

# MEDICAID WAIVER RECOMMENDATIONS: A SYNTHESIS

6/17/11 UHPP DRAFT BASED ON RECENT PUBLIC & WRITTEN TESTIMONY

Specific recommendations are presented in **bold** bullets. Sample relevant comments in *italics* below each bullet.

## Background & General Observations

The Utah Department of Health has asked the community for input on the state's Medicaid "waiver" proposal, the first step in a multi-year process to modernize the way Medicaid services are paid for and delivered in Utah by organizing providers into *accountable care organizations*. Stakeholders and the public have until June 20 to comment on the waiver before it goes forward to CMS (Centers for Medicare and Medicaid Services), the federal agency that oversees Medicaid waivers, on July 1, 2011.

If there is a common denominator or common thread running through the stakeholder input (as presented in 6/7/11 and 6/9/11 public hearings) it is two-fold:

1. The waiver seems heavily weighted toward cost containment as main purpose of Medicaid reform. The focus on quality and better health outcomes is weak or perhaps not as detailed as it should be at this stage of the process. More clarification is needed to determine whether there is an appropriate balance between these inseparable and mutually reinforcing goals.
2. In critical areas (described below) the waiver is lacking in details (*Department of Health said this is on purpose: to get feedback and general direction from CMS as soon as possible*).

*"It is the important that the goal is not just o arbitrarily cut costs without considering the goal of the overall program to serve Medicaid patients (UMA)"*

*With CMS is all about the letter of law: so whatever put in writing needs to be fine tuned. Waiver is ambiguous, risky (Crabtree, U of U).*

*"...but the support of the UMA will depend on the details of the reform and the ability of the Medicaid program under the new system to adequately pay for and provide for healthcare services for Medicaid patients." (UMA)*

## Recommendations by Category

Here we tried to isolate recommendations and arrange examples of relevant input below each in *italics*.

### ACO/MEDICAL HOME STANDARDS/ACCESS TO CARE

- **Need to define medical home at outset (UMA, UHPP, AUCH): definition should support patient-centered medical homes or PCMHs (AUCH, SLCAP, UHPP, Family Voices).**
  - See [American Academy of Family Physicians' definition/standard of PCMHs](#) (Appendix A)
  - Primary care providers should coordinate, not direct care (UMA)
  - Medical home looks more like gatekeeper here—will harm the kids, quality of life (Family Voices)
  - How will the care of enrollees with disabilities be coordinated and managed? How will access to providers with expertise in a range of disabilities be guaranteed? Will the primary care provider be responsible for coordinating non-medical home health and other long-term care services? To what extent? If not, what is the relationship between medical and long term care services? (Disability Law Center)
- **Physicians need to be the front voice for defining what a medical home is and what it means (UMA).**

- **Medicaid ACO contracts should include a provision that would support enhanced payments for medical homes that utilize chronic disease case-managers or require Medicaid ACOs to place such in large volume medical home sites (AUCH).**

*Careful consideration should be given to case-management within the “medical home”. Coordinated case-management between the ACO and the medical home will lead to improved health outcomes and increased savings (UHPP).*

- **We also recommend during the process of defining “medical home” within the Medicaid ACO structure the same accreditation for non-duplication provisions be accepted as meeting and/or exceeding state-specific standards for “medical home” from the following:**
  - NCQA - Patient Centered Medical Home Recognition
  - JCAHO – Primary Care Medical Home Accreditation
  - AAAHC – Medical Home Certification (AUCH)
- **The waiver calls for mandatory enrollment of dual eligible’s but provides no indication how the ACO will work with Medicare: clarify this before submission (UHPP).**

- **Physicians should be able to form ACOs (UMA)**

*... We want to maintain access to care so we need to make sure there is a provision that directs ACOs to allow all physicians who are willing to comply with the requirements of participation to participate and not be kept from providing care by the different ACOs limiting provider panels.(UMA)*

- **Hospitals should be allowed to form ACOs that have the following authority:**
  - must be able to identify their Medicaid beneficiaries at time of enrollment,
  - ACOs must be able to enter into two-sided risk arrangements with physicians and other providers,
  - ACOs must be able to apply ‘best practice’ managed care techniques
  - ACOs must be able to impose additional cost sharing and deductibles if beneficiaries go outside the system
  - ACOs must be able to establish reimbursement rates for participating physicians and other providers **(UHA).**

*ACO structure does not look different from what have now in managed care. CMS wants to see -something different (UHA)*

- **ACOs need to be structured so physicians have a key role in the ACO and in risk sharing.** *Ideally the Waiver should permit flexibility for different groups (insurance plans, physician groups, and hospitals) to organize ACOs. These groups need flexibility to align incentives through collaboration in 1) ACO development and 2) shared risk savings model development. The Waiver should also address what constitutes an ‘ACO’ under the Waiver and the approval process for an ACO to do business with Medicaid (UHA).*

- **Antitrust: Organizing ACOs in the Utah market will likely violate antitrust laws. The FTC and DOJ share jurisdiction over antitrust enforcement. These agencies have issued a Statement of Antitrust Enforcement Policy Regarding ACOs which is now out for public comment. The proposed policy will permit pricing agreements and other normally illegal arrangements to maximize the potentials of integration. The Medicaid Waiver must contain similar flexibility (UHA, UMA).**

- **Waiver of Fraud and Abuse Laws: On March 28, 2011 CMS and the OIG Office of Inspector General) proposed waivers of federal fraud and abuse laws as it pertains to Medicare ACOs. This is critical because ACOs create new and different types of relationships between physicians, hospitals, suppliers, and patients. The application of existing fraud and abuse laws to ACOs could stifle their growth and discourage participation. Utah must adopt similar protections for ACOs under the proposed Medicaid Waiver (UHA).**

- **Medical Records: The Waiver should request that Utah be permitted to allow this medical history sharing upon enrollment of a beneficiary as a matter of course, i.e. the patient is presumed to have automatically opted in. However, If necessary to gain approval of this**

provision from CMS the Waiver could contain a provision that allows the beneficiary to 'opt out' of this requirement (UHA).

- **Nutritional Counseling:** ACOs present opportunity to integrate medical nutrition therapy, which is evidence-based and plays a vital part in well being. *Cost of nutrition consult in Medicare: \$27. Vs. \$57 for doc (Utah Dietetic Association).*

## COST SHARING

- **Create a sliding scale, or a tiered program, acknowledging that different incomes and populations have different abilities to cost share** (UHA, UHPP, SLCAP, Family Voices, others).  
*Main concern is kids w/special health care needs. Could we have tiers on co-pays? Don't want to be unfair to other families, but our kids are not average families (Family Voices).*
- **Provide cost-sharing protections for disability and vulnerable Medicaid communities.**  
*-The changes are startling, of course. I owned my own home before came down with progressive systemic sclerosis. No housing allowance, so no roof repairs at cost of \$6K for 30 years. SSI income is \$7K: so any increase in costs is devastating. For ex: unable to get copy of waiver because not on line, because costs too much! (Rawlins, Dually eligible).*  
  
*Those on waivers are high utilizers. So what would higher cost sharing do to families, especially those that already have co-pays with their private insurance? (Family Voices).*  
  
*...I am writing you today about the proposed changes to Medicaid. My concern is how will the changes affect us people with disabilities for medical. I hope the proposed reforms will make Medicaid better for all of us (Thomas W. Brownlee)*
- **Changes in cost sharing should guard against this (cherry picking) scenario...**  
*-Giving MCOs flexibility to vary co-pays to reward certain health behaviors could place persons with chronic conditions and extensive medical needs at an inherent disadvantage. Under the proposed scheme, nothing stops the plans from using the co-pay structure to draw healthier clients to their Medicaid product, effectively cherry picking. (UHPP)*  
*-What prevents ACO's from using identification data to avoid enrolling kids w/special health needs (DLC)?*
- **Cost sharing changes should be aligned with the intent of Accountable Care Organizations and with changes in ACA related to coverage of preventive care** (UHPP).
- **Take EPSDT out of the proposal entirely:** these families have unusual non-medical expenses needed to address medical conditions (Family Voices)  
*EPSDT is a Federal Guideline for all children who use Medicaid. All children have the right to Early, Periodic, Screening, Diagnosis and Treatment, and these things are federally mandated as "medically necessary". Children with chronic special healthcare needs are an especially vulnerable population. Our kids' needs are ongoing, and most of us have other insurance copayments... for many of us on M, that piece is the wrap around to meet kids needs. What not in plan helps us keep our kids and be productive members of society (Family Voices).*  
*...All of the co-pays together are prohibitive. It's not just medical expenses that kids have: for 9 years we'd lift daughter in & out of van...had to buy specialized vehicle: cheapest = \$32K. Must change shocks & brakes every year. Please take all of our expenses into account (Christine Evans, Family Voices).*  
*...families are cost sharing. Could choose to not pay premium & just have child on full Medicaid. So why punish us? (Tina, Family Voices)*
- **Kids on Disability waiver/waiting list should be exempt from increases to 5% cap.**  
*Tina on tech dept waiver: I didn't want this waiver, but told will need it. Finally took it: has allowed us to remain taxpayers, my husband gets to advance in his job & not work at 7-11 to stay in income range. That's why those exceptions were created in first place.*
- **Cap on Rx copays** (LCPD)
- **Process copays like spend down where out of pocket spending will count toward deductible** (LCPD)

## FINANCING

### Medicaid Restricted Account:

- **Medicaid needs to have first call on the Rainy Day Fund to insure that its needs are met before the Fund is used for other purposes.** *A minimum balance should be retained in the fund to make sure it is not depleted and unavailable during tight state revenue years. One suggested funding source is to deposit any collections from Medicaid provider recoupments into this account (UHA).*
- **Arrange to tap into restricted account earlier than trigger proposed.** *Should be based on what general fund willing to provide. Under SB180: defines state revenue as all revenues except federal. So GME etc is lumped into this: no way to put some of these into the gap. A little tweaking of law would allow us to not reduce benefits (U of U)*

### Hospital assessment:

- **The present Utah Hospital Assessment and related Intergovernmental Transfers (IGTs) for government owned hospitals which include the State Teaching Hospital must be protected.**  
*Introducing more managed care reimbursement will require new methodologies for identifying Medicaid inpatient activity and refining the assessment to maintain adequate funding for the program. It is also critical under the new 'managed care' PMPM reimbursement arrangement that the State insures hospital assessment funds are maintained for hospital related reimbursement and not diverted to fund other non-hospital medical services.*
- **Exchange/private market option for Medicaid could siphon critical funding out of Medicaid: **do a cost-benefit analysis before considering such a change**** (UHA, Disability Law Center, UHPP).
- **Rurals:** Until a rural area does come forward to join the Waiver project rural hospitals continue to receive a "rural differential payment" for both inpatient and outpatient services during the life of the waiver consistent with current policy (UHA).

### Budget Neutrality

- **On cost neutrality: fed law allows flex on this calculation. Maximize this (IHC)**
- **Reinvest the savings in incentives programs like those approved for CA (U of U)**

## POPULATIONS AND PROGRAMS IMPACTED & DISEASES TO BE MANAGED

### Disability Children:

- **Exempt the possibility of cutting children's health care required by Federal EPSDT Guidelines. EPSDT is a safety net for ANY CHILD who uses Medicaid for Health Care, not only children who live with disabilities. This set of guidelines was carefully put together in the interest of all children so that they may have **Early Periodic Screenings, Diagnosis and Treatment.**** (UHPP, UT Family Voices, Voices for Utah Children, others)  
*Jody Hansen: I have son with special health care needs (cystic fibrosis, CP, seizure disorder). We are charged for medicine, feeding supplies, diapers... The proposed 5% cap would have us spending \$380/month-- Too much. When he goes to hosp, they do a "clean out". That bill is \$65-80,000 each time. \$3250 would be co-pay. Last year was in 3 times. We have to do clean out every year, no matter what. \$25K paid for van, 6 years old. Because of the van equipment, constantly changing parts. Had to buy house in Eagle Mtn, so accessible. Adds \$400-500 to monthly cost. It's not that not trying to do all we can; insurance pays 80% and M pays balance. If we paid 5% on that 20%: still too much. For some of these kids, paying double coverage. We need something that gives us credit for paying 1 side of co-pays on other, M side. \$2500 extra—just don't have it. We're not taking vacations in Hawaii, etc.=Too much. When he goes to hosp, they do a "clean out". That bill is \$65-80,000 each time. \$3250 would be co-pay. Last year was in 3 times. We have to do clean out every year, no matter what. \$25K paid for van, 6 years old. Because of the van equipment, constantly changing parts. Had to buy house in Eagle Mountain, so accessible. Adds \$400-500 to monthly cost. It's not that not trying to do all we can; insurance pays 80% and M pays balance. If we paid 5% on that 20%: still too much. For some of these kids, paying double coverage. We need something that gives us credit for paying 1 side of co-pays on other, M side. \$2500 extra—don't have it. We're not taking vacations in Hawaii, etc.*

- **Exempt children with chronic health care needs from cost sharing and benefit changes.**
- **Exempt also all kids on disability waiver waiting lists.**

*These families are on waiting lists for much needed help because the medical costs they are incurring are taking all of their income and requiring them to find lower paying jobs just to meet income eligibility standards so their child can receive the care they so desperately need.*

*We were on the D waiver and told would be years to get on Travis C waiver. The thought of 5% may not sound like much, until supporting 9 people (7 kids). Thrift stores, coupons, limited activities since birth of 1<sup>st</sup> child. 5% would make it even harder (Utah Family Voices)*

*We're told even if have flu, are told to go to hospital—in case shunt is failing ,etc. So can't go against medical advice may be in conflict with new pressure to avoid the E.R.(Family Voices)*

#### Mental Health:

- **This is our chance to integrate behavior health into rest of care in medical home.**

*Head bone connected to neck bone (Joyce, LCPD)*

*Why is inpatient psych carved out? Why are psychology and substance abuse treatment carved out? Are all mental health services carved out or just those for treating severe and persistent mental illness (DLC)?*

- **We support the goal of integrating Rx benefit as part of ACO contract.** *If held financially responsible, ACOs can manage the pharmacy costs. Need integrate MH care. Clients forced to navigate many health care systems. If care driven thru 1 access point, 1 ACO, patients can better meet their needs (Molina).*

#### Long Term Care:

- **Waiver does not tackle LTC which is major cost driver.** *This perpetuates the institutional bias (LCPD, Disability Law Center).*

*To the state's clarification that those on waivers that are enrolled in plans will stay where they are, BUT will be subject to higher cost sharing, a radical proposal...are we thereby undermining the shift to home and community-based services? (Kris, LCPD)*

*Is personal care considered part of LTC? What about private duty nursing? (DLC)*

#### Disease Management:

- **Expand on this for sake of consumer-friendly cost containment and better health outcomes.**

*Why is the list of conditions subject to disease management so limited? Why not the highest cost diseases like diabetes and heart disease? (DLC, UHPP)*

#### Latino and LEP (limited English proficiency) Population

- **In the transition to more electronic forms of communication, ensure linguistically and culturally appropriate communications with patients whose primary language is not English or who may not be comfortable or capable of using electronic modes of communication.**

*The main concerns that were voiced were in regards to the change in the way Medicaid will communicate with clients. Even though I agree that saving 6 million dollars by switching to e-mails as a way of communicating with clients is important, I am afraid that issue will become a barrier for Latino immigrants and could possible result in disenrollment (Maintaining good relationship with provider/Medicaid administration) (Midvale City/minority health perspective on MCAC)*

## PRIORITY LIST

- **Specify the details of the priority list process and how it will operate to ensure quality and access to all medically necessary care while providing good cost containment for the state (UHA, UHPP).**
  - Create a Health Benefits Commission (HBC) comprised of expertise from the private and public sectors to define a minimum level of coverage that individuals must have. The Commission establishes standards and processes for minimizing wasteful procedures (AUCH, UHPP).
  - Create (something akin to Oregon's) Exceptional Needs Care Coordinators (ENCC), which coordinate care between medically fragile consumers within the context of the new ACOs.
  - Create safeguards for vulnerable populations. Like Oregon, consider exceptions for persons eligible for Medicare or those with exceptionally high medical expenses but with income over the poverty level (the Medically Needy Program).
  - Create transparent and extensive review process of the list.
- **Before reducing benefits the state should consider an option where Hospitals would provide the required State match monies to fund amounts up to the full actuarial cost of care using both the Provider Assessment and the IGT funding as a mechanism to sustain Hospital benefits (U of U/Healthy U).**

*The waiver proposal includes a provision that for years when Medicaid growth (per member, per month) exceeds general fund growth targets, benefits would be reduced on a pre-determined and variable schedule. The waiver references the Oregon Medicaid program, which implements service reductions from a prioritized list of health services. In fact, Oregon's priority list has had limited usefulness as a cost-containment tool. Rather, it has painstakingly evolved to achieve a delicate alignment with evidence-based medicine (UHPP).*

## PROVIDER PAYMENT AND PAYMENT REFORMS

- **Ensure that per member/per month spending growth targets are realistic and in line with the needs of the Medicaid population and need for a fair reimbursement schedule for providers.**

*The state should follow the lead of states like Pennsylvania by carefully setting the rates and adjusting them when necessary (UHPP). The waiver proposal does not provide a clear provision for adequate reimbursement—the State is relying entirely up to ACOs to negotiate these rates.*

*The waiver proposal does not provide a clear provision for adequate reimbursement—the State is relying entirely up to ACOs to negotiate these rates (UMA)*

*Out of network payment limits: concerning (SLCAP, UMA)*

## QUALITY MEASURES

- **These measures should be as close as possible to existing agreed upon quality measures to avoid duplication of cost and effort (UHA).**
- **Physicians need to be involved in determining what the quality and outcome measures should be. In fact they should lead this discuss and buy-in to the final agreements (UMA)**
- **Consumers and consumer advocates need to be at the table where quality standards are developed and finalized (UHPP)**
- **Clarify quality measures development process to include benchmarking to assess performance of ACO over time (HealthInsight).**
- **Integrate supports such as HIT exchanges.**

## RISK MANAGEMENT

- Clarify how rate cells will be adjusted as follows...
  - Purchase stop loss protection for the ACOS
  - Establish risk corridors to minimize risk, based on aggregate claims costs.
  - Transition to individual risk adjuster model used by CMS.
  - If members continue from 1 period to another, risk adjustment should be maintained at original levels (SelectHealth).

*Is the ACO at risk for state plan mandatory but not optional services? If so, how are optional services provided and who provides them? Is the ACO at risk for providing hospital and any other mandatory service under section 1905(a) or any three or more mandatory services in that section (DLC)?*

## PREMIUM SUBSIDY OPTION

- Remove this provision entirely (AUCH, UHPP, SLCAP)
- Don't remove it (UMA)
- The exchange subsidy option, if it sticks at all, should have same Medicaid cost sharing protections, 5% of income (SLCAP).
- Create a clear and understandable disclosure process for Medicaid consumers who may elect this option, explaining that the cost sharing portion will be much higher on the exchange or private market.(UHPP, SLCAP, AUCH)
- Adults should be able to opt out at any time, just like the kids

*How is the premium subsidy funded? If it is with Medicaid dollars how will this impact the program's financing and sustainability? If Medicaid-eligible children use a Medicaid-funded subsidy to purchase coverage through the Exchange, do the Medicaid cost-sharing and EPSDT protections apply?*

*Apparently, children can opt out of premium assistance at any time and enroll in Medicaid. Can adults? How will the transition process work for both groups? (DLC)*

*We need extensive education to counter the Medicaid on stigma. We are thankful for M. All consumers should have choice, but giving that choice worsens the stigma for us. Education piece that M is a service that many of us are paying into (Family Voices)*

*Congressional Budget Office decided more cost effective (even for taxpayer) to cover low-income individuals <133% of poverty level, in Medicaid rather than in the ESI (employer sponsored insurance) or private market. Utah has yet to consider the reasons for this, and this may be why deductibles of up to \$2,500 are permitted in this proposed option—quite a stretch even from the new \$40 deductible proposed for enrollees that stay in regular Medicaid (UHPP).*

## TRANSPARENCY TO PUBLIC, BENEFICIARIES

- **The waiver process should be more fully transparent and accessible to the public, particularly to those directly impacted.**  
*-The waiver document needs an index. Needs explanation of vocabulary and less alphabet soup. Not a clear document for us regular human beings (Rawlins, senior dual eligible on Medicaid).*

## WELLNESS & CLIENT INCENTIVES/DISENROLLMENT PROVISIONS

Lifestyle Choices:

- While we want to involve patients in being responsible for their actions when it comes to healthcare outcomes tied to lifestyle choices, **there are many instances when care needed has nothing to do with lifestyle choices and that need to be taken into consideration (UMA).**

*(The proposal) assumes people want to get well. Sorry, but there is a group of Medicaid recipients that do not want to get well...It assumes people will do what they are told to get well. What? We all know that doesn't happen. How many of us maintain an ideal weight, avoid smoking, stick to a healthy diet...It assumes that people in the covered pool are healthy...I would guess that a majority of the population is in need of expensive or extensive medical care (Albert Clark, dentist who's seen many Medicaid patients)*

#### Enrollment Incentives for ACOs:

- **As a constructive alternative to allowing ACOs to do differential copays for unspecified healthy behaviors which has so many risks, structure the default enrollment process to reward those ACOs that are achieving positive outcomes on the wellness front (UHPP & Voices, pp. 33-34).**

*Right now, if the client has no history with a specific physician, they would be defaulted to the lowest cost plan (UHPP)*

- **The waiver should not state that the client will be assigned to the lowest cost ACO. The client should be assigned to the most appropriate ACO to meet their healthcare needs. Don't base assignment on cost but on value (UMA).**

#### Client Incentives:

- **We recommend adding to the list (of client incentives) or replacing limited cash incentives with vouchers for "non-covered" services such as dental care (AUCH).**
- **the state plans to apply for the ACA prevention grant. This grant should be used to structure and support the evaluation component of a new competitive approach to client wellness incentives that is proposed for the new managed care/ACO arrangements (UHPP).**
- **Specify how enrollees with disabilities will participate in incentive programs (DLC)**

#### Disenrollment:

While the state understandably wants Medicaid clients to be responsible for their healthcare and the relationship they form with providers, the following safeguards are needed to protect clients:

- **An ACO may not request disenrollment because of a change in the enrollee's health status or because the enrollee's utilization of medical and/or social services, diminished mental capacity or uncooperative behavior is resulting from his or her special needs (UHPP).**
- **A clear and thorough review process by the State in cases of disenrollment requests by an ACO or the disenrollment survey option should be checked as a quality measurement tool (same).**

*What are the criteria and process/procedure for determining that an enrollee has not followed medical advice or kept a good relationship with his or her doctor? How will ACOs be prevented from using this as a mechanism to cherry pick or dump enrollees (DLC)?*

*The main concerns that were voiced were in regards to the change in the way Medicaid will communicate with clients. Even though I agree that saving 6 million dollars by switching to e-mails as a way of communicating with clients is important, I am afraid that issue will become a barrier for Latino immigrants and could possibly result in disenrollment (Maintaining good relationship with provider/Medicaid administration) (Midvale City/minority health perspective on MCAC)*

## **Appendix A: Amer. Academy of Family Physicians' Joint Principles of Patient-Centered Medical Home**

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

### **Principles of the PCMH**

**Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

**Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

**Quality and safety** are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family;

Evidence-based medicine and clinical decision-support tools guide decision making; Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement; Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met; Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model; and Patients and families participate in quality improvement activities at the practice level.

**Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

**Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit; It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; It should support adoption and use of health information technology for quality improvement; It should support provision of enhanced communication access such as secure e-mail and telephone consultation; It should recognize the value of physician work associated with remote monitoring of clinical data using technology; It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); It should recognize case mix differences in the patient population being treated within the practice; It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting; and It should allow for additional payments for achieving measurable and continuous quality improvements.

# Special Health Matters

Appendix B

**EPSDT**

## ♥ What is EPSDT?

Medicaid's child health component, known as the Early and Periodic Screening, Diagnosis & Treatment (EPSDT) program, has been shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of low-income children.

Federal law – including statutes, regulations, and guidelines – requires that Medicaid cover a very comprehensive set of benefits and services for children, different from adult benefits. Since one in three U.S. children under age six is eligible for Medicaid, EPSDT offers a very important way to ensure that young children receive appropriate health, mental health, and developmental services.

### To remember the elements of EPSDT, use the name of the program:

- **Early**---*Identifying problems early, starting at birth*
- **Periodic**---*Checking children's health at periodic, age-appropriate intervals*
- **Screening**---*Doing 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*
- **Treatment**---*Treating the problems found.*

## ♥ What are the EPSDT requirements?

EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Think of it as the child health coverage package of Medicaid.

Screening services "to detect physical and mental conditions must be covered at established, periodic intervals (periodic screens) and whenever a problem is suspected (inter-periodic screens). Screening includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education.

In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment. The treatment component of EPSDT is broadly defined. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

All **medically necessary** diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

## ♥ Resources

- [U.S. Dept. of Health and Human Services](http://www.hrsa.gov/epsdt/default.htm) <http://www.hrsa.gov/epsdt/default.htm> (source)
- [GWU Center for Health Services Research and Policy](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/Origins%20and%20Continuing%20Role%20of%20Medicaid%20and%20EPSDT.pdf)  
<http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/Origins and Continuing Role of Medicaid and EPSDT>
- [http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/mil\\_prep042605.pdf](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/mil_prep042605.pdf)
- [DHHS Office of the Inspector General](http://www.oig.hhs.gov/oei/etoh.html) <http://www.oig.hhs.gov/oei/etoh.html>
- [National Health Law Program \(NHeLP\)](http://www.healthlaw.org/) <http://www.healthlaw.org/>
- [National Academy for State Health Policy](http://www.nashp.org/) <http://www.nashp.org/>

This was developed, in part, by funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs. The Utah Family Voices Family to Family Health Information Center operates under the auspices of grant #H84MC07996.

Last Updated: June 16, 2010



2290 E. 4500 S. #170, Salt Lake City, UT 84117-4428  
Phone: 801.272.1068 Fax: 801.272.8907  
Toll Free: 800.468.1130 Spanish: 801.272.1067

For more information or clarification, contact us at [info@familyvoices.org](mailto:info@familyvoices.org)