OPTIONAL PURCHASING SPECIFICATIONS FOR SERVICES RELATED TO EPILEPSY

A TECHNICAL ASSISTANCE DOCUMENT

June 2002

This document sets forth illustrative language for the purchase of epilepsy-related services from managed care organizations (MCOs) by state agencies administering Medicaid, other state agencies, and other managed care purchasers. It has been prepared by the George Washington University Center for Health Services Research and Policy in conjunction with officials from the Centers for Disease Control and Prevention (CDC) who provided expertise, direction, and financial support for its development.

These optional purchasing specifications were drafted with guidance from experts in the medical specialties of epileptology, neurology, and primary care, health care services/delivery specialists, and patient advocates. Policy makers, managed care officials, and state Medicaid agency representatives reviewed them. They are recommended for consideration because they reflect good practice in the opinion of experts. The specifications do not reflect a formal legal policy or part of a formal practice guideline.

These optional purchasing specifications set forth a broad menu of draft provisions relating to the medical management of epilepsy. This language may be incorporated into purchasing agreements in any of several types of formats, including contracts, requests for proposals (RFPs), requests for information (RFIs), and general service agreements.

The contents of this document are optional for state policymakers. This document should be viewed as a tool to assist managed care purchasers to identify key epilepsy-related issues as they negotiate and draft their purchasing agreements with MCOs.

This document is not designed to stand alone. Instead, it is designed to be incorporated, in whole or in part, into more comprehensive purchasing agreements. Thus, this document only contains illustrative language relating to the definition and delivery of epilepsy-related services. It does not contain language relating to issues such as payment, resolution of disputes between the state or other purchasers and the MCO, remedies, termination, and other elements that would be essential to any purchasing agreement.
This document is organized into two Parts. The first Part contains illustrative language defining an epilepsy services benefit. The second Part contains illustrative language articulating general MCO duties relating to the delivery of the epilepsy services benefit set forth in the first Part. Taken together, these two Parts reflect a consistent set of policies that are organized to facilitate negotiation and drafting of purchasing agreements. However, the individual elements are designed to be portable so that they can be used independently of the rest of the language. Italic insertions in certain provisions identify provisions where a drafter may wish to insert relevant state laws. Explanatory Commentaries are provided as footnotes to aid in understanding and interpretation.

Unless otherwise noted, all specifications in this document related to medical management services and their delivery are based in whole or in part on the best judgment and opinions of persons knowledgeable in the treatment of epilepsy, general health care practice, health care delivery, and health services organization and management. Of particular note is the specification that enrollees should be reevaluated if they do not experience an outcome free of seizures and side effects within a period of three months. This provision underlines the fact that epilepsy is a chronic disorder that needs to be managed on a continuing basis. As indicated above, these optional specifications do not reflect a formal legal policy or part of a formal practice guideline but are recommended for consideration because they reflect good practice in the opinion of experts.

These specifications, which are part of the Purchasing Specifications Series, may be downloaded from www.gwhealthpolicy.org or may be obtained in diskette form from:

Center for Health Services Research and Policy
Department of Health Policy
School of Public Health and Health Services
The George Washington University Medical Center
2021 K Street N.W. #800
Washington, D.C. 20006
Population-Based Specifications

Adults with Behavioral Health Needs (December 2001)
Child Welfare (December 2001)
Children with Behavioral Health Needs (October 2000)
Children with Special Health Care Needs (August 2000)
Pediatric Services (Medicaid) (November 1999)
Pediatric Services (SCHIP) (April 2002)
Individuals Who Are Homeless (June 2000)

Service-Related Specifications

Child Development Services (August 2000)
Immunizations (May 1998)
Pediatric Dental Care (March 2000)
Pharmaceuticals and Pharmaceutical Services (December 2001)
Prevention of Lead Poisoning (November 1998)
Reproductive Health (May 2000)
School-based Health Center Services (January 2002)
Smoking Cessation

Public Health Conditions Specifications

Asthma
Diabetes (July 2000)
Epilepsy (June 2002)
HIV/AIDS (August 1999)
Sexually Transmitted Diseases (November 1999)
Tuberculosis (August 1999)

Specifications for Programmatic Issues

Access to Services (July 2000)
Cultural Competence (Updated, November 2001)

Data and Information
Memoranda of Understanding between MCOs and Public Health Agencies

Integrated Specifications

User's Guide Relating to Behavioral Health (December 2001)
User's Guide Relating to Pediatrics
User's Guide Relating to Public Health Conditions and Services
PART 1. EPILEPSY-RELATED SERVICE BENEFITS

§101. In General -- describes the general duties of Contractors under this Part to cover and furnish care relating to epilepsy.

§102. Scope of Benefit -- describes in broad terms the scope of what will be considered benefits related to epilepsy.

§103. Medical Management Services -- describes the elements of medical management of epilepsy, including classes of covered services.

§104. Non-Medical Support Services -- describes the elements of non-medical support services for epilepsy.

§105. Diagnostic Procedures and Laboratory Services -- describes covered laboratory services and other diagnostic procedures.

§106. Pharmaceuticals and Therapeutic Devices and Supplies -- describes coverage of pharmaceuticals and therapeutic devices and supplies.

§107. Guidelines and References -- identifies the guidelines and references that apply under this Part to the medical management of epilepsy.

§108. Coverage Determinations -- sets forth specifications regarding the manner in which coverage determinations are made under this Part.

§109. Definitions -- sets forth definitions used in Parts 1 and 2.
PART 2. EPILEPSY-RELATED SERVICE DELIVERY  
AND HEALTH CARE QUALITY

§201. Enrollee Access to Health Care Providers -- sets forth specifications regarding enrollee access to health care providers for epilepsy-related services.

§202. Enrollment and Disenrollment -- sets forth specifications regarding the enrollment and disenrollment of individuals with epilepsy.

§203. Provider Network Requirements -- sets forth specifications relating to the composition of provider networks for the medical management of epilepsy.

§204. Memorandum of Understanding -- [Reserved]

§205. Quality Measurement and Improvement -- sets forth specifications regarding quality measurement and improvement activities related to epilepsy.

§206. Data Collection and Reporting -- sets forth specifications regarding data to be collected and reported.

§207. Information for Enrollees -- sets forth specifications regarding information to be provided to enrollees.
PART 1. EPILEPSY-RELATED SERVICE BENEFITS

§101. In General

(a) Contractor Duties -- Contractor shall, for each enrollee, cover and furnish, or arrange for the furnishing of, epilepsy-related services enumerated in §§102 and 103 in accordance with:

(1) guidelines and references enumerated in §107; and

(2) coverage determination standards and procedures enumerated in §108.

§102. Scope of Benefit

(a) Epilepsy-related Services -- Epilepsy-related services are:

(1) services relating to medical management of epilepsy enumerated in §103;

(2) services relating to the non-medical support services enumerated in §104;

(3) services relating to laboratory services and other diagnostic procedures enumerated in §105; and

(4) services relating to pharmaceuticals and therapeutic devices and supplies enumerated in §106.

§103. Medical Management Services

(a) Medical Management Services -- Services for the medical management (diagnosis and treatment) of enrollees at risk for epilepsy or epilepsy-related medical complications are the following items and services delivered in accordance with subsection (b):
(1) neuropsychological assessments when indicated,\textsuperscript{1} 

(2) laboratory tests enumerated in §105(a); 

(3) pharmaceuticals and therapeutic devices and supplies enumerated in §106(a); and 

(4) in the case of an enrollee in whom epilepsy is diagnosed, epilepsy management services shall include: 

   (A) an individualized assessment of the enrollee for purposes of developing a plan of assistance; 

   (B) a plan of assistance based on the assessment; 

   (C) coordination of epilepsy-related services that are prescribed for the enrollee and covered under this Part; and 

   (D) assistance to the enrollee in gaining access to prescribed services and in adherence to self-management recommendations. 

(b) Delivery of Medical Management Services -- In delivering the medical management services covered under this Section, Contractor shall ensure that: 

(1) an initial or preliminary diagnosis of epilepsy made by a family physician, pediatrician, emergency department physician, internist, urgent care center, or other health care provider is made in accordance with applicable guidelines and references outlined in §107 and is confirmed by a neurologist\textsuperscript{2}, and in the case of any exceptions to this provision, such exceptions must be documented with a justification for such exception; and 

(2) the confirming diagnosis includes: 


\textsuperscript{2} Commentary: Exceptions to the need for a neurologist’s confirmation of a diagnosis of epilepsy may be justified when the primary care pediatrician, family practitioner, or internist has extensive training and experience diagnosing and treating epilepsy and when the condition is uncomplicated and responds fully to initial treatment.
(A) seizure type; and

(B) epilepsy syndrome when possible;

(3) in the event a general neurologist can neither confirm nor exclude a diagnosis of epilepsy, the neurologist may refer the enrollee to a neurologist specializing in epilepsy or to a level three or level four epilepsy center;

(4) for every enrollee with a diagnosis of epilepsy, the physician confirming the diagnosis develops a detailed treatment plan that is implemented at the most primary level of care that is appropriate, including co-management or principal care by a specialist where appropriate;

(5) for every enrollee with a diagnosis of epilepsy, the physician confirming the diagnosis may refer the patient for medical or surgical treatment when the patient has not responded to treatment in a timely manner (e.g., is still experiencing seizures within three months after implementation of the treatment)³;

(6) the treatment plan includes appropriate non-medical support services described in §104;

(7) the treating physician addresses necessary revisions to the treatment plan:

(A) in the case of an enrollee with a diagnosis of epilepsy who has reported a seizure or treatment-related side effects within three months after implementation of the treatment plan, the treating physician will reevaluate and, as necessary, revise the treatment plan, and continue to do so, until the enrollee does not experience any seizures or treatment-related side effects for a three-month period or the patient is referred to a more specialized level of epilepsy care

³ Commentary: Three months is suggested as a practical interval within which a patient’s treatment for epilepsy can be implemented, evaluated, and – where necessary – modified. However, the determination of a timely response to treatment should take into account individual circumstances such as the time required to effect changes in medication regimens and the frequency of subsequent seizures (if any). A high frequency of subsequent seizures may indicate that patient referral is more urgent.
(B) in the case of an enrollee with a diagnosis of epilepsy who has not experienced a seizure or epilepsy-related side effects in the preceding three months, the treating physician periodically will review the treatment plan to determine if any changes are necessary (at a minimum, the treating physician should review the treatment plan once a year);

(8) in the event a treating physician deviates from an established treatment guideline in the treatment of an enrollee with a diagnosis of epilepsy, the medical reason for such a deviation is documented; and

(9) Federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are met for children under age 21 with a diagnosis of epilepsy.4

§104. Non-Medical Support Services

(a) Non-Medical Support Services -- In delivering the non-medical support services that are covered under §102(a)(2), Contractor shall ensure that:

(1) the treating physician, in coordination with a case manager, develops a psychosocial support services plan for enrollees with a diagnosis of epilepsy;

(2) a case manager is provided for enrollees with complicated epilepsy, e.g., enrollees with treatment-resistant epilepsy or enrollees with epilepsy who have physical or mental disabilities that adversely affect their educational or vocational performance, their social participation, or their activities of daily living;

(A) For purposes of this section, a case manager is someone other than the enrollee’s Medicaid social worker or Medicaid case manager, and someone other than a managed care plan’s utilization case manager5;

4 See § 1905(r) of the Social Security Act, 42 U.S.C. § 1396d(r). For additional information on purchasing EPSDT services from MCOs, see Part 1 of Medicaid Pediatric Purchasing Specifications (Sept. 1999), available at www.gwhealthpolicy.org.

5 Commentary. The role of the case manager is to expand access to care and services for enrollees with a diagnosis of epilepsy. Therefore, the case manager in this section is specifically distinguished from a managed care plan’s utilization case manager.
(3) enrollees with a diagnosis of epilepsy receive medical case management services outlined in §103(a)(4) and the psychosocial support services plan described in paragraph (a)(1) outlined in this section; and

(4) enrollees with a diagnosis of epilepsy receive education about the condition and available support services;

(5) enrollees with a diagnosis of epilepsy receive any necessary vocational counseling;

(6) enrollees with a diagnosis of epilepsy receive any necessary occupational, physical, and speech therapy with clearly stated goals; and

(7) special education needs are met for children of school-age with a diagnosis of epilepsy.6

§105. Diagnostic Procedures and Laboratory Services

(a) Laboratory Services -- Laboratory services that are covered under §103(a)(2) are the following tests delivered in accordance with subsection (b) of this Section:

Epilepsy requires a two-part diagnostic procedure that focuses on two questions: Does the patient have seizures? If so, is there an identifiable cause?

Laboratory tests are to be used to address both of these questions and to monitor treatment.

(1) In the case of an enrollee for whom an assessment indicates the possible diagnosis of epilepsy, the following shall be performed:

(A) All hematologic, hepatic, renal, metabolic, endocrine, and other tests of help in general medicine;

(B) Routine electroencephalography (EEG) performed with a minimum utilisation case manager or a Medicaid social worker. The need for a case manager may be stronger for children at lower levels of care.

of 16 channels, asleep and awake with photic stimulation and hyperventilation;
(C) Magnetic resonance imaging (MRI) of high resolution with appropriate sequences prescribed by the treating physician to detect subtle brain lesions; and
(D) Full, prolonged neuropsychological battery to assess intelligence, focal brain damage, and memory.

(2) If the enrollee has the diagnosis of epilepsy, additional tests may be needed:

(A) Antiepilepsy medication blood levels including unbound levels;
(B) Routine hemograms, liver function tests and renal tests for monitoring of possible toxicity. Serum electrolytes and bone density determinations are required in selected cases;
(C) Repeat MRI with high-resolution fields and special angles to assess mesial temporal sclerosis and migration disorders;
(D) Prolonged video EEG monitoring (often for several days) with or without sphenoidal electrodes;
(E) Positron emission tomography (PET), interictal and ictal single photon emission computed tomography (SPECT), functional MRI, magnetoencephalography (MEG) and other neuro-imaging tests may be needed if surgery is being considered; and
(F) Intracarotid sodium amytal test (Wada test) in preparation for surgery.

(b) Delivery of Laboratory Tests -- In delivering the laboratory tests covered under this Part, Contractor shall ensure that the tests are provided in accordance with the guidelines and references enumerated in §107.

§106. Pharmaceuticals and Therapeutic Devices and Supplies

(a) Pharmaceuticals and Therapeutic Devices and Supplies -- Pharmaceuticals and therapeutic devices and supplies that are covered under §103(a)(3) are the following, delivered in accordance with subsection (b):

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7 For additional information on purchasing pharmaceuticals, see Purchasing Specifications for Pharmaceutical and Pharmaceutical Services (Dec. 2001), available at www.gwhealthpolicy.org.
(1) Pharmaceuticals: Contractor shall cover all drugs currently approved by the U.S. Food and Drug Administration for the treatment of epilepsy; and

(2) Therapeutic devices: Contractor shall cover implantation of vagus nerve stimulators.

(b) Delivery of Pharmaceuticals and Therapeutic Devices and Supplies -- In delivering the therapeutic devices and supplies covered under subsection (a), Contractor shall ensure that the devices and supplies are provided in accordance with the guidelines and references enumerated in §107.

(c) Prohibited Substitutions -- In the case that the treating physician considers such substitutions contraindicated, neither Contractor nor its network providers or subcontractors may use any procedure, including a formulary, as a substitute for indicated pharmaceuticals or therapeutic devices or supplies.

§107. Guidelines and References

(a) Guidelines


(3) American Academy of Neurology (www.aan.com):


(D) Vagus Nerve Stimulation for Epilepsy (July 1997)  
(http://www.aan.com/public/practiceguidelines/00000076.pdf)

(E) Reassessment: Vagus Nerve Stimulation for Epilepsy (Sept. 1999)  
(http://www.aan.com/public/practiceguidelines/VNS.pdf)

(4) European Federation of Neurological Societies Task Force, “Pre-surgical  
Evaluation for Epilepsy Surgery – European Standards,”  

(5) The Clinical Standards Advisory Group, Services for Patients with Epilepsy  
(Report for the United Kingdom Health Ministers and National Health Service) (1999).

(b) References

(1) Federal Early Periodic Screening Diagnosis and Treatment (EPSDT)  
requirements for children with a diagnosis of epilepsy, § 1905(r) of the Social Security Act, 42 U.S.C. §1396d(r).

(2) Agency for Health Care Research and Quality, Management of Newly  
Diagnosed Patients with Epilepsy: A Systematic Review of the Literature,  
Technical Assessment No. 39 (2001). A summary of the report is available online at  

§108. Coverage Determinations

(a) Evidence Used in Making Coverage Determination -- In making coverage  
determinations (as defined in §109(a)) with respect to an enrollee at risk or with a  
diagnosis of epilepsy, Contractor shall base such determinations on the following  
evidence:

(1) appropriate clinical guidelines and references enumerated in §107;

(2) the enrollee's health status including pregnancy, psychosocial factors and  
other factors that could adversely affect or complicate successful medical  
management of epilepsy in the enrollee;
(3) clinical evidence of the condition for which approval of services is requested; and

(4) the opinion of the treating physician and the provider confirming a diagnosis of epilepsy.

(b) **Prohibited Substitutions** -- If substitutions are contraindicated under appropriate guidelines and references enumerated in §107, neither Contractor nor Contractor's provider network or subcontractors may use any procedure, including a formulary, to substitute pharmaceuticals, therapeutic devices or supplies, or lab tests unless directed to do so by the treating physician.

§109. Definitions

(a) **Coverage Determination** -- a determination by Contractor (or by the provider or other entity to whom Contractor has delegated such determination as to whether, in the case of an enrollee, an item or service enumerated under §102 is necessary to:

   (1) prevent, correct or ameliorate a condition, disability, illness or injury; or

   (2) maintain functioning.

(b) **Epilepsy** -- a central nervous system disorder that is characterized by unprovoked, recurrent seizures that disrupt communication among brain cells.

(c) **Successor Provider** -- a provider who assumes responsibility for furnishing medical services to a former enrollee of Contractor's plan.
PART 2. EPILEPSY-RELATED SERVICE DELIVERY
AND HEALTH CARE QUALITY

§201. Enrollee Access to Health Care Providers

(a) Timelines for Certain Epilepsy-related Services -- In administering services covered under Part 1, Contractor shall comply with the following timelines:

(1) provider visits for enrollees with epilepsy shall be scheduled to occur in accordance with timelines recommended in appropriate guidelines and references enumerated in §107; and

(2) enrollees should have ready access to consultation and continuing care by generalist and specialist providers.

§202. Enrollment and Disenrollment

(a) Enrollment of an Individual Receiving Medical Management Services for Epilepsy -- In the case that Contractor enrolls an individual who, at the time of enrollment, is receiving medical management services for epilepsy, Contractor shall furnish such medical management services covered under Part 1 until the enrollee has been medically evaluated and medical management services have been prescribed by the enrollee’s treating physician and, if indicated in the opinion of the treating physician, by one or more specialist or subspecialist providers enumerated in §203(a).

(b) Disenrollment of an Individual Receiving Medical Management Services for Epilepsy -- In the case of an individual who ceases to be an enrollee and who, at the time of disenrollment, is receiving medical management services for epilepsy under §103, Contractor shall:

(1) continue to furnish such services until the earlier of:

(A) notice to Contractor that the enrollee is under the care of a successor provider as defined in §109(c); or

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(B) the end of the period for which a premium has been paid to Contractor for coverage of the individual; and

(2) at the request of an enrollee:

(A) arrange for timely transfer of all medical records to the individual's successor provider [drafted insert time frame]; and

(B) ensure that network providers furnishing epilepsy-related medical management services to the individual at the time of disenrollment make themselves available to the successor provider for review of the individual's treatment plan.

§203. Provider Network Requirements

(a) **Network Requirements** -- Contractor’s provider network shall include the following classes of providers:

(1) generalist providers whose practice includes treatment of individuals with epilepsy;

(2) specialist providers who are board-certified or board-eligible in neurology and subspecialist providers who are board-certified or board-eligible in neurology with additional training in epileptology;

(3) comprehensive epilepsy center\(^9\) (either through direct network participation or through a contractual or referral relationship);

(4) referral relationship with a pediatric neurologist;

(5) a medical case manager who has background or training as a registered nurse or social worker;

(6) providers trained to meet the special education needs of school-age

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\(^9\) **Commentary:** The National Association of Epilepsy Centers have established criteria for what constitutes a “comprehensive” epilepsy center. See [www.naecepilepsy.org](http://www.naecepilepsy.org)
children;

(7) epilepsy educators as part of an epilepsy education program;

(8) laboratories that are certified under the Clinical Laboratory Improvements Act of 1988\textsuperscript{10} and provide the services listed under §105;

(9) providers of behavioral health services who may be in one or more of the following classes of providers: clinical psychologists, board-certified or board-eligible psychiatrists, or social workers with Master’s degrees;

(10) speech, occupational, vocational, and physical therapists; and

(11) registered pharmacists.\textsuperscript{11}

(b) \textbf{Network Selection Practices} -- Contractor's provider selection practices shall ensure the inclusion of providers that demonstrate a high level of performance in furnishing epilepsy-related services, including a referral relationship contract with an epilepsy center.

(c) \textbf{Criteria for Provider Network Participation and Compensation}\textsuperscript{12} -- In calculating a network provider’s penalty or incentive payment, Contractor shall not, solely on the grounds of the amount, scope or duration of epilepsy related services covered under §102:

(1) exclude\textsuperscript{13} the provider from participation in Contractor’s provider network; or

(2) reduce or withhold compensation from, or otherwise impose financial penalties upon a provider participating in Contractor’s provider network.

\textsuperscript{10} \textbf{Commentary}: §353 of the Public Health Service Act, 42 U.S.C. §263a.

\textsuperscript{11} \textbf{Commentary}: In the case of a Medicaid purchaser that has elected to “carve out” pharmaceutical services from a purchasing agreement and to continue providing such services on a fee for service basis, this specification would not be applicable.

\textsuperscript{12} \textbf{Commentary}: This provision addresses a specific use of data on the enumerated services. It does not prohibit a Contractor from collecting the data or from using it for other purposes such as quality measurement and improvement.

\textsuperscript{13} \textbf{Commentary}: “Exclusion” refers to a) initial Contractor determinations with regard to including a provider in the Contractor’s network and b) Contractor determinations with regard to retaining a provider in Contractor’s network.
(d) **Payment for Certain Services Furnished by Non-network Providers**\(^{14}\) -- In the event that an enrollee receives treatment for epilepsy on an emergency basis from a provider who is not a network provider, such provider shall be reimbursed for such service at:

1. **[Alternative A]**\(^{15}\) Medicaid rates; or
2. **[Alternative B]** network provider rates; or
3. **[Alternative C]** negotiated rates.

§204. **Memorandum of Understanding** [reserved]

§205. **Quality Measurement and Improvement**

(a) **Quality Measurement** -- Contractor shall measure the quality of care for enrollees with a diagnosis of epilepsy against the following standard: enrollees should experience an outcome in which they have no seizures or treatment-related side effects within a period of three (3) months. If such a standard is not met, providers shall revise an enrollee’s treatment plan in accordance with §103(b)(7)(A).

(b) **Dissemination of Standards, Guidelines, and other Materials** -- Contractor shall make available to all network providers participating in Contractor’s provider network:

1. a full description of all epilepsy-related services and service duties set forth in this Part;
2. any practice guidelines and other materials that Contractor uses to evaluate provider performance; and

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\(^{14}\) **Commentary**: For Medicaid purchasers, the Balanced Budget Act of 1997 requires Medicaid managed care contracts to provide “for coverage for emergency services [as defined in the Act] without regard to prior authorization or the emergency care provider’s contractual relationship with the organization [or primary care case manager].” §1932(b)(1)(A)(i) of the Social Security Act, 42 U.S.C. §1396u-2(b)(1)(A)(i).

\(^{15}\) **Commentary**: Several alternative reimbursement-related specifications are provided for consideration by Medicaid and non-Medicaid purchasers.
(3) any clinical protocols that Contractor uses to monitor provider performance.

(c) Collection of Epilepsy Quality Improvement Project Data -- At least [drafter insert frequency of data collection], Contractor shall collect data on epilepsy-related services to assess the quality of epilepsy-related care provided for enrollees.

§206. Data Collection and Reporting

(a) Quality Assurance Reporting -- At least [drafter insert frequency of reporting], Contractor shall report epilepsy quality improvement indicators.

(b) Availability to Purchaser of Certain Documents -- Upon request, Contractor shall make available to Purchaser the most recent version of each of the following documents:

   (1) Contractor’s provider manual and any other directives, guidelines or protocols transmitted in writing or electronically by Contractor to providers participating in Contractor’s provider network relating to the provision or coverage of items and services covered under §102;

   (c) standards and procedures for Contractor’s coverage determinations under §108; and

   (d) sufficient data collection and monitoring to comply with applicable state laws regarding epilepsy reporting.

§207. Information for Enrollees

(a) Information on Covered Services16 -- Contractor shall make available information on epilepsy-related services covered under §102 before and at the time of enrollment and when there are material changes in epilepsy-related coverage.

16 Commentary: This optional specification is consistent with the requirement in Medicaid law that potential enrollees and enrollees be provided with information about services covered under the state Medicaid agency’s managed care contract. §1932(a)(5) of the Social Security Act, 42 U.S.C. §1396u-2(a)(5).