[4,5]			X	X	X	X	X			Failure to meet statutory financial requirements or to comply with solvency requirements				X	X	X
Failure to comply with marketing requirements						X[4]			X	X						Brokers' fees, contingency fees, bribes, gratuities, or kickbacks paid to secure agreement				X		
Unremedied breach within a specified time					X	X[4]			X	X				X		Unremedied breach within a specified				X		

Cause	MEDICAID															*Cause*	SCHIP					
	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI		CA	CO	MI	MS	NY	TX
period																**time period**						
Loss of qualification for licensure, certificate of authority, or certification		X						X	X	X	X	X				**Failure to provide access to data, documents, information**				X		
Commencement of bankruptcy proceedings						X[4]			X	X		X				**Commencement of bankruptcy proceedings**				X		X
Failure to comply with quality improvement requirements						X[4]										**Failure to meet quality assurance requirements**					X	
Failure to comply with network development and access to services requirements										X	X											
Failure to provide quality services								X														
Failure to monitor network providers													X									
Failure to comply with performance standards or benchmarks									X				X									
Fraud or abuse						X[5]							X									
CAUSES OTHER THAN CONTRACTOR VIOLATIONS																						
Best interest of the state		X			X				X		X					**Lack of funding, appropriated funds**			X	X		
Protection of enrollees from injury		X				X[5]			X	X		X	X			**State no longer needs service**			X			

Source: Rosenbaum *et al.*, *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in the general service agreement only
2. Provision in the behavioral health contract only

3. Provision in the general service agreement only
4. Provision in the general service agreement only
5. Provision in the behavioral health contract only

ENFORCEMENT PAPER APPENDICES

APPENDIX I:

[Individual Medicaid/SCHIP Tables from Contract Analysis]

MEDICAID TABLES

TABLE A.I: Causes of Disenrollment of Current Enrollees, Medicaid Contracts (2000)

	IN	MA	NJ	SC	TX	WI
Failure to comply with contract			X	X		
Failure to comply with Federal laws and regulations					X	
Failure to provide services	X					X
Failure to maintain or provide records						X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE A.II: Causes for Adjusting Capitation Payment Rates, Medicaid Contracts (2000)

	AZ	CA	MA	MN	NJ	OH	SC	TX	WI
Failure to comply with contract	X	X	X[2]	X		X	X		
Failure to comply with Federal laws and regulations		X							
Failure to comply with state laws and regulations						X			
Failure to submit data	X[1]				X				
Failure to comply with timeliness and accuracy of claims processing					X				
Failure to maintain medical loss ratio					X				
Failure to use Medicaid certified providers									X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision found in the behavioral health contract only.
2. Provision found in the behavioral health contract only.

TABLE A.III: Causes of Corrective Action Plans, Medicaid Contracts (2000)

	FL	IN	MA	NJ	NY	OH	SC
Failure to comply with contract	X[1]		X[3]			X	X
Failure to comply with state laws and regulations						X	
Failure to provide quality care				X			X
Failure to maintain efficient delivery system		X					
Failure to provide complete and accurate encounter data			X[4]				
Failure to comply with EPSDT screening rate	X[2]						
Failure to comply with the annual PCP turnover rate			X[5]				
Failure to comply with marketing guidelines					X		
Failure to meet financial stability						X	

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision found in the behavioral health contract only.
2. Provision found in the behavioral health contract only.
3. Provision found in both the general service agreement and the behavioral health contract
4. Provision found in the general service agreement only.
5. Provision found in the general service agreement only.

TABLE A.IV: Causes of Liquidated or Exemplary Damages, Medicaid Contracts (2000)

	AZ	CA	CO	FL	IN	MA	MN	NJ	NY	OH	SC	TX	WA	WI
Failure to comply with contract	X[1]	X		X[3]	X	X[4]	X	X			X	X		
Failure to comply with Federal laws and regulations	X[1]	X		X[3]							X	X		
Failure to comply with state laws and regulations	X[1]	X		X[3]										
Failure to provide medically necessary services								X						
Failure to submit corrective action plan or meet requirements of corrective action plan	X[1]		X								X			
Discrimination of enrollees on the basis of health status or need								X						
Failure to comply with marketing requirements					X			X	X					
Failure to comply with enrollment requirements								X						
Failure to comply with network development and access to services requirements					X	X[4]								
Failure to comply with physician incentive plan requirements								X					X	
Failure to submit data, medical records, or other information or failure to submit them in required form or format by	X[2]		X		X	X[4]		X	X			X		X

	AZ	CA	CO	FL	IN	MA	MN	NJ	NY	OH	SC	TX	WA	WI
specified deadline														
Failure to comply with Federal and state reporting requirements regarding abortions, hysterectomies and sterilizations														X
Failure to comply with quality improvement requirements					X									
Failure to address cultural competency					X									
Failure to have credentialing policies in place and procedures for monitoring and sanctioning providers or failure to adhere to licensure of staff requirements					X						X			
Failure to make payments to network providers								X				X		
Failure to comply with performance standards						X[4]								
Failure to cooperate in carrying out an administrative, investigative or prosecutorial function of the Medicaid program												X		
Failure to comply with prohibition to impose copayments or premiums								X			X			
Failure to maintain the medical loss ratio and any losses if funds incurred by the state due to								X						

	AZ	CA	CO	FL	IN	MA	MN	NJ	NY	OH	SC	TX	WA	WI
contractor's noncompliance														
Failure to enter into a required contract or failure to contract for all services required under the contract												X		
Misrepre-sentation or falsification or information								X						
Offer of employment or gratuity to influence outcome of procurement or secure contract	X[1]													
Employment or contracting abuses								X						

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in general service agreement only
2. Provision in behavioral health contract only
3. Provision in general service agreement only
4. Provision in behavioral health contract only

TABLE A.V: Causes of MCO Payment for Out-of-plan Care, Medicaid Contracts (2000)

	FL
Failure to comply with contract	X[1]
Failure to comply with laws and regulations	X[1]

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in general service agreement only

TABLE A.VI: Causes of Receivership, Medicaid Contracts (2000)

	MA	NJ	SC	TX	WA
Failure to comply with contract			X		X
Failure to comply with Federal laws and regulations				X	X
Egregious behavior		X		X	
Substantial risk to the health of enrollees		X		X	
Failure to cure default within given period of time after notification					X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE A.VII: Causes of Withholding from Capitation Payments, Medicaid Contracts (2000)

	AZ	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
Failure to comply with contract		X	X[2]	X	X[4]	X	X	X		X	X	X		
Failure to comply with Federal laws and regulations	X[1]		X[2]											
Failure to comply with state laws and regulations			X[2]							X				
Termination		X			X[4]						X			
Failure to provide medically necessary services									X				X	X
Failure to comply with financial soundness requirements				X	X[4]									
Failure to comply with reporting requirements			X[3]											X
Failure to comply with cultural competency requirements				X										
Failure to have credentialing policies and procedures for monitoring and sanctioning providers				X										
Failure to pay network providers														X
Discrimination against any qualified employee or applicant for employment or other discriminatory practices (e.g., against enrollee based on health status)					X[4]				X				X	
Imposition of premiums or charges in excess of allowable amounts									X					
Misrepresentation or falsification of information									X				X	
Failure to comply with physician incentive plan requirements									X		X			
Failure to make payments to state, including											X			

	AZ	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
payment of liquidated damages related to failure to complete action required by corrective action plan														

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in general service agreement only
2. Provision in general service agreement only
3. Provision in behavioral health contract only
4. Provision in behavioral health contract only

TABLE A.VIII: Causes of Recoupment of State Payment to Out-of-plan Providers, Medicaid Contracts (2000)

	CO
Failure to reimburse covered services when contractor has received a monthly prepayment to provide these services and enrollee has moved outside of contractor's service area	X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE A.IX: Causes of Suspension of New Enrollment, Medicaid Contracts (2000)

	AZ	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
Failure to comply with contract		X	X[2]	X			X	X		X	X	X	X	X
Failure to comply with Federal laws and regulations												X		X
Failure to comply with state laws and regulations										X		X		X
Failure to comply with marketing guidelines	X[1]					X	X	X	X					
Failure to comply with enrollment requirements							X							
Failure to comply with financial viability standards or adverse action by department of insurance	X[1]											X		
Failure to comply with provider network requirements	X[1]													
Failure to comply with credentialing policies and procedures and procedures for monitoring and sanctioning providers				X								X		
Failure to pay network providers												X		X
Failure to submit data	X[1]											X		
Failure to comply with quality of care and quality management requirements	X[1]		X[2]											
Failure to comply with cultural competency requirements				X										
Failure to pay liquidated damages within specified timeframe									X					
Failure to implement corrective action plan in timely manner									X					
Commission of egregious first-									X					

	AZ	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
time infraction														
Misrepresentation or fraud												X		
Exclusion of Medicaid or Medicare												X		
Placing health and safety of enrollees in jeopardy												X		X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in the general service agreement only
2. Provision in the general service agreement only

TABLE A.X: Causes of Termination, Medicaid Contracts (2000)

	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
Contractor violations:															
Failure to comply with contract	X[1]		X	X[3]	X	X[4]					X	X	X		X
Failure to comply with Federal laws and regulations				X[3]		X[4]						X	X	X	
Failure to comply with state laws and regulations				X[3]		X[4]					X		X		
Failure to meet requirements for participation in the Medicaid program		X												X	
Failure to provide medically necessary services						X[4]					X		X		
Failure to accept state capitation payment						X[4]									
Failure to maintain financial viability or meet financial soundness requirements					X	X[4,5]			X	X	X	X	X		
Failure to pay liquidated damages within specified timeframe										X					
Failure to take corrective action or comply with any corrective action plan	X[1]					X[4]				X					
Discrimination of enrollees on the basis of health status						X[4]									

	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
or need															
Failure to comply with marketing requirements						X[4]			X	X					
Failure to comply with network development and access to services requirements										X	X				
Failure to provide quality services								X							
Failure to comply with quality improvement requirements						X[4]									
Failure to monitor network providers													X		
Failure to make payments to network providers													X		X
Failure to comply with performance standards or benchmarks									X				X		
Imposition of charges on enrollees in excess of allowable amount						X[4]									
Unremedied breach within a specified time period					X	X[4]			X	X				X	
Egregious first-time infraction										X					
Misrepresentation or falsification or information						X[4]							X		
Offer of gratuity to influence outcome of procurement or secure contract	X[1]														
Conflict of	X[1]														

	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
interest															
Adverse action by department of insurance													X		
Exclusion from participation in Medicare, Medicaid and SCHIP											X	X	X		
Debarment, suspension or prohibition from participation in any public procurement activity	X[1]									X					
Loss of qualification for licensure, certificate of authority, or certification		X						X	X	X	X	X			
Discrimination in employment or other violations in employment						X[5]						X			
Appointment of a receiver, trustee or liquidator						X[4]									
Commencement of bankruptcy proceedings						X[4]			X	X		X			
Fraud or abuse						X[5]							X		
Other reasons for termination:															
Change in state needs									X						
Lack of appropriated amounts for the continuation of the program	X[2]														
Best interest of the state		X			X				X		X				
Protection of enrollees from injury		X				X[5]			X	X		X	X		
Protection of state or						X[5]			X	X					

	AZ	CA	CO	FL	IN	MA	MI	MN	NJ	NY	OH	SC	TX	WA	WI
Federal funds or property															

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

1. Provision in the general service agreement only
2. Provision in the behavioral health contract only
3. Provision in the general service agreement only
4. Provision in the general service agreement only
5. Provision in the behavioral health contract only

SCHIP TABLES

TABLE B.I: Causes of Corrective Action Plans, SCHIP Contracts (2000)

	CA	CO	NY	TX
Failure to comply with access standards specified in contract			X	
Knowledge that representations or warranties regarding a participating provider may be untrue or incorrect	X			
Hindrance of enrollee access to covered services due to inability of providers within plan to accept additional enrollees as patients		X		
Deficiency or event causing an assessment of a liquidated damage				X

Source: Rosenbaum *et al.*, *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE B.II: Causes of Liquidated or Exemplary Damages, SCHIP Contracts (2000)

	CA	MS	TX
Failure to comply with contract			X
Failure to establish coverage and related administrative services		X	
Failure to substantially provide medically necessary services			X
Failure to comply with objective performance standards monitored by state	X	X	
Failure to cure default within specified time period			X
Discrimination on the basis of health status or need			X
Misrepresentation or falsification of information			X
Imposition of premiums or charges in excess of allowable amount			X
Failure to file anti-lobbying certificate		X	

Source: Rosenbaum *et al.*, *Negotiating the New Health System (4th Ed, 2001)*, www.gwhealthpolicy.org

TABLE B.III: Causes of Suspension of New Enrollment, SCHIP Contracts (2000)

	CA	CO	TX
Failure to comply with contract	X	X	X
Default declared as a result of imminent danger to health and safety of enrollees			X

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE B.IV: Causes of Termination, SCHIP Contracts (2000)

	CA	CO	MI	MS	NY	TX
Contractor violations:						
Failure to comply with contract	X	X	X			
Significant changes in network composition that negatively affect enrollee access to services					X	
Enrollment procedures resulting in a pattern and practice of inappropriate enrollment					X	
Deficiencies in quality assurance					X	
Failure to meet licensing requirements				X		
Failure to meet statutory financial requirements or to comply with solvency requirements				X	X	X
Failure to provide access to data, documents, information				X		
Unremedied breach within specified time period				X		
Criminal conviction incident to application for or performance of state, public or private contract or subcontract or other criminal offenses (e.g., embezzlement, theft, forgery)			X			
Assignment for the benefit of creditors, appointment of receiver, or bankruptcy proceedings				X		X
Brokers' fees, contingency fees, bribes, gratuities, or kickbacks paid to secure agreement				X		
Conflict of interest				X		
Discrimination in employment				X		
Other reasons for termination:						
Changes in program, laws, regulations			X			
State no longer needs services			X			
Lack of funding, appropriated funds			X	X		
Final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services			X			

Source: Rosenbaum *et al.*, *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

TABLE B.V: Causes of Withholding from Capitation Payments, SCHIP Contracts (2000)

	CA	CO
Failure to comply with contract		X
Failure to make payments to CAHPS vendor	X	

Source: Rosenbaum *et al*., *Negotiating the New Health System (4th Ed, 2001),* www.gwhealthpolicy.org

ENFORCEMENT PAPER APPENDICES

APPENDIX II:

[Tables from Interview Analysis]

Table 1. State Approaches to Performance Measurement of Oral Health Standards

General Approach	Specific Approach
States with clinical performance measures	❖ State program uses one performance measure specific to dental care (i.e., annual dental visit) with three levels of performance: (1) performance minimums, or the minimum performance expected from health plans (i.e., 45% of members must have received an annual dental visit); (2) performance goals, or reachable standards (i.e., 55% of members must have received an annual dental visit); (3) performance benchmarks, or ultimate goals. Program also expects health plans to show improvement from year to year. ❖ State program has performance measures specific to dental care, with performance minimums and performance goals, but program currently looks for annual percentage increase in performance compared to previous year. ❖ Four state programs have performance measures specific to EPSDT well-child visit, with performance minimums, such as Federal participation goals. o First program uses Federal and state goals of participation as a performance minimum; it also uses EPSDT statistics to track the provision of dental services. o Second program sets performance minimums low with the goal to increase them gradually over time. o Third program uses Federal goal of participation as a performance minimum; it also uses several data sources to determine rate of dental service and referral, which serves as a baseline for improvement on an annual basis, and gives plans incentives to increase performance. o Fourth program uses state goal of participation as a performance minimum; while it uses the rate of EPSDT well-child visits as a starting point to determine whether children receive dental care, it plans to use historical data on oral screening to set future performance goals. ❖ State program sets annual minimum performance levels for the HEDIS well-child visit, but they are not specific to any pediatric services delivered during the visit except for immunizations. Program does not measure access to or quality of dental care because it defers to a carve-out managed dental care program to perform these monitoring tasks; although dental referrals constitute the link between the main managed care program and the carved-out program, the program has not yet looked at referrals. ❖ State program has performance measures specific to dental care, with no performance minimums yet. Program expects to set benchmarks at a later date once it knows "what is happening out there."
States without clinical performance measures but with monitoring of dental services through data collection	❖ Two state programs have no performance measures, but use dental statistics to track the provision of dental services.
States without clinical performance measures and monitoring of dental services through data collection	❖ State program does not focus on quality improvement but on ensuring access to care. Program uses a quantifiable access standard (i.e., 90 percent of children must have access to a pediatrician within 10 miles), though it is not specific dental care.

Source: GW CHSRP, 2003.

Table 2. State Approaches to Performance Measurement of Lead Screening Standards

General approach	Specific approach
States with clinical performance measures	❖ State program has performance measures specific to lead screening services, with performance minimums and performance goals, but program currently looks for annual percentage increase in performance compared to previous year. ❖ Four state programs have performance measures specific to EPSDT well-child visit, with performance minimums, such as federal participation goals. o The first program uses federal participation goal as performance minimum and Form 416 EPSDT data as baseline data. Otherwise, the department of health is the lead and the program is working with the department to improve data analysis and set long term goals for targeted screening. Program awaits future guidance from CMS regarding targeted screening before setting performance standards specific to lead. Currently, the program is notified by the department of health with the names and the birth dates of children with elevated blood lead levels who are identified as enrolled in the program. Following verification of eligibility and health plan enrollment, the program contacts the plan for follow-up. Operational and financial reviews focus on whether plans follow-up with the necessary services and whether plans monitor providers to determine if a screen is done according to federal guidelines and the state's EPSDT periodicity schedule. o The second program uses federal and state participation goals as performance minima and EPSDT statistics to track the provision of lead screening services. Otherwise, program has access to surveillance data from the department of health and performs geographic analysis to work with plans to do outreach. o The third program sets performance minimums low with the goal to increase them gradually over time. Program also tracks the provision of lead screening services through Form 416 data, including plan specific Form 416 data and, more recently, through an integrated data warehouse with state laboratories. Finally, the program just started to collect encounter data and generating plan-specific profiles, with the long range goal of collecting and monitoring lead screening data on a quarterly basis. o The fourth program uses federal participation goal for both the EPSDT visit and lead screening services and EPSDT data to determine the rate of lead screening service, which serves as a baseline for improvement on annual basis. Program gives plans incentives to increase performance. Department of health created a database on lead screening. Program shares enrollment files with the department of health and shares the data with plans, which are separated by plan. ❖ State program sets annual minimum performance levels for the HEDIS well-child visit, but they are not specific to any pediatric services delivered during the visit except for immunizations. Program requires submission of encounter data, which are supposed to capture EPSDT encounters and the elements of the EPSDT visit, and is now working with plans on improving the data. They are currently piloting a HEDIS-like measure to look at lead screening prevalence by plan. The program plans to require a minimum performance level for this HEDIS-like measure when it will make it a contractual requirement in 2004.
States without clinical performance measures but with monitoring of lead	❖ State program has no performance measures, but uses the rate of lead screening service from the previous year as a baseline for improvement in the following year. Program gives plans incentives

General approach	Specific approach
screening services through data collection	to improve performance and works closely with the department of health to set up the incentives. Otherwise, it tracks the billing code of laboratories performing blood lead tests from claims data. ❖ State program has no performance measures, but uses HEDIS data to track the provision of well-child services; interest exists in developing measures specific to lead screening but it is currently less of a focus than dental care.
States without clinical performance measures and monitoring of lead screening services through data collection	❖ State program does not focus on quality improvement but on ensuring access to care. Program uses a quantifiable access standard (i.e., 90 percent of children must have access to a pediatrician within 10 miles), though it is not specific lead screening.
States without any monitoring	❖ State program does not have any performance standards and monitoring plan; both are the responsibility of the department of health, with which the SCHIP agency has no collaboration as of now. ❖ State program does not enforce lead component of EPSDT; the department of health is responsible for monitoring lead in the state because of their population-based approach.

Source: GW CHSRP, 2003.

Table 3. State Distribution by Degree of Managed Care Penetration

States with high levels of managed care penetration (n=7)	Seven states fell into this category. The level of managed care penetration ranged from a low 23 percent to a high 52 percent of the general population enrolled in HMOs. Except for one state, all states had a majority of their Medicaid enrollees in managed care (range: 54-100 percent). Six states had all, or close to all, of their Medicaid managed care enrollees enrolled in full-risk MCOs, and one state had about 50 percent of its Medicaid managed care enrollees enrolled in full-risk MCOs. All states had 100 percent, or close to 100 percent, of their SCHIP enrollees enrolled in managed care and in full-risk MCOs. One state had all of its Medicaid and SCHIP enrollees in managed care and in full-risk managed care.
States with medium levels of managed care penetration (n=1)	One state fell into this category, with a 17 percent HMO penetration rate. This state had all of its Medicaid enrollees in managed care and in full-risk managed care, and about 80 percent of its SCHIP enrollees in managed care and in full-risk managed care.
States with low levels of managed care penetration (n=1)	One state fell into this category, with less than two percent of the general population enrolled in managed care. In this state, approximately half of the Medicaid enrollees are in managed care but none are in full-risk. In contrast, all SCHIP enrollees are in managed care.

Source: Kaiser Family Foundation, *State Health Facts*, http://www.kff.org

Table 4. State Distribution by Type of Program Design

States with Medicaid and SCHIP Medicaid expansion programs (n=2)	Two states fell into this category. All Federal Medicaid requirements apply, including those relating to benefits and program monitoring and enforcement. Federal law requires states to have a quality improvement plan in place, which should include quality and access standards, but leaves it up to states to determine the details of the plan and standards. Federal law also requires coverage and monitoring of EPSDT services. Oral screening and referral to a dentist are required as part of EPSDT screening services, more specifically the physical examination required under the program. In addition, other necessary care (i.e., diagnosis, treatment) discovered by the screen should be covered. At a minimum, this should include emergency, preventive and therapeutic services, as defined in law, to relieve pain and infections, restore teeth, and maintain dental health. Dental services must be provided at intervals that meet reasonable standards of medical and dental practice and should be set after consulting with recognized medical and dental organizations involved in children's health care. CMS, ADA, AAP, and AAFP recommend a direct referral to a dentist at 3 years old or earlier if medically necessary and greater frequency of dental visits than physical examinations for older children (AAPD recommends a dental visit within six months of the eruption of the first tooth and no later than the child's first birthday, and subsequently a minimum of two visits per year). Lead screening is also part of EPSDT screening services, more specifically the laboratory tests required under the program, which include a blood lead level assessment appropriate to age and risk. In addition, other necessary care (i.e., diagnosis, treatment) discovered by the screen should be covered. The program assumes that all children are at risk and thus should be tested. Lead screening must be provided according to a mandatory periodicity schedule at 12 months, 24 months and between 32 and 72 months if the child has not been previously screened. If the capillary specimen and the venous blood sample confirm an elevated blood lead level, states must follow CDC guidelines on patient management and treatment, which include a follow-up blood test and investigations on the source of lead. Two EPSDT monitoring requirements are imposed on states. First, they must have information available showing that services were provided. Second, they must file annual 416 reports, which break down EPSDT data by age group and by categorically and medically needy group. The report must include the number and the percentage of children receiving at least one initial or periodic screening service (dental and lead should be specifically listed when all screening services were provided) and the number of children receiving dental assessments. States can include more than the required elements. The program has an 80 percent participation goal for EPSDT in general and for the number of visits required by age group. In 1997, the aggregate Medicaid dental performance across states was 21 percent of Medicaid-covered children receiving the required EPSDT dental services. Similarly, the aggregate Medicaid lead performance across states was low, with 19 percent of Medicaid-covered children ages 1-5 being screened for elevated blood lead levels. In both cases, this performance varied widely by state.
States with Medicaid and separate SCHIP programs, with SCHIP contract integrated with Medicaid contract (n=4)	Four states fell into this category. All Medicaid requirements apply to the Medicaid program (see above) but not the separate SCHIP program, which is governed by the SCHIP statute and regulations. Generally speaking, separate SCHIP programs have more flexibility to determine which benefits they will cover and what program monitoring and enforcement they will pursue. SCHIP requires states to provide an actuarially-equivalent benefit package for basic services, which must include well-baby and well-child care. Unlike Medicaid, dental care and lead screening services are not specifically listed as components of well-baby and well-child care. There are no requirements similar to Medicaid in SCHIP regarding monitoring and enforcement, i.e. there is no requirement to have a quality improvement plan with quality and access standards in place and to monitor and report on the provision of well-baby and well-child care services. When a state

	has integrated its SCHIP contract with its Medicaid contract, it usually means that the same agency is responsible for overseeing both programs.
States with Medicaid and separate SCHIP programs, with SCHIP contract separate from Medicaid contract (n=3)	Three states fell into this category. All Medicaid requirements apply to the Medicaid program (see first column, left) and all SCHIP requirements apply to the separate SCHIP program (see second column, left). When a state has issued a SCHIP contract that is separate from its Medicaid contract, it usually means that two different agencies are responsible for overseeing each program, raising issues of coordination between the two programs.

Source: CMS, 2003, http://www.cms.gov; ADA, 2003, http://ww.ada.org; CDC, 2003, http://www.cdc.org

ENFORCEMENT PAPER APPENDICES

APPENDIX III:

[Interview Instrument]

Interview guide
Non-medical research study

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AN EVALUATION OF THE ACCOUNTABILITY AND QUALITY OF MANAGED CARE FOR PUBLICLY-INSURED LOW-INCOME CHILDREN
IRB#080227ER

INTERVIEW GUIDE

Date:	
Interviewer:	
Interviewee Category (e.g., State Medicaid Official, Texas):	

INTRODUCTION

"As you know, managed care dominates the provision of health services to low-income, publicly-insured children. Both Medicaid and SCHIP managed care tend to be the mirror image of the private market. Under Medicaid, coverage is unusually broad, ranging from comprehensive preventive services to virtually all forms of treatments and medical interventions for children with serious health problems, with no cost-sharing involved. Under SCHIP, coverage is somewhat more limited and cost-sharing is allowed within certain limits. However, there is a trade-off for the broad coverage and no (or in the case of SCHIP, limited) cost-sharing in Medicaid and SCHIP managed care; this trade-off is the MCO's extremely tight controls over access to care. For example, publicly-sponsored managed care arrangements have no point-of-service option, families must use the networks to which they are assigned, and care controls remain far stricter, more closely resembling traditional, tightly structured HMO systems. Because the contracts states negotiate on the behalf of children represent the sum total of the health care that they will receive, the standards of pediatric care that are built into the terms of the agreements themselves, as well as performance monitoring, contract enforcement, and access to patient protections becomes of the utmost importance.

In this interview, we would like to understand your expectations regarding the intentions that underlie two selected performance standards included in the Medicaid and SCHIP managed care contracts. The first standard relates to a high prevalence childhood condition—oral disease; the second standard relates to a low prevalence childhood condition—mental retardation/developmental delay resulting from lead poisoning. In this interview, we also would like to understand how these two standards are actually monitored. We are particularly interested in the process of enforcement for both Medicaid and SCHIP contracts, which involves not only the Medicaid and SCHIP agencies but also other state agencies that may have jurisdiction over certain aspects of contract enforcement. We would like to learn more about how you enforce the contracts, and what barriers, if any, you face in doing so. We would also like to know whether the language used in the contract has posed any problems from an enforcement standpoint and, if so, what kinds of problems.

There are no right or wrong answers to our questions. You may choose to answer or not answer any or all of them, but we believe that your informed experience will assist many others as they develop accountability processes for managed care systems for publicly-insured, low-income children All your answers are confidential. We will not publish any information that could be attributable to you personally. The final report will be sent to you when available.

Any additional comments are also welcome."

A. FORMAL PLAN WITH CLEAR GOALS, ASSIGNMENTS, MEASUREMENTS, MILESTONES

1. Does your agency have a formal, written monitoring and enforcement plan for the provision of pediatric services spelled out in the Medicaid/SCHIP managed care contracts, and if so, what are the main goals of the plan (e.g., to ensure access to quality care)?

2. What are your agency's policy objectives regarding the monitoring and enforcement of the pediatric oral health standards included in the contract?

   2a. Are those objectives stated anywhere else besides the contract (e.g., policy guidance, other policy document), and if so, how enforceable are they?

3. Similarly, what are your agency's policy objectives regarding the monitoring and enforcement of the pediatric blood lead level screening and detection and MR/DD standards included in the contract?

   3a. Are those objectives stated anywhere else besides the contract (e.g., policy guidance, other policy document), and if so, how enforceable are they?

4. Your Medicaid/SCHIP managed care contract contains a number of pediatric oral health standards required of MCOs, why did your agency set the oral health standards this way?

   4a. Did your agency believe that the standards reflected existing industry practices or an advance beyond current standards?

   4b. How were the standards arrived at and negotiated with contractors?

5. Similarly, why did you set the MR/DD and blood lead level screening and detection standards the way you have in your Medicaid/SCHIP contract?

   5a. Did your agency believe that the standards reflected existing industry practices or an advance beyond current standards?

   5b. How were the standards arrived at and negotiated with contractors?

6. Which agency(ies) is(are) responsible for implementing and enforcing the policies regarding oral health, blood lead level screening and detection and MR/DD?

7. Would you say that the personnel responsible for implementing and enforcing the contract are committed to promoting the policy goals regarding oral health, blood lead levels and MR/DD?
8. Do those implementing and enforcing the policy goals regarding oral health, blood lead level screening and detection and MR/DD enjoy the support of superiors?

9. Would you describe policy beneficiaries—Medicaid/SCHIP recipients and MCOs—as organized and as cohesively supporting implementation of the policy regarding oral health, blood lead level screening and detection, and MR/DD?

B. COORDINATION STRATEGIES

1. Do the Medicaid/SCHIP agency and the various other agencies responsible for enforcement (e.g., AG, DOI) administratively coordinate their efforts?

2. Does the Medicaid/SCHIP agency evaluate the results of individual appeals filed on behalf of children who have been denied medical care and, if so, how is this information used?

3. Are the results of internal audits of performance disseminated among companion enforcement agencies?

4. How do the various agencies involved in enforcement coordinate their data, monitoring and investigations to ensure that MCOs that exhibit potentially substandard performance in multiple areas are quickly detected and the problems addressed?

5. Do key staff from the various agencies and programs involved in enforcement share information and communicate on a regular basis?

6. Does the Medicaid/SCHIP agency track out-of-plan use of services and benefits (e.g., furnished by the Title V special needs program) but that also are covered under its managed care agreements, and if so, does it require MCOs, which have received prepayments to provide these services, to reimburse the state?

C. DETECTION STRATEGIES

1. Has the Medicaid/SCHIP agency created a general mechanism for monitoring compliance, and if so, what does it consist of?

2. In general, how does the agency identify certain "early warning signs" that act as an indicator of potential problems?

3. Has your agency specified quantifiable standards for measuring compliance with the pediatric oral health standards, and if so, what are they and how are they measured?

4. Similarly, has your agency specified quantifiable standards for measuring compliance with the pediatric blood lead level screening and detection and MR/DD standards, and if so, what are they and how are they measured?

D. ENFORCEMENT STRATEGIES

1. Would you characterize your agency and state's general approach to monitoring and enforcement as proactive, systematic, ongoing or as reactive, periodic?

2. Are analyses and investigations independently conducted by your agency and the state, by an external organization, or by the plans, or a combination of those?

3. Would you say that the penalties and incentives you have in place favor compliance, and if so, what are they and how have you used them?

4. What are some of the barriers your agency faces in enforcing the contracts, e.g., has the language used in the contract posed any problems from an enforcement standpoint?

E. REPORTING STRATEGIES

1. Would you say that the Federal government is an active participant on behalf of those protected by the existing policies regarding oral health, blood lead levels and MR/DD? Why or why not?

2. Does the state report back to CMS and OIG for additional sanctions beyond the purview of the state? How often?

F. REQUEST FOR REFERRALS

1. Would you be willing to refer us to MCOs that would be willing to participate in our study and to discuss how they internalize contract requirements?

2. Would you be willing to refer us to colleagues in other agencies (e.g., AG, DOI) who would be willing to talk to us about the process they follow to enforce Medicaid/SCHIP contracts?