

Access to Pediatric Services under Medicaid Managed Care in the District of Columbia

Karen Shaw, JD, MPH

Sara Rosenbaum, JD

December, 2001

Executive Summary

This paper presents findings from a study of health care services provided to Medicaid-eligible children in the District of Columbia who are enrolled in managed care organizations (MCOs) through the District's mandatory Medicaid managed care program (MMCP). One of the District's Medical Assistance (MAA) goals is to provide outreach and enroll eligible uninsured children and, in some cases, their parents who live at or below 200% of the Federal Poverty Level (FPL) into the MMCP or the State Children's Health Insurance Program (SCHIP). If the District is successful in their endeavor, many low-income families will depend on the MCOs who contract with the MAA for access to a wide range of health care and other enabling services.

Although the goal of the District is to improve health outcomes by enrolling this uninsured population into mandatory managed care, enrollment in such arrangements does not always translate into increasing access to health care services. Recent literature suggests that enrolling children into Medicaid managed care programs does not necessarily result in increased access to health services, including the Early Periodic, Screening, Diagnostic and Treatment services benefit (EPSDT), for a large number of these enrollees.

This report will identify several basic measures that will permit a rapid assessment of the degree to which children who participate in mandatory Medicaid managed care are receiving EPSDT services in a timely and appropriate manner. The purpose of the study was to provide a gauge from which policymakers could obtain basic, relevant information on how managed care affects access for Medicaid-eligible children enrolled in MCOs in the District and throughout the country. The surveys developed for this study was intended to provide information from the perspectives of the

providers furnishing the services and the children and families receiving such services in the following areas:

- Enrollment and Provider Selection Procedures;
- Delivery of EPSDT screens;
- Referral to Specialty Services;
- Access to Providers and Specialists;
- Information Provided by the MCO and Providers.

Findings: Some of the findings from the study include:

- ❑ Medicaid enrollees reported receiving little information beforehand to facilitate their enrollment process.
- ❑ The Spanish-speaking parents reported that they did not have access to culturally competent material, either from the enrollment broker or from the managed care organization.
- ❑ The Spanish-speaking parents faced significant obstacles when attempting to access specialty services for their children due to lack of adequate translation services.
- ❑ Families and providers faced significant obstacles when attempting to facilitate access both early intervention as well as mental health services.
- ❑ Some of the providers and the families reported that they faced significant obstacles when attempting to access diagnostic services.

Introduction

The Center for Health Services Research and Policy (CHSRP) at The George Washington University School of Public Health and Health Services conducted analyses in 1999 and 2000 to focus on the delivery of and access to services to potentially Medicaid eligible families in the District of Columbia.

This study on access to pediatric services in DC's Medicaid managed care program assessed whether or not Medicaid managed care enrolled children were receiving Early and Periodic Screening Diagnostic and Treatment services (EPSDT) in a timely and appropriate manner. A related study focused on the insurance history and experiences of Medicaid-eligible patients who obtained health care services in the non-profit health centers located throughout the District.¹ A survey instrument was developed for this study to include questions which focused on services for children who are enrolled in the mandatory managed care program, with the goal of developing a better understanding of how care is provided under this system by assessing the experiences of beneficiaries and their providers.

In response to the high rate of uninsured children, the District enrolled 60% of its Medicaid-eligible population in its mandatory Medicaid managed care program in 1998.² The District's goal in enrolling the uninsured children into mandatory Medicaid managed care was to improve health outcomes while controlling health care costs; however, enrollment in managed care does not always translate into increasing access to health care services. In fact, recent studies have documented some of the challenges that arise when this vulnerable population attempts to negotiate the mandatory managed care

¹ Shaw, K and Maloy, K et al., *Neglected and Invisible, Understanding the Insurance Status of Patients in Thirteen District of Columbia Health Centers*. Prepared for the Non-Profit Clinic Consortium, April 2000.

² AARP Public Policy Institute, *Reforming the Health Care System: State Profiles*, 1999, p. 35.

system³ and a review of literature suggests that enrolling children into Medicaid managed care programs does not necessarily result in increased access to health care services, including the EPSDT benefit, for large numbers of these enrollees.⁴

The results from the survey instruments have been compiled into this report in order to identify several basic measures that will permit a rapid assessment of the degree to which children who participate in mandatory Medicaid managed care are receiving EPSDT services in a timely and appropriate manner. The purpose of the study was to provide a gauge from which policymakers could obtain basic, relevant information on how managed care appears functions for the pediatric enrollees not just in the District, but in managed care markets throughout the country.

This report will provide an overview of the District's health status indicators and its Medicaid managed care program, and present the major findings from the results of the survey and interviews with providers and the families and children enrolled in Medicaid managed care. The report will conclude with recommended measures to assess the quality of services provided to children enrolled in Medicaid managed care in the District of Columbia.

Overview of Medicaid Managed Care in the District of Columbia

Background. In 1999, the District of Columbia had a population of more than 572,000 individuals, with more than 81,000 uninsured. The District of Columbia has relatively higher uninsured rates when compared to national statistics for its general population and children under the age of nineteen. In addition, the District often rates

³ Gavin, N., Farrelly, M. and Simpson, J., Children's Use of Primary and Preventive Car Under Medicaid Managed Care. *Health Care Financing Review* 19(4), Summer 1998. Simpson, L. and Fraser, I., Children and managed care: What research can, can't and should tell us about impact. *Medical Care Research and Review* 56, March 1999.

lower than national statistics in key health indicators that help to predict children's health outcomes. For example, one report noted that the District, compared to national statistics, has almost one third more children living in poverty and twice as many teen births.⁵ A second set of health indicators show that 18.7% of the District's population was uninsured compared to 15.5% nationwide.⁶ Furthermore, 15.1% of the District's children were uninsured compared to 10.4% of children nationwide.⁷

The District of Columbia's Medicaid program, the Medical Assistance Administration (MAA), has contracted with managed care organizations (MCOs) since 1994 to enroll beneficiaries in their Medicaid managed care program (MMCP). In implementing its Medicaid managed care program, the District, like many other states in the country, has faced many challenges in providing Medicaid services through its managed care contractors. In 1996, a court order from a class action lawsuit filed in the District determined that MAA problems with eligibility determination, enrollment, and compliance with EPSDT requirements were so severe that it warranted the court to appoint a monitor to oversee timetables within which the MAA had to improve performance.⁸ The EPSDT service delivery claim included deficiencies in the following areas: screening services, dental, vision, and hearing services, monitoring functions, assignment to providers, case management services, referrals for follow-up treatment, and other evidence regarding EPSDT services.

In 1998, after HCFA approved a Section 1915(b) freedom-of-choice waiver, the District began to enroll the AFDC/TANF population into mandatory managed care. In

⁴ Sasso, A., Gavin, N. and Freund, D., Children's preventive care use under two mature Medicaid managed care plans in California *Health Care Financing Review* 19(4) Summer 1998.

⁵ 2000 Kids Count Data Online, Anne E. Casey Foundation. Profile for The District of Columbia.

⁶ State Health Facts Online, The District of Columbia at a Glance, the Kaiser Commission on Medicaid and the Uninsured.

⁷ Id.

⁸ Salazar v. District of Columbia, Civil Action No. 93-452. U.S. District Court, District of Columbia, October 11, 1996.

addition, through the State's Children's Health Insurance Program (SCHIP), the District chose to expand its Medicaid program to an additional 10,000 women and children under their "Healthy Families" program. These SCHIP children are entitled to receive all benefits under Medicaid, and the District must comply with federal Medicaid requirements.

As of December 2000, there were approximately 79,000 individuals enrolled in the District's Medicaid Managed Care Program.⁹ Children under the age of 21 who are enrolled in Medicaid automatically become eligible for a wide range of benefits under EPSDT as specified in federal Medicaid law.¹⁰ The EPSDT benefit consists of periodic and interperiodic (i.e., as needed) comprehensive examinations (screens), comprehensive vision, dental and hearing care, and any medical care and services that are described in the federal definition of 'medical assistance' and that are necessary to treat or ameliorate physical and mental conditions discovered during a screen. The EPSDT screen consists of a comprehensive health and development history, assessment of physical and mental health development, a comprehensive unclothed physical examination, all age appropriate immunizations, laboratory tests including blood level testing, and health education and anticipatory guidance.¹¹ However, enrollment in Medicaid managed care does not necessarily result in access to the wide range of services that is statutorily defined for the pediatric enrollees.¹² As in the District, there

⁹ Approximately two thirds of the Medicaid Managed Care Program(MMCP) enrollees (slightly more than 52,000) are children.

¹⁰§1902 a(a)(43) and 1905(a)(4)(B)and (r) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(43), 1396 (a)(4)(B), 1396d(r).

¹¹ For more information on the EPSDT benefit, see Schneider and Garfield, *Medicaid Benefits* (August 2000), Kaiser Commission on Medicaid and the Uninsured, www.kff.org.

¹² For more information about managed care organizations, see Rosenbaum, et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, Volume 1, Edition 3*.

are many lawsuits throughout the country brought on behalf of Medicaid-enrolled children to enforce their rights to receive EPSDT service.¹³

Other Related Studies in the District of Columbia. As discussed above, a related study was conducted by CHSRP with patients at community health centers. These patients were asked a series of questions ranging from their insurance status to the source of their health care coverage. In addition, patients were asked questions about their beliefs or opinions about participating in Medicaid and welfare programs. CHSRP researchers hoped to gain a better understanding of the health insurance patterns and experiences of the individuals and families who obtain their health care from this network of health care centers.

¹³ See National Health Law Program's EPSDT Case Docket, www.healthlaw.org.

Table #1
Snapshot of Responses from NPCC Study

Questions Asked	Yes	No	Don't Know
Do you have health care coverage?	55%	45%	—
Do your children have health care coverage?	74%	26%	—
Do you have to be on welfare to get Medicaid?	15%	65%	20%
Do TANF work requirements apply to people on Medicaid?	33%	41%	26%
Do TANF time limits apply to children on Medicaid?	32%	27%	41%
Can you apply for Medicaid at places other than the welfare office?	44%	22%	33%

Patients reported that almost half (45%) did not have any health care coverage. In addition, patients also indicated that 26% of the children did not have health insurance. When we spoke with these patients about their knowledge of Medicaid and welfare, patients' responses indicated a high level of misunderstanding about eligibility rules for the Medicaid program. For example, 35% of patients either did not know or believed that one had to be on welfare to get Medicaid. Further 59% either did not know or believed that the Temporary Assistance for Needy Families (TANF) work requirements apply to Medicaid enrollees. Seventy three percent of patients believed that TANF time limits apply to children who are enrolled in Medicaid while 55% either did not know or believed that individuals could only apply for Medicaid at the welfare office.

This information is important because given the income of the majority of these patients, it is likely that many of these uninsured patients or their children, could be eligible to apply for Medicaid or SCHIP. Unless these individuals are educated about the differences between Medicaid and TANF (there are time limits and work requirements for

TANF with no such requirements for Medicaid) it is likely that many potentially eligible families will continue to remain outside the reach of the Medicaid/SCHIP system.¹⁴

The District's Medicaid Managed Care Contract.¹⁵ One of the ways of assessing the service delivery of managed care is to look at the contract between the Medicaid Agency and the MCOs to assess the extent of the MCOs obligations to furnish Medicaid covered services to enrollees in the managed care arrangement. The following section provides an overview of the contractual provisions relating to EPSDT from the District's contract effective, April 1, 1998 through March 31, 2000: ¹⁶

- “The EPSDT program is the pediatric component of Medicaid and requires coverage of periodic and interperiodic screens, vision, dental, and hearing care, diagnostic services needed to confirm the existence of a physical or mental illness or condition and all medical assistance services that are recognized under Section 1905 of the Social Security Act, even if not offered under the state plan to persons age 21 and older. In operating the EPSDT program, Provider shall be bound by all federal laws applicable to the program (including 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)).”¹⁷
- “The Providers shall be responsible for coverage and provision of all periodic screening services in accordance with the Department's periodicity schedule, as well as interperiodic screening services which shall be furnished to any child who is suspected by a health care provider or any person authorized to make decisions regarding the child's health of having a physical or mental health problem.”¹⁸
- “The Provider shall be responsible for coverage and provision of all EPSDT [dental, vision and hearing screening services in accordance with the Department's periodicity screening schedule and at other interperiodic intervals whenever a problem is expected and all medically necessary diagnosis and treatment services...].”¹⁹

¹⁴ For further information, see Stuber, J., *Stigma and Other Barriers to Medicaid Participation*, March 2000. Prepared for The Robert Wood Johnson Foundation.

¹⁵ Rosenbaum, S, et.al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, Third Edition, June 1999, Volume 1, www.gwhealthpolicy.org. Click on “Managed Care Contract” on the Menu Bar.

¹⁶ Provider, as used in this contractual sense, refers to the MCOs who, in turn, subcontract with clinicians to actually deliver services to the enrollees.

¹⁷ District of Columbia Contract, page 22.

¹⁸ District of Columbia Contract, page 22.

¹⁹ Id. Pages 22 and Attachment I, page 4. The District follows the American Academy of Pediatric guidelines (AAP) health recommendations in consultation with the local health department and medical community.

- “The Provider shall be responsible for coverage and provision of all medically necessary services recognized under Section 1905(a) of the Social Security Act, other than mental illness and addiction disorder, transplant services, long term facilities. Provider must cover all federally recognized services regardless of whether such services are available to enrollees age 21 or older. In the case of services which are required to treat a mental illness or addiction disorder in an individual under age 21, or which are needed for organ transplants or a condition that requires institutionalization in a long-term care facility, Provider shall arrange for such treatment services but is not responsible for the cost of providing such treatment services.”²⁰
- “The Provider shall be responsible for the provision of pediatric vaccines in accordance with the standards established by the Advisory Committee on Immunizations Practices. All members of Provider’s network who immunize children must participate in the Vaccine for Children Program as a condition of this contract.”²¹
- “Provider is responsible for the provision of necessary scheduling and transportation services requested by a child’s family.”²²
- “Provider shall offer scheduling and transportation assistance prior to the due date of each eligible child’s periodic screening, laboratory tests and immunizations, when this assistance is requested and necessary as required by 42 CFR §440.170.”²³
- “Provider shall conduct outreach activities to assist enrollees make and keep EPSDT appointments for eligible children. The outreach activities shall include every reasonable effort, including telephone calls, scheduling of appointments for recipients, mailed reminders and personal visits, to contact parents, guardians of children, or the children themselves, if appropriate, based on the child’s age, who are due for, or who have failed to keep appointments for, EPSDT screens and laboratory tests set forth in the District’s periodicity schedule, immunizations, or follow-up treatment to correct or ameliorate a defect identified during an EPSDT screen or laboratory test, or have otherwise not obtained EPSDT screens, laboratory tests, immunizations, follow-up treatment or other services, in order to assist them to obtain such services.”²⁴
- “In making medical necessity-related coverage determinations in the case of children under 21, Provider must authorize coverage if, taking into account the clinical evidence, as well as the recommendations of the child’s PCP and other health, educational and social service professionals caring for the child, Provider determines that a service covered under this contract is necessary to:
 - (a) correct or ameliorate a physical or mental condition; or

²⁰ District of Columbia Contract, page 23.

²¹ Id., page 23.

²² Id., page 23.

²³ Id., page 21.

²⁴ Id., page 21.

(b) prevent the onset or worsening of a disabling or chronic condition.”²⁵

The contract sets forth the statutory requirements under the EPSDT benefit and makes clear that all medically necessary services must be covered for children, even if such services are not covered for adults under the District’s Medicaid plan. However, the contract does specify that mental illness, addiction disorder, transplant services and long-term care facilities are not to be paid for by the contracting MCO, but they must arrange for the treatment of such services. Although this implies that the District’s Medicaid program would cover the costs of such services for a child enrolled in the Medicaid MCO, the contract, however, does not specify how the coverage bifurcation is explained to beneficiaries.

The following contractual provisions, although not contained in the EPSDT section, were

applicable to the access issues that we discussed with providers and the families:

- “All material furnished to prospective and current enrollees shall be available in English and in Spanish, as well as other languages designated by the District.”²⁶
- Provider shall offer health education classes in both English and Spanish, as well as other languages identified by the District.”²⁷
- “Provider shall furnish all medically necessary transportation for non-emergency situations.”²⁸
- Provider shall offer and provider, if requested and necessary, transportation to EPSDT services.”²⁹
- “Provider shall offer and provide, if requested and necessary, assistance with scheduling EPSDT appointments.”³⁰

²⁵ District of Columbia Contract, page 24.

²⁶ Id., page 30.

²⁷ Id., page 30.

²⁸ Id., page 31.

²⁹ Id., pages 31.

³⁰ Id.

The pediatric medical necessity standard under EPSDT and as set forth in DC's contract³¹ imposes upon the MCOs the obligation to provide or arrange for a wide range of services for individuals who are under the age of twenty one. This contractual provision reflects the statutory requirements to cover services in order to prevent, correct or ameliorate an injury, illness or condition. This report is an effort to assess just how well children, and in some cases their families, who are enrolled in MCOs are receiving EPSDT services under the mandatory Managed Care Program.

Scope and Approach

With the assistance of a Technical Advisory Committee comprised of health professionals from a wide range of public health backgrounds, CHSRP researchers developed two instruments: one for providers and one for families of children enrolled in Medicaid managed care. Providers were asked questions about challenges associated with performing components of EPSDT screens, whether or not they differentiated in their well child visits for Medicaid versus non-Medicaid patients and whether or not the referral process differed for their Medicaid patients. The survey took approximately forty minutes to administer.

Parents were asked questions about the enrollment process and primarily whether they received information before or after they enrolled their child into a managed care organization. Parents were also asked a series of questions that pertained to access issues, such as whether or not they need translation services to communication with their child's provider and whether or not they have had any problems if their child had to access specialty care services. Our research questions for the parent focus groups were divided into the following topics: Enrollment, Health Care Access, and Health Care

³¹ District of Columbia Contract, page 24.

Status (including Mental Health Status.) CHSRP staff conducted four focus groups in District at diverse locations in an attempt to get a representative sample of Medicaid managed care patients throughout the city. The sample included: 1) parents whose children were primarily seen via a mobile clinic that comes to their neighborhood in far southeast D.C., 2) parents in a community health center with at least half of these interviews being conducted in Spanish or Vietnamese, 3) parents who had been educated about mandatory Medicaid managed care by employees of the District’s Office of Maternal and Child Health, and 4) parents of children with special health care needs who receive care at Children’s Hospital.

We conducted interviews with seven providers who practiced in a variety of clinical settings and were located in diverse geographical locations throughout the District (see Tables 3 and 3-A.) By speaking with providers and enrollees who participate in the Medicaid managed care program, or who were potentially eligible to enroll in the program we hoped to gain insight into the issues surrounding access to services for these families. In addition, we hoped to better understand some of the issues pertaining to access to health insurance for many of these families.

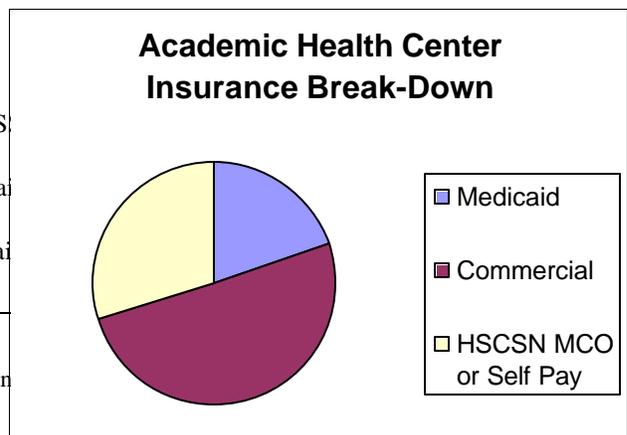
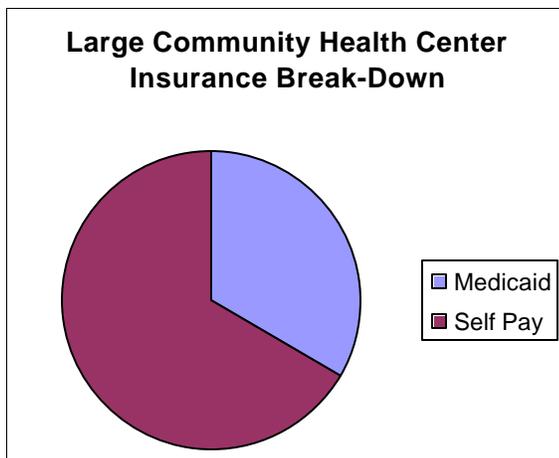
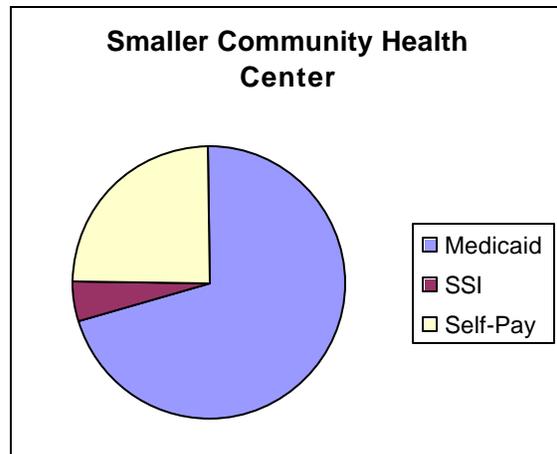
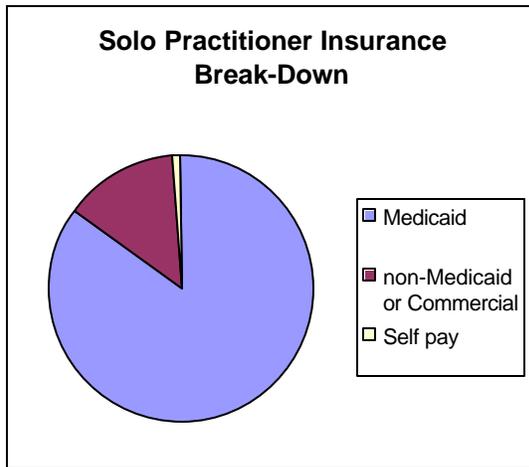
Table #2

Focus Group #	Focus Group Description/Location
1	Parents whose children received their primary care at a Mobile Clinic which traveled to their community in Southeast Washington DC
2	Parents whose children received primary care at FQHC with half the patients’ primary language being Spanish or Vietnamese
3	Parents whose children received primary care at a variety of locations but were also involved in a District sponsored MCH community group who had been educated about working within the MMCP system. Some of their children were diagnosed as having Special Health Care Needs.
4	Parents of children with special health care needs receiving primary care at Children’s Hospital.

Table #3

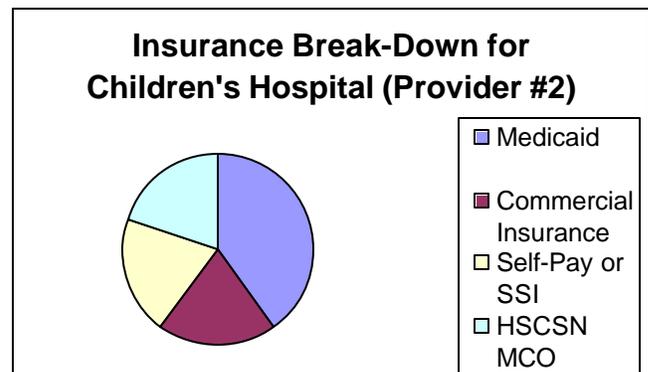
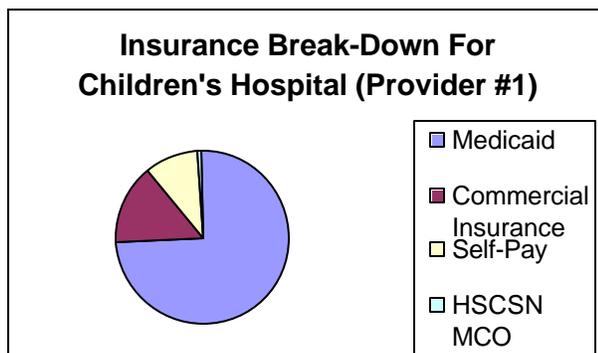
Provider #	Provider Description/ Location	Insurance Mix			
		Medicaid	Commercial (Non-Medicaid)	HSCSN	Self-Pay or Other
1	Solo Practitioner East of the River	85%	14%	—	1%
2	Provider A - FQHC	33%	—	—	66%
3	Provider B - FQHC	33%	—	—	66%
4	Provider in smaller, community health center	70%	—	5% ³²	25%
5	Provider A – Children’s Hospital	70%	15%	4%	10%
6	Provider B – Children’s Hospital	40%	20%	20%	20% ³³
7	Provider in academic medical center	20%	50%	30% ³⁴	—

**Table #3-A
Provider Estimation of Insurance Break-Down**



Major Findings From the Provider Interviews

The overall findings from the provider interviews were: (1) providers face significant obstacles when attempting to access diagnostic services for their patients; (2) providers do not necessarily all agree on problems associated with performing some of the EPSDT screens, yet, almost all agreed that documentation of services provided to Medicaid managed care enrollees, because of time constraints, was a challenge; and (3) providers recommended that the Medical Assistance Administration improve and expand



outreach in the community.

This section will report on the responses of the providers in the following areas:

- Background information on providers
- Scope and duration of EPSDT visits or encounters
- Outreach activities
- Time Frame Of EPSDT visit (compared to non-Medicaid well-child visits)
- Referral Process
- Documentation of EPSDT visits
- Payment Issues involved in providing EPSDT services
- Administrative issues pertaining to EPSDT screens
- Challenges associated with providing EPSDT screens

Background Information

We conducted interviews with providers who practiced in a variety of clinical settings as well as in diverse geographical locations throughout the city. All of these providers had some degree of patients who were either uninsured or enrolled in the

Medicaid program (See Tables 3 and 3-A.) We asked each provider how long had they been in practice and to describe the insurance mix of his/her patients.

Scope of EPSDT Encounters

Providers are responsible for carrying out EPSDT screens in accordance with the MAA Department's periodicity schedule and interperiodic screens for any child who is suspected of having a physical or mental problem.³⁵ When asked if there were any differences between the well-child visit for Medicaid versus the non-Medicaid patients, all of the providers stated that they do not differentiate in terms of patient care when they perform well-child visits. Two of the providers explained that they had to document well-child visits for Medicaid patients more extensively than for non-Medicaid patients. Next, we asked what information was discussed with parents during a well-child visit. Although all providers reported that they cover anticipatory guidance with the parents, most of the providers clarified that safety issues concerning the children were foremost in any discussion. For example, one of the providers from Children's noted:

We discuss whatever problems the child may have or find out whatever difficulties that child may be having. I always talk about lead paint, electrical outlets and whether or not anyone smokes in the household. We discuss safety issues such guns in the house and whether the child uses a car seat. We talk about what should be happening developmentally with the child before the next scheduled visit.

The provider from a smaller health center explained, "We use a targeted intake sheet for each well-child screen that we developed using the Bright Futures and the American Academy of Pediatrics Guidelines for Health Supervision. For example, at the six month visit, we discuss child-proofing the home with the parents, at the one-year visit we talk a lot about speech milestones and what parents can do to encourage speech development."

Finally, one of the providers from a large community health center stated:

After I cover all of the information with my patients, instead of telling them to make an appointment for six months or a year from now, I just tell them that their child has to come in for their next set of shots in six or twelve months. They may not remember to make an appointment before they leave, but my experience has taught me that they always remember to bring their child back in for the next set of immunizations.

Outreach Activities

Outreach is a required component of EPSDT and is required in the District's contract to assist enrollees in making and keeping EPSDT appointments.³⁶ We asked the providers if anyone in their office engages in outreach for the Medicaid MCO children. Almost all of the providers reported that they provide outreach to all of their patients without specifically targeting the Medicaid MCO enrollees. Thus, there is no way that a provider could document that they are fulfilling this requirement.

The provider from the academic health center reported that when her office is informed that an individual or family is enrolled into their MCO, someone from her office will call the home to remind the parent that the child(ren) have to come in for their initial visit within a specified time frame. If unable to contact the family by phone, the provider noted that someone would conduct outreach by travelling to the home of the recent enrollee. Six of the seven providers reported that someone calls from their office the day before the visit to remind all of the parents of the scheduled appointment. Two of the providers explained that when patients miss appointments, the office mails a missed appointment card to the family. One provider reported when a child misses an appointment, office staff calls the home to reschedule the visit.

Scheduling of EPSDT Visits

When asked how often providers perform EPSDT screens during the course of one day, three of the providers reported that they do not track the number of daily EPSDT

³⁵ District of Columbia Contract, page 22.

screens. One physician from a large community health center noted that she sees approximately twenty to thirty patients each day and, with such a patient load, she cannot focus on whether or not the well-child visit is an EPSDT screen. This provider further explained that the only time that the Medicaid status becomes an issue is if the child needs a prescription or a referral to a specialist. If the child is a Medicaid enrollee, the provider must verify the patient's insurance before writing a prescription or choosing the appropriate referral paper. Three providers estimated that between five to ten patients a day are EPSDT visits (estimating that approximately one third of the thirty patients that they see each day are Medicaid well-child visits (and thus subject to EPSDT guidelines) with the remainder being urgent or non-Medicaid visits.) The solo practitioner reported that the majority of his appointments were EPSDT visits (including follow-up screening), but he was unsure of how much of his patient mix, on a daily basis, were Medicaid beneficiaries.

We asked about the amount of time spent during an EPSDT encounter with a Medicaid child and his or her parent(s). Five of the seven providers replied that they spend the same amount of time with a Medicaid child during a well-child visit as with a non-Medicaid child. One of the seven providers qualified that many of the children that she sees in her clinic have complex health care issues, so these children have to come back to the clinic for more than one visit, often a series of visits. The academic health center provider noted:

I easily spend twice as much time with Medicaid patients because these children have complex problems. They require a lot of assistance with issues such as transportation or other social services. Many of these children come into the office with a host of health issues. Even after the children have been in the system for a while, I still spend more time with these children.

³⁶ District of Columbia Contract, page 21.

One of the providers from Children’s Hospital explained, “I don’t think the child’s health insurance status matters. What does matter is the problem that some of these children have. Some of our patients have a lot of complex social problems and even though you may not have scheduled sufficient time, in the end, you take the time to discuss what is going on with the family at that moment in time.”

We asked whether or not the providers differentiated in terms of the timing of the delivery of various components of the EPSDT benefit, such as lead screenings, comprehensive health and development histories (with follow-up lab services, if necessary), screening for mental health and/or substance abuse illness and health education services.³⁷ The providers all reported that they do the required screening at set intervals, in compliance with EPSDT standards and they do not differentiate in terms of providing these services between the Medicaid and non-Medicaid children.³⁸ In addition, all of the providers reported that they fill out the paperwork for billing and reporting at the time that they see the patient.³⁹

Referral Process

We asked if there was any difference in the way the providers handled referrals for Medicaid MCO enrollees versus the privately insured children. We also asked the providers if someone from their department intervenes when a patient is having a difficult time accessing specialty services. We received a range of responses from “no

³⁷ The District’s State Plan specifies timelines for well-child visits, immunizations, elevated lead blood level testing, anemia screens, urinalysis screens, cholesterol screens, TB screens, oral screens and STD screens. District of Columbia [State Plan] Narrative Explaining the EPSDT Screening Schedule.

³⁸ One of the providers mentioned that, in certain instances when he would prefer to send his patients to an ophthalmologist, he has to refer them to an optometrist because Medicaid will not reimburse for the former.

³⁹ The providers explained that they have a standardized form that they fill out for each visit that captures information such as what they did during the visit, whether or not the patient has to be referred to a

problems” in referring to significant barriers that slowed the process of the children accessing specialty care. The Solo Practitioner noted:

Whenever I send a patient to see a specialist, I estimate the amount of time it will take for my patient to get an appointment and any connected services. For example, if I think my patient should be able to access a specialist within one month, then I make a follow-up appointment for the patient to come back to see me in a little over one month. That is the only way to keep track of whether or not the patient saw the specialists and received the appropriate services.

The recurring challenge that providers reported in the referral process involved the barriers that providers faced when attempting to access mental health, substance abuse or Individualized Educational Program (IEP) services for their patients. One of the providers noted:

I telephoned the appropriate person from the manual provided by the MCO (in the DC public school system) but I never received a return phone call. So I kept calling and leaving messages on the answering machine but I never received a phone call back from this individual. It can be very frustrating when you think you have the correct information but individuals, for whatever reason, will not return your phone calls.

Five of the seven providers stated that they intervene (e.g., they will telephone the specialist) when their patients have a difficult time accessing a specialist. Two of the providers explained that someone on their staff intervenes if their patients have difficulty. One provider explained that because his office has a 30% no-show rate, he assumes that specialists have the same, if not a higher no-show rate. As a consequence, when his staff tries to make appointments for his patients, the specialists’ office often insists on speaking with the patient’s family before they will verify an appointment.

Documentation of EPSDT Encounters

specialist and when the patient is due for a return visit. Their administrative staff translates that form into billing and reporting information to the MCOs.

When asked to discuss documentation of EPSDT services, more than half the providers reported that documentation was a challenge. Some of the providers explained that documentation was difficult because of time constraints.⁴⁰ For example, with a non-Medicaid patient, a provider can tell the parent to take their child to the dentist but with a Medicaid patient the provider must document the fact that he had that conversation. Similarly, with non-Medicaid patients the providers can tell the parent that their child needs a hearing or a vision referral, but with a Medicaid child, this information has to be transferred to the chart and a billing ticket.

Three of the providers reported that documentation did not pose any problem in their medical practice. The solo practitioner explained that, over the years, his office staff has worked out a system under which he fills out one encounter form during a patient visit. The relevant information is then transferred to a fee ticket and then into their computer system. The MCOs have agreed to access their reporting information from the data that is entered into this providers' computer records. The two other providers reported that they follow similar procedures in that they complete one standardized form. In turn, their office staff takes whatever information they need for record keeping, reporting and billing from this form. Most providers reported that they fill out the paperwork for each visit as soon as possible after the visit is completed, and that they filled out the paperwork at set intervals.

All of the providers reported that they do not fill out specific documentation forms just for their EPSDT patients and that the forms do not necessarily capture the nature of the EPSDT service provided. Instead, they fill out standardized paperwork for all of their

⁴⁰ One provider explained that she sees thirty patients each day and often completes documentation on all of her patients during her lunch hour or after hours. While she is confident that she remembers all the major health issues, she may not chart all of the information she covered during the visit. For instance, information like the vision, hearing, height and weight documentation will get charted but information such as whether the physician remembered to talk with the parent about car seats or other safety issues will not get documented.

patients which captures information such as what they do during a visit and whether or not a patient has to be referred to a specialist. The office staff is responsible for entering that information into the computer from which data is reported to the MCOs

One of the providers explained that documentation of the EPSDT dental screens is somewhat misleading since primary care providers do not provide dental exams. When a primary care provider documents that he has performed a dental screen, he or she simply performs an oral exam and then refers his or her patient to a dentist according to specified time frames.

Payment Issues Between Providers and MCOs

When asked about payment arrangements and billing procedures, most providers reported they are not involved in the billing process and know very little about billing procedures. Two providers noted that their facilities do not bill for vaccination stock because they get their vaccine material through the Vaccines For Children program. The solo practitioner explained that he does get a small fee for administering the vaccines. He also explained that his office no longer bills for lab work, since all their lab work is referred to outside facilities. The provider from the smaller, non-profit clinic stated that the lab work is billed separately from their in-house laboratory.

Administrative Issues that Affect Delivery of Services

When asked about administrative procedures after an EPSDT encounter, five of the seven providers talked about the increase in the paperwork that is required to be filled out for each visit.⁴¹ A few of the providers specifically mentioned the fact that many of the MCOs have different referral forms (as opposed to one universal form), so when a child needs to see a specialist, the doctor first has to figure out which is the appropriate

⁴¹ The providers talked about the various referral forms that the MCOs insist must be filled out before their patients can make an appointment to see a specialist. They also talked about the documentation of services

form for his patient. In fact, the providers at Children's Hospital explained that that their hospital hired a full time staff person, part of whose job it is to keep abreast of the changing MCO forms.

One of the providers spoke about the fact that the MCOs do not necessarily lend much support in terms of managing their patients. For example, if the clinic has a patient that belongs to a Medicaid MCO and that patient misses a scheduled appointment, even though the clinic may send out a missed appointment post card, no one from the MCO or the clinic is really tracking the patients to find out why they do not show up for their visits. The provider stated that the clinics are too busy to do this kind of follow-up service.

The solo practitioner who spoke earlier about the fact that vision and hearing screening has to be referred to another provider discussed the fact that it used to be a lot easier when he could do vision and screening in his own office and keep track of all patient information in one central location. He explained that when his patients have to go to a third party for lab services or specialty screening, they may or may not follow through with getting the lab work or seeing the specialist. He also talked about how the lab may take an inordinate amount of time to report test results to his office.

We asked the providers whether or not their practice limits the number of EPSDT visits that they are scheduled to perform each day. We also wanted to know if the Medicaid patients were scheduled differently in terms of the amount of time that the providers were given to spend with their patients. All of the providers stated that their practices do not schedule patients' visits for different time frames. However, one provider explained that children who are enrolled in the HSCSN MCO⁴² are scheduled for

provided and the fact that the Medicaid MCOs require more documentation than the commercial insurers (such as writing down that the doctor spoke with the parent about taking the child to the dentist).

⁴² The District's MAA contracts with a separate MCO called Health Services for Children With Special Needs or HSCSN. This MCO enrolls children who have been diagnosed as having one or more chronic condition and therefore warrant services such as individualized case management services on an ongoing basis.

initial visits that last one hour, as opposed to the usual thirty minute for the first visit. Because these children have complex problems, their physicians will often bring the patients back in for a second visit to deal with problems that could not be addressed during the initial visit.

Challenges Associated with EPSDT Screens

The providers discussed some of the challenges associated with performing components of EPSDT screens. Almost all of the providers reported problems with attempting to complete the hearing, vision or dental components.⁴³ The solo practitioner explained that since the MCOs no longer reimburse him for performing hearing or vision screening, he now refers his Medicaid patients to other network providers who contract with the MCOs to perform these services. Three of the providers stated that they had difficulty performing the hearing component of the EPSDT screen because they do not have access to soundproof facilities in which to perform accurate tests. The providers explained that because they get many false positives in their initial hearing screens, many children have to undergo a second hearing exam. Almost half the providers reported difficulties with some part of the vision screening. For example, one provider explained that her health center does not have the equipment to check for color vision and binocularity (whether or not the eyes function together). Another provider noted that the young children (e.g., the four-year-old patients) often don't have the attention span to finish the eye exam.⁴⁴

A few providers discussed the fact that the MAA requires that dental services must be provided in accordance with their established screening schedule. However,

⁴³ The District requires that vision testing should begin at age three and oral inspection of a child's mouth should begin at age twelve months with annual referrals starting at age three. District of Columbia [State Plan] Narrative Explaining the EPSDT Screening Schedule.

these providers explained that most clinicians interpret screening to involve a dental exam of the child, when all the providers do is perform an oral inspection and refer the child to a dentist when the child receives their twelve month exam.

The solo practitioner reported that another challenge associated with performing some of the EPSDT screens is that he has to refer patients to outside providers for laboratory services. Furthermore, he explained, since he is no longer able to maintain a laboratory in his office he must contend with longer timeframes for turnaround of laboratory results.⁴⁵ This provider explained,

If you think about it for a minute, these parents, many of whom rely on public transportation, have to take time off from their job to bring their child in for an examination. These parents then have to leave here and travel to another facility to get lab work done. I would estimate that 50% of the lab work that we order for our Medicaid managed care patients never gets completed. Furthermore, many of my patients who rely on public transportation often postpone travelling to that second provider for their laboratory services.

Summary of Provider Interviews

Some of the common themes that providers discussed during their interviews were problems with attempting to access specialty care for their patients. In addition, they also discussed the time constraints under which they operate and the fact that documentation of EPSDT services was, at times, problematic.

- Providers noted that they face significant obstacles when attempting to access specialty care services for their Medicaid managed care enrollees. Such obstacles include incorrect specialty listings from the MCO or problems with attempting to make phone contact with an individual to discuss IEP problems for their patient.

⁴⁴ The District's guidelines specify that vision testing should begin at age three and if the patient is uncooperative, the child should be rescreened in six months. District of Columbia [State Plan] Narrative Explaining the EPSDT Screening Schedule.

⁴⁵ The solo practitioner used to have lab work done in his office but faced with the cost of complying with CLIA standards and the reality that many MCOs required that lab work be analyzed at an outside contracting facility, he decided it was not cost-efficient to continue to operate his own laboratory. The physician explained that in instances where the patient may have a serious, but not life-threatening condition, it may take as long as twenty-four hours to get the lab results analyzed and reported to his office.

- Providers agreed that documentation of EPSDT services often proved to be challenging and the forms do not always capture what they cover during an EPSDT visit.

Our final question for the providers was what steps would they suggest that the DC Medical Assistance Administration adopt to improve the program so more children of all ages could be enrolled in the Medicaid programs. Many of the providers' responses focused on education and outreach to the enrollees or potential enrollees:

- Focus on improving community outreach efforts;
- Ensure that easy-to-read, culturally competent material is placed in provider's offices that serve the uninsured;
- Target and educate previously ineligible low-income families regarding the expanded eligibility requirements under Medicaid;
- Recognize that many of the potential enrollees are illiterate and need additional help throughout the enrollment process;
- Target uninsured pregnant women who visit providers for pre-natal care with the goal of enrolling these women into a health plan before the child is born;
- Work with grassroots organizations to provide outreach services within their communities;
- Educate enrollees about how to access primary and specialty care services and the importance of managing health care;
- Update and distribute provider manuals on a more frequent basis; and
- Re-assess the current capitation rate paid to providers, given the complex health care needs of many of the Medicaid managed care enrollees

Major Findings From Interviews With Families

Major Findings from the family interviews included:

- Respondents reported receiving little information beforehand to assist them in the enrollment process.
- The Spanish-speaking respondents reported that they did not have access to linguistic-appropriate material, either from the enrollment broker or the MCO.

- The Spanish-speaking respondents faced significant obstacles when attempting to access specialty services for their children due to lack of adequate translation services.
- Respondents and providers face significant obstacles when attempting to secure access to both early intervention services as well as mental health services.
- Respondents indicated that informational material mailed to them by the MCO was often incorrect in terms of accurate provider listings.

While the use of focus groups generally limits our ability to make broad generalizations about the experiences of Medicaid enrollees, our findings are consistent with prior studies that recognize the value of this kind of data collection when attempting to understand the experiences of these vulnerable populations in mandatory managed care programs.⁴⁶

Enrollment Process

When asked about enrollment into the plan, seventy five percent of the respondents indicated that they had chosen their child's health plan rather than being automatically assigned to the plan by the enrollment broker. In discussing the criteria used to choose their child's MCO's the respondents indicated that continuing a pre-established relationship with their child's existing PCP, rather than assessing the different plan benefits or services, was the critical factor. Almost seventy percent of the respondents reported that they received some help in choosing their child's MCO. However, such assistance did not come from the enrollment broker. Instead, respondents talked with translators from various community clinics (where they had received care) who explained the material to them or spoke with their child's pediatrician to clarify which MCOs included their child's PCPs within their network.

⁴⁶ Chaudrey, Rosemary; Brandon, William and Schoeps, Nancy 1999. Medicaid Recipient's Experiences Under Mandatory Managed Care. *The American Journal of Managed Care*. 5:413-426. York Fraser, Pamela; Slatt, Lisa; Kowlowitz, Vicki, Kollisch, Donald; Mintzer, Melanie 1997. Focus Groups: A Useful Tool for Curriculum Evaluation. *Family Medicine*. 29: 500-507.

One of the parents who spoke only in Vietnamese explained, “If it were not for the clinic [case managers], it would have been very difficult for me or my children to see the doctors or to get services at this clinic.” She suggested that the materials should be translated in her native language and sent to her home prior to the time she had to choose a doctor or an MCO.

Slightly less than half of respondents reported that they did not receive written materials before they enrolled in the health plans. Twenty percent of respondents stated the materials that they did receive was not presented in a format that was easy to understand. Approximately ten percent of respondents noted that the material that they received was not written in their language and therefore, they had to seek out a translator to understand the materials.⁴⁷

Eighty percent of respondents reported that they had enough information to make an informed choice. However, it is noteworthy that “enough information” meant, more often than not, that these respondents looked for the MCO which including their child’s current PCP and thus made their MCO choice. Therefore, even though the majority of respondents indicated that they chose their child’s MCO, this information was not based on a comprehensive or even cursory examination of the differences between the various plans, and there was little to no assistance from the enrollment broker.

Selection of PCP and Enrollment Information

As stated above, eighty percent of respondents reported that they selected their child’s PCP because they wanted to continue with a provider who had been serving the child. One of the Hispanic-speaking parents stated:

⁴⁷ The District’s contract stipulates that that materials furnished to enrollees must be written in English and Spanish and other languages as specified by the District.. District of Columbia Contract, page 30.

I chose the health plan because I liked the benefits offered by the plan and I wanted my child to continue to be seen by the doctors at this health center.

Over sixty five percent of respondents indicated that the MCO had provided them with a list of doctors and clinics. However, twenty five percent of respondents indicated that the MCO did not provide sufficient information about network specialists. Furthermore the Spanish-speaking respondents reported that the information, both from the enrollment broker and from the MCOs, was not provided in their language. Over sixty percent of respondents reported while the provider listing was easy to use, it was not accurate (e.g., incomplete and outdated.)

When we asked the respondents if any had received any information from the MCO which explained their child's benefit package, fifty percent reported that they received information pertaining to their child's benefits from the MCO. We also asked respondents if they had encountered any problems with their child's MCO and if so, were they aware of the conflict resolution process. Sixty five percent of respondents indicated that they have had some problems with their child's MCO. Seventy five percent of the respondents indicated that they were aware of the conflict resolution process with twenty percent indicating that they had utilized the process and had a satisfactory resolution to a complaint. When we asked about the nature of the problems, responses ranged from problems with referrals, problems with being given incorrect physician information, problems with the MCO's transportation services and problems with attempting to schedule physician appointments.

Access to Primary Care Providers

We spoke with the respondents about whether or not their child had a primary care physician before joining the MCO and almost ninety percent responded in the affirmative. We wanted to know how long it took for respondents to get an appointment

for their child and whether they had any problems making appointments. Thirty three percent of the respondents reported that it took several weeks to a month to get an appointment for their child.⁴⁸ Twenty five percent of respondents stated that is was difficult to make or keep an appointment.

One of the Hispanic-speaking respondents stated:

One of the reasons that I miss an appointment is when I have to see a doctor who is not my child's regular doctor. If that person does not speak Spanish and there is no one to translate, then I have to reschedule the appointment.

Another respondent stated, "I have made regular scheduled appointment but it always takes over a month for my child to be seen. During that time, when his asthma often gets worse, I end up taking my child to the emergency room."

Approximately seventy percent of respondents indicated that access to their child's PCP was not problematic. These respondents reported that they live within thirty minutes travel time to their child's health care facility. More than twenty five percent of respondents revealed that the MCO facilitates transportation services (providing cab fare or van service.)⁴⁹ Slightly more (thirty five percent) reported that they rely on a third party (other than the MCO) to provide transportation to and from the physician's office.

We asked the respondents if they were aware of EPSDT and whether or not they receive EPSDT reminders from their doctor or their MCO. Slightly more than sixty percent of respondents indicated that they were aware of the EPSDT benefits. Slightly more than half the respondents noted that they receive EPSDT information from their MCO or their doctor and such information has proven to be helpful in accessing such services. Approximately thirty five percent of respondents (those who had been learned

⁴⁸ The District of Columbia Contract specifies that non-urgent appointments shall take place within thirty days of the request. District of Columbia Contract, page 29.

about managed care via outreach by the Office of Maternal and Child Health) stated that if it had not been for their participation in the community center, they would not have been aware of EPSDT or many of their rights under Medicaid managed care.

Access to Specialist Services

We asked respondents if they had problems getting specialty referrals for their children. Approximately twenty five percent said that they did encounter some problems with getting referrals. When asked to explain, respondents indicated that it takes a lot of time and energy to call for the referral, pick up the paperwork, call for the specialist appointment and in some cases to be vigilant about repeated phone calls if lines are busy or if they are put on hold for long periods of time or if they leave a message for a return phone call but no one calls them back.

Forty two percent of respondents reported that they have children who need regular medications. The respondents stated that it was relatively easy to get prescriptions filled for their children. Seven percent of respondents indicated that one of their children sees a provider for mental health problems. However, these respondents reported that the MCO did not assist in the process of them finding a mental health provider for their child. Moreover, the list of mental health providers that was given to the respondents by the MCO was often outdated and inaccurate.

Translation Services

We asked the non-English speaking respondents if their child's doctor speak to them in their native language and who if anyone, helps with translation services. Approximately twenty percent of respondents indicated that English was not their primary language. Of this group, forty percent stated that their child's doctor speaks their

⁴⁹ The District of Columbia's contractual provisions that clarify EPSDT requirements specifies that the MCOs shall be responsible for transportation services if requested by the child's family. District of Columbia Contract, page 23.

language, with the remaining sixty percent reporting that someone from their doctor's office performs translation services.

The Vietnamese respondent explained that lack of translation services served as a significant barrier to her obtaining specialty services outside of the clinic. The patient explained:

I very seldom miss my appointments inside the clinic because most of the time, I have translators who help me to talk to the doctors. But if I have to go outside the clinic to see another doctor, many times I have to reschedule the appointment because when I get to the other doctor's office, there is no translator available.

This respondent further explained that, in some cases, she has been told that telephone translator services would be available at the specialists' office but when she arrived for her appointment, she found that no translation services were available. The lack of adequate translation services has served as a great disincentive for this patient to travel outside of the clinic to attempt to access specialty care.

Children With Special Health Care Needs

We asked the respondents if their children had any serious medical problems that require specialty care and if so, had their child seen a specialist since joining the MCO. Approximately forty six percent of the respondents stated that their child has serious health problems ranging from learning disabilities, asthma, sickle cell anemia, lead poisoning complications, and mental health problems. Approximately thirty three percent of respondents who had children with serious health problems reported that they had problems accessing specialty services. The respondents all agreed that the process of attempting to schedule a specialist appointment was difficult and time consuming, requiring respondents to obtain phone contacts and to follow up with providers to verify their child's appointment. Two respondents from Children's Hospital indicated that they had to "walk a referral through the system" in order to ensure that their child actually was

scheduled for a visit (as opposed to calling from home and having to deal with phone prompts, busy signals or being put on hold for long periods of time.) The respondents discussed a variety of barriers such as difficulties obtaining referrals from their PCPs, problems with the MCOs transportation services, challenges with scheduling the specialty care appointments, and problems with misinformation pertaining to which specialists were participating network physicians.

The MCOs are responsible for coordinating with the District's Individualized Education Plan (IEP) in order to develop a plan a care for children with developmental disabilities.⁵⁰ A respondent with a learning-disabled child explained what happened when she tried to access IEP services for her son:

I tried, along with my child's doctor, to contact a number of people in the school system to get my child early intervention services and was not successful. Then I contacted a legal aid lawyer and we went to court. My child is now getting the services that he needs.

Of the parents who reported that their children need regular medication (forty two percent), most of the parents agreed that it was somewhat difficult to get prescriptions filled. One parent stated:

I had to pay up-front to get an expensive prescription filled for my child and I was not reimbursed for months and the MCO kept coming up with different excuses for why I was not being reimbursed for this initial expense.

Fifty percent of respondents reported that either their child's doctor or the MCO written materials gave them information on health care access during an urgent or emergency situation. One parent spoke about trying to get her son admitted through an emergency room without calling for preauthorization:

One evening when my asthmatic son had a serious attack, I took him to the emergency room without calling his doctor beforehand. The emergency room doctor kept telling me that my son was O.K. and that I should take him home. After staying in that emergency room for over four

⁵⁰ District of Columbia Contract, page 26.

hours and refusing to listen to the doctor's advice that my son was, "just fine", the staff finally agreed to admit my son. My son is a severe asthmatic and no one wanted to listen to me – all they wanted me to do was to take him home.

Summary of Parent Focus Groups

There were a number of recurring themes with all of the families who participated in the focus groups. Most of the families did not receive information beforehand to facilitate their enrollment process. Of the families who did receive the information, the Spanish-speaking families did not receive culturally competent material either before or after enrollment in the MCO. Some of the families noted that the information that they received from the MCOs was not necessarily accurate in terms of participating providers.

In addition, Spanish-speaking families relied heavily on their PCPs to facilitate accessing specialty providers. In cases where the enrollees had to go outside of the clinic for access to a specialist, lack of adequate translation services was the defining factor in determining whether or not the patient could receive the needed service. Both patients and providers spoke about the difficulty in attempting to access mental health or IEP services for the children. Some of the common themes that emerged from the interviews with the families were as follows:

- The non-English speaking parents reported lack of adequate translation services often served as a barrier to accessing health care services
- The parents reported that few received information before the enrollment to assist in the process of choosing a health plan or a PCP
- The non-English speaking parents reported that they faced significant obstacles when attempting to access specialty services for themselves or their children due to lack of adequate translation services
- Families reported that they faced significant obstacles when attempting to access both early intervention and mental health services for their children.
- Parents more often than not expressed satisfaction with their MCO if they were satisfied with their child's PCP

Overall Findings and Recommended Measures to Access Quality of Care for Enrolled Children in Medicaid Managed Care

Although the majority of the respondents who we interviewed reported that they were satisfied with their child's managed care organization, this satisfaction appeared to be a function of their relationship with their child's PCP. When we look more closely at some of the comments provided by the parents as well as the providers, it is obvious that the potential or current enrollees should be receiving information to facilitate decision-making to various points once the individual or families become Medicaid-eligible and will be enrolled in an MCO. For instance, even though more than half the enrollees received information about the enrollment process, it needs to be understandable and translated into the parent's primary language if such information is to be useful.

Furthermore, enabling services such as translation services which are provided for in the MCO contract have to be offered consistently to ensure consistent and comprehensive care for non-English speaking individuals. The case of the Vietnamese patient who spoke of the fact that she often had problems accessing specialty care outside of the clinic because of translation services should serve as an indication of a system that is functioning at some moments while at other equally critical moments appears not to function at all.

Finally, the measures that we would recommend be utilized to assess whether or not children are receiving services in a timely fashion include.⁵¹

- As part of the enrollment process, are families receiving materials in a timely fashion to facilitate choosing a managed care organization?

⁵¹ Please see the National Health Law Program Website for further EPSDT information and analysis www.healthlaw.org/children.shtml#EPSDT. See also the Families USA Medicaid Clearinghouse website, citing a GAO report, Medicaid Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, www.familiesusa.org/html/medicaid/medicaid.htm.

- Is the enrollment material which is mailed to the families easy to understand and culturally competent?
- Once enrolled, are plan materials concerning health care treatment and other administrative information easy to understand and culturally competent?
- Do the non-English speaking families have access to translation services on a consistent basis?
- How does the MCO perform in terms of enrollees' overutilization and underutilization of specialty care and emergency and urgent services?

Conclusions and Implications

In conclusion, the suggestions provided to us by the providers and Medicaid beneficiaries who experience the challenges of Medicaid managed care on a daily basis can help place a number of issues in a policy context. For example, parents of the children suggested that information, both pre-enrollment material from the enrollment broker and the material sent from the MCO be printed in easy to understand language and in a language that is understood by the non-English speaking enrollees. There also seems to be a host of problems surrounding the issue of accessing specialty care. Recommendations would include further education from the MCOs to enrollees about the process of accessing a specialist. However, the MCOs could help to make the system more user-friendly by ensuring that information provided to enrollees and PCPs in terms of provider networks is accurate and timely.

Some of the providers suggested that the MCOs do a better job of outreach in the community in terms of educating uninsured individuals about the Medicaid and SCHIP programs. If the results from our NPCC survey addressed above are indicative of the misinformation that many uninsured residents still believe to be true, (e.g., that there are work requirements and time limits attached to enrollment in Medicaid), then outreach should be a high priority for the MAA.

Finally, as the MAA seeks to enroll more of the District's uninsured population into Medicaid and SCHIP, it is important to remember that enrollment alone should not be the end goal. For if enrollment into mandatory managed care simply leads to another set of hurdles for patients, as well as their providers, then the District may well miss its goal of attempting to improve health outcomes for the District while providing a wide range of services to these enrollees.

