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SENT VIA EMAIL TRANSMISSION

December 16, 2013

Suzanne Brennan
Judy Zerzan
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

RE: Draft EPSDT Personal Care Services Benefit Standard

Dear Ms. Brennan and Dr. Zerzan:

Thank you for the opportunity to comment on the draft personal care services (PCS) benefit standard, which we discussed during our December 4 meeting. We are pleased that the Department of Health Care Policy and Financing (HCPF) worked to quickly develop this standard and look forward to working together with the Department as you revise and implement this draft standard. That being said, we continue to have concerns that HCPF does not fully understand or acknowledge the breadth of its obligations under the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the federal Medicaid Act. These comments begin first with an overview of EPSDT requirements followed by specific comments on the draft PCS benefit standard.

EPSDT Overview

EPSDT is the comprehensive benefits package available to all Medicaid-eligible children under the age of 21.[1] This includes all children that have Medicaid coverage, regardless of the basis of eligibility (including those who receive state-plan Medicaid, receive Supplemental Security Income, receive federal foster care or adoption assistance, and receive Home and Community-Based Services (HCBS). EPSDT is and should be thought of as part of the core children's Medicaid benefit and not as a separate program. Thus, we are concerned when HCPF staff repeatedly refer to EPSDT as a separate benefit or program rather than a core requirement that dictates that all medically necessary services be made available to each Medicaid enrolled child under the age of 21. The hallmark of the EPSDT benefit is that it requires coverage of all medically necessary care and services for children, including all mandatory and optional services

[1] 42 U.S.C. § 1396d(a).

that the state may cover under the Medicaid program, whether or not such services are covered for adults and whether or not the services are specifically covered for children under Colorado's state plan.

Screenings

Under EPSDT, Colorado must provide regularly scheduled screens (examinations and evaluations of the general physical and mental health of eligible children).[2] Children must receive screenings pursuant to a "periodicity schedule," which is set by the state after consultation with a recognized child health care organization, such as the American Academy of Pediatrics.[3] Four different types of screens are required: medical, vision, hearing, and dental.[4] Medical screenings at a minimum must include a health and developmental history, an unclothed physical exam, immunizations, lab testing (including lead tests), and health education.[5] States must also conduct periodic vision, hearing, and dental screens.[6]

In addition, "interperiodic screens," which occur outside the periodicity schedule, must also be conducted, as medically necessary.[7] Persons outside the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen, and "any encounter with a health care professional acting within the scope of practice is considered to be an interperiodic screen, whether or not the provider is participating in the Medicaid program at the time those screening services are furnished."[8]

Treatment

Under EPSDT, the Colorado Medicaid Program must cover medically necessary "health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions."[9] Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening – even if the condition cannot be prevented or cured.[10] Covered services include case management, transportation, home health, personal care services and "any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability."[11] As we discussed in our meeting, the specific language of the statute is very important, for example we discussed the importance of using the word "ameliorate" rather than "mitigate" in the personal care services benefit standard.

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[2] 42. C.F.R. § 441.56(b)
[3] 10 CCR 2505-10 8.280.4.A; 42 USC 1396d(r)(1)(A).
[4] 42 U.S.C § 1396d(r).
[5] 42 U.S.C § 1396d(r)(1)(B).
[6] 42 U.S.C § 1396d(r)(2)-(4).
[7] *See*, 10 CCR 2505-10 8.280.4.B
[8] National Health Law Program, *Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet*, 4, http://www.healthlaw.org/images/stories/epsdt/3-ESDPT08.pdf (2008)
[9] 42 U.S.C. § 1396d(r)(5)
[10] National Health Law Program, *An Advocate's Medicaid EPSDT Reference Manual*, at p. 6 (1993).
[11] 42 U.S.C. § 1396d(a)(13)

No Arbitrary Limitations on Services may be imposed on Medicaid enrolled children

The CMS State Medicaid Manual imposes strict requirements regarding limitations on services provided as part of the EPSDT benefit. Specifically, the manual states:

> 42 CFR 440.230 allows [a state] to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that **all services included in §1905(a) of the Act that are medically necessary** to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.[12]

CMS also issued strong guidance to the State of Washington regarding the imposition of caps and quantitative limitations on PCS. The guidance states:

> CMS guidance: Under EPSDT, children are entitled to all medically necessary personal care services. States may impose prior authorization standards to ensure that the services provided are medically necessary, but individuals under age 21 must be permitted to access personal care service hours that exceed a cap if the additional hours are determined to be medically necessary. To the extent that Washington may be using its CARE process to assign a number of personal care services hours that cannot be exceeded, effectively imposing restrictions on the number of hours available to an individual child which are not based on the needs of that child, such practice would not be consistent with federal law.[13]

In addition to this CMS guidance, courts throughout the country continue to issue strong holdings that states may not impose quantitative caps or limits on Medicaid services for children if those services are medically necessary to correct or ameliorate the child's condition.[14]

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[12] Centers for Medicare and Medicaid Services State Medicaid Manual, 0-494 at pages 5122-23. (Emphasis added).

[13] Centers for Medicare and Medicaid Services letter dated March 20, 2013 addressed to Edward Dee and Amy Crewdson, on file with author.

[14] *See, Rosie D. v. Romney*, 410 F. Supp. 2d 18, 25 ("[A]s broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are far more expansive"); *see also, Collins v. Hamilton*, 349 F.3d 371, 375-76 n.8 (7th Cir. 2003) (citing 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r) and holding "a state's discretion to exclude services deemed 'medically necessary' by an EPSDT provider has been circumscribed by the express mandate of the statute"); *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F. Supp. 2d 905, 912 (S.D. Ohio 2008). 1173, 1179 (D. Ariz. 2006).

COMMENTS TO DRAFT EPSDT PERSONAL CARE SERVICES BENEFIT

1. Four areas of services requirement, page 2

Page 2 of the draft PCS standard describes the following eligibility requirement: "The client requires moderate to total assistance in at least four areas non-medical activities of daily living as defined in the this Benefit Coverage Standard."

This standard establishes inappropriate entry criteria to the personal care services benefit. The PCS benefit must be made available to all children for whom it is medically necessary. Requiring a client to demonstrate a need for multiple areas of personal care services imposes an unreasonable, arbitrary limitation on access to these services. We are very concerned with this language and believe it is contrary to the federal EPSDT requirement that Colorado cover *all* "health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions."[15] This requirement is also contrary to your own requirement expressed in your 2013 EPSDT Fact Sheet, which states "[n]o arbitrary limitations on services are allowed."[16]

It is improper to base medical necessity for any one particular personal care service on whether or not a child demonstrates a need for another service. Because of this requirement, a child demonstrating a need for assistance with dressing, feeding and ambulation would not meet the medical necessity standard for any of those services. However, if that same child also demonstrates a need for toileting assistance (in addition to the other three), then all four services suddenly change into being "medically necessary" after all.

Additionally, this standard undermines a provider's determination of medical necessity. Even in cases where a treating provider determines that PCS are medically necessary with respect to one, two or three areas of assistance, this unreasonable and arbitrary requirement will supersede the provider's independent medical judgment.

Please replace this requirement with the following language: ***"The client requires moderate to total assistance in at least one area of activities of daily living as defined in this Benefit Coverage Standard."***

2. Use of the word "non-medical" throughout the document

Throughout the draft PCS benefit standard document, PCS are referred to as "non-medical" and are also referred to as assisting clients with "non-medical" activities of daily living. Using the term "non-medical" unnecessarily creates tension with the EPSDT requirements to cover all medically necessary services. Because of the broad medical necessity definition required under EPSDT—requiring coverage of services that ameliorate the effects of a condition, even if treatment is not possible—services, such as PCS, must be considered medically necessary even though those services might be considered "non-medical" in nature.

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[15] 42 U.S.C. § 1396d(r)(5)

[16] HCPF, Early Periodic Screening Diagnosis and Treatment Fact Sheet, available at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251900936352&ssbinary=true

Please remove the term "non-medical" and refer throughout the document to these services as: ***"personal care services, which are intended to provide assistance with a client's activities of daily living and instrumental activities of daily living."***

3. General Requirements, page 3

Current language: the first bullet point on page three states that PCS must be "[p]rovided to assist in the treatment or mitigation of an illness, injury, or disability, which…."

Please replace the word ***"mitigation"*** with ***"amelioration"*** to align the language with the EPSDT statutory language. Amelioration and mitigation have different meanings and it is important to align with the statute.

4. Usual Frequency of Task, throughout the document

Under the description of each area of personal care service, the "usual frequency of task" field is followed by an asterisk which clarifies at the end of the document that additional services may be appropriate in certain circumstances. We support HCPF's acknowledgment that imposing strict limitation on the amount or frequency of services is inappropriate for children under age 21. Instead of the current language, we request that all "usual frequency of task" fields contain the following language: ***"As ordered by the qualified physician on the plan of care or the prescribing physician on the PC plan of care."*** This language will help to avoid confusion and ensure that all children are scored consistently. It would be unfortunate if a child were not scored properly for lack of understanding on the part of a home health agency .This is a potential problem that is easily avoided by the addition of clarifying language.

5. Medication reminders, page 15

The draft PCS benefit standard removes medication reminders as a possible personal care services benefit. We fully understand that granting authority for medication reminders to personal care services workers may create certain licensure and scope of practice issues. However, we are concerned that children on strict medication management programs may require medications during a personal care services visit. We strongly encourage HCPF to seek feedback on this issue from home health agencies, pediatrician, parents and the stakeholder community at large regarding this issue to ensure that PCS may be provided to the maximum benefit of the client.

6. Protective oversight special considerations, page 19

Current language: "Protective Oversight may only be provided during the completion of activities of daily living listed in this benefit coverage standard. Protective Oversight shall not be the standalone reason. Documentation shall specify the level of impairment and demonstrate the need for protective oversight."

While we are very pleased that HCPF included an initial draft definition of protective oversight services in the PCS benefit standard, requiring a demonstrated need for other areas of PCS in order to obtain protective oversight services is contrary to the language and intent of the federal EPSDT statute. Again, establishing medical necessity for a particular service must not be dependent on also requiring assistance in some other unrelated area. As written, this standard

imposes an arbitrary limitation on services and would violate the state's obligation to provide children under age 21 with all medically necessary services.

Please strike the following language from the draft benefit standard: "Protective Oversight may only be provided during the completion of activities of daily living listed in this benefit coverage standard. Protective Oversight shall not be the standalone reason."

7. Limitations, page 23

Limitation number 7 on page 23 states the following: "All PC services will be reimbursed at the Medicaid personal care rate even if the person providing personal care holds credentials for CNA, RN or other skilled profession." We are concerned this language may cause unnecessary confusion. You explained to us during our December 4 meeting that Certified Nurse Aids (CNAs) shall be paid CNA reimbursement rates for unskilled personal care services that are related to the skilled CNA service and performed during the same visit. We are very pleased that you made this commitment and believe this policy will help to ensure that home health services are delivered as seamlessly as is allowable under federal law. However, limitation number seven could be interpreted to mean that CNAs may not be paid CNA rates to perform PCS related to skilled CNA tasks. To eliminate this confusion, we suggest adding the following sentence to limitation number 7: ***"However, CNAs shall be reimbursed at a CNA reimbursement rate for unskilled services that are related to skilled services performed during the same CNA visit."***

8. Non-covered services and general limitations, page 26

Number 18 prohibits the following service: "Personal Care or homemaker tasks that are directly related to a skilled task ordered in a Home Health plan of care." Just because a skilled service (and related unskilled service) may be authorized under a client's plan of care does not necessarily mean those services will actually be provided. We are concerned the language in Number 18 may prevent clients from receiving medically necessary PCS in instances where related skilled services authorized under a plan of care are not actually provided. Please replace number 18 on page 26 with the following language: ***"Personal Care or homemaker tasks that are directly related to a skilled task ordered in a Home Health plan of care and actually performed by a CNA, RN or other skilled professional."***

Number 19 prohibits the following service: "Personal Care Services provided and/or billed during a skilled CNA visit or when the client or Family Member/Caregiver is willing and able to perform the services or tasks independently." We are concerned that this language could prevent a personal care worker from performing a PCS that is unrelated to a CNA service if both the PCS worker and CNA visit occur during the same time. In order to maximize the flexibility for home health providers to schedule visits at times most appropriate for clients, please replace the language in number 19 with the following language: ***"Personal Care Services provided and/or billed by a skilled CNA or Personal Care Services when the client or Family Member/Caregiver is willing and able to perform the services or tasks independently."***

IMPLEMENTING PCS BENEFIT AND CONDUCTING PROVIDER OUTREACH

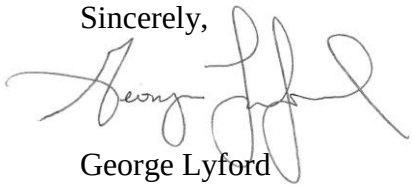
We appreciate that HCPF has committed to conduct monthly community and provider feedback sessions until the PCS benefit is fully implemented and on an ongoing basis to ensure the benefit

standard is structured in a manner that maximizes appropriate access to these essential services. It is crucial that HCPF capitalize on the breadth of knowledge and expertise that exists in the provider and consumer community to ensure the PCS benefit standard is appropriate and sufficient. Moreover, we encourage HCPF to implement a recurring and thorough provider outreach and education campaign regarding PCS. This should include instructions and notifications through provider bulletins concerning the scope of PCS and procedures for requesting and administering PCS through Medicaid. Moreover, since PCS is a new benefit, HCPF should establish a dedicated point of contact through the department to ensure providers may provide ongoing feedback while also be able to seek guidance as issues arise.

Again, we appreciate the request for our comments on the draft PCS benefit standard. We request a follow up meeting before January 10 to discuss your progress of applying these revisions and implementing the benefit standard. In the meantime, please do not hesitate to contact me should you have any questions.

Thank you again for your work in implementing the PCS standard.

Sincerely,



George Lyford