

From: [Cherryl L. Ramirez](#)
To: [HFS.Webmaster](#)
Subject: ACMHAI Comments on HFS Coordinated Care Program
Date: Friday, July 01, 2011 11:17:46 AM
Attachments: [Appendix C - Data Request on Children's Crisis Care Costs.doc](#)
[Appendix F - Rule 132 recs 2-8-2011.doc](#)
[Appendix G - IPHA Res 11 EPSDT FINAL.doc](#)
[Appendix E - EPSDT Policy Instructions - North Carolina.docx](#)
[ACMHAI Comments on Coordinated Care in IL 7-1-11.docx](#)
Importance: High

Dear Director Hamos:

We are appreciative of the opportunity to comment on the Coordinated Care Program Key Policy Issues document.

The Association of Community Mental Health Authorities of Illinois (ACMHAI) represents local government authorities for the planning, funding, monitoring and evaluating mental health, substance abuse and developmental disabilities programs and services. Collectively, we provide over \$60,000,000 of local revenue to support these programs.

It is important for you to know who we are and why we are commenting. We do not provide direct services, therefore, financially we have nothing to gain or lose with respect to Coordinated Care Program policies. We, like you, are only concerned about having an effective healthcare system which addresses the physical and behavioral health needs of people in our communities.

Please feel free to call if you have questions or require clarification about our comments.

Sincerely,

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Comments in Response to Coordinated Care Program Key Policy Issues
Association of Community Mental Health Authorities of Illinois
(ACMHAI)

July 1, 2011

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Director, ACMHAI

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1. How comprehensive must coordinated care be?

Questions for Comment

a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration? Alternatives to consider are collaborative care as a first stage for communities that are not ready to fully integrate multiple settings and providers and ACMHAI proposes a pilot for successful behavioral health coordination in communities with less than 350,000 in population in response to Question 8.

ACMHAI believes entities chosen to coordinate care for Medicaid clients should be required to arrange care for the entire range of services across multiple settings and providers. The central philosophy for coordinated care should be individual- and family-centered, community-based, culturally responsive, appropriate, least restrictive, and multi-disciplinary. Specific expectations in the contract, recommended by Monica Oss of Open Minds and the American Academy of Child and Adolescent Psychiatry should include:

- How "hard-to-serve" geographic regions will be covered
- Philosophical orientation to service delivery (family-centered, community-based, culturally responsive, etc.)
- On-going reporting requirements
- Intake and access provisions (clear eligibility criteria)
- Credentialing requirements of all providers
- Expectations for collaboration with multiple care-giving and community service systems (schools, community mental health centers, medical care providers, community extension/education programs, child welfare services, juvenile justice services, etc.)
- Stipulations for addressing consumer grievances and appeals
- Pricing assumptions

- Payment mechanisms and risk sharing arrangements (fee-for-service, case rate, capitation, risk corridors, etc.)
- Sanctions for not meeting contract stipulations and incentives for “exceptional” performance
- The needs of other family members are identified, and appropriate services are coordinated with their providers.
- Physical health needs of family members are addressed and coordinated with the primary care provider.

Qualifications of potential managed care organizations are, of course, the financial and administrative capacity to manage risk; the systems capability to measure and report on service utilization, costs, outcomes and quality; and a corporate commitment to and experience with specialized behavioral health systems.

b) Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?

ACMHAI suggests taking a close look at the North Carolina Medicaid Managed Care System’s approach to addressing these issues. Although the ideal is that the managed care entity would be able to coordinate care for the entire range of services, it is widely believed among the behavioral health community that managed care organizations’ strength is not behavioral health. Therefore, we would expect these entities to accept extensive input from consumers, family members, providers, advocates, and the state, county, and local governments to design and collaborate on the behavioral health care component of the system.

According to Kaiser Family Foundation research on the North Carolina Medicaid managed care system, the community team approach to care, with a network of physicians, hospitals, social service agencies and health departments, is essential to successful coordinated care. These team members also collect a broad range of data to help assess performance and guide continuing program improvements. Care managers, or navigators, are the key to continuity of care, coordination across providers, and provision of a coaching relationship with the patient. For children with severe emotional disorders, the interdisciplinary team would also include a child and adolescent psychiatrist, psychologist, social worker, psychiatric nurse, the parent(s), other relevant family members, and the child, if appropriate. The team’s purpose is to devise a care plan, which details and supports the child’s and family’s strengths and skills, but also identifies problem areas and deficits that prevent the child and family from functioning independently and appropriately. The plan identifies interventions to address these problems and the discipline, professional, or agency responsible for each intervention. Additionally, a transition plan from youth to adult services is necessary to detail how changes in services will be made as individuals progress into adulthood (e.g., from Juvenile Justice, Child Welfare, Special Education, etc.)

Considerable resources must be spent in training care managers/navigators and placing them strategically around the state to help Medicaid clients with everything from enrollment, primary care assignment, screening for behavioral health problems, linking to social services and other supports, to managing chronic conditions. It is

important for care managers to be “locals” of particular communities in order to gain trust of the participants and to be culturally competent in the town or neighborhood they are serving. Realistically, a care manager would have a caseload of 60 – 80 participants, and could specialize in serving children, adults or seniors, depending on the population of the service area. The care manager component of coordinated care is so important as the human face to the system of care and to ensuring continuity of care from one payer or provider to another, that it will be vital to have these positions in place at the beginning, even if the system is not fully integrated.

A consideration for easing into coordinated care is the notion of collaborative care, which could serve as a phase-in to fully integrated care in Illinois. As described by Ron Manderscheid, Executive Director, National Association of County Behavioral Health and Developmental Disabilities Directors, collaborative care refers to primary care programs working effectively with specialty providers to deliver mental health/substance use care and medical care. Both controlled and field studies conducted by Jürgen Unützer, the Director of the Advancing Integrated Mental Health Solutions (AIMS) Center, show dramatic improvements in outcomes for consumers with behavioral health conditions who participate in collaborative care. The Center is currently working with more than 570 primary care and/or behavioral health practices across the United States to improve the delivery of coordinated care, including a statewide program in Washington in which community health centers and community mental health centers collaborate to care for a population of patients with medical and behavioral health needs (<http://integratedcare-nw.org>). Based on the Center’s studies, key examples of care outcomes that must be improved include:

Screening. Effective screening tools for behavioral health conditions are very important in primary care settings that seek to do collaborative care. At present, the most common tool used is the Patient Health Questionnaire-9 (PHQ-9) which screens for depression. Primary care providers see many consumers with depression or anxiety, and they also are seeing greater numbers with bipolar disorder. Of significance, the PHQ-9 is used not only for screening, but also to assess changes in symptom severity over time and to facilitate consultation, change in treatment, and engagement of more experienced behavioral health specialists if clients are not improving as expected. There are two questions going forward: Should screening tools be changed? Are these tools adequate to assess treatment outcomes?

ACMHAI’s recommendation is that all adult participants in coordinated care should be screened for depression and substance use disorders, and all children should be screened for behavioral health problems with appropriate statewide tools. Children identified with behavioral health disorders should be further evaluated and referred for specialty care through the CANS (Child and Adolescent Needs and Strengths), a common comprehensive assessment tool across child serving agencies for the purpose of improving the quality and cost effectiveness of behavioral health services for children and adolescents; used across child-serving systems in Indiana and other states. In Illinois, the CANS has been used for 3 years in DCFS to support a system of coordinated behavioral healthcare for children and youth and to improve the responsiveness to the mental health needs of children and youth in state custody.

Benefits: 1) crosses barriers of multiple systems by creating a common assessment language while addressing the child and family status in a comprehensive manner; 2) sharing demographic information and assessment data ensures families only complete forms once; 3) enables each of the agencies involved to have their process and data needs met; 4) provides data need to report on all outcome measures required for mental health block funding; and 5) informs individualized care plans and level of care decisions, and provides a means for quality improvement.

Standards. To be able to implement collaborative care effectively, one needs to be able to describe the services which will be essential for success, e.g. care coordination. One way to put this issue into the context of national health reform is to determine the essential services of a medical/health home and use these services as a frame to elaborate the services of collaborative care. Once this relationship is clearly specified, then standard setting organizations can be engaged in defining the future standards for care.

Parity. A primary question is whether the services required for behavioral health-primary care collaboration are actually available and paid for like services required for care coordination in other fields. Three services stood out in this dialogue: care coordination, screening, and services offered through telemedicine or other electronic connections. An important future step will be to use the Wellstone-Domenici parity legislation and our own state's parity legislation (SB 1530), assuming it is signed into law, to test and move this agenda.

Payments. Because collaborative care moves beyond traditional clinical care delivered in primary care settings to include a broader array of services, a very important question is whether the services delivered are reimbursable, and whether better mechanisms are available for making payments, e.g. case rates versus encounter payment systems. It also would be very useful to have toolkits available to help primary care providers through the complex array of payment systems currently used, e.g., payments by both a managed care carve-out and a managed health care entity.

Consumer-Friendly Environment. Shared decision making, peer supports and a strong recovery orientation are essential features of modern specialty care that will need to be imported into the collaborative care environment.

c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

ACMHAI believes the medical or health home model has been shown to make a difference and produce savings through basic delivery changes. Medical homes are an integral component of coordinated care as a desired outcome – an individual

associates a primary care provider as his/her medical home and routinely visits or contacts this provider to prevent health crises and early death. A good place to start is with federally qualified health centers, working in collaboration with health departments and community mental health centers, with private, smaller primary care physician's offices or groups joining later. Referring to the 4-quadrant model, if there were to be a progression of increasing requirements, it would make sense to start with the quadrants that are best served by FQHCs (people with less severe behavioral health issues).

As mentioned before, ensuring that sufficient numbers of care managers/navigators are in place at the outset will help improve timeliness of care and access. Care managers are the participant's communication link to services such as 24/7 on call, comprehensive disease management, screening for depression and substance use disorders, referrals to mental health and substance use treatment, and they can facilitate the "warm hand-off" between primary and behavioral health care at co-located settings.

d) How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

The common set of outcome measures determined by consensus of stakeholders should dictate how an entity achieves coordinated care. Timeliness of access should be a critical outcome. An integrator/care manager/navigator should definitely be assigned to each enrollee.

e) Where, if at all, should HFS provide some kind of umbrella coverage for entities, e.g. negotiate a master pharmaceutical contract that would be available to all coordinated care entities?

A master pharmaceutical contract would be very helpful and there may be other examples of umbrella coverage that would be cost efficient and useful for entities.

f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

It is important to realize that coordinated care represents huge system changes for providers in monitoring outcomes, providing service utilization data, performance guidelines, and increased sharing of financial risk. Rates, access, and preferred provider status are incentives to help enlist providers. We may also see these demands to operate differently result in attempts of provider agencies to integrate services through affiliations and mergers.

Many providers have inadequate HIT systems, and in the case of behavioral health providers, they were excluded from the previous federal HITECH bill to incentivize providers to update their health information technology systems. We are hopeful that S 539, which adds behavioral health as a necessary component of electronic health records and meaningful use of health information technology, will ultimately pass.

This is important to ensure that mental health providers are able to collaborate and coordinate care with other health care providers.

2. What should be appropriate measures for health care outcomes and evidence-based practices?

Questions for Comment

a) What are the most important quality measures that should be considered?

Health care outcomes measures should be aligned with national health care reform outcome measures and should be further defined for Illinois by a group of stakeholders representing state and local government, providers, individuals and families, and social service organizations. An example of good behavioral health-related measures is from the National Behavioral Health Quality Framework draft in Appendix A. The Healthy People 2020 leading health indicators, which include the most important determinants of health (i.e., those which have the most effect on morbidity and mortality), are in Appendix B. These two documents provide a foundation for ensuring that the services we fund and provide in the coordinated care program result in better health and a higher quality of life for the people we serve.

ACMHAI suggests the following specific quality measures to consider:

- Timely access to care
- Periodic screenings
- Health status (including mental health)
- Patient longitudinal symptom management (rather than “snap shot” symptom management)
- Mid-course corrections based on clinical and patient feedback
- Progress toward achieving goals established in a treatment plan
- Reduction in mortality
- Reduction in rehospitalizations
- Improvement in school performance
- Improvement in family’s ability to successfully parent their child
- Tracking service utilization to identify trends and project future costs
- Adherence to fidelity models
- Consumer satisfaction

b) Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

There are some differences as noted above, between children’s and adult measures, and there are certainly additional measures based on the services applicable only to people with disabilities. These measures can be added to the health, quality of life, and cost effectiveness measures rather than separated out as an entirely different set.

Examples of additions to the measures particularly relevant to children who are high service utilizers include:

- Availability of pooled funds from contributions of all child-serving agencies
- Seamless transitions between levels of care
- Access to intermediate-level, alternative services (e.g., intensive home-based services)
- Availability of a continuum of case management services (ranging from benefits management to intensive clinical case management)
- Reduction in percentage of children requiring out-of-home, high cost placements (foster care, residential care, juvenile detention/incarceration, psychiatric hospitalization) due to emotional or behavioral problems

d) What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?

Prior medical history and data on crisis care would be helpful (*see Appendix C for example of request submitted to HFS in 2010*) to determine measures around cost effectiveness of care. We would also look to federal sources, such as SAMHSA, CDC, and HHS, for guidance on measures.

e) What percentage of total payment should be specifically tied to quality measures?

An alternative would be to adjust the Medicaid rate by 1-2% up or down based on whether the targets for the quality measures have been reached.

f) How can the Department most effectively work with other payers to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

After determining the payers who would be involved, ACMHAI recommends assigning representatives to review other state systems and use national guidance to create a working list of measures. Convene meetings to hone down or enhance the list to make it workable for Illinois. **As a representative of local government funders of behavioral health and developmental disabilities services, ACMHAI volunteers to work with HFS on adopting a coordinated set of quality measures.**

g) How will we know when we have achieved care coordination, i.e. how should we measure success?

Participants will have timely access to care, the capacity of the network will improve, screenings will increase, and cost shifting/reduction will occur. Not only will primary care welcome behavioral health care as a component of its regular service delivery (e.g., *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* - developed by the Health Resources and Services Administration, in conjunction with pediatricians, consumer representatives, and other experts, to serve as a national standard for quality well-child care), behavioral health will expand its parameters to include primary care (e.g., evolving wraparound program beyond solely behavioral health services and supports).

3. To what extent should electronic information capabilities be required?

Questions for Comment

a) What type of communication related to the clinical care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?

The communication among providers is another area in which care managers/patient navigators will be critical. Medication management and general chronic disease management, screening and test results, longitudinal symptom information, measures of the effectiveness of therapeutic interventions, as well as adherence to the interventions by clients and families, should be shared among providers.

b) Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

HFS should definitely offer bonuses for investments in EHR systems, with particular regard to behavioral health providers if the Behavioral Health IT Act does not pass and they are not able to receive substantial incentives from ARRA.

c) If additional incentives were going to be added for being electronically enabled, that would inevitably mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to induce electronic connectivity? What trade-offs would be appropriate to support such incentives? (For instance, should the amount of money available for outcome incentives be reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)

There should be a rate differential or lower base rate for providers until their electronic health records are fully compliant.

d) On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?

In order to expect all practices to be electronically enabled, state agencies' electronic systems would first need to be fully integrated with a data warehouse system that combines physical health and behavioral health data, including claims and care management information, that will produce meaningful and actionable reports on member status and care needs by municipality. An integrated state system will allow for accurate baseline data on which to build the coordinated care program measures. Therefore, the time frame for providers to be electronically enabled is dependent on the length of time required for the State's electronic reporting systems to be updated and integrated.

Sufficient health information systems must include intake, assessment, treatment planning, service utilization, outcomes measurement and pricing documentation.

4. What are the risk-based payment arrangements that should be included in care coordination?

The Medicaid reform law is clear that risk is a key component of coordinated care. Capitated payments paid to traditional managed care organizations are obvious; however, the law is not specific as to whether coordinated care entities need to assume 100% of the risk and other risk-based arrangements might be considered. The Department is mindful that provision of efficient, high quality care is most determined by the people closest to providing that care, and providing appropriate incentives is the best way to fully engage them in focusing on outcomes. We understand, however, for many providers this is a challenge to current operations.

Questions for Comment

a) How much risk should be necessary to qualify as risk-based?

It is difficult to respond with a specific percentage of risk, but we defer to David Lloyd's payment model list, with fee-for-service as the highest payer risk and lowest provider risk to full risk capitation per member/per month. He suggested that a system which is primarily fee-for-service could achieve a shift to a shared risk model of bundled rates/episodes of care rates.

b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

Realistically, as Illinois is primarily fee-for-service, it would be a stretch to implement a model other than pay-for-performance or shared savings, at least in the beginning. A risk/reward system should be structured so that savings from decreases in inpatient costs can be re-invested in outpatient service initiatives.

c) If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?

2013 or 2014, when the ACA is fully implemented, assuming an operational Health Benefits Exchange and an integrated electronic health records system in Illinois with good baseline data and at least one year of performance measurement, would be an appropriate time for a higher level of accountability.

d) What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?

This should be revisited after the coordinated care program has been operating for one year and could possibly be discerned from the integrated care pilot results.

e) In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?

Same as d) above; Research needs to be conducted on states with capitated and shared-savings models.

f) Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

At the beginning, the risk should be shared by the Department and the care entity, with transitions to sharing risk with providers as mentioned above.

g) How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

HFS and the Department of Insurance should make the decisions on risk adjustment, stop loss and reinsurance programs.

h) How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

ACMHAI believes capitation rates must be built on historical intake, assessment, and service utilization data. In Tennessee, for example, the state oversight agencies specify funding for behavioral health services and track expenditures separately from the primary health benefit. If behavioral health is carved-in with primary health care, there must be a shared understanding of the funding associated with behavioral health benefits among the state oversight agencies, the health plans, and the behavioral health organizations. Pooling or blending funding from multiple sources is another way of enabling care coordination entities to provide wrap-around services, perhaps decreasing the limitation of appropriate care for treating complex and expensive conditions.

5. What structural characteristics should be required for new models of coordinated care?

Assuming the Department enters into contracts with entities other than managed care entities, the Department must have criteria to determine if the entity has the capability to successfully coordinate care for Medicaid clients.

Questions for Comment

a) Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?

Initially, Medicaid should contract only with entities with operational, proven models.

b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different

for one and two-sided risk arrangements? Should Department of Insurance certification be required?

Yes, ACMHAI supports the involvement of the Department of Insurance in risk-based arrangements including certification.

c) Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?

Yes, with the exception of rural pilot programs.

d) What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

Requirements should be based on the quality measures established for timeliness to accessing care, distance to and between primary care, specialty care and social service providers, and available transportation to ensure that services are convenient to individuals and families.

Within the network there should be providers with experience in specialized treatment and support programs, such as assertive community treatment for adults and home and school-based services for children.

e) Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

ACMHAI believes it will be necessary to make special arrangements for coordinated care by developing protocols to address the unique needs of highly resistant or difficult to serve, multi- problem adults, children and families. There will be an even higher need for interagency coordination, culturally competent interventions and more effective interventions pursued after review of services utilized. Because of the complex needs of this population, the division of responsibilities and access procedures among state agencies may require a well-defined interagency memorandum of agreement or a legislative proviso. Additionally, the coordinated care entity should provide a mechanism for dealing with members whose behavior is disruptive to the treatment process to ensure specialized support programs to address their needs.

6. What should be the requirements for client assignment?

Care coordination entities must serve an identified population that is enrolled in Medicaid; they cannot exclude any member of the population for which they are responsible – or individually “cherry-pick” their own enrollees. The current Illinois Health Connect program (Medicaid’s Primary Care Case Management program) requires that all Medicaid clients be enrolled with a specific primary care provider. Under the new policy, Medicaid clients may be required to enroll in a specific care coordination program, with enrollee protections to assure quality and access. Steps should be taken to maximize the proportion of clients who voluntarily enroll (self-assign), but when clients do not choose, how should they be assigned?

a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

ACMHAI strongly believes medical necessity must be viewed as a pathway to care, not a barrier, so that services such as home- based care for children and adolescents with severe emotional disturbance (SED) and psychosocial rehabilitation programs for adults are available. Administrative rules should be reviewed and revised to coincide with the coordinated care program. Otherwise, those individuals needing access to specialty care will run up against the same barriers of access to evidence-based programs in their communities because of the belief that they are not covered under Rule 132 or other applicable rules for specialty care.

Clients with specified behavioral health issues should not be required to choose among a different set of providers, but all providers in the program should be able to refer to specialty providers.

ACMHAI has serious concerns about existing medical necessity definitions such as in Part 132 (Medicaid Community Mental Health Services), especially as it pertains to children and adolescents. We see part 132 medical necessity as an example of a barrier to services and believe this definition should be revised and expanded to adhere to the “correct or ameliorate” standard under the federal EPSDT (Early and Periodic Screening, Diagnosis and Treatment) requirements. For example, North Carolina’s definition of ameliorate is “to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient’s condition, it must be covered if the service is medically necessary to improve or maintain the recipient’s overall health.” Jane Perkins of the National Health Law Program contends that a definition excluding the notion of improvement would not be consistent with previous CMS statements. Moreover, under EPSDT, states must cover rehabilitative services if they will correct or ameliorate the child’s condition, and rehabilitative services are defined in the Medicaid Act as those recommended by a physician or other licensed practitioner “for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.” 42 U.S.C. 1396d(a)(13). *(See Appendix D for a Medicaid Managed Care Check List, Appendix E for the North Carolina model EPSDT Policy instruction*

sheet, and Appendix F for ACMHAI's letter to DMH regarding the Medical Necessity definition in Rule 132.)

Concerning enrollment in specific care coordination programs and with specific primary care providers, it would be beneficial from the disease management standpoint to ensure that behavioral issues are not overlooked in the existing disease management program and that care managers work more collaboratively with the behavioral health providers. One of the key principles of chronic disease management is patient education and self-management. The process of engaging a person to accept the status of his or her health and embracing the lifestyle changes required to enhance daily living is focused on changing negative behaviors. Many of the patients with chronic diseases have co-morbid conditions, with depression as the most prevalent.

b) How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

It is very important to stratify by geography, making choices based on public transportation and distance from participants to providers and between providers.

c) Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

Yes, particularly specialty service providers will most likely limit the populations they serve. For example, behavioral health providers would potentially contract with a primary care entity to bring in a physician, nurse practitioner, or physician assistant to provide primary care services for their recipients with SPMI or SED.

In many states, children with severe emotional disturbance (SED) are considered eligible for care management through state Title V CSHCN (Children with Special Healthcare Needs) programs. In Illinois, the CSHCN care management does not include children with SED unless they have a co-existing specified physical disability even though children with SED most often have life long chronic conditions which require expensive medications and frequent hospitalizations. Illinois Medicaid children with SED do not receive integrated care even though they are likely involved with multiple systems and they only receive episodic care management when they experience a crisis. With care management services such as those already available in Illinois for CSHCN, a more holistic and continuous approach to their care might alleviate high cost crisis care, hospitalizations and out-of-home placements. There is an inherent conflict with care management for children with SED in Illinois in that the "case management" must be provided by a community mental health agency that is delivering the treatment. The resulting care management/treatment plan usually involves only the services which that center can deliver, excluding necessary medical

and social services for children with SED to thrive emotionally and physically, adding to the disparity in treatment options facing this special population. **ACMHAI supports an administrative rule change to expand the scope of CSHCN to include children with SED, which will allow them to have the same benefits of care management as other children in the CSHCN program and will reduce high costs of crisis driven care.**

In addition to reducing the high costs of crisis driven care, all CSHCN program participants, including children with SED, qualify for the new Medicaid option that permits enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition, to designate a provider as a health home. The ACA's added incentives to develop this type of health home are: 1) 90% FFP to states for two years; and 2) Grants to states to promote Community Health Teams that support the patient-centered medical home through collaboration with providers, coordination of disease prevention and management, case management, and support for transitional health care needs from adolescence to adulthood.

(Relating to this topic, see Appendix G for the Illinois Public Health Association's resolution to work with other stakeholders to expand access to services under EPSDT through interagency agreements between Title V programs and Medicaid.)

d) On what basis should assignment of clients who have not self-assigned be made in the first year?

Geographic congruence, transportation availability, and history of specialty care use are important factors in assigning clients.

e) One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?

At the beginning, it may be best to auto assign proportionately among the provider pool, but over time it makes sense to auto assign in relation to both cost and health outcomes.

f) Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?

One year seems reasonable if the electronic system for tracking measures and sharing health records is in place at the start.

g) Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?

Clients should have the flexibility to change providers if they are not satisfied with their care. This is an issue that requires the assistance of the care manager and possibly a special advocate.

h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

There may be some lessons to be learned from the Integrated Care pilot to assist in launching care coordination enrollment.

In the children's system, Illinois currently has a SASS (Screening and Support Services) program for Medicaid children with SED who are often the high utilizers of psychiatric hospitalization and intensive community based services. Participation of coordinated care through an MCO could be mandatory for that population as a stipulation for receiving the enhanced behavioral health EPSDT treatment services.

i) How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

This is a policy issue to be resolved at the federal level, but the care coordination could primarily be the same, except that senior service providers and additional payers would be involved.

7. How should consumer rights and continuity of care be protected?

Over the last 20 years, the managed care model has matured significantly. It has moved from an emphasis on disapproving care to an emphasis on actually coordinating care. This emphasis has been reinforced by the more rigorous review of managed care entities (such as NCQA assurances) and, at the current time, there is good reason to believe that the degree of quality assurance and oversight in the managed care market is greater than what exists in the fee-for-service market, in which every patient is required to fend for herself with little oversight or assistance. As part of maintaining, and building on, these improvements, however, it is appropriate to assure that clients have reasonably defined ways of expressing their satisfaction with the care they are receiving and have issues addressed, whether they are enrolled in traditional managed care entities or some alternative coordinated care model.

In addition, after January 1, 2014, the Health Benefits Exchange will become operational under the Affordable Care Act. Newly eligible Medicaid clients in Illinois would likely be offered coordinated care; other clients over the 133% Federal Poverty Level threshold would be shopping for private health insurance, with tax subsidies. The Department is committed to

making sure that clients' can continue to use the same providers, even if their source of funding is changed due to shifting income.

Questions for Comment

a) How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for whom Medicaid is their only coordinated care contact.)

Care managers/patient navigators play a critical role in ensuring participants do not fall through the cracks as coordinated care entities change contractual status. Keeping the payment source current as clients' income levels change should be the function of an updated health information technology system (EVE) at the State level and through Medicaid/HBE enrollment managers.

b) Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs-- such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

It will be important for care managers/navigators to be familiar with the provisions of the Health Benefits Exchange so that they can counsel participants as they may move back and forth between programs. It would be beneficial and less confusing to have a basic health plan for those clients with incomes between Medicaid eligibility and 200%, as they would be the most likely population to move back and forth.

c) Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?

Yes, it would be best for both the participant and the coordinated care entity.

d) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

The client should have the option of a 6-month to 1-year enrollment period before transitioning to a different medical home. Within this time a transition plan should be prepared that addresses the individual's and family's clinical needs to minimize disruption to existing care and to optimize services.

e) What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

ACMHAI strongly supports the involvement of primary consumers and family members in the design, implementation, quality improvement initiatives,

approaches to grievance, and appeal processes by serving on advisory boards or as peer mentors. TennCare, for example, requires that each managed care organization's advisory board includes primary consumers and family members as 51% of its membership. As reported by Monica Oss of Open Minds, recent research by the University of Vermont suggests that when families are actively involved in the treatment planning process of their children, the service plans are consistently less restrictive and less costly over time than those designed solely by professionals.

While the care manager could routinely obtain information from the client about plan quality, it would be more objective to involve a separate advocate to conduct these assessments as well as inform participants of their rights to appeal.

8. What is your organization's preliminary anticipation of how it might participate in coordinated care?

While this paper makes it clear that there are numerous policy issues that are open for discussion, it is our hope that the range of issues raised also makes it clear that the State is committed to testing new models in addition to traditional managed care. Recognizing that any intentions at this point are preliminary, it would be useful to get some sense of how various providers and provider groups are thinking they might participate in coordinated care.

Questions for comment:

a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

The Association of Community Mental Health Authorities (ACMHAI), representing mental health boards across the state that plan, fund and coordinate behavioral health and developmental disabilities services in their communities, would serve as a source of information for providers, social service agencies, other local governmental entities, schools, individuals and families. Additionally, some of the mental health boards may be able to fund care managers depending on the local situation. Many of our members have strong working relationships with their local health departments and federally qualified health centers, and have already embarked on initiatives to integrate primary and behavioral health care. Local mental health authorities could also be instrumental in collecting community level outcomes data and share these reports with the State when the local and state electronic systems are compatible. As funders of community-based organizations such as NAMI, we will support the dissemination of the coordinated care program through these organizations as well as health promotion and wellness information. NAMI and other community-based organizations will be critical for gaining buy-in from individuals and families for the coordinated program. As local mental health authorities are not providers of direct service, we are in a pivotal position to fund ancillary services to support the infrastructure requirements for coordinated care.

b) Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.

Although ACMHAI and our members do not directly serve the Medicaid population, we have funded services for adults and children with Medicaid and many people who are not Medicaid eligible. In anticipation of the exciting changes in local funding of community mental health services with the advent of Medicaid expansion and Health Benefit Exchange, we offer support to help ensure the success of the Coordinated Care Program. ACMHAI proposes a pilot to be conducted in communities with less than 350,000 residents, which have local mental health authorities, to provide coordinated care to specialty populations. Our proposal follows Question 8.e.

ACMHAI also recommends Massachusetts' exemplary program, MassHealth, a Children's Behavioral Health Initiative (CBHI), as a model to successfully coordinate care for children with severe emotional disturbance/disorders. Through CBHI, MassHealth requires primary care providers to offer standardized behavioral health screenings at well child visits, mental health clinicians to use a standardized behavioral health assessment tool, and provides new or enhanced home and community-based behavioral health services. (*See Appendix H for MassHealth's CBHI services listing.*)

c) Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?

Although we are tracking the developments of ACOs, at this time local mental health authorities are not directly involved in forming or implementing an ACO. However, a draft graphic for a proposed public/private partnership to develop an ACO is on page 19.

d) If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?

Yes, this timeline is reasonable.

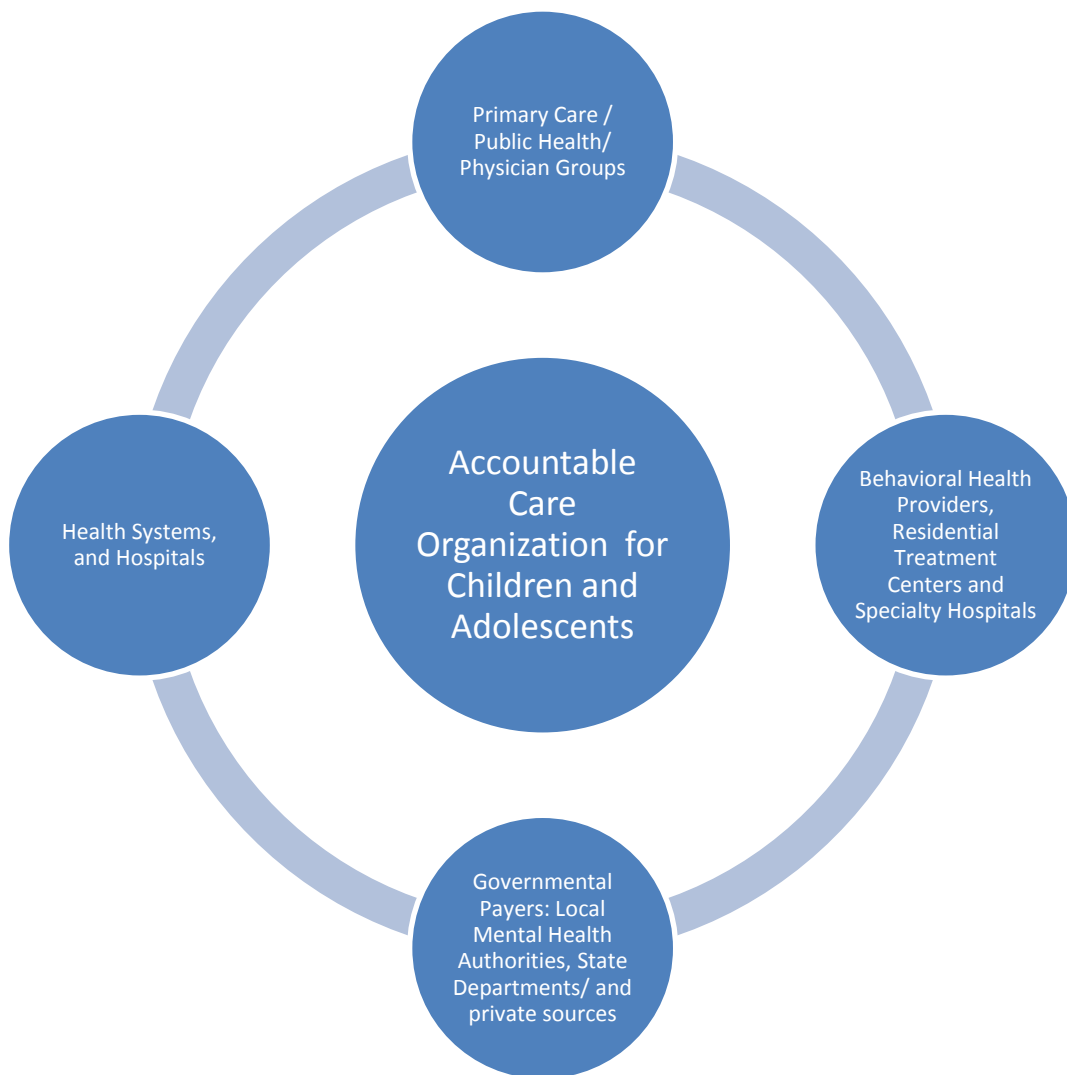
e) For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?

Approximately 90% of our members' funding has been for non-Medicaid clients, especially in the last year with the decreasing State funding for this population. Most of these clients would qualify for the Health Benefits Exchange or move back and forth between HBE and Medicaid.

A group of clients that several ACMHAI members are particularly interested in assisting with the development of a coordinated care program are children with severe emotional disturbance. Coordinated care is critical for these children with so many

families caught in the cycle of having to relinquish custody of their children due to the lack of a continuum of care infrastructure. Implementing the MassHealth (*described above and in Appendix H*) model would address the needs of these children and their families and help Illinois avoid a lawsuit, as Massachusetts had to endure (*Rosie D.*) before initiating this program. A pilot project in one or more areas of the state would be able to demonstrate this approach by mid-2013.

Public/Private Partnership to Develop an Accountable Care Organization



COORDINATED CARE PILOT FOR SPECIAL POPULATIONS

Background: In response to HFS's request for comment on the Coordinated Care Program, ACMHAI Medicaid Committee Members identified the continued need for special strategies to address two vulnerable and medically complex populations. The first population is Medicaid, including KidCare children who have a severe emotional disorder, potentially at risk for psychiatric hospitalization and/or residential treatment and may also have co-morbid physical health conditions such as obesity, traumatic brain injuries, or other developmental issues. These children may have also been or are currently involved in other systems, such as child welfare and juvenile justice.

The second population is adults with severe and chronic mental illness represented by low GAF scores, diagnosis requiring constant psychiatric attention and need for rehabilitative services. This population is at risk for hospitalization and may have co-morbid physical health conditions such as obesity, traumatic brain injuries or hypertension. They may also be at risk for institutional care, such as in nursing homes.

Project Description:

In population areas of less than 350,000 - rural or suburban settings in which the community system can demonstrate coordinated efforts to plan, evaluate, and monitor mental health, substance abuse, and developmental disabilities and an adequate publicly supported provider system specializing in behavioral health and developmental disabilities as well as access to medical provision of care for the Medicaid population, HFS should consider a multi-year pilot to provide for a community based Coordinated Care project. The project is designed to share planning, monitoring and oversight with community stakeholders and to provide eligible services to the defined and enrolled population as stated above on a continued fee for service, non-risk basis. It is expected that cost reporting will be provided by HFS to compare the pilot medical exposure of cost with cost avoidance of inpatient, residential treatment, or institutional care for the same period.

The following principles will guide the project:

- Shared Governance representing a public-private partnership among HFS, Local Mental Health and Developmental Disabilities Authorities and Health Departments, Federally Qualified Health Clinics, Hospitals or Health Systems, and consumers.
- Client centered, family focused approach to care built on Wraparound models for Children and Adolescent and Recovery Action Models for Adults.
- Use of evidence-based practices in all behavioral healthcare provision.
- Appropriate and timely access to care, including specialty psychiatric and medical care.
- Identified quality outcomes that drive performance improvement and documented impact.

APPENDIX A

National Behavioral Health Quality Framework:

Priorities, Goals, Opportunities for Success and Illustrative Measures

DRAFT

Priority Statement	Goal Statements and Illustrative Measures		
<p>#1 – Promote the most effective prevention, treatment and recovery practices for BH disorders</p>	<p>Goal: Prevent and reduce the harm caused by mental illness and addictions</p> <p>Opportunities for success:</p> <ul style="list-style-type: none"> • Reduce suicides • Reduce underage and problem drinking • Reduce binge drinking • Reduce illicit drug use • Reduce tobacco use • Improve functioning • Increase the number of individuals who achieve recovery goals of health, home, purpose, and community 		
	<p>Illustrative Measure: SAMHSA</p> <p>Percentage of clients receiving services who report: improved functioning; improved living conditions; improved social supports</p>	<p>Illustrative Measure: System/Provider</p> <p>Use of recovery measures</p>	<p>Illustrative Measure: Population</p> <p>Percentage of youth/adults reporting binge drinking in the past 30 days</p>
<p>#2 – Assure BH care is person- and family-centered</p>	<p>Goal: Structuring services in ways that meet individual and family needs and making patients centrally involved in decision-making about their care. Includes enhancing capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with behavioral health care</p> <p>Opportunities for success:</p> <ul style="list-style-type: none"> • Integrate behavioral health consumer feedback on preferences and experiences of care into all care settings • Increase use of electronic health records (EHRs) that capture the voice of the behavioral health consumer 		

Priority Statement	Goal Statements and Illustrative Measures		
	Illustrative Measure: SAMHSA Number of States adopting shared decision-making paradigms	Illustrative Measure: System/Provider Percentage of facilities with functioning EHRs	Illustrative Measure: Population Percentage of individuals receiving information to make informed decisions about treatment options
#3 – Encourage effective coordination within BH care, and between BH care and other health care and social support services	Goal: Create a less fragmented and more coordinated behavioral health care system, and improve coordination of this system with other health care and social support systems Opportunities for success: <ul style="list-style-type: none"> • Reduce preventable behavioral health hospital admissions and readmissions • Prevent and manage chronic illness and disability among behavioral health consumers • Ensure secure information exchange to promote efficient behavioral health care delivery 		
	Illustrative Measure: SAMHSA Percentage of grantees that provide screening and/or assessments that are coordinated among or shared across agencies	Illustrative Measure: System/Provider Percentage of individuals with MH/SUD with an inpatient readmission within 30-, 60-, and 90-days of a previous admission for the same condition, as measured by diagnostic codes	Illustrative Measure: Population Percentage of individuals with severe mental illness who report social supports/social connectedness
#4 – Assist communities to utilize best practices to enable healthy living	Goals: Support every U.S. community as it pursues local behavioral health priorities and support individuals in achieving recovery Opportunities for success: <ul style="list-style-type: none"> • Increase the provision of preventive behavioral health services for children and adults • Increase the adoption of evidence-based behavioral health interventions to improve public health 		
	Illustrative Measure: SAMHSA Percentage of service population receiving any	Illustrative Measure: System/Provider Percentage of adults screened for depression	Illustrative Measure: Population Percentage of adults with a behavioral health disorder

Priority Statement	Goal Statements and Illustrative Measures		
	evidence based practice	and receiving a documented follow-up plan, or screened for risky alcohol use and if positive, receiving brief counseling	who report stable housing
<p>#5 – Make BH care safer by reducing harm caused in the delivery of care</p>	<p>Goal: Eliminate preventable and/or adverse behavioral health care induced consequences</p> <p>Opportunities for success:</p> <ul style="list-style-type: none"> • Reduce adverse medication events • Eliminate abuse and neglect in psychiatric facilities 		
	<p>Illustrative Measure: SAMHSA</p> <p>Percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change as a result of PAIMI involvement</p>	<p>Illustrative Measure: System/Provider</p> <p>Number of cases of abuse and neglect in psychiatric facilities</p>	<p>Illustrative Measure: Population</p> <p>Number of individuals with a behavioral health disorder reporting an emergency department visit for an adverse medication event</p>
<p>#6 – Foster affordable high quality BH care for individuals, families, employers and governments by developing and advancing new delivery models</p>	<p>Goal: Reduce behavioral health costs while improving service quality and efficiency for individuals, families, employers and government</p> <p>Opportunities for success:</p> <ul style="list-style-type: none"> • Increase health insurance coverage • Improve access to behavioral health care • Reduce financial barriers to care 		
	<p>Illustrative Measure: SAMHSA</p> <p>Number of admissions to substance abuse treatment programs receiving public funding</p>	<p>Illustrative Measure: System/Provider</p> <p>Percentage of individuals enrolled in health insurance</p>	<p>Illustrative Measure: Population</p> <p>Percentage of individuals who report that financing and/or cost is a barrier to accessing ad/or receiving behavioral health services</p>

Appendix B

Healthy People 2020

Leading Health Indicators

1. Healthy and Active Lifestyle

- a) Increase the proportion of adolescents and adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.
- b) Reduce the proportion of children, adolescents, and adults who are obese.
- c) Reduce food insecurity for children and households.
- d) Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older.

2. Tobacco

- a) Reduce tobacco use by adolescents and adults.
- b) Reduce the initiation of tobacco use among children, adolescents, and young adults.

3. Substance Abuse (other than tobacco)

- a) Reduce past-month use of illicit substances.
- b) Reduce the proportion of adolescents and adults engaged in binge drinking of alcoholic beverages.

4. Oral Health

- a) Reduce the proportion of children and adolescents who have dental caries in their primary or permanent teeth.
- b) Reduce the proportion of children, adolescents, and adults with untreated dental decay.

5. Injury and Violence

- a) Reduce fatal and nonfatal injuries.
- b) Reduce motor vehicle crash-related deaths.
- c) Reduce homicides.

6. Responsible Sexual Behavior

- a) Reduce pregnancy rates among adolescent females.
- b) Increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse.
- c) Increase the proportion of sexually active persons, between 15 and 44 years, who use condoms.

7. Mental Health

- a) Reduce the suicide rate.
- b) Reduce the proportion of adolescents and adults who experience major depressive episodes (MDE).

8. Maternal, Infant, and Child Health

- a) Reduce infant deaths.
- b) Reduce low birth weight (LBW) and very low birth weight (VLBW).
- c) Increase the proportion of pregnant women who receive early prenatal care.

9. Environmental Determinants: Natural and Built Environment

- a) Reduce the number of days the Air Quality Index (AQI) exceeds 100.
- b) Reduce the proportion of nonsmokers exposed to secondhand smoke.

10. Social Determinants

- a) Increase educational achievement of adolescents and young adults.
- b) Improve the health literacy of the population.
- c) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotion development, approaches to learning, language, and cognitive development.
- d) Reduce the number of individuals and households who score highly on the Economic Hardship Index.

11. Clinical Preventive Services

- a) Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.
- b) Increase the proportion of adults with hypertension whose blood pressure is under control.
- c) Increase the proportion of the diabetic population with an A1c value less than 7 percent.
- d) Increase the proportion of persons who receive appropriate evidence-based clinical preventive services.

12. Access to Care Services

- a) Increase the proportion of persons with health insurance.
- b) Increase proportion of persons with a usual primary care provider.
- c) Increase the proportion of persons who have a specific source of ongoing care.

13. Preparedness Infrastructure

- a) Reduce the time necessary to activate designated personnel in response to a public health emergency.
- b) Reduce the time for State public health agencies to establish after action reports and improvement plans following responses to public health emergencies and exercises.

14. Public Health Infrastructure

- a) Increase the proportion of tribal, state, and local public health agencies that are accredited.

Appendix D

Medicaid Managed Care and Children with Special Needs Outreach and the Provision of Information *National Health Law Program*

1. Do guidelines and contracts set forth the specific responsibilities of plans, contracting providers, and the state agency for conducting outreach and to inform special needs children, adolescents, and their families?
2. Will each enrollee be provided information, in writing and face-to-face about:
 - (a) the need for preventive care;
 - (b) EPSDT services;
 - (c) appointment scheduling and transportation assistance;
 - (d) managed care, gatekeepers, and accessing specialists.
3. Will plans be required to document when enrollees decline EPSDT services *and* to deem the rejection as specific to that particular service (so that outreach and informing for future EPSDT services continues)?
4. Will "high-risk" enrollees receive targeted outreach and informing regarding EPSDT (e.g., families of children with developmental disabilities, adolescents, children in foster care, pregnant adolescents)?
5. Will the state agency, health plans, and providers use written and other appropriate means to communicate with persons who are hearing or visually impaired?
6. Will the state agency, health plans, and providers use written and other appropriate means to communicate with children and families who speak a primary language other than English?
7. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees of transportation assistance -- including the availability of medical/specially equipped van transport -- and arranging for or providing non-emergency transportation coverage?
8. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees, if needed, of related transportation services, which include meals and lodging, and the cost of an attendant?

Screening Services

9. Do the managed care guidelines and contracts specify separate screening schedules for medical, vision, hearing, and dental screens and allocate responsibility for each of these screens?
10. Will medical screens minimally include:
 - (a) comprehensive physical health and developmental history;
 - (b) comprehensive mental health and developmental history;
 - (c) a comprehensive unclothed physical exam;

- (d) immunizations as set by CDC;
- (e) laboratory tests, *including lead blood tests*;
- (f) health education, *including anticipatory guidance to the child and family*.

11. Are network providers required to provide health education to family members, including information on monitoring and improving specific health conditions?

12. Are plans/providers required to use mental health and developmental screening tools developed by child health experts in these fields?

13. Do the contracts provide that primary care providers will be trained in the use of mental health screening tools and identification of children needing referrals?

14. Are plans prohibited from requiring prior authorization for periodic and interperiodic screens?

15. Are plans/providers required to make referrals for necessary follow-up and treatment, assure timely receipt of services, and maintain accurate health records for all screening components?

Treatment and Provider Participation

16. Do the managed care contracts list *all* of the services included in 42 U.S.C. § 1396d(a), specify which services the plan is expected to provide, and describe the coordination process to ensure that all services listed in 1396d(a) are met, regardless of who provides them?

17. Are plans prohibited from placing caps on the number of services a child can receive (e.g. 2 psychology visits per month)?

18. If plans are permitted to place tentative limits on treatment services, are the plans required to have an accessible, easy to use prior authorization system to obtain additional medically necessary services without interrupting continuous care?

19. Does the contract specify the EPSDT definition of medical necessity (42 U.S.C. § 1396d(r)(5)(services to correct or ameliorate physical or mental conditions)?

20. Does the contract clearly explain that habilitative -- and not just rehabilitative -- services are covered under Medicaid EPSDT and also who has responsibility for these services?

21. Are plans required to determine medical necessity based on the individual needs of the child?

22. Is the plan required to provide family centered services and involve families of children with special needs in treatment decision making?

23. Does the plan's benefit package cover consumer-run services, family-to-family supports, and family monitoring of care?

24. Are providers encouraged to provide services in a manner that promotes hope, recovery, independence, and respect?
25. Do treatment services emphasize early intervention, use of alternatives to restricted/institutional care, use of self-help, and health counseling?
26. Are plans required to pay for out-of-network second opinions when services are denied to children with special needs?
27. Are plans required to provide written notice to families when services to their children are denied, delayed, terminated, or reduced (i.e. the plan takes an "adverse action")?
28. Are plans required to notify enrollees of the circumstances under which benefits will continue pending resolution of disputes regarding terminated or reduced services?
29. Do the plan's written notices explain the right to a fair hearing to challenge the adverse action?
30. Do contracts specify that the plan must provide "case management" services as defined by the Medicaid Act (to assist individuals in gaining access to needed medical, social, educational, and other services)?
31. Will the plan be required to have a specially designated case manager/case coordinator to assist children with special needs and their families?
32. Will enrollees be informed of the availability of family planning services, both in and outside of the plans?
33. Will plans and providers be required to report encounter data sufficient to complete the HCFA Form 416?
34. Do guidelines and/or contracts include specific incentives/sanctions to assure at least 80% EPSDT participation?
35. Are screening and referral rates publicly disclosed for each plan?
36. Are payment rates adequate to enlist enough providers for special needs children's services so that services are available to Medicaid eligibles at least to the extent services are available to the general population in the geographic area?
37. Does the contract require the plan to make available a pediatrician or adolescent specialist within stated travel standards for every child/family who requests one?
38. Are plans required to guarantee access to pediatric specialists, children's hospitals, school clinics, and other children's providers in their plan networks?
39. Are payment rates adequate to compensate gatekeepers to provide primary care and case management services to children with special needs?
40. Will plans and providers be required to coordinate with other services, e.g. WIC, Title V, Part B and Part H, school based services, Head Start?

41. Are plans required to honor treatment plans developed by, or cooperate with the development of treatment plans under, Part H, Part B, and Title V?
42. Are health plans required to monitor the development of children who are at risk of development disability or delay?
43. Is the plan required to maximize coordination of care and smooth transitions among care-givers and care sites?
44. Is the plan required to honor ongoing plans of care initiated prior to enrollment until the enrollee is evaluated by her or his primary care provider and a new plan of care is established?
45. Do quality of care and outcome measures look for discernable improvements in children's physical and psychological health, community-based living arrangements, and relationships?
46. Do consumer satisfaction surveys include measures of satisfaction with staff, appropriateness and accessibility of care and services, and consumer rights?
47. Are plans required to comply with the Americans with Disabilities Act/ Rehabilitation Act (e.g. facility access standards; treatment in the most integrated setting)?
48. Is each provider and service site wheelchair accessible?

Appendix H

Massachusetts MassHealth Children's Behavioral Health Initiative

Children's Behavioral Health Initiative services include:

- **Outreach:** The state must educate MassHealth members and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT is a federal Medicaid program for children under 21 that emphasizes prevention and early intervention. EPSDT includes periodic well-child visits and screenings.
- **Behavioral Screening:** Health care providers must screen all MassHealth members under 21 for behavioral health as well as physical health during well-child visits. The behavioral health screening tool may be a short list of questions or a checklist that parents/caretakers discuss with the child's health care provider. If the screening shows areas of concern, the child can get further evaluation or treatment, as needed.
- **Assessment:** Children needing further evaluation or treatment are referred to a behavioral health specialist. The behavioral health specialist assesses and diagnoses children using the Child and Adolescent Needs and Strengths (CANS) survey and other tools. Children diagnosed with severe emotional disturbances (SED) are referred to a Care Coordinator.
- **Intensive Care Coordination (ICC):** The Care Coordinator works with family, friends, support service providers, and other team members to develop an Individual Care Plan (ICP). The ICP outlines the child's needs, the family's goals, the treatment schedule, and support services. A major goal of intensive care coordination is to make sure that all medically necessary services are provided in a manner that is sensitive to the child and family's background and needs.
- **Family Support and Training:** Qualified Family Partners paraprofessionals give one-on-one support to parents/caregivers in their homes or other community settings.
- **Mobile Crisis Intervention:** Mobile emergency services are available 24 hours a day, seven days a week, to help children and youth who are having a behavioral health crisis. A crisis team goes to the child/youth in crisis, stabilizes the situation, and helps the child and family get any services they need.
- **In-Home Behavioral Services:** Children and youth with challenging problem behaviors that interfere with their daily lives can get individualized intensive at-home behavior therapy and monitoring.
- **Therapeutic Mentoring Services:** Children who need help with social skills as part of their treatment plan can get one-on-one mentoring to learn how to interact with others in an age-appropriate way.
- **In-Home Therapy Services:** In-home therapy services treat the behavioral health needs of the child, while also helping family members learn how to provide effective support at home. In-home therapy services can help children remain at home instead of being placed in residential treatment facilities or hospitals.

Appendix C

DATA REQUEST ON CHILD AND ADOLESCENT CRISIS CARE COSTS

DATA NEEDED	AGENCY
# Unduplicated Psychiatric Hospitalization Medicaid Eligible Children and Adolescents 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
# Total Psychiatric Hospitalizations Medicaid Eligible Children and Adolescents 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
Average Length of Psychiatric Hospitalization 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
# Repeat Psychiatric Hospitalizations (2-5 times or more per year) Medicaid Eligible Children and Adolescents 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
# Repeat Psychiatric Hospitalizations (6-10 times or more per year) Medicaid Eligible Children and Adolescents 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
# Repeat Psychiatric Hospitalizations (11 times or more per year) Medicaid Eligible Children and Adolescents 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
Average Hospitalization Costs for Day 0-18 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
Transportation Costs paid to and from Psychiatric Hospitals 0-18 2005-2006-2007-2008-2009	HFS/First Transit
Initial SASS Screening Crisis Costs 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH
Hospital Emergency Room Costs (including physician) For SASS Screenings 2005-2006-2007-2008-2009	HFS
Parent/Guardian Transportation Costs to visit child in Psychiatric Hospital 2005-2006-2007-2008-2009	HFS/First Transit
Ratio of SASS Screening Psychiatric Hospitalization/Community Deflection 2005-2006-2007-2008-2009	Tri-Agency SASS HFS, DCFS, DMH

DATA NEEDED	SOURCE
# ICC APPLICANTS 2005-2006-2007-2008-2009	Tri-Agency SASS
#ICG GRANTED 2005-2006-2007-2008	Tri-Agency SASS
#IGC APPLICANTS MEDICAID ELIGIBLE 2005-2006-2007-2008-2009	Tri-Agency SASS
# ICG MEDICAID ELLIGIBLE DENIED FOR LACK OF PSYCHOSIS DIAGNOSIS 2005-2006-2007-2008-2009	Tri-Agency SASS
# RESIDENTIAL ICG 2005-2006-2007-2008-2009	Tri-Agency SASS
AVERAGE LENGTH OF STAY RESIDENTIAL ICG 2005-2006-2007-2008-2009	Tri-Agency SASS
# ICG RESIDENTIAL PLACEMENTS MEDICAID REIMBURSABLE 2005-2006-2007-2008-2009	Tri-Agency SASS
TOTAL COSTS ICG RESIDENTIAL PLACEMENTS 2005-2006-2007-2008-2009	Tri-Agency SASS
COMMUNITY BASED ICG 2005-2006-2007-2008-2009	Tri-Agency SASS
TOTAL COSTS COMMUNITY BASED ICG 2005-2006-2007-2008-2009	Tri-Agency SASS
#JUVENILES ADMITTED TO DJJ For 90 Day COURT EVALUATION 2005-2006-2007-2008-2009	DJJ/AOIC

APPENDIX C

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

2

EPSDT POLICY INSTRUCTIONS UPDATE

Background

Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. “**Ameliorate**” means to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient’s condition, it must be covered if the service is medically necessary to improve or maintain the recipient’s overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients 21 years of age and over). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient’s condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient’s conditions. The services must be prescribed by the recipient’s physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. See the *Basic Medicaid Billing Guide, Section 6* (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information about EPSDT and prior approval requirements.

EPSDT Features

Under EPSDT, there is:

1. No Waiting List for EPSDT Services

EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under 21 years of age.

2. No Monetary Cap on the Total Cost of EPSDT Services*

A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT

services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), the recipient under 21 years of age may receive **BOTH** waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care must not exceed the waiver cost limits specified in the CAP waivers for Children (CAP/C) or Disabled EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

3

Adults (CAP/DA). Should a recipient enrolled in the CAP waiver for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD) need to exceed the waiver cost limit, prior approval must be obtained from ValueOptions.

***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing.**

3. No Upper Limit on the Number of Hours or Units under EPSDT

For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician

To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

6. No Co-payment or Other Cost to the Recipient

7. Coverage for Services That Are Never Covered for Recipients 21 Years of Age and Older

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.

2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services

that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

3. The requested service must be determined to be medical in nature.

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

4

4. The service must be safe.

5. The service must be effective.

6. The service must be generally recognized as an accepted method of medical practice or treatment.

7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

IMPORTANT POINTS ABOUT EPSDT COVERAGE

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. “**Ameliorate**” means to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child’s condition regardless of eligibility for CAP waiver services.

4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance’s (DMA) clinical coverage policies or service definitions or billing codes.

5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

6. EPSDT operational principles include those specified below.

a. When state staff or vendors review a covered state Medicaid plan services request for prior approval or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that:

(1) Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

(2) The decision to approve or deny the request will be based on the recipient’s medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].

b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

EPSDT Policy Instructions Update
07/31/07

REV. 03/23/09

REV. 01/11/10

5

d. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. See DMA's *Basic Medicaid Billing Guide*, **Section 6** (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information regarding the provision of out-of-state services.

e. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.

f. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services regarding further detail about information to be submitted.

g. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

h. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).

i. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in

order to be covered under EPSDT subject to meeting the criteria specified in this policy.
j. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

6

k. Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

l. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

m. The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a reauthorization request.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the CAP waiver program and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).

2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT.

3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.

4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/C or CAP/DA, the cost of the recipient's care must not exceed the waiver cost limit. Should the recipient be enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD), prior approval must be obtained to exceed the waiver cost limit.

5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT" on page 2 of this instruction.

6. EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/MR-DD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.

7. Case managers in the Community Alternatives Program for Disabled Adults (CAP/DA) can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's recipient notices procedure.

No other case manager can deny a service request supported by a licensed clinician, either

formally or informally.

8. When a recipient under 21 years of age is receiving CAP services, case managers must request covered state Medicaid plan services as indicated below. Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.

a. **CAP/C:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

7

vendor and a plan of care revision submitted to the CAP/C consultant at DMA in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.

b. **CAP/DA:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/DA case manager in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. **All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.**

c. **CAP/MR-DD:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to ValueOptions. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **NOT** submit such requests to ValueOptions. Plan of care revisions must be submitted in accordance with the CAP/MR-DD policy.

EXCEPTION: Behavioral health services requested for individuals residing in the Piedmont Cardinal Health Plan (PCHP) catchment area. See item d below.

d. All EPSDT and covered state Medicaid plan requests for *behavioral health services* for Medicaid recipients in the Piedmont Cardinal Health Plan (PCHP) catchment area must be forwarded to PCHP. The PCHP catchment area includes Cabarrus, Davidson, Rowan, Stanly, and Union counties. Requests for *medical and dental services* covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do *not* submit such requests to PCHP. Plan of care revisions must be submitted in accordance with the Piedmont Innovations waiver policy.

9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age.

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by local management entities (LMEs) CANNOT deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.

2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.

3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or LME if providing utilization review for their catchment area. If the request

needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.

4. If a recipient under 21 years of age has a developmental disability diagnosis, this 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 [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

8

PROCEDURE FOR REQUESTING EPSDT SERVICES

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. **If prior approval is required** and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary and meets all EPSDT criteria, including to correct or ameliorate a defect, physical or mental illness, or condition [health problem], to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the *Basic Medicaid Billing Guide*, section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the Provider Documentation section of these instructions for information regarding documentation requirements.

In the event **prior approval is not required** for a service and the recipient needs to exceed the clinical coverage policy limitations, prior approval from a vendor or DMA staff is required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

Services Formerly Covered by Children's Special Health Services (CSHS)

Previously, requests for pediatric mobility systems, cochlear implants and accessories, ramps, tie-downs, car seats, vests, DME, orthotics and prosthetics, home health supplies, not listed on DME fee schedules for recipients under 21 years of age, oral nutrition, augmentative and alternative communication devices, and over-the counter medications were approved and processed by CSHS. These services have been transferred from CSHS to Medicaid as specified below.

Pediatric Mobility Systems, including non-listed components—Send to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form). Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>).

• **Cochlear/Auditory Brainstem Implants and Accessories**—Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.

• **Oral Nutrition Formula on DMA Fee Schedules**—Send requests except those for metabolic formula to HP Enterprise Services. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>). Metabolic formula requests should be sent to the Division of Public Health.

- **Augmentative and Alternative Communication Devices on DMA Fee Schedules**—Send requests to HP Enterprise Services.
- **Ramps, Tie Downs, Car Seats, and Vests**—Effective with date of request September 1, 2008, CSHS no longer authorizes payment for ramps, tie-downs, car seats, and vests. These items are not included in the DME covered by Medicaid, nor are they covered under EPSDT services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered **if covered under the waiver**.

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

9

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but are coverable** under federal Medicaid law, 1905(r) of the Social Security Act, for recipients under 21 years of age. See attached listing. **Medical and dental** service requests for non-covered state Medicaid plan services, and requests for a review when there is no established review process for a requested service, should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs, at the address or facsimile (fax) number specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. Requests for non-covered state Medicaid plan **mental health services** should be submitted to ValueOptions. The Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age is available on the DMA Web site <http://www.ncdhhs.gov/dma/provider/forms.htm>. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a noncovered state Medicaid plan service includes a determination that **ALL** EPSDT criteria specified in these instructions are met.

Requests for the services listed below should be sent to the Assistant Director, Clinical Policy and Programs, DMA and should be submitted on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age as specified at the end of this section and unless otherwise specified.

- **Any other service not listed on the DMA fee schedules for recipients under 21 years of age that appears at 1905(a) of the Social Security Act**
- **Over-the-Counter (OTC) Medications**—If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS), but the drug does not appear on DMA's approved coverage listing of OTC medications.

Send requests for the services immediately above, any other non-covered state Medicaid plan services that are coverable under 1905(a) of the Social Security Act, or requests for a review when there is no established review process for a requested service on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age and mail or fax to

Assistant Director for Clinical Policy and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh NC 27699-2501

FAX: 919-715-7679

Provider Documentation

Documentation for either covered or non-covered state Medicaid plan services should show how the

service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes

1. documentation showing that medical necessity and policy criteria are met;
2. documentation to support that all EPSDT criteria are met; and
3. evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

10

Instructions to Vendors Who Receive Prior Approval Requests Inappropriately from Providers

Vendors (HP Enterprise Services, ACS Pharmacy, CCME, and ValueOptions, etc.) may receive service requests from providers for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests should be forwarded to the appropriate vendor for review. For example:

1. If ValueOptions receives a request for breast surgery, the request should be forwarded to the prior approval section at HP Enterprises Services.
2. Should HP Enterprise Services receive a request for physical therapy, the request should be forwarded to CCME.
3. Should a vendor receive a request for Medicaid Personal Care Services (PCS) for a recipient **under 21 years of age**, the request should be forwarded to DMA, PCS Nurse Consultant, if the PCS clinical policy requires prior approval for the service requested in that case.

It should be noted that there may be a delay in making a decision when a provider sends a prior approval request to a vendor for which the vendor is not responsible for conducting the prior approval review. Once the request is received by the appropriate vendor, a decision will be reached promptly, usually within 15 business days of receipt of the request by the appropriate vendor.

Outreach

A special mailing publicizing Medicaid's EPSDT Policy instructions will be distributed to recipients and their legal representatives in the near future. The document will address general information about EPSDT, the Division's EPSDT Policy Instructions, and procedures for requesting services under EPSDT. This policy instruction shall remain posted at both DMA and DMH websites. DMA and DMH will regularly inform their staff, related DHHS Divisions, vendors, agents, Medicaid providers, families, and other agencies working with children on Medicaid (e.g. schools, Headstart, WIC, Smart Start, etc.) about this EPSDT policy and its procedures for EPSDT services. A summary of this policy and procedure, and a reference to the website address where it is posted, will be included in the Medicaid Consumer Guide for Families, in annual inserts with Medicaid cards, and in Medicaid provider bulletin articles at least annually. All affected staff, vendors, and providers will receive training on EPSDT policy and procedures. DHHS Division Directors will transmit these instructions to staff and vendors/ contractors.

For Further Information about EPSDT

Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the DMA EPSDT provider page. The web addresses are specified below.

Basic Medicaid Billing Guide

<http://www.ncdhhs.gov/dma/basicmed/>

Health Check Billing Guide

<http://www.ncdhhs.gov/dma/healthcheck/>

EPSDT Provider Page

<http://www.ncdhhs.gov/dma/epsdt/>

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

11

DMA and its vendors will conduct trainings beginning fall 2007 for employees, agents, and providers on this instruction. Details will be published as soon as available.

ATTACHMENTS:

Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]

Non-Covered State Medicaid Plan Services Request Form

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

12

LISTING OF EPSDT SERVICES FOUND AT 42 U.S.C. § 1396d(a) [1905(a) OF THE SOCIAL SECURITY ACT]

Inpatient hospital services (other than services in an institution for mental disease)

Outpatient hospital services

Rural health clinic services (including home visits for homebound individuals)

Federally-qualified health center services

Other laboratory and X-ray services (in an office or similar facility)

EPSDT (*Note: EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition*)

Family planning services and supplies

Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)

Medical and surgical services furnished by a dentist

Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)

Private duty nursing services

Clinic services (including services outside of clinic for eligible homeless individuals)

Dental services

Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

Prescribed drugs

Dentures

Prosthetic devices

Eyeglasses

Services in an intermediate care facility for the mentally retarded

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)

Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional

level

- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

DMA-3510 Rev 5 10

1

Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*

This form is available on DMA's Web site at:

<http://www.ncdhhs.gov/dma/provider/forms.htm>.

Definitions of the federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:

http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance,

2501 Mail Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply

any other information you think would be helpful. **Include evidence-based literature, if available.**

I. Recipient Information. This must be completed by a physician, licensed clinician, or other provider.

Name _____

Date of Birth ____/____/____ (mm/dd/yyyy) Medicaid Number _____

Address _____

II. Medical Necessity. All requested information, including CPT and HCPCS codes, if applicable, as well as

provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name _____ Provider Name _____

Medicaid Provider # _____ Medicaid Provider # _____

Address _____ Address _____

Telephone _____ Telephone _____

Fax _____ Fax _____

Requested procedure, product or service: _____ **CPT/HCPCS code:** _____/_____
In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)

What is the recipient's health history? (Include chronic illness.)

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)

DMA-3510 Rev 5 10

2

Name _____ **MID** _____ **DOB** _____

What treatment has been given for the diagnosis(es) above? [Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).]

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition [the problem]. This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? _____ Yes _____ No
If yes, provide name and protocol #

Is the requested product, service, or procedure considered to be safe? _____ Yes _____ No
If no, please explain. _____

_____ **Is the requested product, service or procedure effective?** _____ Yes _____ No

If no, please explain. _____

_____ **Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective?** _____ Yes _____ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available.

_____ **What is the expected duration of treatment?**

_____ **Requestor's Signature & Credentials Date**

Lorrie Rickman Jones, Ph.D.
DHS/DMH
160 North LaSalle
Chicago, Illinois 60601

February 11, 2011

Dear Dr. Jones,

The Association of Community Mental Health Authorities (ACMHAI) would like to comment on the proposed Rule 132 revisions, particularly regarding medical necessity. As another public payer, we seek clarification in order to determine our communities' use of local funds for mental health services, both for adults and children.

To reiterate our position stated in December, the treatment component of EPSDT for children with mental illness and/or serious emotional disturbance is not adequately addressed in Part 132 as currently written and/or proposed. Please consider the following facts and observations:

1. Part 132 (i.e., the Rehabilitative Option) is an optional Medicaid program, while EPSDT is a mandated Medicaid program. This is an important distinction since optional benefits can be modified, while mandated programs cannot be reduced and are subject to a different standard by CMS.
2. As a mandated program specifically for children, the EPSDT has been organized "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." Part 132 fails to address the critical linkages between early screening and treatment which are described above.
3. EPSDT is mandated to provide a comprehensive set of benefits and services for children, different from adult benefits. Part 132 is clearly an adult service driven rule which fails to provide a "comprehensive set of benefits and services" for children.

Our review of HFS and DHS behavioral health treatment services for EPSDT suggests treatment is limited to SASS (Screening Assessment and Support Services) and Part 132 (Medicaid Community Mental Health Services Program). This combination of programs/services falls short of the stated EPSDT threshold of a comprehensive set of benefits and services for children.

According to guidance from CMS and HHS, when determining necessity for services for a beneficiary under age 21, states must conform to the statutory definition of necessity in the EPSDT statute (“necessary to correct or ameliorate”) and cannot impose cost limits through the guise of medical necessity. Moreover, states are not permitted to deny medically necessary treatment under EPSDT solely based on cost or the existence of hard caps on services for adults.

Additionally, Congress intended that the treating physician play a central role in determining utilization of health services in the Medicaid program and that the physician should decide the appropriate type and amount of services for an individual, particularly within the context of EPSDT requirements.

There are many fine examples in other states of EPSDT programs which include a comprehensive treatment component. We would like to discuss these models with HFS and DMH to bring Illinois into compliance with EPSDT standards and requirements. We feel the development of appropriate treatment options for children with mental illness and serious emotional disturbance should be our highest priority. Let’s work together to accomplish this objective.

Sincerely,

Cherryl L. Ramirez
Director
Association of Community Mental Health Authorities of Illinois

Members of the ACMHAI Children’s Mental Health Committee: Dee Ann Ryan (Vermilion County); Peter Tracy (Champaign County); Sandy Lewis (McHenry County); Debbie Humphrey (St. Clair County); Carol Flessner (Livingston County).

cc: Michael Gelder, Senior Health Advisor to the Governor
Julie Hamos, Director, Healthcare and Family Services
Frank Kopel, Deputy Administrator, Division of Medical Programs, HFS
Jackie Manker, Associate Director, DMH



EXECUTIVE COUNCIL
Approved March 31, 2011
Not Approved _____

MEMBERSHIP
Approved June 14, 2011_
Not Approved _____

**ILLINOIS PUBLIC HEALTH ASSOCIATION
RESOLUTION NO. 11
2011**

**EXPANDING EARLY AND PERIODIC SCREENING, DIAGNOSIS AND
TREATMENT (EPSDT) PROGRAM IN ILLINOIS**

WHEREAS, The Early Periodic Screening, Diagnosis, and Treatment (EPSDT)ⁱ Program is a required component of Medicaid, in every state to improve the health of low-income children (up to 21-years-of-age), through two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources;

WHEREAS, the core requirements of EPSDT include not only periodic well-child visits (behavioral, developmental and physical health screens), diagnosis, and treatment services but also must support families' access to these services through methods such as outreach about the program, assistance with scheduling, translation, and case management (care coordination);

WHEREAS, Title V of the Social Security Act was enacted in 1935 as a health services safety net for all women and children, and State Title V agencies can play an important role in guiding state EPSDT programs, as federal rules for the EPSDT program encourage state Medicaid agencies to delegate tasks to Title V agencies to assure access and receipt of the full range of screening, diagnostic, and treatment servicesⁱⁱ;

WHEREAS, recent Medicaid reform legislation mandates that by 2015, 50 percent of Medicaid clients be involved in coordinated care, which includes a full range of health care and support services to address the client's needs;

WHEREAS, Federal financial participation (FFP) is available to share the costs to public agencies of providing direct services under the EPSDT program, including care management;

WHEREAS, other states have developed creative interagency agreements between Title V, Medicaid (EPSDT) and other partner agencies to improve child health, to maximize Medicaid claiming, care management and administrative services, and to improve compliance with federal EPSDT

requirements of ensuring all children with Medicaid receive screenings, diagnosis and necessary treatment through EPSDTⁱⁱⁱ; and

WHEREAS, the State of Illinois has made substantial commitments to the improvement of child health through the expansion of Medicaid eligibility, close coordination between Medicaid and the State Child Health Insurance Program under Title XXI of the Social Security Act and through the creation of the AllKids program; and

WHEREAS, the Illinois Department of Healthcare and Family Services has established Primary Care Case Management as an essential strategy for improving access to primary health care, controlling program costs and providing every child eligible for Medicaid with a medical home;^{iv} and

WHEREAS, the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services and the Illinois Department of Public Health have collaborated successfully in the past in matters related to the EPSDT program, including childhood immunization, lead poisoning, newborn metabolic and hearing screening, school health centers, well-child care, Early Intervention Services for infants and toddlers with developmental challenges and other services which are coordinated with the Title V program; and

WHEREAS, it is very important to the health and well-being of mothers and newborns to have access to mental health services to treat perinatal mood disorder and promote the development of young children; and

WHEREAS, it is important for children and families to have access to mental health and behavioral health care for the prevention and treatment of wide array of conditions;

THEREFORE BE IT RESOLVED, that IPHA advocate for the development of a blueprint to address EPSDT outreach, screening, provider training, monitoring and quality improvement for EPSDT treatment for children, including children and youth with special health care needs, to be led by the Department of Healthcare and Family Services (HFS), in collaboration with the Department of Human Services (DHS) and the Department of Public Health (DPH); and

LET IT BE FURTHER RESOLVED, a workgroup of the Illinois Public Health Association, the Association of Community Mental Health Authorities of Illinois, the Illinois Chapter of the American Academy of Pediatrics, the Children's Mental Health Partnership, and other stakeholders convenes to examine: EPSDT components that are working in Illinois and lessons learned; best practice models in other states of developing a system of EPSDT care which provides oversight in Primary Care Case Management, paying for performance, containing costs, and measuring quality and performance while providing children and families the full range of screening, diagnosis and treatment; and

LET IT BE FURTHER RESOLVED, that responsibility for each EPSDT component is assigned through interagency agreements among Title V programs, HFS, DHS, DPH, and other child-serving agencies before restructuring essential child serving programs among state agencies.

ⁱ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) statute requirement of services necessary "to correct or ameliorate" a child's health condition. 42 U.S.C. § 1396d(r)(5).

ⁱⁱ U.S. Department of Health and Human Services, Health Resources and Services Administration: EPSDT Overview and Title V Rules for EPSDT Linkages.

ⁱⁱⁱ Enhancing Partnership between Title V, Medicaid and Local Health Departments through EPSDT, Webcast, September 2003.

^{iv} As defined by the American Academy of Pediatrics, National Center for Medical Home Implementation