Medicaid's Early and Periodic Screening, Diagnostic and Treatment Benefit

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National Health Law Program (NHeLP)

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels.

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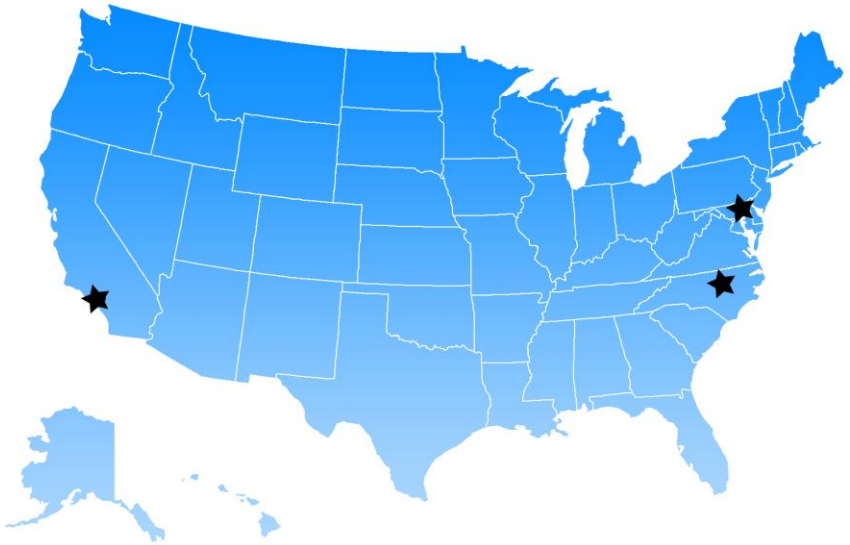

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Session Outline

- Medicaid basics
- EPSDT
- Managed care
- Complaint resolution

What judges say

- Byzantine construction" makes Medicaid "almost unintelligible to the uninitiated"
- Medicaid Act is "an aggravated assault on the English language"
- Medicaid "regulations so drawn they have created a Serbonian bog"
  - SO – PLEASE ASK QUESTIONS AS WE GO!

Medicaid Basics

- Entitlement
  - Covered population groups, *e.g.*
    - Children, pregnant women, aged, blind, disability
  - Covered services, *e.g.*
    - Mandatory and optional
    - Hospital, physician, home health, **behavioral health**
  - Due process notice and hearing rights if eligibility/services are denied/terminated

Why a separate benefit for children and adolescents?

- Children are not little adults
- Adolescents are not big children (or little adults)
- Time of rapid brain and body development
- Common behavioral health diagnoses:
  - ✓ Attention-deficit hyperactivity disorder
  - ✓ Depression
  - ✓ Behavioral or conduct problems
  - ✓ Anxiety
  - ✓ Substance use disorders
  - ✓ Autism spectrum disorders

Why a separate benefit?

- Poor children are more likely to have:
  - ✓ Vision, hearing and speech problems
  - ✓ Untreated tooth decay
  - ✓ Elevated lead blood levels
  - ✓ Asthma
  - ✓ Behavioral health problems

Why a separate benefit for children & youth with disabilities?

- Family impact
  - Increase in single parent households
  - Increase in divorce
  - Increase in behavioral problems & academic failure of siblings
- Financial stress
  - **54%** report family member stopped working
  - **45%** report a family member cut back working
  - **>20%** report financial problems b/c of child's condition
- Caregiving stress
  - **58%** report spending >40 hours per week providing support
  - **46%** report more caregiving responsibilities than they can handle

Medicaid's Benefit for Children & Youth

E = Early

P= Periodic

S = Screening

D = Diagnostic

T = Treatment

EPSDT: Laws and Guidance

- 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)
- 42 C.F.R. §§ 441.50-441.62
- CMS, *State Medicaid Manual*, part 5
- CMS, *EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014)

EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents

Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html (June 2014)

EPSDT Guidance

"The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible, The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

CMS, *EPSDT – A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS* (June 2014)

EPSDT Screening

- Medical
  - Developmental history
  - Unclothed physical exam
  - Immunizations
  - Lab testing
  - Health education
- Vision
- Hearing
- Dental
  - Periodic – pre-set intervals
  - Interperiodic – as needed
    - Any encounter with a treating provider is a screen

EPSDT Treatment Requirements

- States must arrange (directly or through referral) for corrective treatment needed as a result of a screen
  - Federal scope of benefits
  - Federal definition of medical necessity

EPSDT
Federal Scope of Benefits

All necessary treatment within 1396d(a)

Mandatory services	Optional Services
Physician services	Prescription drugs
In-patient hospital	**Rehabilitation services**
Laboratory/x-ray	**Physical, speech, & other ther**apies
Outpatient hospital	Other licensed practitioners
Nursing facility services	**Private duty nurs**ing
Home health care*	Home health care*
Personal care services	
Case management	Transportation

EPSDT
Broad Nature of EPSDT

- **The EPSDT statutory language is broad and includes:**

"Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to **correct or ameliorate** defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d (r)(5).

EPSDT settings

- *Out-of-state services* are **NOT** covered if medically necessary similarly efficacious services are available in state
- *Services in schools* can be covered, e.g., service provided through an IEP, basic health services such as vaccinations
- *Most integrated setting appropriate*, if necessary to comply with Title II of the ADA

EPSDT
Available to HCB Waiver Recipients

- Additional services can be offered through waivers
  - Respite, home modifications
  - NOT covered by EPSDT mandate

EPSD “T” Features

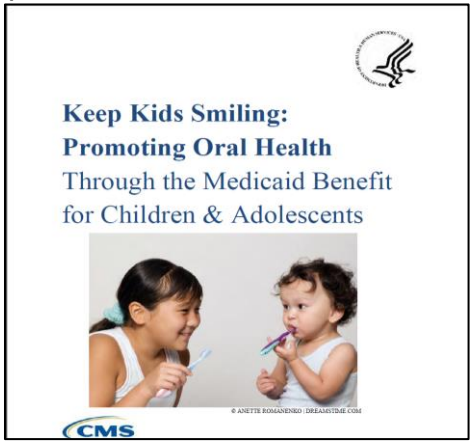
- Coverage of short-term & long-term services
- No waiting list for services
- No monetary cap on total cost
- No “hard” limit on number of hours or units
- No “hard” limit on number of MD, DDS, therapist, clinician visits
- No copayments for screening services

EPSD “T” Features

- Service “fits within a Medicaid box”
- Necessary to correct or ameliorate the individual child’s condition
- Safe and effective
- Not experimental
- No less costly, equally effective & available alternative in the geographic area
- May require prior authorization (15 business days)

EPSD "T" Features

- Oral health services required
  - Dental care "for relief of pain, infection, restoration of teeth, and maintenance of dental health"
  - At as early an age as possible
  - Emergency, preventive, and therapeutic services for dental disease that may become acute or cause irreversible damage if not treated
  - https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html



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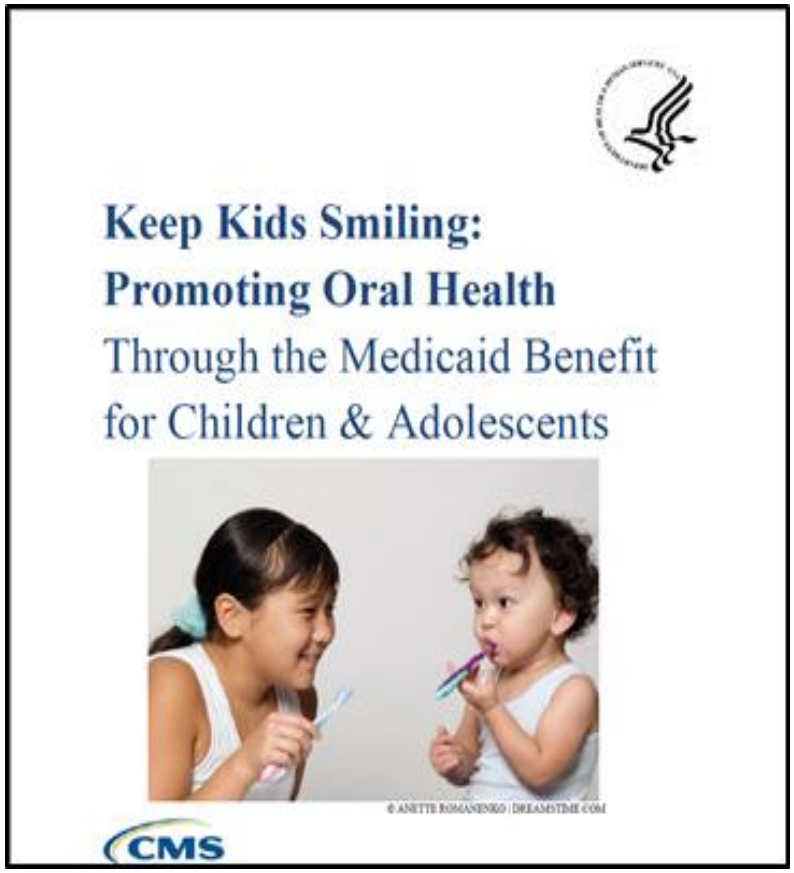


EPSD "T" Features

- Vision and hearing services
  - Screening services
  - Diagnosis and treatment including
    - Glasses
    - Hearing aids

EPSD"T" Examples

- *Case management*, available under the federal Medicaid plan
  - Case management is an EPSDT service and must be provided if medically necessary to correct or ameliorate regardless of eligibility for a waiver.

EPSD"T" Examples

- *Rehabilitation/other licensed practitioner/ preventive, e.g.*
  - Intensive behavioral health services (individualized, intensive, coordinated, comprehensive, culturally competent, and home and community based)
  - ABA therapy for a child with autism
- *Transportation*, to & from facility (including "related costs" of attendant's meals, accommodations, gas, etc.)
- *Personal care services*

EPSD “T” Examples

- a developmental disability diagnosis does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition applies. All individual facts must be considered.
- Clarification of coverage of services for children with autism spectrum disorder - https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

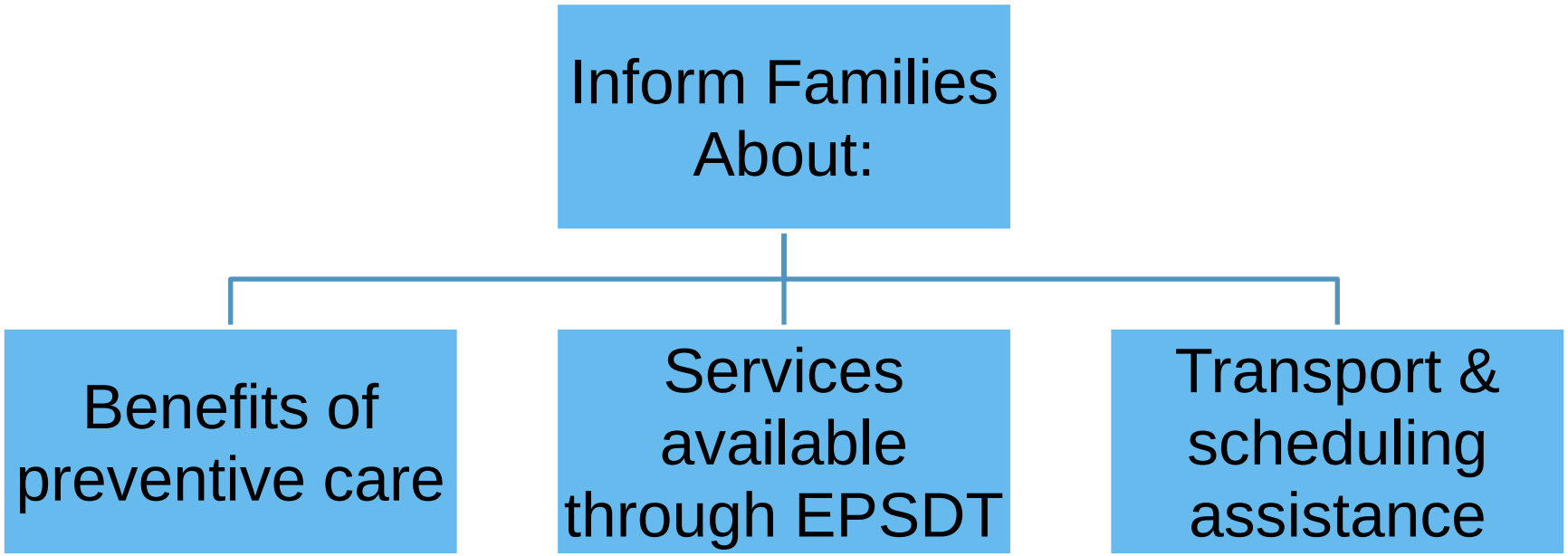
EPSD “T” Examples

- *Language access and culturally appropriate services,*
  - Must “effectively” inform those with limited English proficiency
  - May include interpreter services, translated materials

EPSDT Informing Requirements

- States must inform Medicaid families & children about EPSDT
- Informing must be effective
  - Oral and written
  - Translated for LEP
  - Accessible for hearing/vision impaired
  - Targeted (e.g. pregnant teens, non-users)
- Transportation & appointment scheduling assistance (prior to due date of each periodic screen)
- Coordinate with other entities

EPSDT Informing



EPSDT - Reporting

- Annual reporting required—CMS Form 416
  - https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
- Report by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)
  - Medical screens
  - Referrals for treatment
  - Dental treatment
  - Lead blood testing

EPSDT - Reporting

- ND, age 6-9, % receiving any EPS:
  - 2014: 28%
  - 2013: 28%
  - 2012: 26%
- National, age 6-9, % receiving any EPS
  - 2014: 67%
  - 2013: 65%
  - 2012: 63%

Form 416 – ND 2014

Annual EPSDT Participation Report
Form CMS-416
Fiscal Year: 2014
State: North Dakota

Description	Cat	Total	< 1	1-2	3-5	6-9	10-14	15-18	19-20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN	42,394	3,138	7,501	7,922	8,936	8,137	5,324	1,436
	MN	342	2	4	6	29	42	50	209
	Total	42,736	3,140	7,505	7,928	8,965	8,179	5,374	1,645
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN	19,213	2,788	4,701	3,939	2,530	3,274	1,784	197
	MN	48	2	1	2	1	10	6	26
	Total	19,261	2,790	4,702	3,941	2,531	3,284	1,790	223
10. PARTICIPANT RATIO	CN	0.45	0.89	0.63	0.50	0.28	0.40	0.34	0.14
	MN	0.14	1.00	0.25	0.33	0.03	0.24	0.12	0.12
	Total	0.45	0.89	0.63	0.50	0.28	0.40	0.33	0.14

Medicaid Managed Care

- 74% of Medicaid population
- All states but AK, WY
- High enrollment (>95%): HI, ID, MO, OR, SC,TN, VT

SOURCES: Kaiser Family Foundation (www.kff.org); CMS (www.cms.gov)

Managed Care positives

- Coordination of care
- Potential emphasis on preventive services
- Potential to change behaviors
- Cost predictability
- Integration of services
- Potential for innovation
- Data

Managed Care Concerns

- Lack of information re: covered services & rights
- Inadequate networks
- Application of improper coverage standards
- Poor dispute resolution

Medicaid Managed Care Authority

- Federal Medicaid statutes and regulations
- State statutes and regulations
  - Medicaid
  - Insurance regulation, consumer protection
- CMS Guidance
- State plan amendments, waivers
- Contracts

Managed Care Authority

- 42 U.S.C. § 1396u-2 (state plan option)
- 42 U.S.C. § 1396n(b)(3) (managed care waivers)
- 42 U.S.C. § 1315 (1115 demonstrations)
- 42 U.S.C. § 1396b(m) (MCO stds.)
  - http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/combined-1915-b-c.html

- MC regulations: 42 C.F.R. pt 438

Medicaid Managed Care – Vocab

- Capitation v. fee for service
- Risk contracts
- Grievance v. Appeal
  - “action”

Medicaid Managed Care- vocab

- Managed Care Entities
  - MCO (managed care organization)
  - PIHP, PAHP – prepaid health plan (inpatient and ambulatory)
  - PCCM – primary care case management (managed fee for service)
  - PACE (Program of all-inclusive care for the elderly)

Enrollee Rights and Protections

Right to:

- Adequate provider networks
- Timely access to services, including specialists
- Receive information on available treatment alternatives
- Disenroll due to poor quality or lack of access
- Be treated with respect and dignity
- Be free from discrimination
- Participate in health care decisions

Information for Consumers

Consumers have the right to receive:

- Current list of plan providers
- Disenrollment information
- Information on how to obtain services
  - ER, family planning
- Instructions on filing grievances/appeals
- (in mandatory enrollment systems) chart comparing
  - plan benefits
  - cost sharing (if any)
  - quality and performance indicators

Information for Consumers

- Right to written information in alternative formats that take into consideration special needs, e.g., visual impairment
- Right to oral interpretation in any language
- Must be informed that they can get the information in accessible formats

Nondiscrimination

- Contracts must prohibit discrimination in enrollment, disenrollment, and re-enrollment on the basis of health status or need for health services.
- Plans must comply with the ADA, Section 504, and other civil rights laws.
- States must take into consideration the extent to which locations are physically accessible.

State Monitoring Requirements

- *"At a minimum*:"
- Beneficiary enrollment and disenrollment.
- Processing of grievances and appeals.
- Violations subject to intermediate sanctions.
- Violations of the conditions for federal matching.
  - *Also* - All other contract provisions, "as appropriate."

Information about the Plan - General

- Medicaid.gov: State Managed Care Profiles
  - North Dakota

Network Adequacy

- Services must be available to the same extent available under state plan
  - No federal specifications about numbers/travel times
- Plans must provide potential enrollees in MCO system:
  - Names, locations, qualifications
  - Non-English languages spoken
  - Whether provider is accepting new patients

Network Adequacy

- States must ensure access to women's health specialists
- Children and adolescents must have access to pediatric and family nurse practitioners and midwives
- PCCM contracts must provide for access to sufficient numbers of health professionals to ensure prompt delivery of services

  - 42 U.S.C. § 1396d(a)(21); 42 C.F.R. § 438.6(k); § 438.206(b)(2)

Services for enrollees for individuals with special health care needs

- States must:
  - Identify such persons* to plans
  - Assess individual needs (using appropriate health care professionals)
  - Allow direct access to specialists
- Require plans to produce a treatment plan (optional)
  - Developed by provider with enrollee input
  - Approved by plan

*as defined by the state

ND: Enrollees with special health care needs

- Those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by enrollees, generally.
  - North Dakota Medicaid, Quality Strategy Plan, p. 5 (Draft 1/2/2014)
  - http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf

Required quality activities

- Ongoing quality assessment and improvement
  - State quality assessment and improvement strategy
  - Performance improvement plans
  - External quality review

Proposed Rule

- 80 Fed. Reg. 30198 (June 1, 2015)
- More than 800 comments submitted
- Final rule expected late spring/early summer

Network Adequacy

- Would require states to establish network adequacy standards for specified provider types
  - Does not specify what those standards must be
  - Did *not* impose national standard for provider ratios

Continuity of Care (COC)

- Requires states to adopt a COC policy for enrollees who move from fee-for-service (FFS) to managed care or who switch plans
  - Maintenance of comparable level of services during transition, continuation of care with out-of-network provider when risk of serious detriment to enrollees' health or risk of hospitalization or institutionalization

Quality and transparency

- Generally increases access to and availability of information, opportunity for input, strengthens current requirements for reporting.

Resolving Problems

- Administrative due process
  - Written notice
  - Opportunity to be heard
- Court action

Medicaid Due Process: Legal Authority

- 14th Amd., U.S. Const.
- 42 U.S.C. § 1396a(a)(3)
- 42 C.F.R. pts. 431, 438 pt E (MC)
- Contracts (MC)

What triggers right to hearing

- Denial of application for benefits/failure to act with reasonable promptness
- Agency has taken an action erroneously
- Reduction, suspension, termination of service
- PASRR, transfer or discharge from NF
    - 42 C.F.R. § § 431.220, 438.400; U.S. Const. 14th Amendment

Right to Appeal, cont'd

- "Action" of MCO:
  - Denying, reducing, terminating or otherwise limiting services or denying payment for services
  - Failing to timely provide services
  - Denying request for disenrollment or exemption
  - "otherwise adversely affecting the individual"

42 C.F.R. §§ 438.400(b), 410(f)

What triggers right to appeal

- BUT NOT: if *sole* issue is federal or state law requiring automatic change
  - 42 C.F.R. § 431.220
- BUT: may have a hearing if there is a valid factual dispute
  - *Washington v. DeBeaugrine* (N.D. Fla.)
  - *Rosen v. Goetz* (6th Cir.)

Grievance

- An expression of dissatisfaction about any matter other than an action

  42 C.F.R. § 438.400(b)

Continued Benefits

- Must continue pending final hearing decision if hearing is requested w/in 10 days of action
  - Beneficiary can be required to pay for benefits if he ultimately loses

42 C.F.R. §§ 431.230, 438.420(d)

Litigation - Themes

- Responsibility for complying with Medicaid requirements
- Scope of benefits
- Provider issues – particularly rates
- Enforceability of Medicaid requirements

Litigation – Responsibility

- *J.K. v. Dillenberg (*AZ)
- *Westside Mothers v. Olszewski* (MI)
- *L.S. v. Cansler* (NC)

Litigation – EPSDT requirements

- *Memosovski v. Maram* (IL)
- *John B. v. Goetz* (TN)
- *Emily Q v. Bonta* (CA)
- *Rosie D. v. Romney* (MA)
- *L.S. v. Cansler* (NC)

Questions?

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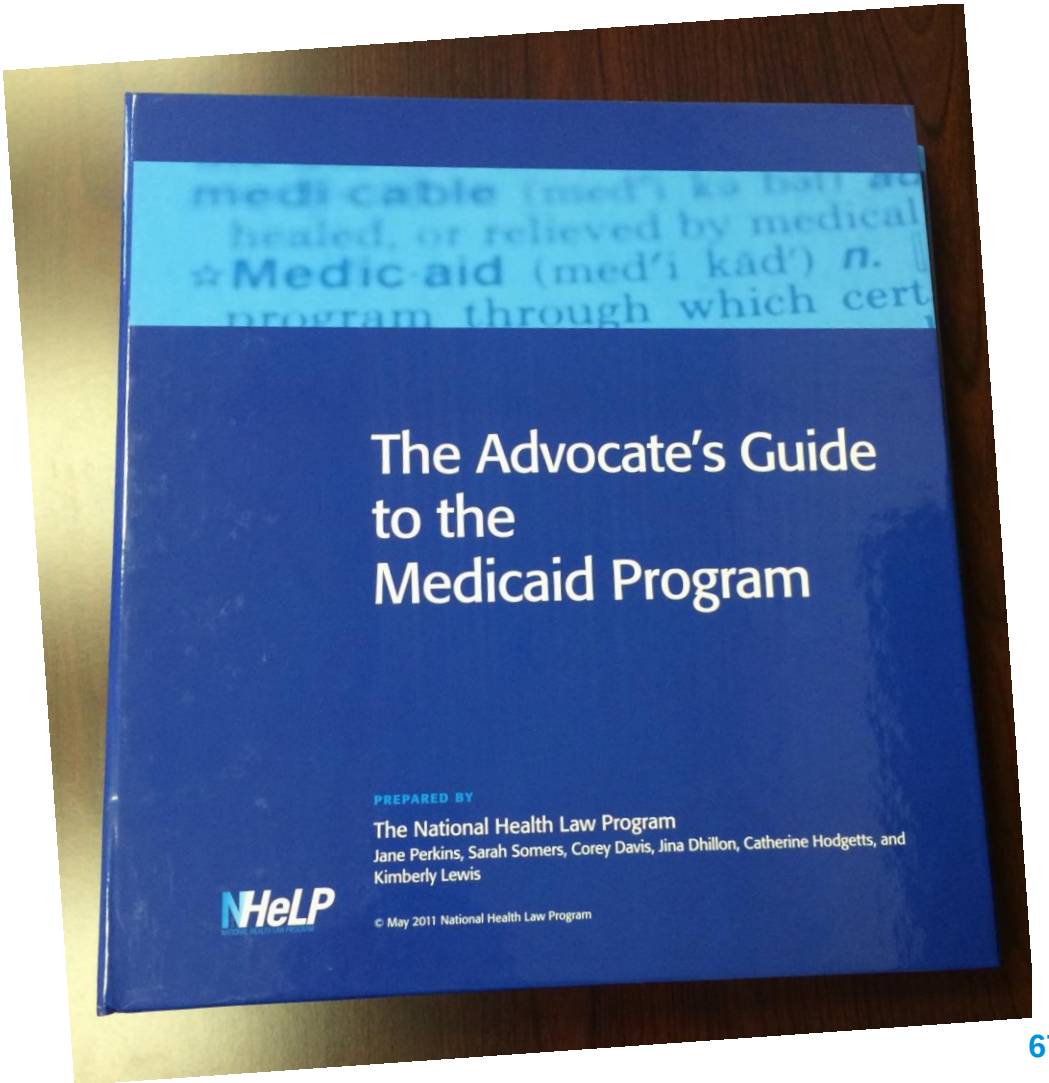
Medicaid Expertise

- Eligibility
- Services
- Administration
- *Update: this summer*



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