

September 11, 1997

EPSDT is Medicaid's mandatory benefit package for children under age 21. It includes well-child screening and a broad treatment package. As children eligible for SSI are increasingly being required to enroll in Medicaid managed care, it is critical to ensure that these children receive all of the EPSDT services to the same extent that they are entitled to such services under fee-for-service. Unfortunately, many managed care organizations do not know what they are getting into, and they might not be familiar with the services included under EPSDT.

Fortunately, there are numerous opportunities for EPSDT advocacy in managed care settings. Important documents "proposed state legislation, waiver applications to the federal government seeking permission to require children with special health care needs to enroll in managed care entities, Medicaid managed care contracts, enrollment broker contracts" can be reviewed for compliance with the EPSDT requirements. Audits and surveys of plans, utilization data, and any records of sanctions applied against plans also can be reviewed with respect to EPSDT. The enclosed EPSDT Check list can be used to guide your review of these various documents.

Comments and suggestions should be provided to state Medicaid, the state's EPSDT coordinator, division of mental health/substance abuse, and maternal and child health personnel. Meetings can be scheduled with health plan personnel to sensitize them to your findings, based on the Checklist. You should work with and distribute your findings to the parent groups in your area, so that they can use this information and work with you as they advocate for their children.

### ***Outreach and the Provision of Information***

1. Do guidelines and contracts set forth the specific responsibilities of plans, contracting providers, and the state agency for conducting outreach and to inform special needs children, adolescents, and their families?

2. Will each enrollee be provided information, in writing and face-to-face about:

- (a) the need for preventive care;
- (b) EPSDT services;
- (c) appointment scheduling and transportation assistance;
- (d) managed care, gatekeepers, and accessing specialists.

3. Will plans be required to document when enrollees decline EPSDT services *and* to deem the rejection as specific to that particular service (so that outreach and informing for future EPSDT services continues)?

4. Will "high-risk" enrollees receive targeted outreach and informing regarding EPSDT (e.g., families of children with developmental disabilities, adolescents, children in foster care, pregnant adolescents)?

5. Will the state agency, health plans, and providers use written and other appropriate means to communicate with persons who are hearing or visually impaired?

6. Will the state agency, health plans, and providers use written and other appropriate means to communicate with children and families who speak a primary language other than English?

7. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees of transportation assistance -- including the availability of medical/specially equipped van transport -- and arranging for or providing non-emergency transportation coverage?

8. Do the managed care guidelines and contracts clarify who has responsibility for informing enrollees, if needed, of related transportation services, which include meals and lodging, and the cost of an attendant?

### ***Screening Services***

9. Do the managed care guidelines and contracts specify separate screening schedules for medical, vision, hearing, and dental screens and allocate responsibility for each of these screens?

10. Will medical screens minimally include:

- (a) comprehensive physical health and developmental history;
- (b) comprehensive mental health and developmental history;
- (c) a comprehensive unclothed physical exam;
- (d) immunizations as set by CDC;
- (e) laboratory tests, *including lead blood tests*;
- (f) health education, *including anticipatory guidance to the child and family*.

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

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

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

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

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

***Treatment and Provider Participation***

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

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

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

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

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

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

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

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

24. Are providers encouraged to provide services in a manner that promotes hope, recovery, independence, and respect?

25. Do treatment services emphasize early intervention, use of alternatives to restricted/institutional care, use of self-help, and health counseling?

26. Are plans required to pay for out-of-network second opinions when services are denied to children with special needs?

27. Are plans required to provide written notice to families when services to their children are denied, delayed, terminated, or reduced (i.e. the plan takes an "adverse action")?

28. Are plans required to notify enrollees of the circumstances under which benefits will continue pending resolution of disputes regarding terminated or reduced services?

29. Do the plan's written notices explain the right to a fair hearing to challenge the adverse action?

30. Do contracts specify that the plan must provide "case management" services as defined by the Medicaid Act (to assist individuals in gaining

access to needed medical, social, educational, and other services)?

31. Will the plan be required to have a specially designated case manager/case coordinator to assist children with special needs and their families?

32. Will enrollees be informed of the availability of family planning services, both in and outside of the plans?

33. Will plans and providers be required to report encounter data sufficient to complete the HCFA Form 416?

34. Do guidelines and/or contracts include specific incentives/sanctions to assure at least 80% EPSDT participation?

35. Are screening and referral rates publicly disclosed for each plan?

36. Are payment rates adequate to enlist enough providers for special needs children's services so that services are available to Medicaid eligibles at least to the extent services are available to the general population in the geographic area?

37. Does the contract require the plan to make available a pediatrician or adolescent specialist within stated travel standards for every child/family who requests one?

38. Are plans required to guarantee access to pediatric specialists, children's hospitals, school clinics, and other children's providers in their plan networks?

39. Are payment rates adequate to compensate gatekeepers to provide primary care and case management services to children with special needs?

40. Will plans and providers be required to coordinate with other services, e.g. WIC, Title V, Part B and Part H, school based services, Head Start?

41. Are plans required to honor treatment plans developed by, or cooperate with the development of treatment plans under, Part H, Part B, and Title V?

42. Are health plans required to monitor the development of children who are at risk of development disability or delay?

43. Is the plan required to maximize coordination of care and smooth transitions among care-givers and care sites?

44. Is the plan required to honor ongoing plans of care initiated prior to enrollment until the enrollee is evaluated by her or his primary care provider and a new plan of care is established?

45. Do quality of care and outcome measures look for discernable improvements in children's physical and psychological health, community-based living arrangements, and relationships?

46. Do consumer satisfaction surveys include measures of satisfaction with staff, appropriateness and accessibility of care and services, and consumer rights?

47. Are plans required to comply with the Americans with Disabilities Act/ Rehabilitation Act (e.g. facility access standards; treatment in the most

integrated setting)?

48. Is each provider and service site wheelchair accessible?