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Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

MEDICAL NECESSITY AND EPSDT: TOOLS FOR PROVIDERS AND ADVOCATES

WEDNESDAY, SEPTEMBER 20TH
1 PM – 2:30 PM EASTERN

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Agenda Overview

Welcome and Introductions

Marielle Kress, MPP, Director, Federal Advocacy, American Academy of Pediatrics

Overview of Medical Necessity Definitions Across the States

Anne Markus JD, PhD, MHS, Associate Professor, Milken School of Public Health, George Washington University

Best Practices for Ensuring Children Receive Medically Necessary Services: A Pediatrician's Perspective

Angelo Giardino, MD, PhD, FAAP, Chair, Department of Pediatrics; Chief Medical Officer, Primary Children's Hospital, University of Utah

Medical Necessity Decision-Making: A Medicaid MCO Medical Director's Perspective

Greg Barabell MD, CPC, FAAP, Chief Medical Officer, Clear Bell Solutions, Former Chief Medical Officer, Select Health of South Carolina

Discussion

Kelly Whitener, JD, Associate Professor of the Practice, Georgetown University Center for Children and Families

Overview of Medical Necessity Definitions Across States

Anne Markus
Associate Professor
Department of Health Policy and Management

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Disclosure

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EPSDT's Origins

- **SSA Amendments of 1967 (P.L. 90-248)**
  - Evidence that basic benefits were not enough for low-income children enrolled in Medicaid and who need comprehensive services aimed at "ameliorating" conditions that would affect growth and development:
    - *One Third of a Nation* (1964) and health of military recruits
    - Results from Head Start demonstration projects

- **OBRA of 1989 (P.L. 101-239)**
  - Broadened coverage to address benefit limits for children with mental and developmental disabilities

EPSDT's Purpose

- Mandatory, federally-defined preventive pediatric benefit
  - National standard of coverage for children
- More than a preventive benefit, also comprehensive treatment
  - Constructed broadly through a set of rules to cover other federally-defined benefits, including habilitative and rehabilitative care, regardless of whether they are covered for adults under the state Medicaid plan

Scope of EPSDT

Early: Identifying problems early, starting at birth

Periodic: Checking children's health at reasonable, age-appropriate intervals

Screening: Conducting physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnosis: Performing diagnostic tests to follow up when a risk is identified, and

Treatment: Treating the problems found

Examples of Children Who Benefit From EPSDT

- Healthy infants and toddlers with "primary prevention" needs
  - Regular and "as needed" checkups, complete vision, dental and hearing care, parenting support
- Children born extremely prematurely (<1000 g) and at-risk for lifelong disabilities
- Foster care children and children in the child welfare system
- Children with special educational needs and special health care needs

Medical Necessity Definition Under Medicaid

In general, under Medicaid, the medical necessity definition must be consistent with the purpose of the benefit, reasonable, and nondiscriminatory.

State Medicaid Agencies have discretion within these parameters to establish their own medical necessity definition.

Medical Necessity Standard under EPSDT

In the case of EPSDT coverage, medically necessary is defined as “such other necessary health care, diagnostic services, treatment, and other measures described [as medical assistance] to correct or ameliorate defects and physical and mental illnesses and conditions…whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r)(5)

- Medical necessity standard is “built into” the federally-defined EPSDT benefit
- Mandatory, national standard since EPSDT is federally required

Medical Necessity Decision-making Process & Criteria under EPSDT

- States can use prior authorization for certain services, such as DME, medical supplies, but cannot impose hard service limits.
- States have to “employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months” after the initial request. (42 CFR 441.56)
- States must implement a regular process of review to determine whether continued treatment is medically necessary.
- States can cover experimental treatments, using the latest scientific evidence to inform coverage decisions.
- State can cover a cheaper treatment as long as it is clinically equivalent or better, but cannot deny care based on cost alone.

Deference to Treating Provider

Federal Medicaid law mandates that the treating health professional's recommendation for a medically necessary service carry great weight in the evaluation of subsequent diagnosis, treatment, or prevention options.

Private contracting with health plans (MCOs) is likely to have diminished that weight by imposing additional authorizations.

Role of Managed Care

- Most states contract with full-risk MCOs to deliver care to enrollees.
- Most Medicaid-covered children are enrolled in full-risk MCOs.
- Scope of benefits is defined in contracts between each state Medicaid agency and each MCO contractor.
- What is not covered in the contract but medically necessary for a child must be covered by the state (residual liability) regardless of whether the benefits are covered for adults (EPSDT rule).
- Because EPSDT, inclusive of its medical necessity standard, is a federally-mandated standard, it should at a minimum be replicated in contractual provisions to ensure consistency of expectations across the delivery system.

* Source: CMS (2018) Medicaid Managed Care Enrollment and Program Characteristics 2016. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Defining and Determining Medical Necessity in Medicaid Managed Care

Anne Rossier Markus and Kristina D. West

Pediatrics 2014;134;516
DOI: 10.1542/peds.2014-0843 originally published online August 11, 2014;

Research Objective and Design

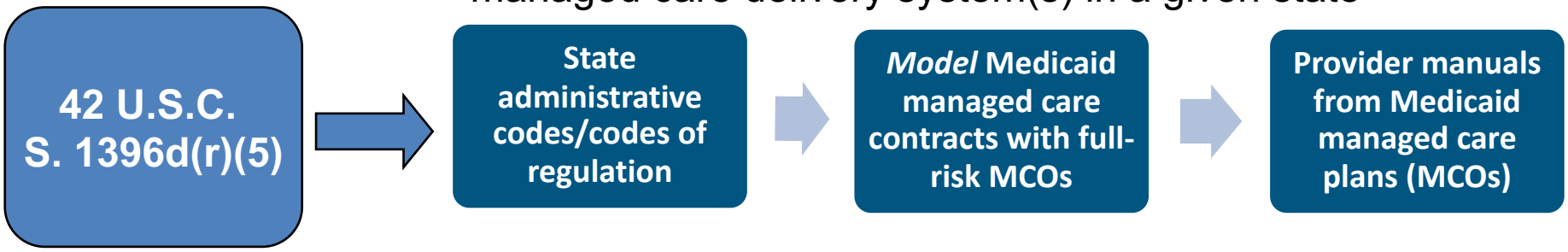
How consistently are federal expectations regarding EPSDT medical necessity replicated within Medicaid managed care at the state level?

Systematic desk review of the “cascade” of legal/policy documents in effect as of Spring 2012 in all states with full-risk MCOs (n=33) to determine the presence of the federal standard and state-specific definitions.

Hierarchy or "Cascade" of Laws and Legal/Policy Documents

Federal standard

Translated into state expectations throughout the Medicaid managed care delivery system(s) in a given state



Source: Markus A & West K (2014) *Pediatrics* Vol. 134, No. 3: 516-522

Main Conclusions

Federal medical necessity standard ("to correct and to ameliorate…") is not replicated consistently within Medicaid managed care from a state to MCOs to network providers.

Explicit "preventive" or pediatric medical necessity definition is not the norm.

Replication of the Federal "to Correct and Ameliorate" Standard by Level

State regulations Yes, in all states (100%)

(n=33 or 100% collected)

MCO model contracts Yes, in 13 states (72%)

(n=18/33 online or 55% collected)

Provider manuals (PMs) Yes, in 29 PMs (54%)

(n=54 online; at least 1 per state; 2 for 78% of states)

Consistency Across All Levels Within States

Few states replicated the federally-required “to correct and ameliorate” standard consistently at all levels of regulation within their state.

Explicit Medical Necessity Definition

Very few states (n=9; 27%) had an explicit "preventive" or pediatric medical necessity definition in state regulations.

Even fewer consistently replicated it at all levels of regulation with their state.

Sample Language Applicable to Children and Adults in MMC and FFS

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that: (1) Will, or is reasonably expected to, ***prevent the onset of an illness, condition, injury or disability.*** *(2) Will, or is reasonably expected to,* ***reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.*** *(3) Will* ***assist the recipient to achieve or maintain maximum functional capacity in performing daily activities,*** *taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.*

Definition from Pennsylvania Medicaid Program found in PA Code & MCO model contract as of Spring 2012.

Other Sample Language Applicable to Children Only and MMC & FFS

A proposed or furnished benefit, treatment, item or service shall be considered medically necessary in the case of individuals under age twenty-one (21) if the benefit, treatment, item or service is covered under the State Plan or pursuant to 42 U.S.C. § § 1396d(a)(4)(B) and 1396d(r) ("EPSDT") and if relevant medical evidence supports the conclusion that the proposed or furnished treatment, item or service is:

(a) Appropriate to the age, functional, and developmental status of the individual;

(b) Consistent with current and generally accepted standards of medical, developmental health, behavioral, or dental practice; and

(c) Likely to assist in achieving one or more of the following:

I. Promoting growth and development;

II. Preventing, correcting, or ameliorating a physical, mental, developmental, behavioral, genetic or congenital condition, injury, or disability that can affect a child's healthy growth and development; or

III. Achieving, maintaining, or restoring health and functional capabilities.

Look for an update

- New Medicaid managed care contract analysis study focused on primary care

- Results anticipated within a year

ENSURING CHILDREN RECEIVE MEDICALLY NECESSARY SERVICES: A PEDIATRICIAN'S PERSPECTIVE

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WILMA T. GIBSON PRESIDENTIAL PROFESSOR
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UNIVERSITY OF UTAH SCHOOL OF MEDICINE
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OVERVIEW

- AAP Committee on Child Health Financing.
  - Essential Contractual Language for Medical Necessity in Children (2005, 2013 & 2018 Draft)
- Clinical Examples
  - Habilitation vs. Rehabilitation Services
  - Off-label Prescription Drug Use
  - Expensive Medications
- Questions/Comments

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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POLICY STATEMENT

Essential Contractual Language for Medical Necessity in Children

FREE

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS
medical necessity, contractual language, pediatric care, children, insurance, health plans, payment

ABBREVIATIONS
AAP—American Academy of Pediatrics
ACA—Patient Protection and Affordable Care Act

abstract

The previous policy statement from the American Academy of Pediatrics, "Model Language for Medical Necessity in Children," was published in July 2005. Since that time, there have been new and emerging delivery and payment models. The relationship established between health care providers and health plans should promote arrangements that are beneficial to all who are affected by these contractual arrangements. Pediatricians play an important role in ensuring that the needs of children are addressed in these emerging systems. It is important to recognize that health care plans designed for adults may not meet the needs of children. Language in health care contracts should reflect the health care needs of children and families. Informed pediatricians can make a difference in the care of children and influence the role of primary care physicians in the new paradigms. This policy highlights many of the important elements pediatricians should assess as providers develop a role in emerging care models. *Pediatrics* 2013;132:398–401

The American Academy of Pediatrics (AAP) published the policy statement "Model Contractual Language for Medical Necessity in Children" in July 2005.[1] The chief principles articulated in that statement are still relevant, but given the structural shifts in the

American Academy of Pediatrics Committee on Child Health Financing. Essential Contractual Language for Medical Necessity in Children. *Pediatrics*. 2013;132(2)396-401

THE PEDIATRIC DEFINITION OF MEDICAL NECESSITY (2013)

Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and

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THE PEDIATRIC DEFINITION OF MEDICAL NECESSITY (2013)

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THE PEDIATRIC DEFINITION OF MEDICAL NECESSITY (2013)

Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to **promote** optimal growth and development in a child and to **prevent, detect, diagnose, treat, ameliorate, or palliate** the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.

American Academy of Pediatrics Committee on Child Health Financing. Essential Contractual Language for Medical Necessity in Children. *Pediatrics*. 2013;132(2)396-401

THE PEDIATRIC DEFINITION OF MEDICAL NECESSITY (2018 DRAFT)

Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities. Furthermore, new evidence, new community influences, and emerging societal changes dictate the form and content of necessary health care for children (Bright Futures, AAP. 2017).

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; **2017**)

FROM A PEDIATRIC PERSPECTIVE

The lack of conclusive scientific evidence should not be the sole reason that coverage is denied. (AAP, 2005)

- assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental anomaly;
- be appropriate for the age and developmental status of the child;
- consider the setting that is appropriate to the specific needs of the child and family; and,
- reflect current bioethical standards.

American Academy of Pediatrics Committee on Child Health Financing. Model contractual language for medical necessity for children. *Pediatrics*. 2005; 116(1)261-261

FROM A PEDIATRIC PERSPECTIVE

….high cost of an intervention should not be the sole basis for services to be denied,

but as cost escalates, it becomes important that the intervention

- achieves a significant incremental benefit,
- and has a compelling evidence basis compared to the next best and less expensive intervention

CLINICAL EXAMPLES

- Habilitation vs. Rehabilitation Services
  - Prescribing Physical, Occupational and Speech Therapy Services for Children with Disabilities (AAP's Council on Children with Disabilities--Draft)
- Off-label Prescription Drug Use
  - Off-Label Medications in the Pediatric Setting (AAP's Committee on Drugs, 2014)
- Expensive Medications
  - Pediatric therapeutic review committee (U of Utah approach)

American Academy of Pediatrics Committee on Drugs. Off-Label Use of Drugs in Children. Pediatrics. 2014, 133:3. 563-567

HABILITATION VS. REHABILITATION SERVICES

Indications:

- Information about:
  - the trajectory of disability associated with the condition,
  - the evidence of the value of therapies to improve functioning, and,
  - how the individual child is expected to benefit from the interventions is important when writing a letter of medical justification.

AAP's Council on Children with Disabilities—Draft -- Prescribing Physical, Occupational and Speech Therapy Services for Children with Disabilities.

OFF-LABEL PRESCRIPTION DRUG USE

- It is important to note that the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use.
  - Therapeutic decision-making should always be guided by the best available evidence and the importance of the benefit for the individual patient.

American Academy of Pediatrics Committee on Drugs. Off-Label Use of Drugs in Children. Pediatrics. 2014, 133:3. 563-567

OFF-LABEL PRESCRIPTION DRUG USE

- Institutions and payers should not use labeling status as the sole criterion that determines the availability on formulary or reimbursement status for medications in children.
- Similarly, less expensive therapeutic alternatives considered appropriate for adults should not automatically be considered appropriate first-line treatment in children.

American Academy of Pediatrics Committee on Drugs. Off-Label Use of Drugs in Children. Pediatrics. 2014, 133:3. 563-567

PEDIATRIC THERAPEUTICS REVIEW COMMITTEE

- The purpose of this committee is to provide consultation to providers who treat patients with _____.
  - The committee shall recommend whether the proposed prescription medication is either more likely than not to provide a significant medicinal benefit that outweighs the risks to the patient
- Membership
- All but one payer agree to process
- Experience

Drs Ed Clark and Fran Filoux

SAMPLE LETTER

UNIVERSITY OF UTAH HEALTH CARE | Division of Pediatric Pulmonary and Sleep Medicine

Pediatric Cystic Fibrosis Therapeutics Committee
University of Utah Health Sciences

RE:

Dear_____:

On 03/28/2018 the Pediatric Cystic Fibrosis Therapeutics Committee met to assist you in determining your patient's suitability for treatment with XXXXX for Cystic Fibrosis.

The consensus of the Pediatric Cystic Fibrosis Therapeutics Committee is that for this patient the likely benefits of treatment with XXXXX outweigh the risks and therefore the committee members recommend that this child/patient receive treatment with XXXXX.

The committee's initial intention is to review the patient's response to the treatment plan after one year.

Please understand that this constitutes the consensus of the committee members based on their understanding of the specific circumstances of this patient.

Please do not hesitate to contact me if you have any questions or if we as a committee can be of further assistance.

Sincerely,

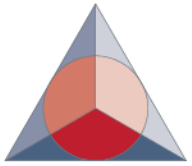
QUESTIONS/COMMENTS

Medical Necessity Decision-Making: A Medicaid MCO Medical Director's Perspective

Greg Barabell, MD, CPC, FAAP

September 20th, 2018

Clear Bell Solutions



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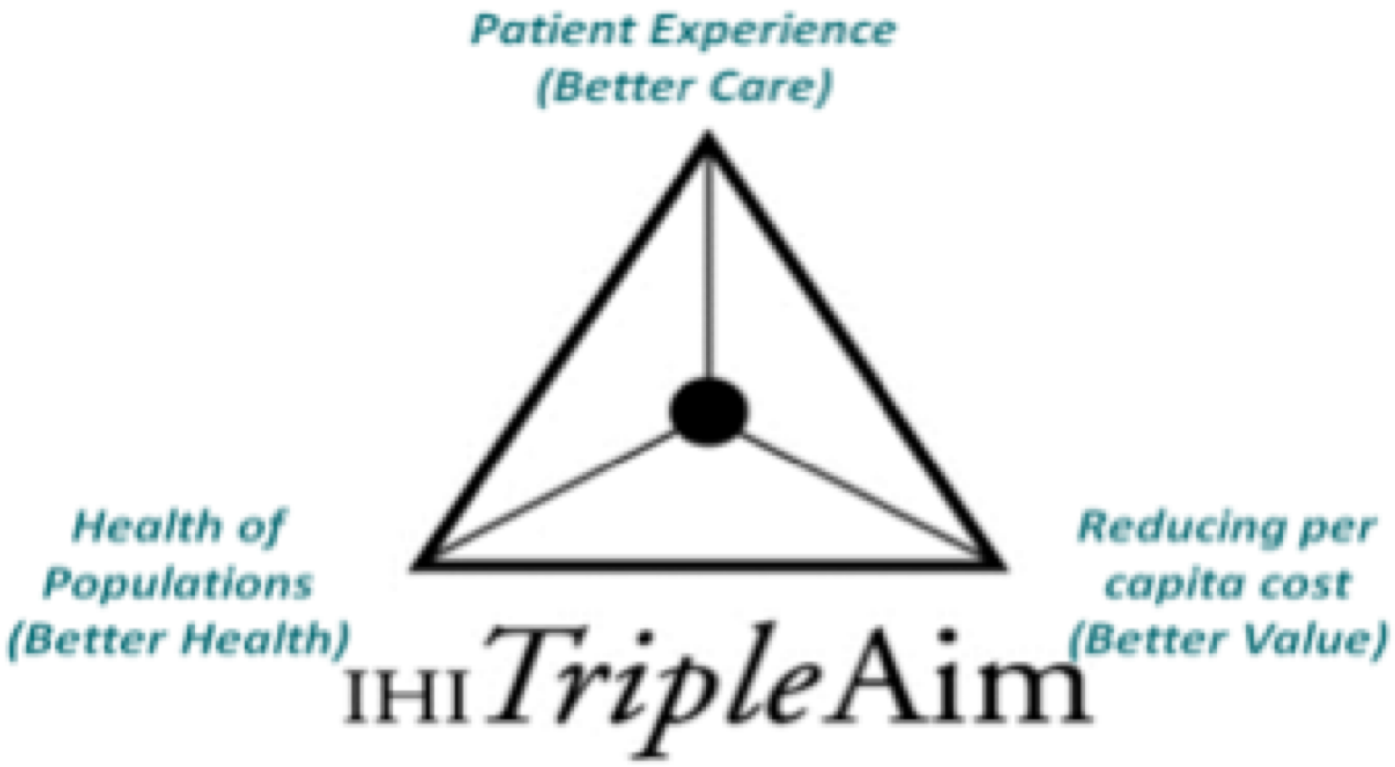
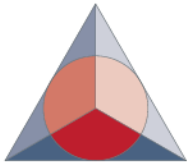
And I couldn't be happier!

Clear Bell Solutions Roots



South Carolina Medicaid Managed Care



Healthy Connections

absolute total care

BlueChoice HealthPlan South Carolina

FirstChoice by Select Health of South Carolina

Your Hometown Health Plan

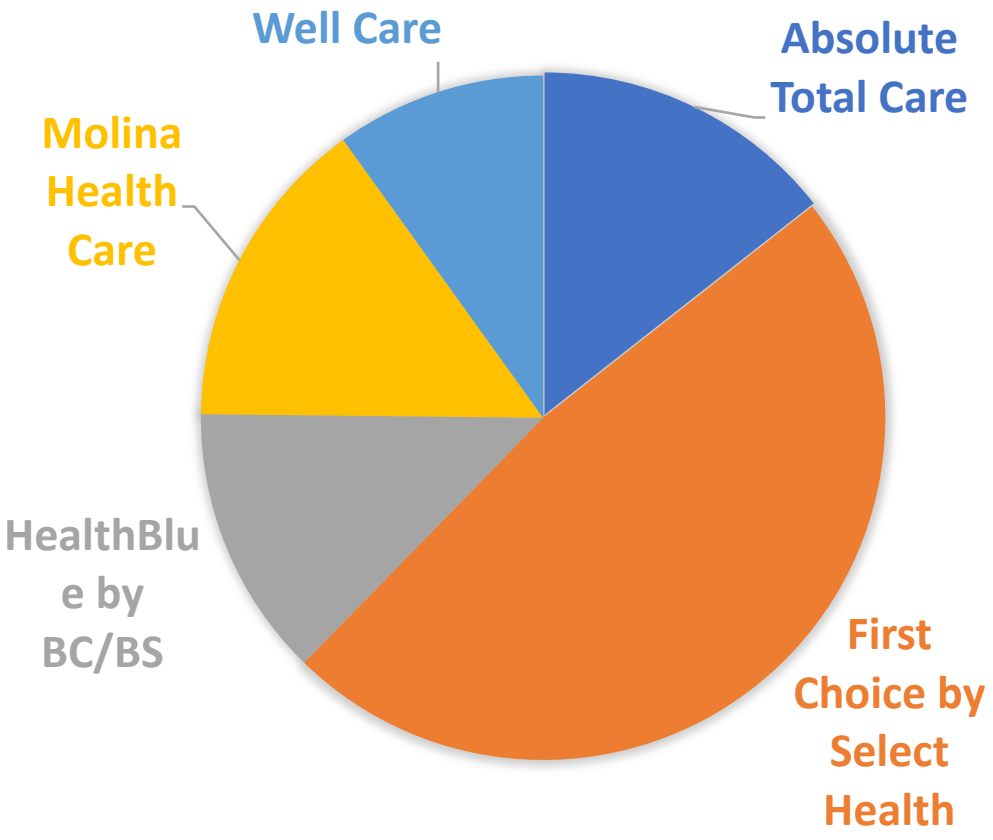
MOLINA HEALTHCARE

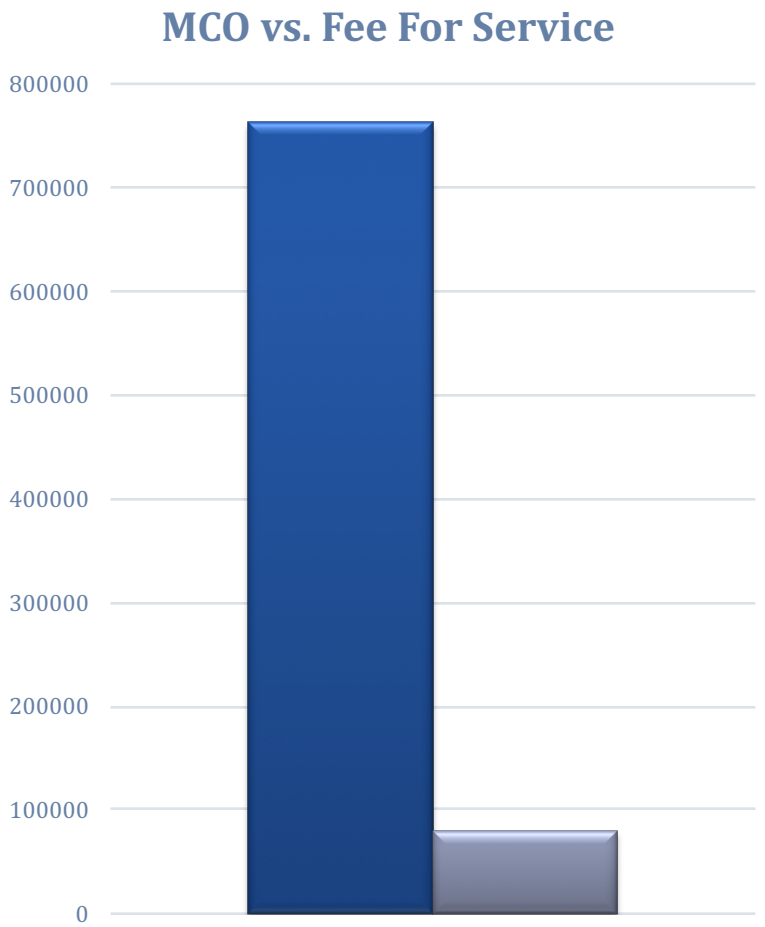
WellCare Health Plans

SC MCO Core Benefits

Ambulance Transportation	Hearing Aids and Hearing Aid Accessories	Outpatient Services
Ancillary Medical Services	Home Health Services	Physician Services
Audiological Services	Hysterectomies, Sterilizations and Abortions (as covered in policy guidelines)	Prescription Drugs
Autism Spectrum Disorder Services	Independent Laboratory and X-Ray Services	Preventive and Rehabilitative Services for Primary Care Enhancement
Communicable Disease Services	Inpatient Hospital Services	Psychiatric, Rehabilitative Behavioral Health, and associated outpatient mental health services
Disease Management	Institutional Long-Term Care Facilities/Nursing Homes for short-term stays	Rehabilitative Therapies for Children - Non-Hospital Based
Durable Medical Equipment	Maternity Services	Substance Abuse
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) / Well Child	Newborn Hearing Screenings	Transplant and Transplant-Related Services
Family Planning Services	Outpatient Pediatric AIDS Clinic Services (OPAC)	Vision Care Services

South Carolina Medicaid Enrollment





Bright Futures as the Standard Definition for Quality

- Bright Futures Periodicity Schedule
- Healthcare Effectiveness Data and Information Set (HEDIS)
- CMS EPSDT Annual Performance Reporting

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

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Bright Futures
preventive and health promotion for infants, children, adolescents, and their families

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

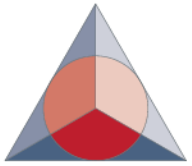
	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	●	★	●	★	★	★	★	★
Hearing		●[8]	●[9]	⟶	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	⟵	●	⟶	●	⟵	●	⟶	⟵	●	⟶	
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]							●				●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	⟶																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunizations[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★		● or ★[26]		★	★	★															
Tuberculosis[27]				★			★		★			★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	⟵	●	⟶	★	★	★	★	★	⟵			●	⟶
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	⟵		●	⟶	★	★	★
Cervical Dysplasia[31]																																●
ORAL HEALTH[32]							●[33]	●[33]	★			★		★	★	★	★															
Fluoride Varnish[34]							⟵				●				⟶																	
Fluoride Supplementation[35]							★	★	★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153197).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)30048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.cuasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟵ ● ⟶ = range during which a service may be provided

Bright Futures as the Standard Measure of Quality



- All resources have specific technical specifications to outline the Who, What, Where, When of a service
- Based on medical and pharmacy claims data

CHILD HEDIS Documentation and Coding Guidelines 2018

UTILIZATION

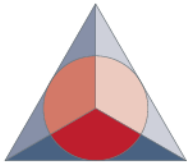
Measure/coding tips	Measure description	Documentation required	Coding
Well-child visits in the first 15 months of life (W15)	Members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	Documentation from the medical record must include a note indicating a visit with a PCP (PCP or OBGYN for an adolescent), the date when the well-child visit occurred, and evidence of all of the following: • Health history. • Physical developmental history. • Mental developmental history. • Physical exam. • Health education/anticipatory guidance. **Common chart opportunities** • Lack of documentation of education and anticipatory guidance. • Children or adolescents being seen for sick visits only and no documentation related to well visits. **Note:** Preventive services may be rendered on visits other than well-child visits. Medical records must include documentation of preventive services.	**Use age-appropriate preventive E&M** **CPT:** 99381 – 99385, 99391 – 99395, 99461 **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9 (Any doctor's office or outpatient visit procedure code meets requirements when billed with ICD-10 codes listed.) **HCPCS:** G0438, G0439
Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	Members 3 – 6 years of age who had one or more well-child visits with a PCP during the measurement year.		
Adolescent well-care visits (AWC)	Members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.		

Bright Futures as Financially Quantifiable Services

- Medicaid Actuaries base part of the monthly capitation rates assuming a person would receive (and an MCO would pay) for all necessary defined services each year
- Increasing use of Withholds or Incentives for MCOs to improve targeted categories

		Including Supplemental Teaching Payments		
Rate Cell	Dec 2016 Membership	SFY 2017 Rate	SFY 2018 Rate	Increase/ (Decrease)
TANF: 0-2 months old (AH3)	7,020	$ 2,077.59	$ 2,167.59	4.3%
TANF: 3-12 months old (AI3)	29,302	265.07	266.07	0.4%
TANF: Age 1-6 (AB3)	179,007	138.10	134.00	(3.0%)
TANF: Age 7-13 (AC3)	201,418	145.21	144.48	(0.5%)
TANF: Age 14-18, Male (AD1)	54,899	155.22	156.73	1.0%
TANF: Age 14-18, Female (AD2)	56,969	179.62	185.26	3.1%
TANF: Age 19-44, Male (AE1)	21,629	230.59	225.89	(2.0%)
TANF: Age 19-44, Female (AE2)	108,504	366.93	341.22	(7.0%)
TANF: Age 45+ (AF3)	16,732	$ 599.05	$ 555.19	(7.3%)
SSI - Children (SO3)	13,731	$ 628.30	$ 682.45	8.6%
SSI - Adults (SP3)	50,738	$ 1,127.33	$ 1,197.01	6.2%
OCWI (WG2)	13,157	$ 362.31	$ 355.08	(2.0%)
DUAL	-	$ 157.94	$ 155.19	(1.7%)
Foster Care - Children (FG3)	4,238	$ 880.80	$ 950.75	7.9%
KICK (MG2/NG2)[1]	2,153	$ 7,164.09	$ 6,855.46	(4.3%)
Composite	**757,344**	**$ 316.43**	**$ 316.93**	**0.2%**

Screening and Diagnosis

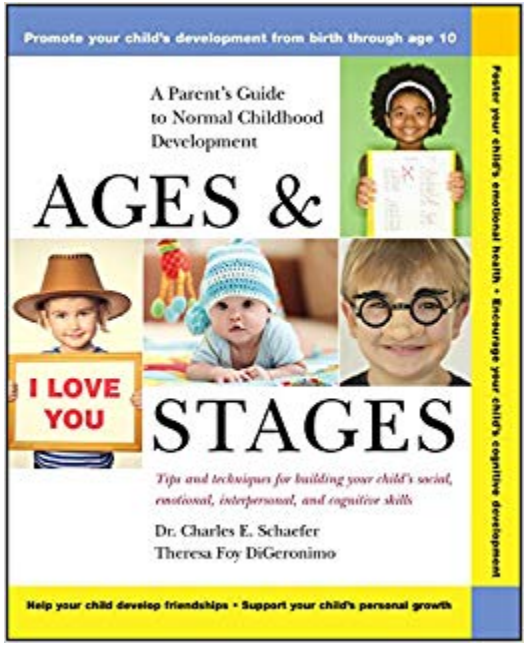


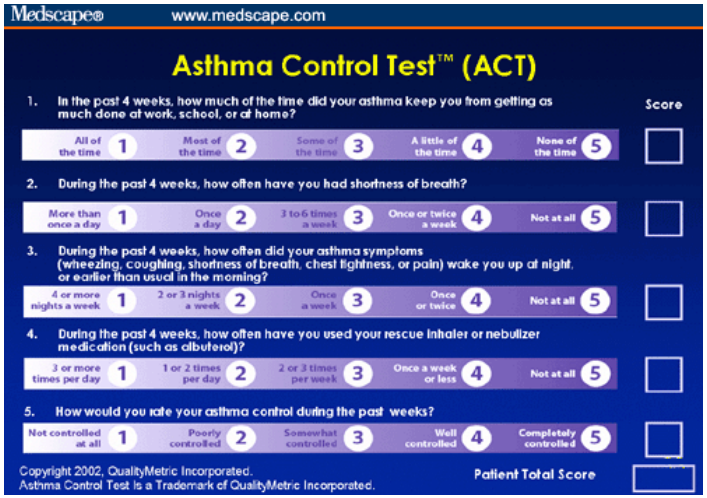
- Section 4106 of the Affordable care Act requires Medicaid to cover preventative services recommended by the USPSTF with a grade A or B, as well as those recommended by ACIP

- State level advocacy is necessary to ensure the services are unbundled and reimbursable

- Denials due to Medicare Policy application
    - National Coverage Determinations (NCDs)
        - Blood Glucose Testing (NCD 190.20)
    - Local Coverage Determinations (LCDs)
        - Ensure appropriate geographic region LCD is used

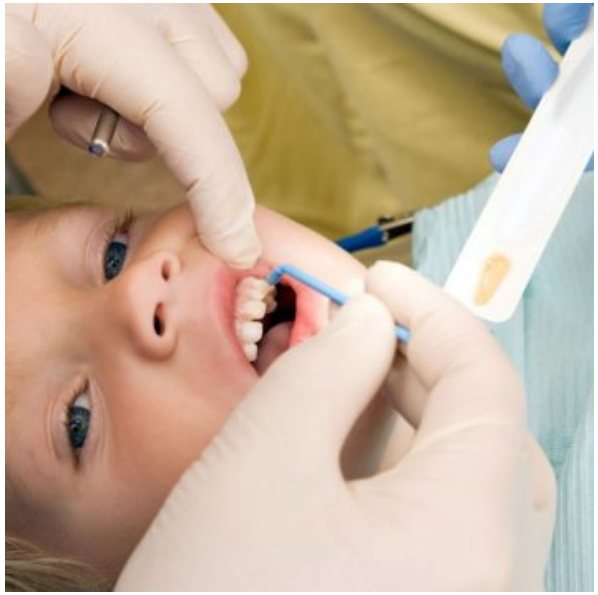
What We've Accomplished in South Carolina





M-CHAT

REVISED WITH FOLLOW-UP

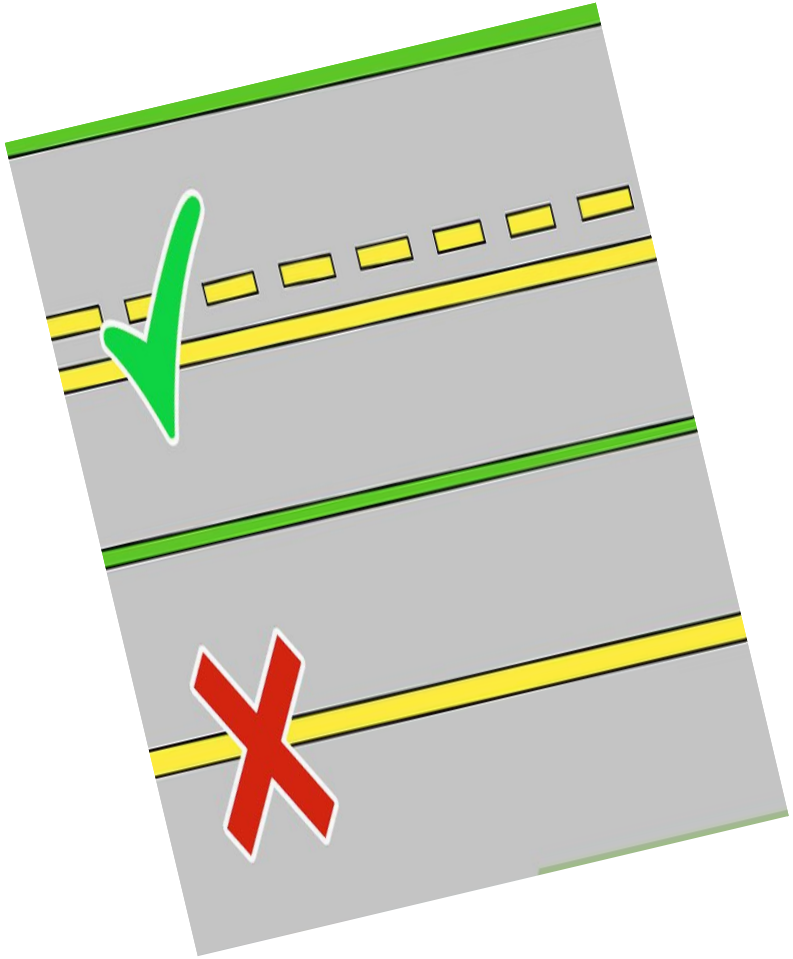


South Carolina – Next Steps

ASK	about tobacco **USE**
ADVISE	tobacco users to **QUIT**
ASSESS	readiness to make a **QUIT** attempt
ASSIST	with the **QUIT ATTEMPT**
ARRANGE	**FOLLOW-UP** care

Medicaid Sets the Most of the Rules

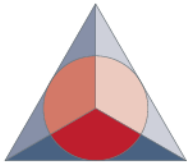
- Fee Schedule
  - Defined Reimbursement
  - Manual Pricing
- Provider Policy Manuals
- MCO Contract with Medicaid
- Policy and Procedure Guide
- Carved In vs. Carved Out
- Similar Covered Services



Managed Care Adds their own

- MCO Corporate Policies – Should be posted on website
- MCO Provide Manual – Compare to Medicaid Manual
- Standard Deviation Rules

Treatment –When You Request



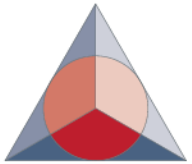
- Defined
  - Objective Summary is Key
  - Still include all applicable documentation with notation/highlighting of referenced information
  - Match objective screening results to level of medical necessity
- Measurable and Longitudinal
  - Define what objective measure of habilitative/rehabilitative function will be modified and to what extent over what time frame.
- Financially Quantifiable
  - Manually Priced → Include Vendor Invoice
  - Not on Fee Schedule → Ensure Vendor will except pricing rules
  - Avoiding other more costly services?

Reviews Available to MCO Members

	MCO Appeal	State Fair Hearing	MCO Grievance
MCO denial or limited authorization of requested service	X	X	
MCO reduction, suspension or termination of previously authorized service	X	X	
MCO denial of payment for a service in whole or in part	X	X	
MCO failure to provide services in timeframe established by state	X	X	
MCO failure to resolve grievances or appeals in timeframe established by state	X	X	
MCO denial of request to obtain services outside network for enrollees in rural areas with only 1 MCO	X	X	
Enrollee dissatisfaction about quality of care or services provided			X
Provider or MCO employee failure to respect enrollee rights			X
MCO denial of enrollee request for expedited appeal			X
Other matters about which enrollee is dissatisfied that are not subject to MCO appeal			X

Source: Kaiser Foundation, A Guide to the Medicaid Appeals Process

Managed Care Appeal Process



Written notice of action issued by MCO, at time of denial of payment,
or at least 10 days in advance of termination, suspension or reduction of previously authorized services

Enrollee requests MCO level appeal
within timeframe established by state
(20 to 90 days from date of MCO's notice)
*Benefits continue while appeal is pending if
enrollee appeals within 10 days of mailing of notice
** Beneficiary has right to appeal even if no notice
sent

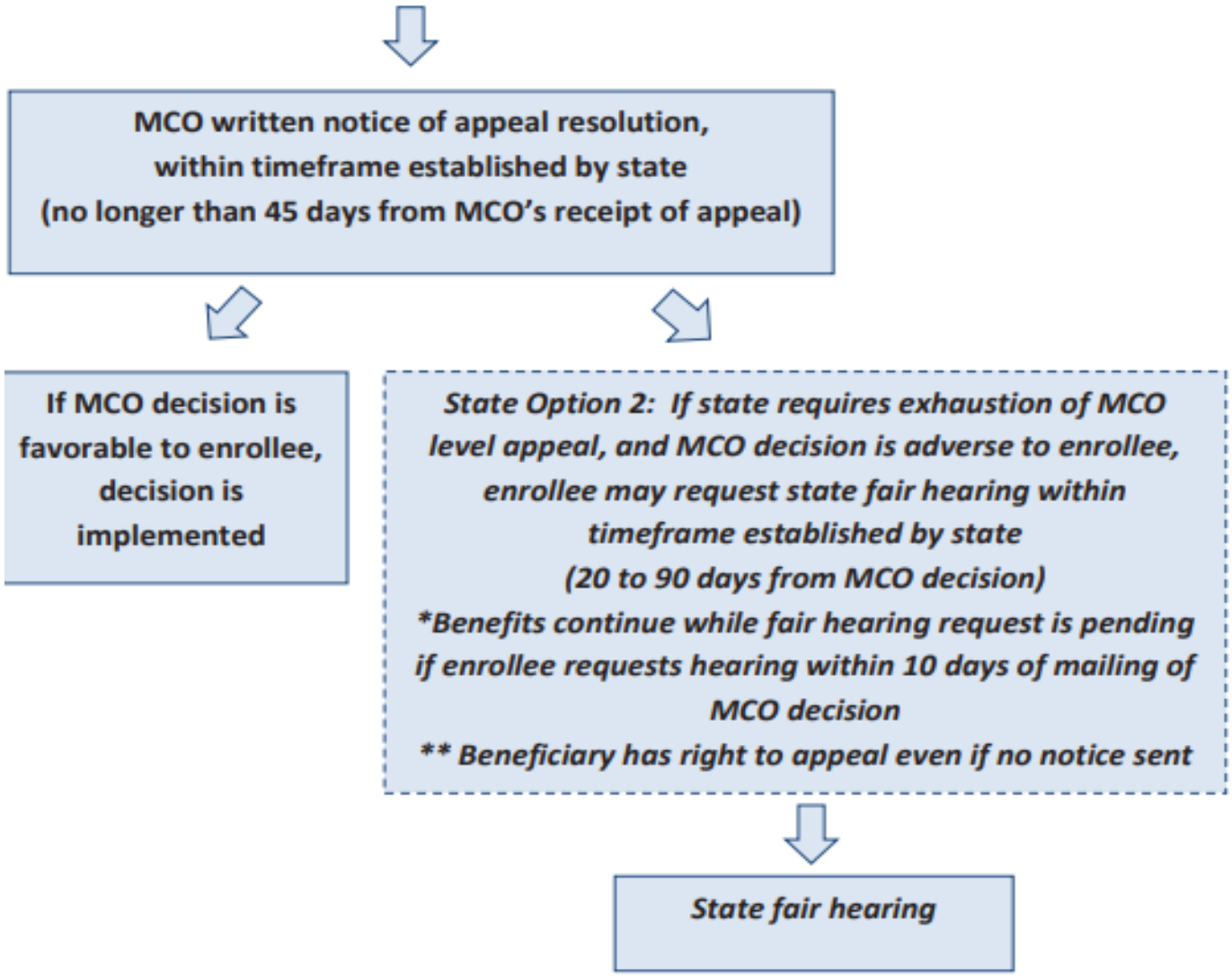
MCO appeal

*State Option 1: If state does <u>not</u> require exhaustion of MCO level appeal, enrollee requests state fair hearing, within timeframe established by state (20 to 90 days from date of MCO's notice of action) *Benefits continue while fair hearing request is pending if enrollee requests hearing within 10 days of mailing of notice ** Beneficiary has right to appeal even if no notice sent*

State fair hearing

Source: Kaiser Foundation, A Guide to the Medicaid Appeals Process

Managed Care Appeal Process (cont'd)



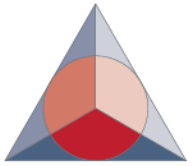
Source: Kaiser Foundation, A Guide to the Medicaid Appeals Process

Required Elements of Notice

	When applying for benefits	When agency intends to take action affecting claim for benefits, such as termination, suspension, or reduction of eligibility or covered services
Statement of intended action		X
Reasons for intended action		X
Citation to specific regulations that support, or change in law that requires, action		X
Explanation of right to request a hearing	X	X
Method by which hearing can be requested	X	X
Right to represent oneself or be represented by legal counsel, relative, friend or other spokesperson	X	X
Explanation of circumstances under which benefits will continue if hearing requested		X

Source: Kaiser Foundation, A Guide to the Medicaid Appeals Process

Treatment Denial – What to do next to Appeal



- Ask for the specific criteria(s) used in determination
  - Clinical Decision Support Tools
  - Medical Evidence Aggregators
- Ask if the determination was made internally or by a 3rd party vendor contracted for review services
- Request a Peer to Peer
  - Understand the restrictions medical directors have in their decision making capacity
  - Form a relationship - Being Known Counts!
- Reformulate Request with the information gathered to speak directly to criteria used. However, Medicaid/MCO still sets medical necessity definition at this point

50-70% of Denials are due to Lack of Documentation!

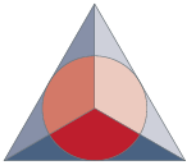
State Fair Hearings – Burden of Proof

The Burden of proof is on the party asserting the affirmative of an issue

- Issue is suspension, reduction or termination of a previously authorized service → MCO or State Agency

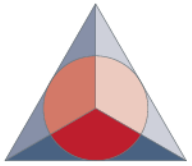
- Issue is denial or a limited authorization of services → Member and Representatives

State Fair Hearings – Avoid Reasons for a Dismissal



- The Office does not have jurisdiction over the subject matter of the request
- The member has not completed a plan appeal
- Untimely Request
- The fair hearing request was made without the members written authorization to do so
- The member does not appear at the scheduled fair hearing without good cause

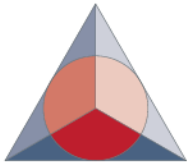
State Fair Hearings Officers



- Credentials and subject matter expertise can vary widely

- The Hearing Officer must
  - Ensure the hearing is conducted in a manner consistent with state/federal regulations and promotes fair, just, and speedy resolution of the proceeding
  - Be impartial to the case giving rise to the state fair hearing
  - Refrain from unilateral communications with each party to the case regarding the substance of issues to be presented; if any such communications occur, the Hearing Officer must document the communication in the record of the fair hearing

State Fair Hearings – Proving Your Case



Evidence should help the judge understand the type of service needed, the level or amount of hours you need, how the service will correct/ameliorate and the consequences of you not getting the service.

- Witnesses – Anyone who can advocate for the service from a professional standpoint
- Records/Documents - This includes letters from your physician, medical records, school records, information about the service or equipment, or any other records that help the judge understand what the service/equipment is and why it is needed
- The Managed Care documentation of the request/appeal process up to the state fair hearings
- Print, Bind, Collate and Bring at least 4 copies

No T → Back to the EPS

- Inter-periodic Screenings to follow metrics defining medical necessity. Longitudinal data can help paint a better picture
- Utilize the MCO Nurse Care Managers. They are vastly underutilized and can be a powerful advocate inside the insurer
- If a child's mental status is effected by the condition, make sure to engage behavioral health resources