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The Integrated Care for Kids Model (InCK) Model and InCK Marks: Using EPSDT

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Agenda: Using EPSDT

1. InCK Marks Overview and Framework
2. Basics of the Integrated Care for Kids (InCK) Model
3. Basics on Medicaid's EPSDT benefit for children 0-21
4. Role of EPSDT in InCK Model and state InCK design
5. Next steps and opportunities for child health champions

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Purpose and Disclaimer

- InCK Marks developed under funding from the Robert Wood Johnson Foundation and the Perigee Fund to:

  provide resources and supports to child health advocates and experts, practitioner champions, family and community leaders, state administrators, and policy makers regarding reviewing and developing applications for the InCK model.

- InCK Marks has no affiliation with CMS, produces only nonproprietary information, and does not claim to be an authoritative source for developing a competitive application.

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InCK Marks: Modus Operandi

- InCK Marks offers "state of the field" information on Medicaid and child health that brings the best thinking and research to inform application review and to advance innovation in child health
  - Through website, webinars, shared resources from partners, and new syntheses of resources relevant to different aspects of the InCK Model.
- InCK Marks has established a guiding framework that emphasizes:
  1. prevention, early intervention and treatment responses to child health,
  2. a developmental approach that recognizes the need for different responses and pediatric roles by child age, and
  3. building upon high-value, evidenced-based practices and their value in providing care in developing payment systems.

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Frame: Child Health Outcomes by Developmental Stages

Infant/Toddler

Perinatal – Optimal birth outcomes for mother and child

Birth to 3 – Optimal physical health, secure attachment and early development of self-regulation, language, and identity

Child

3 to 6 -- School readiness (physical health, language & literacy, approaches to learning, social & emotional development, cognition)

6 to 11 -- Staying healthy and strengthening social, emotional, and cognitive skills, including learning to read and on-grade school performance

Adolescent

12 to 17 -- Staying healthy and successful in school, responsible behaviors (alcohol, tobacco, and drug use; sexual activity; law-abiding behavior)

17-21 -- Staying healthy and transitioning to adulthood to succeed in the world of work and community, school/lifelong learning, responsible parenting

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Partner Resource Network

Help Me Grow National Center
MHA Mental Health America
Family Support Network
Partnership for America's Children
The National Alliance To Advance Adolescent Health
FAMILIES USA The Voice for Health Care Consumers
CHCS
NCCP National Center for Children in Poverty
Children's Hospital Association
Building Community Resilience
HealthySteps
Family Voices
manatt
Nemours Child Trends
Center for Children and Families
American Academy of Pediatrics
Center for Youth Wellness
Center for the Study of Social Policy Ideas into Action
NICHQ National Institute for Children's Health Quality
CAHMI The Child & Adolescent Health Measurement Initiative
United Hospital Fund
Community Catalyst

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Federal InCK Model Basics

- The Center for Medicare and Medicaid Innovation (CMMI) was established and received $10 billion in funding (over ten years) under the Affordable Care Act to promote innovation in health care payment and service delivery.
- CMMI's grants primarily have supported innovations related to (adult) high cost and chronic care populations in Medicare and Medicaid, including state SIMs grants.
- New *Integrated Care for Kids* (InCK) model is the first CMMI funding effort specifically focused upon children and on social and behavioral as well as physical health.

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Basics – The InCK Initiative Framework

- Provides up to $16 million in funding over 7 years to eight states in competitive grant model ($128 million total)
- Applications described in Notice of Funding Opportunity (NOFO) and due June 10, 2019
- Funds to design and implement an alternative payment model and integrated service delivery model for children prenatal to 21 within a specific, sub-state geographic area
- State Medicaid agency must be involved and partner with a Lead Organization to develop an integrated community model.
- Emphasis includes reducing and preventing unnecessary out-of-home placements and hospitalizations

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Basics: Three Entities Must be Engaged

Medicaid Agency
- Partner with Lead Organization
- Responsible for Alternative Payment Model and data

Lead Organization
- Established entity
- Local convening of Partnership
- Coordination & accountability

Partnership Council
- Represent core service areas
- Chartered, formal, engaged

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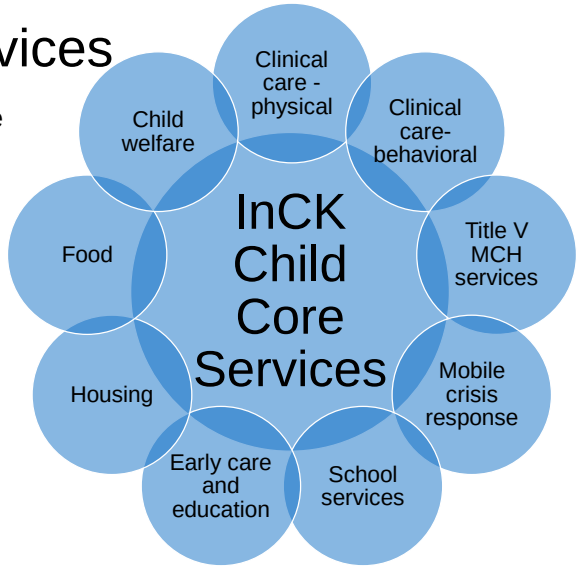
Basics: Child Core Services

- Lead Organizations must coordinate the systematic integration of Core Child Services within model service area for the purposes of integrated care coordination and case management.
- Partnership Council must include representatives from these service areas.
- Lead Organizations and community partners will coordinate these services so families receive an integrated experience of care despite separate funding streams.



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What the InCK NOFO says related to EPSDT

- Includes all Medicaid children (age 0-21) in selected geographic area, all of whom must receive the EPSDT benefit (no specific references to EPSDT benefit or any changes to it in the Notice of Funding Opportunity).
- Risk stratification of children requires additional, integrated care coordination for those at service integration levels (SILs) 2 and 3.
- Direct services paid for by Medicaid/EPSDT or other programs, with InCK payments for integrated care coordination/case management.
- Broad definition of health (preventive, developmental, ecological) consistent with EPSDT benefit and *Bright Futures* guidelines.
- References to responding to ACEs and providing trauma-informed care and providing "health-related services," preference to two-generation approaches also consistent with preventive EPSDT benefit.

WWW.INCKMARKS.ORG

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Understanding EPSDT

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DISCLAIMERS

- Medicaid benefits, EPDST subject to legal interpretation. I am not an attorney (but steal from friends who are).
- Medicaid is administered differently in each state. I am not an expert on all of your state policies or procedures.

EPSDT is the child health benefit package under Medicaid.

- EPSDT gives legal authority to finance for virtually all services Medicaid covers for children.
- States required to finance an array of prevention, diagnostic, and medically necessary treatment services to children.

Source: US HHS Centers for Medicare and Medicaid Services (CMS).
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html and
http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf
Also see: MACPAC https://www.macpac.gov/subtopic/epsdt-in-medicaid/

EPSDT Participation Data

Children in Medicaid receiving at least one EPSDT well-child visit/screen, 2017

State/U.S.	All ages	Under age 1	1-2	3-5	6-9	10-14	15-18	19-20
U.S.	58%	88%	78%	68%	57%	54%	45%	22%

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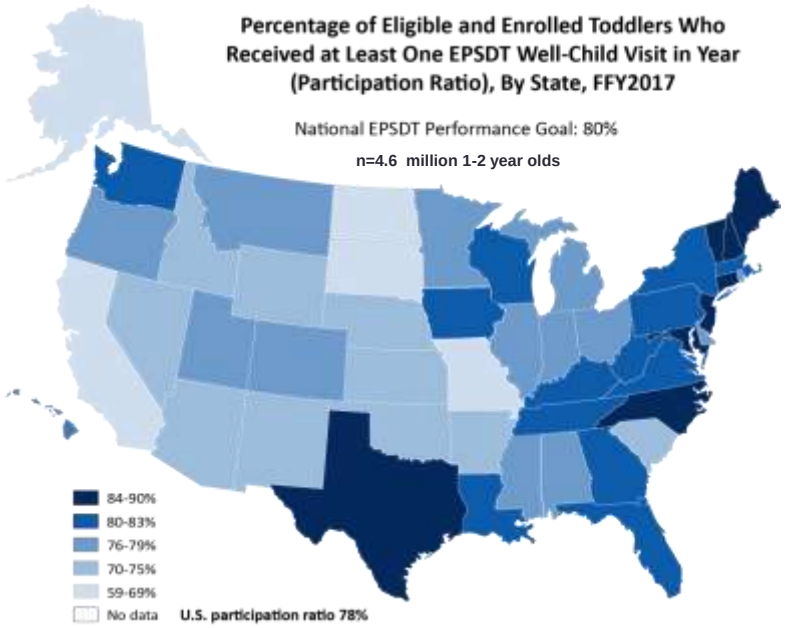
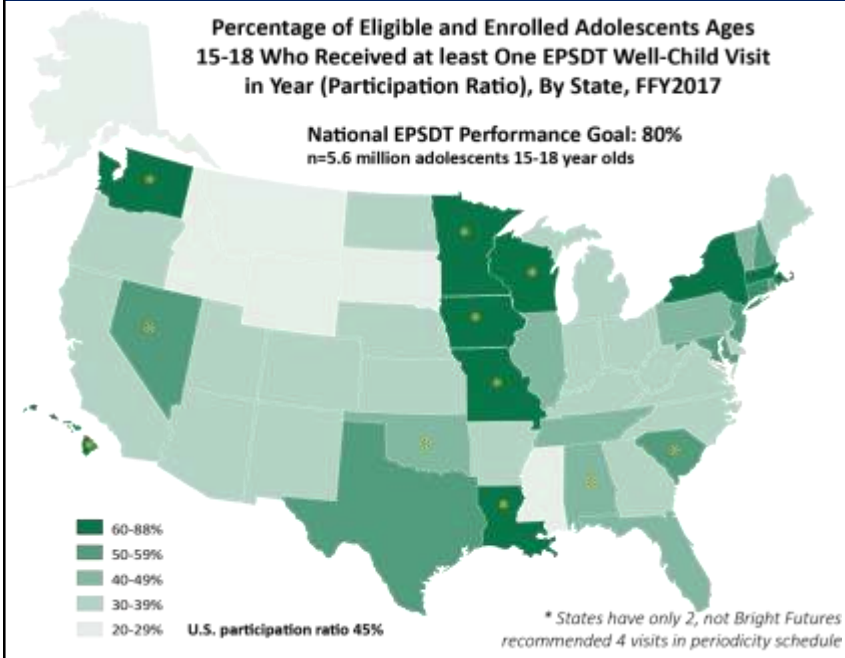


While the AAP Bright Futures schedule calls for 2 visits per year, in about half of states <80% of toddlers ages one and two enrolled in Medicaid/EPSDT receive at least one visit.

The US average is 78%.

Based on CMS EPSDT 416 data for FFY 2017. Also see: Johnson & Bruner. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing high performing medical homes and improving lifelong health*. 2018. Figure 9.



While the AAP Bright Futures schedule calls for annual visits, in most states <80% of adolescents in Medicaid/ EPSDT receive at least one visit.

The US average is 45%.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT is the Medicaid program's federally guaranteed benefit for all Medicaid enrollees under age 21. Under EPSDT, Medicaid must provide a comprehensive array of preventive, diagnostic, and treatment services.

Early and Periodic Screenings

- *EPSDT screening = comprehensive well child visit*
- Regularly scheduled comprehensive well child visits and screening
- Comprehensive unclothed physical exam
- Developmental screening
- Appropriate vision and hearing testing
- Appropriate immunizations (according to recommendations age and history)
- Appropriate laboratory tests (including lead screening)
- Dental screenings and referrals to a dentist (for children beginning at age 1)
- Health education/anticipatory guidance for parents, children, and youth

Diagnostic Services

- Diagnostic services when a risk is identified, including follow-up testing, evaluation, and referrals

Treatment Services

- States must provide timely treatment services based on risks and conditions identified
- Health care or treatment services include those that are **medically necessary** to correct or ameliorate defects and address physical and behavioral health conditions

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Source: SSA § 1905(r); 42 CFR § 441.56

Treatment services

EPSDT Requirements Create a Strong Legal Standard of Coverage for Children Whether in Fee for Service or Managed Care

Medical Necessity	Scope of Services
✓ **Definition unique to children:** Medicaid must cover treatments or procedures necessary to "correct or ameliorate defects and physical and mental illnesses and conditions"	✓ **Scope of services unique to children:** Medicaid must cover all medically necessary services that *could be covered under Medicaid*, **regardless of whether they are covered under the State Plan**

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Source: Social Security Act §§ 1905(r); Centers for Medicare and Medicaid Services, "EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents," (June 2014) available https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

CREDIT: Cindy Mann, J.D. Manatt Health, EPSDT webinar slide presentation 7.18.18

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Medicaid Covered Services for Children– Statute Says…

Under EPSDT, states must cover all medically necessary services, including those that are "optional" for adults

Mandatory Services

- ✓ Family planning services and supplies
- ✓ Federally Qualified Health Clinics and Rural Health Clinics
- ✓ Home health services
- ✓ Inpatient and outpatient hospital services
- ✓ Laboratory and X-Rays
- ✓ Medical supplies and durable medical equipment
- ✓ Non-emergency medical transportation
- ✓ Nurse-midwife services
- ✓ Pediatric and family nurse practitioner services
- ✓ Physician services
- ✓ Pregnancy-related services
- ✓ Tobacco cessation counseling and pharmacotherapy for pregnant women

~~Optional~~ Services

- ✓ Community supported living arrangements
- ✓ Chiropractic services
- ✓ Clinic services
- ✓ Critical access hospital services
- ✓ Dental services
- ✓ Dentures
- ✓ Emergency hospital services (in a hospital not meeting certain federal requirements)
- ✓ Eyeglasses
- ✓ State Plan Home and Community Based Services
- ✓ Inpatient psychiatric services for individuals under age 21
- ✓ Intermediate care facility services for individuals with intellectual disabilities
- ✓ Optometry services
- ✓ Other diagnostic, screening, preventive and rehabilitative services
- ✓ Other licensed practitioners' services
- ✓ Physical therapy services
- ✓ Prescribed drugs
- ✓ Primary care case management services
- ✓ Private duty nursing services
- ✓ Program of All-Inclusive Care for the Elderly (PACE) services
- ✓ Prosthetic devices
- ✓ Respiratory care for ventilator dependent individuals
- ✓ Speech, hearing and language disorder services
- ✓ Targeted case management
- ✓ Tuberculosis-related services

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Adapted from: Cindy Mann, J.D. Manatt Health, EPSDT webinar slide presentation 7.18.18

Source: Social Security Act §1905(a)

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Coverage to promote health and development

- **Examples of key services covered for children, (even if not for adults)**
  - Case management
  - Speech-language-hearing, physical & occupational therapy
  - Eyeglasses and hearing aids
  - Dental care
  - Mental/behavioral health
  - Personal care services
  - Assistive technology and durable medical equipment
- **Focus on optimal health & development**
  - Risk screening with objective tools (e.g., developmental, social-emotional-behavioral, maternal depression, and SDOH)
  - Parent-child "dyad" early childhood mental health treatment
  - Home visiting and other "two-gen" approaches
  - School health and health services related to special education

Sources: Johnson K. *Managing the T in EPSDT*. NASHP. 2010. www.nashp.org/sites/default/files/ManagingTheTinEPSDT.pdf ; NASHP. EPSDT Resources to Improve Medicaid for Children and Adolescents. https://nashp.org/resources-improve-medicaid-children-and-adolescents/ Rosenbaum. www.milbank.org/quarterly/articles/old-new-medicaids-epsdt-benefit-fifty-future-child-health-policy/; Kaiser Family Foundation analysis of 2011-12 data from http://www.kff.org/medicaid/issue-brief/medicaid-restructuring-and-children-with-special-healthcare-needs/ , Johnson and Bruner. Sourcebook. 2018. www.cfpc.org

Three E's for Understanding Medicaid /EPSDT Coverage

- Eligible services covered for
- Eligible and enrolled individuals delivered by
- Eligible and enrolled providers

EPSDT "Medical Necessity"

- "*Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child's needs*." (CMS)

- EPSDT medical necessity definition is broader than private plans
- Medical necessity determinations
  - Must be individualized.
  - Are made by states with health provider input.
- EPSDT purpose includes prevention & early intervention
  - if service will prevention condition
  - if service will improve health or ameliorate condition
  - if service will cure, maintain, or restore health

Medical Necessity for Children

- Broader in Medicaid than in Medicare and private plans ("correct or ameliorate")
- Decision must be made on a case-by-case basis
  - States may not impose hard limits on pediatric services
  - States may impose *tentative* limits on services pending an individualized determination, a decision shared by the state and the child's treating provider
- Medicaid MCOs/ACOs may not use a definition of medical necessity for children that is more restrictive than the state's.

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Helping stakeholders improve EPSDT

Protect and strengthen children's Medicaid benefits under EPSDT at the federal and state levels by:

- Educating and raising awareness among policymakers and other stakeholders about EPSDT and its critical role for children
- Strengthening the capacity for collaborative initiatives between state child advocates and AAP chapters (including technical assistance with 6 states)
- Identifying and executing state-level strategies to strengthen EPSDT protections for children enrolled in Medicaid

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EPSDT and InCK

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EPSDT benefit is central to InCK Model

- Everything Medicaid covers for kids is EPSDT
- Built to be flexible and adapt to what kids need and what we know works
- States have responsibility to make services fit with individual child needs to promote, maintain, and improve health
- We know what works, have evidence-based interventions for prevention and treatment
- InCK provides an opportunity for states to use and test EPSDT flexibility, scale up what works

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Under the InCK Model, states can and should

- Design and apply alternative payment model appropriate for children
- Focus beyond short-term savings
- Finance services that change child health trajectories – prevention today to demonstrate savings long term
- Braid dollars from Medicaid, Title V MCH, IDEA, mental health, child welfare, state & local general revenues, and other funds to maximize resources
- Incentivize high performing pediatric medical homes
- Apply family-centered, two-generation approaches

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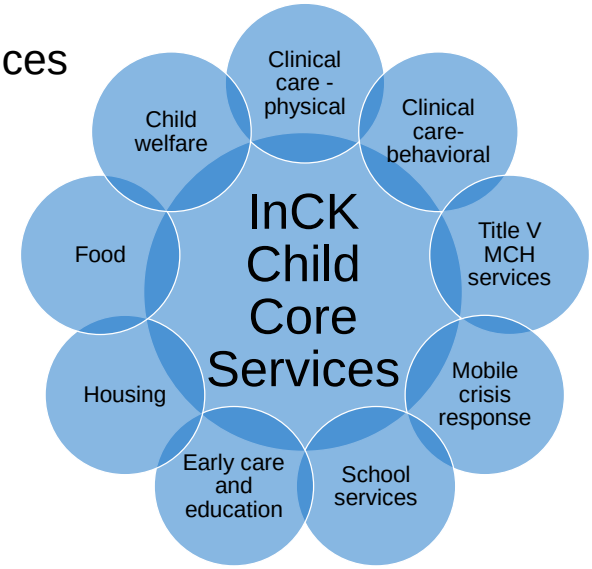
Funds from Child Core Services

- InCK Model assumes resources from each core service area will be used.
- Some are eligible for Medicaid financing under the EPSDT benefit.
- Others/all can be blended and braided to support integrated services, as part of an alternative payment model.



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Today, every state Medicaid program can and should…

- Align with Bright Futures & other care standards.
- Improve quality and performance of medical home.
- Increase use of preventive, developmental, and mental health services.
- Expedite and individualize medical necessity determinations process.
- Use measurement and reward performance.
- Better link Medicaid, Title V, MCH, IDEA, mental health, child welfare
- Use child-focused payment approaches in managed care, accountable care, and value-based purchasing.

Source: Johnson & Bruner. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing high performing medical homes and improving lifelong health*. 2018 . www.cfpc.org

For More Information:

- **Future of Children's Health Coverage Series**
  - https://ccf.georgetown.edu/2016/08/09/the-future-of-childrens-health-coverage/
- **Check Out Our Website:**
  - ccf.georgetown.edu
- **Follow Us on Twitter:**
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Other Resources

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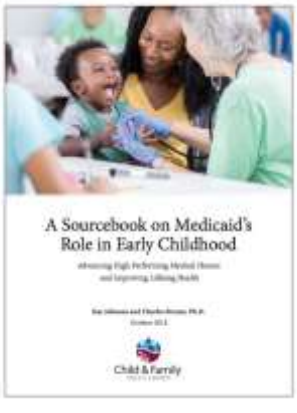
State EPSDT Profiles

https://www.aap.org/en-us/Documents/Using_Your_EPSDT_State_Profile.pdf

New report: www.aap.org/NationalEPSDTReport



https://www.cfpciowa.org/en/issues/health_equity/sourcebook_on_medicaids_role_in_early_childhood/

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Next Steps: **Future InCK Marks Webinars**

- InCK Model and Family-Centered Care
- InCK Model and Prevention – Root Causes and Risk Stratification
- InCK Model and Health Equity
- InCK Model and Alternative Payment Models and High Value Care
- InCK Model and Foster Care

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Next Steps: Champions

- Complete Survey on Webinar
- Sign Up for and Participate in Future Webinars
- Share State Experiences
- Provide Ideas for InCK Marks Activities

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