



STATE OF DELAWARE  
**STATE COUNCIL FOR PERSONS WITH DISABILITIES**  
MARGARET M. O'NEILL BUILDING  
410 FEDERAL STREET, SUITE 1  
DOVER, DE 19901

VOICE: (302) 739-3620  
TTY/TDD: (302) 739-3699  
FAX: (302) 739-6704

**MEMORANDUM**

DATE: April 25, 2016

TO: Ms. Kimberly Xavier, DMMA  
Planning, Policy and Quality Unit

FROM: DM-P/ARB  
Daniese McMullin-Powell, Chairperson  
State Council for Persons with Disabilities

RE: 19 DE Reg. 898 [DMMA Proposed Medicaid Autism Disorder Services  
Regulation (4/1/16)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend the Medicaid State Plan to address coverage and reimbursement of treatment services for beneficiaries up to age 21 with a diagnosis of autism spectrum disorder (ASD). The proposed regulation was published as 19 DE Reg. 898 in the April 1, 2016 issue of the Register of Regulations. As background, CMS issued the attached July 7, 2014 guidance outlining approaches to provide Medicaid services to eligible individuals with ASD. CMS noted that services often "fit" under the following categories: 1) other licensed practitioner services; 2) preventive services; 3) therapy services; 4) waivers; and 5) EPSDT benefit. See also related articles. DMMA is now implementing the guidance by adopting conforming Medicaid State Plan amendments. SCPD has the following observations.

First, there is some "tension" between the proposed requirement that a Medicaid beneficiary be "under 21 years of age" to qualify for "autism spectrum disorder treatment services" (p. 900) and special education eligibility extending to the end of the school year in which a student turns 21. See Title 14 Del.C. §3101(1). The age standard is ostensibly based on the EPSDT age limit but EPSDT should not be the sole eligibility basis for autism-related services. Moreover, "other licensed practitioner services", "preventive services", and "therapy services" are not limited to individuals under age 21.

Second, ASD services are barred if an individual is not "medically stable" At 900. Therefore, individuals with the most severe medical needs are anomalously ineligible for services. For example, query whether a beneficiary would be unable to obtain occupational or physical therapy services to remediate an "unstable" medical condition (e.g. helmet or assistive technology to address head banging or SIBS). Conceptually, the autism treatment services may be necessary to achieve medical stability.

Third, ASD services are barred if an individual qualifies for ICF/IID placement. At 900. This would ostensibly exclude anyone enrolled in the DDDS waiver (in which eligibility begins at age 12) which categorically requires that participants meet an ICF/IID level of care. See attached excerpts from DDDS waiver.

Fourth, the projected fiscal impact of the regulation is high, i.e., \$1,223,105 in State funds in FFY17. At 901. Since the identified services (other licensed practitioner services; preventative services; therapy) are already covered by the State Plan, it's unclear why the projected fiscal impact is so high. Moreover, since private insurers must cover treatment of autism spectrum disorders (S.B. No. 22 from 146<sup>th</sup> General Assembly), private insurance should cover most services if an individual has both Medicaid and private health insurance.

Fifth, an individual cannot obtain a functional behavioral assessment, a behavioral support plan, or any ASD treatment services until a licensed medical professional under Delaware State regulation completes an evaluation. See Attachment 3.1-A, Page 6 Addendum 1a. This categorical requirement appears unduly strict if an individual with an ASD diagnosis for years, perhaps based on an out-of-state evaluation, desires a behavioral support plan or ASD services.

Sixth, there is some “tension” between the following requirements:

These evaluations may not be performed by the same professional who delivers or supervises the beneficiary’s direct ASD treatment.

Attachment 3.1-A, Page 6 Addendum 1b (describing neurodevelopmental review by psychologists and psychiatrists).

The provider who develops the behavioral plan of care should be the same provider who performed the behavioral assessment, except in extenuating circumstances, ...

Attachment 3.1-A, Page 6 Addendum 1g.

As a practical matter, it may be impractical and counterproductive to exclude an evaluator from also providing services. This is not the standard model within the Delaware Medicaid program. For example, an ST, OT, or PT often performs an assessment of need, develops a treatment plan, and provides therapy pursuant to the plan.

Seventh, the sources of information for the functional behavioral assessment includes everyone but the individual with the ASD diagnosis. See Attachment 3.1-A, Page 6, Addendum 1c. It would be preferable to include the individual in the list which otherwise includes schools, family, pediatricians, etc.

Eighth, DMMA may wish to amend the following provision in Attachment 3.1-A, Page 6, Addendum 1d by adding the underlined language: “(6) The use of Behavior Modifying Medications without a formal assessment and diagnosis of a corresponding mental health

disorder by physician or advance practice registered nurse.” See 24 Del.C. §1902.

Ninth, in Attachment 3.1-A, Page 6 Addendum 1e, Par (12), DMMA may wish to substitute “individual” for “child”.

Tenth, the following requirement is highly objectionable:

(e) Presence/Availability of Caregiver. In order to ensure that the services are covered under the preventive services benefit category and do not include non-coverable services such as child care, respite, or related services, as well as to ensure the clinical success of the services, a caregiver must be present and/or available in the setting where services are being provided at all times (even when not directly participating in the services) in order to care for individuals under the age of eighteen.

Attachment 3.1-A, Page 6 Addendum 1f.

This is a discriminatory requirement which “stereotypes” all individuals under 18 with an ASD diagnosis as requiring 24/7 care under constant adult supervision. It is not required that parents of minors with other conditions be physically present on-site when a minor receives Medicaid services. There are 17 year old individuals with Aspergers who could drive themselves to an appointment and have absolutely no need for parental accompaniment. Moreover, the statement that “respite” is categorically a “non-coverable” service is incorrect. It is a covered service under the DSHP+ program and may be available under the EPSDT benefit.

Eleventh, the following utilization limit is highly objectionable:

(f) Limitations on ASD Treatment Services: Total ASD treatment services from all sources may only be the amount medically necessary for each individual, up to 25 hour (sic “hours”) per week, which may be exceeded with prior authorization based on medical necessity.

Attachment 3.1-A, Page 6 Addendum 1f.

A. This limitation is at odds with the EPSDT expectation that covered individuals will receive all Medicaid services needed to ameliorate conditions identified through screening and assessment. See Attachment 3.1-A, Page 6 Addendum 1. See also attached CMS EPSDT guidance:

The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions - the right care to the right child at the right time in the right setting. This broad scope supports a comprehensive, high-quality health benefit.

NHELP characterizes attempts to place hard caps on ASD services as illegal under EPSDT:

Another common problem is that some states place hard limits on the hours of service Medicaid will provide in a week or a month. These limits, which are illegal under EPSDT, prevent children with the highest need from getting all the medically necessary care to which they are entitled. (See CMS, EPDST Coverage Guide at 23).

NHeLP, “Autism Spectrum Disorders”, Health Advocate (October, 2015) at 3 (attached).

The CMS EPSDT Guide is corroborative:

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. ...For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a “hard” limit could not be applied to children.

At 23-24 (attached). Although CMS suggests some leeway with “soft” limits incorporated into medical necessity standards, DMMA is not amending its medical necessity regulation. Rather, it is manifestly imposing a cap based on budgetary considerations.

B. There is no comparable cap on ST, OT, or PT, preventive services, and other licensed practitioner services in the Medicaid State Plan generally so imposing a cap simply because a beneficiary has an ASD diagnosis is ostensibly impermissible discrimination under the ADA and Section 1557 of the ACA. See attachment.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or position on the proposed regulation.

cc: Mr. Stephen Groff, DMMA  
Mr. Francis McCullough, CMS  
Ms. Teresa Avery, Autism Delaware  
Mr. Keith Morton, Parent Information Center  
Mr. Brian Hartman, Esq.  
Governor’s Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

19reg898 dmma-medicaid autism spectrum disorder services 4-19-16

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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## CMCS Informational Bulletin

**DATE:** July 7, 2014

**FROM:** Cindy Mann, Director  
Center for Medicaid and CHIP Services

**SUBJECT:** Clarification of Medicaid Coverage of Services to Children with Autism

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

### Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.<sup>1</sup>

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine.<sup>2</sup> While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)<sup>3</sup>. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

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<sup>1</sup> <http://www.cdc.gov/ncbddd/autism/facts.html>

<sup>2</sup> <http://www.cdc.gov/ncbddd/autism/treatment.html>

<sup>3</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf>

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

### State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

### Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are “medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider’s qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state’s Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state’s Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

### Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are “services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency”

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long as the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

#### Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

#### Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

#### Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

#### Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

#### Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

#### EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

### **Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs**

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to [AutismServicesQuestions@cms.hhs.gov](mailto:AutismServicesQuestions@cms.hhs.gov).

American Speech-Language-Hearing Association

## CMS Issues Clarification of Medicaid Coverage of Services to Children With Autism

(July 17, 2014) Centers for Medicare & Medicaid Services officials released federal guidance for states on Medicaid coverage of therapies for autism, and that guidance indicates such treatments are covered for beneficiaries under age 21. While the guidance focuses on the provision of applied behavior analysis (ABA) therapy, it also acknowledges other treatments.

The Center for Medicaid and CHIP (Children's Health Insurance Plan) Services, a division of CMS, released an informational bulletin to clarify Medicaid coverage of services to children with autism. The bulletin was issued in response to increased interest in this topic—specifically, the provision of ABA therapy. Although the bulletin was written to address services for children with autism under the Medicaid program, it also serves to clarify services that speech-language pathologists and audiologists may provide to individuals diagnosed with other conditions.

Melissa Harris, director, Division of Benefits and Coverage, Disabled and Elderly Health Program Group at CMS, addressed the meeting of the Interagency Autism Coordinating Committee (IACC) regarding this bulletin and emphasized that Medicaid covers ABA and similar services for children with autism. Ms. Harris noted that Medicaid and programs such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirements do not name a specific treatment, but instead address the service needs of the individual. As noted in the bulletin, "the goal of EPSDT is to assure that children get the health care they need, when they need it—the right care to the right child at the right time in the right setting." For children, states must cover services consistent with the EPSDT provision. Ms. Harris also discussed the application of habilitative and rehabilitative services as defined in the Affordable Care Act (ACA) as extended to the Medicaid population and reminded the group of the definitions of those services as developed by the National Association of Insurance Commissioners (NAIC).

The bulletin outlines four major categories of treatment that are beneficial for children with autism spectrum disorder (ASD)—specifically, services available to individuals with ASD through the federal Medicaid program. The categories are (1) behavioral and communication approaches, (2) dietary approaches, (3) medications, and (4) complementary and alternative medicine. ABA therapy is recognized as one treatment for the child with autism, but the bulletin also identifies other treatments that are available to the ASD population and to others in need of those services.

Medicaid funding for services to children with ASD and other conditions may be reimbursed through a variety of authorities, such as specific sections of the Social Security Act, including Section 1915(c) Home and Community-Based Services and Section 1115 Waiver and State Plan Authorities. States are required to submit a state plan amendment (SPA) to address how all services are addressed, with inclusion of therapy services covered under the Medicaid therapies benefit at 42 Code of Federal Regulations (CFR) 440.110 as relating to qualified provider, referral, scope of services, and supervision/direction of services.

## Background

About 1 in 68 children has been identified with autism spectrum disorder (ASD), according to estimates from Centers for Disease Control and Prevention's Autism and Developmental Disabilities Monitoring (ADDM) Network. The number of individuals with ASD has increased in the past several years, along with interest in associated treatments and resources to cover payment for those services.

## Resources

- Clarification of Medicaid Coverage of Services to Children With Autism [PDF]
- Habilitative and Rehabilitative Services Defined [PDF]

For more information, please contact Laurie Alban Havens, ASHA's director of private health plan and Medicaid advocacy, at [lalbanhavens@asha.org](mailto:lalbanhavens@asha.org)

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# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:  
This is a renewal of the DDDS Waiver that has been in continuous operation since 1987. The DDDS waiver is targeted to individuals with intellectual disabilities and autism spectrum disorder who can no longer live independently or with their family. The waiver includes an array of services and supports designed to enable the individual to live safely in the community and to respect and support their desire to work or engage in other productive activities.

The following changes are being made in this renewal application:

The term "Mental Retardation" has been changed to "Intellectual Developmental Disability" throughout the document.

#### Appendix A

- \* Performance measure A-3: Number and percent of performance reports reviewed by the Medicaid agency" was deleted. DDDS felt that this measure was redundant of PM A-5: Number and percent of DMMA/DDDS Quarterly Waiver Mandatory meetings during which the waiver quality assurance and quality improvement activities are discussed."
- \* Performance measure "A-1: Number and percent of waiver policies approved by the Medicaid agency prior to implementation" was deleted.

#### Appendix B

- \* Minimum waiver eligibility age changed from four (4) years to twelve (12) years of age. There were only three clients under the age of 12 who have ever received a waiver service under any of the previous renewals. These clients were all eligible for SSI prior to their enrollment in the DDDS waiver.
- \* Qualifications for who may perform a Level of Care initial certification and recertification were changed from a physician and a psychologist, respectively, to a QIPD for both the initial and recertifications
- \* The minimum requirement for waiver services received per month was reduced from two (2) to one (1) because case management is no longer claimed as a waiver service
- \* Per the CMS Crosswalk of Current vs Revised Assurances, sub-assurance B-b-1, LOC annual reevaluations completed within 365 days of previous determination was deleted. DDDS will no longer report on this measure in the annual 372 report but will continue to track it

#### Appendix C

- \* Supported Living was added as a new waiver service under "Other".
- \* Clinical Consultation: Behavioral and Nursing was broken out into two different waiver services. In the previous version of the application, these two distinct services were combined into a single service category with different provider types

3 years  5 years

Original Base Waiver Number: DE.0009

Draft ID: DE.08.07.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/14

**1. Request Information (2 of 3)**

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

[Empty text box for hospital subcategories]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

[Empty text box for nursing facility subcategories]

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

[Empty text box for ICF/IID subcategories]

**1. Request Information (3 of 3)**

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

[Empty text box for waiver program specification]

Specify the §1915(b) authorities under which this program operates (check each that applies):



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# Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Control, correct or reduce health problems found.

## EPSDT Services

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic, and treatment services:

### Screening Services

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

### Vision Services

At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.

### Dental Services

At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

### Hearing Services

At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

### Other Necessary Health Care Services

States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

### Diagnostic Services

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to assure that comprehensive care is provided.

### Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

## State Program Guidelines

State Medicaid agencies are required to:

- Inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age-appropriate immunizations;
- Provide or arrange for the provision of screening services for all children;
- Arrange (directly or through referral) for corrective treatment as determined by child health screenings; and
- Report EPSDT performance information annually via [Form CMS-416 \(/medicaid-chip-program-information/by-topics/benefits/downloads/form-416.zip\)](#).

## Periodicity Schedule

Periodicity schedules for periodic screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child health care in developing their schedules. Alternatively, states may elect to use a nationally recognized pediatric periodicity schedule (i.e., [Bright Futures \(http://brightfutures.aap.org/index.html\)](#)). A separate dental periodicity schedule is also required.

## Developmental and Behavioral Screening

Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective. These screenings are required for children enrolled in Medicaid, and are also covered for children enrolled in CHIP. This [CMS Fact Sheet \(/medicaid-chip-program-information/by-topics/quality-of-care/downloads/cms\\_fact\\_sheet\\_dev\\_screening.pdf\)](#) describes CMS resources to support states in ensuring enrolled children receive these screenings. [Birth to 5: Watch Me Thrive! \(http://www.acf.hhs.gov/programs/ecd/watch-me-thrive\)](#), a joint effort between the Department of

Health and Human Services and the Department of Education, provides additional resources to support states, providers and communities to increase developmental and behavioral screening of young children.

## Lead Screening

CMS has updated its Medicaid lead screening policy for children eligible for EPSDT services. For more information, see the [June 2012 Informational Bulletin \(/federal-policy-guidance/downloads/cib-06-22-12.pdf\)](#). CMS recognizes that lead poisoning continues to be a problem for a small share of low-income children. To improve screening of children most at risk for lead exposure, CMS is aligning Medicaid lead screening policy with current recommendations of the Centers for Disease Control and Prevention (CDC). The new policy encourages a targeted screening approach in States that have sufficient data to support this action. We have developed materials to assist States with the process of determining their lead screening approach going forward. CMS and CDC have developed [guidance and process \(/medicaid-chip-program-information/by-topics/benefits/downloads/targetedleadscreening.pdf\)](#) for States that want to request to move to a targeted screening approach. Interested States should send requests and supporting documentation to the EPSDT mailbox at [EPSDT@cms.hhs.gov](mailto:EPSDT@cms.hhs.gov) (<mailto:EPSDT@cms.hhs.gov>), with the subject line: "Request for Use of Targeted Lead Screening."

## EPSDT Strategy Guides to Support States with the Medicaid Benefit for Children and Adolescents

In 1967, Congress introduced the Medicaid benefit for children and adolescents, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions – the right care to the right child at the right time in the right setting. This broad scope supports a comprehensive, high-quality health benefit. States share responsibility for implementing the EPSDT benefit with the Centers for Medicare & Medicaid Services. (For more information, see "[What You Need to Know about EPSDT \(/medicaid-chip-program-information/by-topics/benefits/downloads/what-you-need-to-know-about-epsdt.pdf\)](#)".)

As one outcome of a National EPSDT Improvement Workgroup, the Center for Medicaid & CHIP Services is developing a set of strategy guides, each on a specific topic, to support states and their partners as they implement the EPSDT benefit. Each strategy guide identifies specific, doable approaches to improve access, utilization and quality of care for children and adolescents enrolled in Medicaid. Examples of state successes are offered along with web-based links to resources, tools and more in-depth.

The first four guides in the series are:

- [EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents \(/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt\\_coverage\\_guide.pdf\)](#)
- [Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents \(http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf\)](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf)
- [Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits \(/medicaid-chip-program-information/by-topics/benefits/downloads/paving-the-road-to-good-health.pdf\)](#)

- [Making Connections: Strategies for Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents \(/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf\)](#)

## EPSDT Data

The [Form CMS-416 \(/medicaid-chip-program-information/by-topics/benefits/downloads/form-416.zip\)](#) is used by CMS to collect basic information on State Medicaid and CHIP programs to assess the effectiveness of EPSDT. See [Form CMS-416 instructions \(/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf\)](#). States must provide CMS with the following information:

1. Number of children provided child health screening services
  2. Number of children referred for corrective treatment
  3. Number of children receiving dental services
  4. State's results in attaining goals set under section 1905(r) of the Social Security Act.
- [CMS-416 Instructions \(/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf\)](#) (Version 3, Updated 11/17/2014)
    - [Webinar Slides on CMS-416 Instructions \(/medicaid-chip-program-information/by-topics/benefits/downloads/revise416instructionswebinar.pdf\)](#) (12/11/2014)
    - [Crosswalk of CPT Codes to CDT Codes \(01/22/2015\)](#)
    - [CMS-416 Final Revised Instructions: Questions and Answers \(/medicaid-chip-program-information/by-topics/benefits/downloads/416-faqs.pdf\)](#) (02/19/2015)
    - [Learn How to Report the CMS 416 Dental Data \(/medicaid-chip-program-information/by-topics/benefits/416-dental-reporting-training.html\)](#)
  - [Electronic Form CMS-416 \(Excel\) \(/medicaid-chip-program-information/by-topics/benefits/downloads/form-416.zip\)](#). To request a 508-version of the form, please email [EPSDT@cms.hhs.gov](mailto:EPSDT@cms.hhs.gov) (<mailto:EPSDT@cms.hhs.gov>).
  - [FY 2014 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-2014-epsdt-data.zip\)](#) (as of 1/15/16. Now includes data from PR)
  - [FY 2013 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-2013-epsdt-data.zip\)](#) (as of 10/22/14)
  - [FY 2012 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-2012-epsdt-data.zip\)](#) (as of 10/22/14)
  - [FY 2011 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-2011-epsdt-data.zip\)](#) (as of 1/07/14)
  - [FY 2010 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-2010-epsdt-data.zip\)](#) (as of 11/19/14)
  - [FY 1995-2009 Data \(/medicaid-chip-program-information/by-topics/benefits/downloads/fy-1995-to-2009-epsdt-data.zip\)](#)

## National EPSDT Improvement Workgroup

In December 2010, CMS convened a National EPSDT Improvement Workgroup that included state representatives, children's health providers, consumer representatives, and other experts in the areas of maternal and child health, Medicaid, and data analysis. The members of the group will help CMS identify the most critical areas for improvement of EPSDT. The group, which meets periodically throughout the year, will also discuss steps that the federal government might undertake in partnership

with states and others to both increase the number of children accessing services, and improve the quality of the data reporting that enables a better understanding how effective HHS is putting EPSDT to work for children.

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## Benefits Content

- [Autism Services \(/medicaid-chip-program-information/by-population/autism-services.html\)](/medicaid-chip-program-information/by-population/autism-services.html)
  - [Early Periodic Screening Diagnosis & Treatment \(/medicaid-chip-program-information/by-topics/benefits/early-and-periodic-screening-diagnostic-and-treatment.html\)](/medicaid-chip-program-information/by-topics/benefits/early-and-periodic-screening-diagnostic-and-treatment.html)
  - [Dental Care \(/medicaid-chip-program-information/by-topics/benefits/dental-care.html\)](/medicaid-chip-program-information/by-topics/benefits/dental-care.html)
  - [Alternative Benefit Plans \(/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html\)](/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html)
  - [Prescription Drugs \(/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/prescription-drugs.html\)](/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/prescription-drugs.html)
  - [Prevention \(/medicaid-chip-program-information/by-topics/benefits/prevention.html\)](/medicaid-chip-program-information/by-topics/benefits/prevention.html)
  - [Behavioral Health Services \(/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html\)](/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html)
  - [Tobacco Cessation \(/medicaid-chip-program-information/by-topics/benefits/tobacco.html\)](/medicaid-chip-program-information/by-topics/benefits/tobacco.html)
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## Related Resources

- [CMS and State EPSDT Contacts \(/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-contacts.pdf\)](/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-contacts.pdf)
  - [InsureKidsNow.gov \(http://www.insurekidsnow.gov/\)](http://www.insurekidsnow.gov/)
  - [EPSDT Information from the Health Resources & Services Administration \(http://mchb.hrsa.gov/epsdt/\)](http://mchb.hrsa.gov/epsdt/)
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# Health Advocate

E-Newsletter of the National Health Law Program

Volume 42

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## Autism Spectrum Disorders

Prepared by: Abigail Coursolle

### Key Resources

[NHLP Q&A: CMS Guidance on EPSDT Services for Children with ASD in Medicaid](#)

[NHLP Lessons from California: Covering Behavioral Health Treatment in Med-Cal](#)

[Autism Speaks - ASD and Medicaid](#)

[CMS on ASD and Medicaid](#)

[CMS EPSDT Coverage Guide](#)

[Coming in November's Health Advocate:](#)

[Reproductive Health: Data Project Round-Up](#)

### Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate of the Medicaid Act requires states to cover a wide variety of health services to correct or ameliorate the illnesses or conditions of children under age 21 in Medicaid. As new treatments and services are developed and incorporated into the standard of care for treating children's illnesses and conditions, the Centers for Medicare & Medicaid Services (CMS) has struggled to ensure that state EPSDT programs keep up with the evolving standard of care for children.

A recent example involves behavioral treatments for Autism Spectrum Disorder (ASD), a developmental disability that can cause significant delays in social, communication, and other behavioral skills. The standard of care for children with ASD for many years has included intensive behavioral interventions such as Applied Behavioral Analysis (ABA) therapy. ABA therapy is based on a one-on-one teaching approach that relies on reinforced practice of various skills. Yet states have been slow to cover these interventions under their Medicaid programs, and CMS had also not required states to cover them until last year. Due in part to NHLP's advocacy, in July 2014, CMS issued a *Clarification of Medicaid Coverage of Services to Children with Autism (ASD CMS Guidance)*, which made clear that states must provide evidence-based treatments for children with ASD in Medicaid. This month's *Health Advocate* reviews the advocacy history that led up to this guidance, and then examines trends in the states' implementation of the guidance.

### Treatment for Autism Spectrum Disorders

The CDC recently estimated that approximately one in every 68 children has been identified with ASD. (CDC, *Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years* (2014).) Since the 1980s, intensive behavioral interventions have become increasingly used to treat children with ASD by assisting them in building skills and reducing maladaptive behaviors. ABA therapy is perhaps the best-known of these therapies. ABA therapy is based on a one-on-one teaching approach that relies on reinforced practice of various skills. ABA therapy is typically provided by certified therapists and a team of behavior technicians, pursuant to a referral from a licensed practitioner such as a neurologist or psychologist. Although state laws are beginning to change, in most states, the therapists and paraprofessional staff who administer ABA therapy, though certified by a national board, are not licensed under state law. While ABA therapy is particularly well-known, many individuals with ASD receive other evidence-

based intensive behavioral interventions. These interventions may be as effective, or even more effective, for some children with ASD, depending on their individual needs. Together, this cohort of intensive behavioral interventions constitutes the standard of care for in treatment for children with ASD.

### CMS Issued Guidance on Treatment for ASD in Medicaid Under EPSDT

Since the late 1990s through the 2000s, advocates began to push their states to provide intensive behavioral interventions for ASD in Medicaid. For several years advocates around the county—including NHeLP—have argued that for children with ASD, ABA therapy and other intensive behavioral interventions for ASD must be covered under EPSDT, since they have been shown to be effective treatments at correcting and ameliorating ASD. But many states considered these intensive behavioral interventions to be “habilitative” services aimed at acquiring new skills rather than restoring or preventing deterioration of an existing condition. States are not required to cover habilitative services under EPSDT. As such, many states only provided ABA therapy and other intensive behavioral interventions through a Medicaid waiver home and community-based waiver programs, which may limit the number of children who can get the services and how much of the services they can get.<sup>1</sup> Therefore, not all children with ASD in Medicaid were able to access treatments they need. In the late 2000s, families in Florida, Louisiana, Ohio, and Washington successfully sued their states to obtain coverage of intensive behavioral interventions in Medicaid pursuant to the EPSDT mandate. Moreover, in the months before releasing its July 2014 Guidance, CMS approved requests by Louisiana and Washington to cover ABA therapy under EPSDT.<sup>2</sup>

NHeLP and other advocates asked CMS to clarify that states must provide evidence-based treatments for children with ASD, including intensive behavioral interventions, under EPSDT. In July 2014, CMS responded to these requests by releasing guidance that explained that states are obligated to cover these services for children under age 21 when they are medically necessary, even if they are not covered for adults in Medicaid. In September 2014, CMS issued an FAQ, further explaining states’ obligation to cover services for children with ASD under EPSDT. The FAQ stated that CMS would be working with states to update and expand the menu of services available to children with ASD. It clarified that CMS would require states that previously only offered intensive behavioral interventions for children with ASD through a Medicaid waiver to transition provision of those services to regular Medicaid program. CMS declined to set a particular deadline by which states must come into compliance with its guidance, but indicated that states should “work expeditiously and should not delay or deny provision of medically necessary services.”

### State Activity to Provide Treatment for ASD in Medicaid in the Last Year

Following up on last year’s guidance and FAQ, NHeLP and other advocates quickly began working with states to add intensive behavioral interventions for children with ASD to their state Medicaid programs under EPSDT. Our research suggests that as of September, 2015, 24 states and the District of Columbia are already offering intensive behavioral interventions to children with ASD in their regular Medicaid programs. Following the plans CMS approved last spring for Washington and Louisiana, the agency has approved requests (through state plan amendments) in three additional states to include intensive behavioral interventions for children with ASD in their Medicaid programs.

<sup>1</sup> Home and community-based waiver programs allow states to provide long-term care services in home and community-based settings under the Medicaid Program. Programs can provide a combination of standard medical services and non-medical services. But states can also place limits in these programs that would not be allowed in their regular Medicaid programs. (*See CMS, 1915(c) Home and Community Based Waivers.*)

<sup>2</sup> Each state must submit a state Medicaid plan to CMS that sets forth, among other things, the benefits that the state covers in its Medicaid program. When a state changes the benefits offered in its Medicaid program, it generally must submit a proposal, called a “state plan amendment,” to CMS for approval.

Several other states have submitted state plan amendments to CMS proposing to add intensive behavioral interventions to their Medicaid programs (and many of those states have already begun providing services while CMS reviews their proposals). Other states had existing language in their state Medicaid plan that permitted them to offer intensive behavioral interventions without submitting a state plan amendment to CMS. Some states are still in the very early planning stages of crafting a state plan amendment or other policy documents to make intensive behavioral interventions available in their Medicaid programs. Some states have not yet taken any steps to implement the guidance.

### Next Steps

While nearly half of states are working to implement CMS's guidance on services for children with ASD under EPSDT, 25 states have yet to make significant headway. NHeLP is working with advocates in those states to push their states and CMS to ensure that children with ASD gain access to the full scope of services to which they are legally entitled.

Even among the states that have already begun providing intensive behavioral interventions to children with ASD, we are seeing some common themes that can create barriers to care. In many states, advocates report the reimbursement rates for intensive behavioral interventions are very low. As a result, those state Medicaid programs struggle to attract enough trained, quality providers to meet the state's need. Another common problem is that some states place hard limits on the hours of service Medicaid will provide in a week or a month. These limits, which are illegal under EPSDT, prevent children with the highest need from getting all of the medically necessary care to which they are entitled. (*See CMS, EPSDT Coverage Guide at 23.*) Another common problem is state refusal to provide services to children during the school day. Such limitations violate EPSDT and can prevent children who experience the most severe symptoms of their ASD at school from receiving adequate treatment. *See 42 U.S.C. § 1396b(c).* NHeLP is working with advocates around the country to address these and other barriers to care under EPSDT. We encourage advocates to work with CMS and their states to ensure that intensive behavioral interventions for children with ASD are available through Medicaid whenever they are needed.

### About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

### Author

This month's *Health Advocate* was prepared by:

Abigail Coursolle  
Staff Attorney  
Los Angeles Office



### Offices

**Washington, DC**  
1444 I Street NW, Suite 1105  
Washington, DC 20005  
(202) 289-7661  
[nhelpdc@healthlaw.org](mailto:nhelpdc@healthlaw.org)

**Los Angeles**  
3701 Wilshire Blvd, Suite 750  
Los Angeles, CA 90010  
(310) 204-6040  
[nhelp@healthlaw.org](mailto:nhelp@healthlaw.org)

**North Carolina**  
101 East Weaver Street, Suite C-7  
Carrboro, NC 27510  
(919) 968-6308  
[nhelpnc@healthlaw.org](mailto:nhelpnc@healthlaw.org)

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EXCERPT



# EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents



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Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

JUNE 2014

Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

## V. PERMISSIBLE LIMITATIONS ON COVERAGE OF EPSDT SERVICES

### A. Individual Medical Necessity

Services that fit within the scope of coverage under EPSDT must be provided to a child only if necessary to correct or ameliorate the individual child's physical or mental condition, i.e., only if "medically necessary." The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. The state (or the managed care entity as delegated by the state) should consider the child's long-term needs, not just what is required to address the immediate situation. The state should also consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders. States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement. As discussed above, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose.

*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.*

\* Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.<sup>42</sup> States may adopt a definition of medical necessity that places tentative limits on services pending an individualized determination by the state, or that limits a treating provider's discretion, as a utilization control, but additional services must be provided if determined to be medically necessary for

<sup>42</sup> HCFA, *Regional Transmittal Notice* (Region IV) (Sept. 18, 1990); Memorandum from Rozann Abato, Acting Director, HCFA, to Associate Regional Administrator, Atlanta (Sept. 5, 1990); Memorandum from Christine Nye, HCFA Medicaid Director, to Regional Administrator Region VIII (FME-42) (1991).

an individual child.<sup>43</sup> For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a “hard” limit could not be applied to children. A state could impose a “soft” limit of a certain number of physical therapy visits annually for children, but if it were to be determined in an individual child’s case, upon review, that additional physical therapy services were medically necessary to correct or ameliorate a diagnosed condition, those services would have to be covered.

While the treating health care provider has a responsibility for determining or recommending that a particular covered service is needed to correct or ameliorate the child’s condition,<sup>44</sup> both the state and a child’s treating provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating provider and the state’s expert as to whether a service is medically necessary for a particular child, the state is responsible for making a decision, for the individual child, based on the evidence. That decision may be appealed by the child (or the child’s family) under the state’s Medicaid fair hearing procedures, as described in Section VIII below.

## **B. Prior Authorization**

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States may impose utilization controls to safeguard against unnecessary use of care and services. For example, a state may establish tentative limits on the amount of a treatment service a child can receive and require prior authorization for coverage of medically necessary services above those limits.<sup>45</sup> Prior authorization must be conducted on a case-by-case basis, evaluating each child’s needs individually. Importantly, prior authorization procedures may not delay delivery of needed treatment services and must be consistent with the “preventive thrust” of EPSDT.<sup>46</sup> As such, prior authorization may not be required for any EPSDT screening services. In addition, medical management techniques used for mental health and substance use disorders should comply with the Mental Health Parity and Addiction Equity Act.

## **C. Experimental Treatments**

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EPSDT does not require coverage of treatments, services, or items that are experimental or investigational. Such services and items may, however, be covered at the state’s discretion if it is determined that the treatment or item would be effective to address the child’s condition.<sup>47</sup> Neither the Federal Medicaid statute nor the regulations define what constitutes an experimental

<sup>43</sup> 42 C.F.R. §§ 440.230(c), (d); HCFA Dear State Medicaid Director (May 26, 1993).

<sup>44</sup> Sections 1905(a) and (r) of the Social Security Act.

<sup>45</sup> *Id.*

<sup>46</sup> H.R. Rep. No. 101-247 at 399, reprinted in U.S.C.C.A.N. 1906, 2125.

<sup>47</sup> CMS, State Medicaid Manual §§ 4385.C.1, 5122.F.

**HHS.gov**

U.S. Department of Health &amp; Human Services

**Civil Rights****Section 1557 of the Patient Protection and Affordable Care Act**

Section 1557 is the civil rights provision of the Affordable Care Act. Section 1557 prohibits discrimination on the ground of race, color, national origin, sex, age, or disability under “any health program or activity, any part of which is receiving Federal financial assistance ... or under any program or activity that is administered by an Executive agency or any entity established under [Title I of ACA]....” Section 1557 is the first Federal civil rights law to prohibit sex discrimination in health care. To ensure equal access to health care, Section 1557 also applies civil rights protections to the newly created Health Insurance Marketplaces established under the Affordable Care Act.

Section 1557 is consistent with and promotes several of the Administration's key initiatives that advance prevention and wellness, reduce health disparities, and improve access to health care services. The Office for Civil Rights in HHS is responsible for enforcing Section 1557 with respect to covered programs. The law was effective upon enactment and OCR has been accepting and investigating complaints under this authority. If you believe you have been discriminated against on one of the bases protected by Section 1557, you may file a complaint with OCR. OCR also addresses Section 1557 in conducting outreach and providing technical assistance to covered entities and consumers.

ACA Enforcement: Sex Discrimination Cases**OCR Issues Proposed Rule on Nondiscrimination under Section 1557 of the Affordable Care Act**

Note that the comment period ended at midnight on November 9, 2015. The NPRM is available for review at: <http://www.regulations.gov/#!docketDetail;D=HHS-OCR-2015-0006>

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