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PRELIMINARY THOUGHTS ON RESTRUCTURING MEDICAID TO PROMOTE ADOLESCENT HEALTH

Adolescents are an underserved population in Medicaid. Their EPSDT screening rates are low and states' preventive care requirements for them are weak. Payment policies discourage preventive counseling and the delivery of integrated physical and behavioral care in primary care sites. This issue brief proposes an enhanced set of health promotion and primary care benefits designed specifically for adolescents that can be offered through EPSDT or as an alternative benefit package under the Deficit Reduction Act. It also suggests possible changes to payment policies to support comprehensive preventive and primary care service delivery for adolescents.

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THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH

Medicaid is now insuring approximately one out of every 5, or 7.2 million, adolescents ages 12 through 20 in the United States,[1] and that proportion is likely to continue to increase in the coming decades. Yet, state Medicaid programs have not fully addressed the unique health care needs of the adolescent population. Although adolescents are generally thought to be a healthy age group, their rates of morbidity and mortality are actually twice those of younger children. Moreover, many of their health conditions have lifelong consequences but can be prevented if identified and treated early.

Adolescents in low-income families are an especially vulnerable population. Compared to adolescents in higher income families, those in families with incomes at or below 100% of poverty have higher rates of physical and mental health problems as well as higher rates of mortality. They are more likely to be in fair or poor health;[2,3] suffer from chronic physical conditions,[4] such as diabetes[5] and asthma;[6] have developmental delays;[7] have had behavioral or emotional problems;[8,9] and have health conditions that result in disability.[10,11] Poverty status is also associated with diminished adult supervision, fewer school and community opportunities, and much greater exposure to violence at home and in their neighborhoods -- contextual factors linked to victimization, risk-taking behaviors, and poor health.[12,13] Rates of physical and sexual abuse, for example, are much higher among poor adolescents, as are violent injuries.[14] Poor adolescents are more likely to be overweight and less likely to participate in regular physical exercise.[15,16,17] They also have higher rates of early sexual activity, sexually transmitted infections (STDs), pregnancy,[18,19] and illegal drug use.[20]

Effective primary and preventive care for all adolescents, but particularly those who are poor, needs to offer intensive health promotion and risk reduction interventions and to integrate, to the extent possible, physical, behavioral, and reproductive health care in a respectful and supportive environment. This is an approach that recognizes that normal development for an adolescent involves major changes in physical maturity and sexuality, emotional feelings, relationships, and cognitive processes. It also recognizes the complexity of adolescent health needs in the context of various biological, familial, and environmental factors that affect their well-being and takes into account the complicated inter-relatedness of developmental changes and behavioral, reproductive, and physical conditions. In addition, it acknowledges the reticence of adolescents to seek care and their need for teen-friendly settings that engage them in their own care and the

care of their peers, at the same time involving parents and recognizing that they have an essential role in supporting their adolescents' healthy transition to adulthood.

An integrated model of adolescent health care focused on health promotion and risk reduction is consistent with the "medical home" concept, widely promoted by the American Academy of Pediatrics (AAP)[21] and other medical organizations.[22] Conceived as a model for improving the care of children and adults with chronic conditions, the medical home concept has not yet been applied to the redesign of practice patterns to meet the unique health care needs of adolescents. Nevertheless, many of the models' components -- an emphasis on team approaches, ongoing care management and monitoring, efficient use of the physician's time, and patient-focused interventions appropriate to the patient's level of need -- are essential to improving preventive and primary care for adolescents.

Medicaid Mismatched to Adolescent Needs

Although it is clear that major reforms are needed in the training of physicians and other health professionals to ensure high quality interdisciplinary care for adolescents,[23] it is also true that Medicaid is not structured to support this care. Benefits are theoretically available. EPSDT requires states to provide all eligible children and adolescents up to age 21[24] with periodic screening services to detect physical or mental health problems and to furnish them with all federally allowable services determined to be medically necessary as a result of a screen. However, most states interpret the EDSDT mandate primarily as a screening requirement. Even so, only 33 states have policies consistent with the AAP's standard, which calls for annual preventive care for adolescents ages 10 to 21.[25] In addition, state-reported data from 2003 reveal a national EPSDT screening rate for adolescents of 46% -- this despite the fact that a number of states contracting with managed care organizations (MCOs) presume a 100% screening rate and report that figure to CMS.[26] HEDIS® data from Medicaid managed care plans in 2005 show an average preventive care visit rate for adolescents of only 39%.[27]

Requirements regarding the content of screening services for adolescents are also weak. An analysis of EPSDT screening requirements for 11 conditions and behaviors, including hypertension, abuse, alcohol use, contraception use, depression, eating disorders, obesity, risky sexual practices, school problems, substance use, and tobacco use, found that the largest proportion of states (40%) required screening for hypertension, but 35% or less required screening for the remaining conditions.[28] Similarly, state requirements regarding anticipatory

guidance fail to reference topics critical to adolescent health and development. In fact, only 50% require anticipatory guidance on nutrition, and less than 40% require guidance on substance abuse.[29]

Moreover, state Medicaid payment policies do not support the delivery of integrated physical, behavioral, and reproductive health services that emphasize health promotion and risk reduction. The time needed to talk with adolescents, screen them for high-risk behaviors, and provide age-appropriate health education services in a comprehensive visit is simply not reimbursed, either under fee-for-service or capitated arrangements. There are 2 billing options available for more extensive counseling, guidance, or education services furnished during the EPSDT preventive visit. Yet, neither is commonly allowed by state Medicaid agencies and neither is well aligned to adolescents' needs. The first option is to bill for individual preventive medicine or risk reduction counseling to address issues such as family problems, substance abuse, sexual practices, injury prevention, and diet and exercise, provided that the adolescent has no manifest symptoms or established illness. About half of the states allow physicians to bill for preventive counseling -- on their own behalf or on behalf of the nurses, social workers, or psychologists they may supervise -- but in virtually all cases the service cannot be furnished on the same day as the preventive care visit, requiring adolescents to make a follow-up appointment and return on another day. Even when allowed, reimbursement rates for preventive medicine counseling in many of these states are inadequate, as low as $10 in Texas, for example.[30] The one state that pays providers separately for preventive counseling services in conjunction with the well-child visit is Mississippi.[31]

The second option, billing for an evaluation and management sick visit with a same-day modifier, would allow for the provision of additional health education and counseling at the preventive visit. Physicians could address presenting health problems that may indicate or exacerbate an acute or chronic condition, such as ADHD, asthma, or overweight, and that require education and counseling. This modifier option appears to be rarely reimbursed, however. Eighteen states expressly deny reimbursement for the modifier. Only 7 states expressly accept it[32] and, while other states may do so in practice, acceptance does not usually translate into actual payment.

Should a sexually active female adolescent require a pelvic exam as part of a comprehensive preventive visit, primary care providers who are capable of and interested in providing pelvic exams would rarely be compensated for their additional time. Consistent with pediatric guidelines, the majority of states require that preventive visits include pelvic exams for sexually active female

adolescents. Yet, except for lab tests, no state pays primary care providers separately for this component of the preventive visit or directs their MCOs to do so.[33] In large part because of this financial disincentive -- but because of confidentiality concerns as well[34] -- adolescents seen in office-based practices, which are the usual source of care for almost two-thirds of adolescents covered by Medicaid,[35] are often referred to another health care site to receive reproductive health services that include pelvic exams.[36] Adolescents may be referred to family planning clinics**,** community health centers (CHCs), hospital-based adolescent clinics, or gynecologists in private practice. In many cases, these adolescents are unable to schedule appointments and follow through on referrals.[37]

Should an adolescent need to receive periodic counseling for behavioral risk management or short-term counseling for emerging mental health problems related to issues such as stress, learning differences, physical or sexual abuse, or conflicts with friends or family, states generally provide no mechanism for payment. To be reimbursed, a mental health service typically must meet the criteria of a DSM-IV diagnosis. V codes (for symptoms) are seldom accepted, making coverage for counseling services furnished by a clinical social worker or psychologist or even a pediatrician or adolescent medicine specialist extremely difficult in any primary care site, be it a hospital-based clinic, CHC, or physician's office.

Moreover, since just over half of state Medicaid agencies assign responsibility for behavioral health to a separate capitated plan or another state agency, mental health staff in comprehensive primary care sites generally cannot be compensated for interventions pertaining to diagnosed mental health disorders.[38] Virtually all hospitals or community-based health clinics have clinical social workers and psychologists on staff and psychiatrists available at least part-time. Increasingly primary care practices are making arrangements to have a mental health professional available part-time as well. Yet, these professionals usually are not participating in behavioral health plans or state mental health agency networks, and again, adolescents are usually referred to another site for care, without follow-up or care coordination.[39] Even when states do not create a bifurcated health care system, general managed care plans are likely to subcontract mental and substance abuse treatment services to separate behavioral health plans.

Financing issues also pose barriers to effective adolescent health care in CHCs and hospital outpatient settings. Federally qualified CHCs, which are paid on an encounter basis, irrespective of MCO network participation, receive adequate reimbursement for each intervention[40] but generally are unable to bill for more than one intervention on a given day. Adolescent hospital outpatient clinics, which are paid an encounter rate that includes a facility and provider

component, can usually bill for more than one service on the same day**,** provided that the services are furnished by different providers and are not presumed to be part of a comprehensive EPSDT preventive visit. In general, the billing code and V-code diagnostic restrictions that apply to physicians and other health professionals also apply in hospital outpatient settings**.** In addition, hospital outpatient clinics may participate in MCO networks, where they could be subject to capitation limits. They may also operate independently of MCO networks in communities where a high proportion of adolescents may be mandatorily enrolled.

Low-income adolescents, for a variety of reasons, are often left to seek care on their own and find it difficult to navigate the fragmented service system confronting them with few health professionals available to help. Providers report, however, that inadequate payment and health plan expectations to meet daily patient quotas make it difficult to spend sufficient time with adolescents and to furnish care coordination.[41] Not surprisingly, surveys of adolescents enrolled in Medicaid MCOs show that when adolescents come in for care, their providers do not take the opportunity to screen and counsel them on key issues affecting their health, despite the fact that adolescents say they trust doctors, often more than teachers or their parents. As many as 44% of these adolescents say they did not talk with their primary care providers about risky behaviors; 43% did not talk about sex, birth control, and STDs; 41% did not talk about emotional problems; and 36% did not talk about weight, diet, and exercise.[42]

Involving families in the care of adolescents, while respecting the adolescent's right to confidentiality, is crucial to successful health promotion and healthy development. Yet, families are often ignored in care delivery. Anticipatory guidance is required to be part of an EPSDT preventive visit to help families understand adolescent development and what to expect in terms of changes and growth. State provider requirements governing the content of anticipatory guidance, however, usually focus on the development of young children and not adolescents. Moreover, we found that only Minnesota pays providers separately for family education and counseling for child development.[43]

Medicaid Benefit and Financing Opportunities

State Medicaid agencies have a vital role to play in supporting a more effective and responsive service delivery system for low income adolescents, one that provides holistic care, encompassing physical and behavioral health and promoting health and development even in the absence of disease. Certainly, many systemic changes related to medical education and

physician practice arrangements are needed. However, state Medicaid agencies can make an important contribution to the advancement of adolescent health and well-being by articulating a more effective set of adolescent health benefits, paying appropriately for improved models of adolescent primary and preventive care, and establishing new standards of quality and safety to better meet their needs.

A first step for states is to define the appropriate primary care and health promotion benefits that need to be in place for adolescents. These would include preventive, physical health, and behavioral health services available in teen-friendly hospital-based adolescent clinics, CHCs, and other comprehensive primary care sites whose staff include clinical psychologists and social workers, health educators, and nurse practitioners. We offer a proposal for an enhanced health promotion and primary care benefit package for adolescents. It consists of two core sets of services -- screening and health promotion services and primary care services **--** some of which are not currently paid for but all of which are federally reimbursable.

Enhanced Screening and Health Promotion Benefits

- STD screening for sexually active adolescents and, as necessary, pelvic exams and Pap smears
- Identification and assessment of behavioral, and reproductive health problems or disorders
- Identification and assessment of behavioral risk factors and strengths
- Health education and health promotion, including peer health education
- Behavioral health and disease prevention counseling
- Family health education and support on adolescent development

Enhanced Primary Care Benefits

- Comprehensive mental, emotional, and behavioral health evaluation (if psychiatrist is part of interdisciplinary team)
- Neuropsychological testing and evaluation
- Counseling for emerging mental health issues
- Individual, group, and family psychotherapy
- Reproductive health care, including birth control and treatment for STDs and menstrual irregularities
- Nutrition counseling for obesity and diabetes
- Interdisciplinary team management
- Care management support, including telephone and email communications

- Consultation with medical and health care specialists
- Collateral contacts and coordination with school and community agencies

States could include these benefits in a revised EPSDT benefit for adolescents that would respond more directly to Congressional intent to promote healthy development. These benefits would be furnished by appropriately qualified providers. A revised EPSDT benefit would enable states to offer these benefits to all adolescents statewide without requiring prior authorization, which would make EPSDT less difficult to administer -- a complaint often heard from Medicaid directors.[44] In addition, it would herald a welcome revitalization of a program whose regulations were written more than 30 years ago.

Alternatively, states might want to offer these enhanced primary care and health promotion benefits in particular counties where needs are greatest and providers of comprehensive, integrated primary and preventive care are most available, in which case they could use the flexibility in the Deficit Reduction Act of 2005 (DRA) to develop an alternative set of benefits for adolescents. The DRA gives states the option not only to limit the geographic scope of benefits but also to tailor benefits to a particular population. These benefits, which could be offered on an optional basis, could be designed to meet the needs of adolescents without complex physical or mental health conditions. They would include, in addition to the enhanced primary care and health promotion benefits, dental services, vision and audiology services, short-term ancillary therapies, medical specialty services, inpatient hospital services (including alcohol and drug detoxification services), inpatient psychiatric services, and maternity care and teen parenting services. At the same time, they could exclude certain long term care and intensive community-based mental health services, which adolescents would have access to as EPSDT wrap- around benefits. Provider qualification standards would be established and perhaps even a specialized MCO for adolescents would be formed to offer the alternative benefits.

In addition to defining appropriate benefits, state Medicaid agencies would need to make changes in payment policies under both fee-for-service and managed care systems. States should consider:

- allowing reimbursement for health promotion and risk reduction counseling;
- allowing primary care providers to bill separately for pelvic exams provided to sexually active adolescents during the EPSDT preventive care visit;
- accepting V codes as diagnoses made by qualified health professionals offering short-term counseling to at-risk adolescents;
- assuring that licensed clinical psychologists and social workers in primary care settings are able to receive payment for the therapy services they furnish;

- allowing same-day billing for primary care providers, and clinics that provide interdisciplinary care to adolescents;
- assuring confidentiality of sensitive services to adolescents by directing their MCOs to discontinue mailing home explanation of benefits notices; and
- establishing bonus payments or other enhanced payment arrangements for comprehensive primary care sites that offer at least some interdisciplinary care to adolescents (and meet state standards for teen-friendly care).

Mounting evidence suggests that current Medicaid policies do not adequately support the type and amount of primary and preventive care that adolescents require. To establish a publicly financed system of care that supports adolescents in maintaining their health, limiting their exposure to risk, and successfully assuming more responsibility for their care will require more than adding screening requirements to EPSDT. It will take a fundamental re-examination of the design of and payment for Medicaid's preventive and primary care policies. It also will require major changes in the way that health professionals are trained and physical and behavioral health care services are organized. Unless the adequacy of Medicaid benefit and payment policies is assured, however, infrastructure improvements are unlikely to occur.

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Endnotes

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[23] Incenter Strategies is currently conducting a study of the financial and organizational issues to be addressed in order to improve pediatric residency training in adolescent health and to expand the number of adolescent medicine fellows. This study is being carried out with a team of experts in graduate medical education and will involve surveys of directors of pediatric residency and adolescent medicine programs.
[24] The EPSDT benefit is available for all Medicaid-eligible adolescents up to age 21 even though not all states cover 19- and 20-year olds as children. States are all required to cover adolescents up to age 19 with family incomes at or below 100% of poverty and those receiving SSI payments up to age 18 or up to age 22 if they are full-time students. Low income 19- and 20-year olds who are themselves parents could also be eligible for Medicaid, and therefore EPSDT, through the section 1931 pathway that requires states to cover low income parents in families with dependent children who meet the AFDC income and resource standards in effect as of July 1996. Pregnant 19- and 20-year olds would also be eligible for Medicaid because of the federal requirement to cover pregnant women with incomes at or below 133% of poverty. States may also choose to cover 19 and 20 year olds under the Ribicoff option, which allows states to extend eligibility to all adolescents up to age 20 or 21 who meet their AFDC income and resource standards in effect in July 1996. In addition, the Chafee Foster Care Independence Program gives states the option to extend Medicaid eligibility to adolescents formerly in the federally subsidized foster care system up to age 21. For more information on these and other eligibility options, please see Fox HB, Limb SJ. *States' Use of Medicaid Options for Expanding Children's Medicaid Eligibility*. Washington, DC: Maternal and Child Health Policy Research Center, 2005. Available at www.mchpolicy.org.
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[27] National Committee on Quality Assurance. *Medicaid HEDIS 2005 Means, Percentiles, and Ratios*. Available at www.ncqa.org/programs/HEDIS/Audit/2005MPR/Medicaid.htm. Accessed December 2006. Preventive visit rates for commercially insured adolescents are similar (38%).
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[29] Incenter Strategies' analysis of 2006 physician and EPSDT provider manuals for requirements governing nutrition, sexuality, family planning, substance abuse, tobacco use, relationships, and violence.
[30] Incenter Strategies' analysis of current Medicaid reimbursement amounts for billing code 99402, preventive medicine counseling for an individual for 30 minutes.
[31] Psychologists, social workers, and nurses are generally unable to bill on their own for individual health education services. Only 3 states, for example, permit billing for nonmedical family planning education services, and only 2 permit billing for behavioral health prevention education. Incenter Strategies' analysis of current Medicaid reimbursement policies for 2 HCPCS billing codes related to health education: H1010, nonmedical family planning education and H0025, behavioral health prevention education.
[32] Incenter Strategies' analysis of state Medicaid agencies' reimbursement of the -25 modifier to allow providers to bill for an EPSDT preventive visit and a sick visit on the same day.
[33] Incenter Strategies' analysis of physician and EPSDT provider manuals and MCO contracts.
[34] Confidentiality is compromised by the MCO practice of mailing home explanation of benefit notices (EOBs).
[35] Fox HB, McManus MA, Zarit M, Fairbrother G, Cassedy AE, Bethell CD, and Read D. *Racial and Ethnic Disparities in Adolescent Health and Access to Care*. Washington, DC: Incenter Strategies, January 2007.
[36] Only 43% of pediatric practices, for example, are reported by their office managers to make pelvic exams available to adolescent patients. Akinbami LJ, Gandhi H, and Cheng TL. Availability of adolescent health services and confidentiality in primary care practices. *Pediatrics*. 2003; 111:394-401.
[37] McManus MA, Shejavali KL, Fox HB. *Is the Health Care System Working for Adolescents? Perspectives from Providers in Boston, Denver, Houston, and San Francisco.* Washington, DC: Maternal and Child Health Policy Research Center, 2003.
[38] Incenter Strategies' analysis of 2006 state Medicaid carve-out policies.
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[40] States are required to reimburse FQHCs the difference between the MCO reimbursement rate and the encounter amount the FQHC would have received if it were in the state fee-for-service system.
[41] McManus MA et al, 2003.
[42] The Child and Adolescent Health Measurement Initiative. Special tabulations prepared by Christina Bethell of the Oregon Health and Science University from the Young Adult Health Care Survey Medicaid Benchmarking Database, 1999-2002, December 2006.
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The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

For more information about our work and available publications, contact Corinne Dreskin at The National Alliance to Advance Adolescent Health: cdreskin@TheNationalAlliance.org. Also visit our website: www.TheNationalAlliance.org.

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