

A Legal and Policy Overview of Pediatric Medical Necessity

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Sources of Coverage for Children

2010

- If low income and eligibility categories
 - Medicaid (133% 0-5; 100% 6-18)
 - CHIP (>Medicaid levels, up to 300%+)
- If can afford
 - Private (I, SG, LG)
 - Federal, state, CHAMPUS employees

PPACA

- Starting in 2014
 - Medicaid for all <133% (138% AGI), including children
 - Medicaid/CHIP MoE until 2019
- By 2014
 - I and SG in HIE with subsidies 133%-400%
 - CHIP option to cover state employees' children

Private Insurance Approach to Coverage

- Private insurers take steps to (1) maintain a predictable and stable level of risk within their risk pool and (2) make the individual costs predictable and manageable as well
- Coverage decisions
 - ‘Macro-level’
 - Exclusions, limitations, cost-sharing
 - ‘Micro-level’
 - Medical necessity standard and determination

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Public Insurance: MEDICAID Approach to Coverage

- Medicaid is (1) designed to be available to eligible low income and medically impoverished persons at the *point of greatest health care need* and (2) structured to pay for *comprehensive health services necessary for children and adults with serious and chronic health problems*
- Coverage decisions = mix of federal and state benefit and coverage rules
 - ‘Macro-level’
 - **Federally-defined mandatory (includes EPSDT) and optional benefits, cost-sharing federally prohibited for children**
 - ‘Micro-level’
 - **Federal “preventive” medical necessity standard for children and state-defined determination process**

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Public Insurance: CHIP

Approach to Coverage

- CHIP is a hybrid between private-like insurance and Medicaid
- Coverage decisions, depends
 - If private-like (separate),
 - State-designed actuarially equivalent benefit packages, but federally-required well-baby and well-child care, including age-appropriate immunizations, permissible cost-sharing within limits, allowable exclusions/limitations on covered services
 - Insurer-designed medical necessity definitions and determination processes unless otherwise directed by the State or in states that don't contract with insurers, their own definition of medical necessity
 - If Medicaid, same coverage rules

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Medicaid Coverage Rules

- Set of defined mandatory and optional benefit classes
- Amount, duration and scope rules of coverage
 - Reasonable and adequate coverage (“sufficient in amount, duration and scope to reasonably achieve its purpose;” limits admissible with emergency exceptions)
 - Availability of benefits statewide
 - Comparability of benefits among sub-groups
 - Non-discriminatory coverage in terms of the types of conditions covered
 - Medical necessity definition consistent with the purpose of the benefit, reasonable, comparable, and non-discriminatory

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Federally-Defined Medicaid Benefits

“Mandatory” Items and Services

- Physicians services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- **Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21**
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility (NF) services for individuals 21 or over

“Optional” Items and Services

- Prescription drugs
- Medical care or remedial care furnished by licensed practitioners
- Diagnostic, screening, preventive, and rehab services
- Clinic services
- Dental services, dentures
- Physical therapy
- Prosthetic devices, eyeglasses
- TB-related services
- Primary care case management
- ICF/MR services
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21
- Home health care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice services

Source: KFF, 2005.
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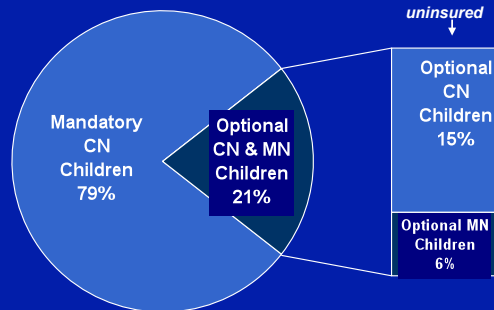
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Scope of EPSDT Requirement

- Mandatory for all categorically needy (CN) children – 94% of all Medicaid children
- Optional for medically needy (MN) children – 6% of all Medicaid children – and children covered through separate CHIP plans

Children’s Enrollment in Medicaid as “Mandatory” and “Optional” Groups, 2001



Total: 24.7 million children

Source: Sommers A, Ghosh A, & Rousseau D. Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefit Categories. KFF. June 2005.

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Medicaid's Built-In 'Preventive' Medical Necessity Definition

- Medically necessary services for children < age 21 are services and benefits that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.
- The health care intervention should:
 - Assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality;
 - Be appropriate for the age and developmental status of the child;
 - Take into account the setting that is appropriate to the specific needs of the child and family; and
 - Reflect current bioethical standards. Medically Necessary interventions must be reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects.

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Example of "Restorative" Medical Necessity Standard

"p. Medically Necessary Services - means those Covered Services that are, under the terms and conditions of this **Contract**, determined through Plan utilization management to be:

- (1) Appropriate and necessary for the symptoms, diagnosis, and treatment of the condition of the Enrollee.
- (2) Provided for the diagnosis or direct care and treatment of the condition of the Enrollee enabling the Enrollee to make reasonable progress in treatment.
- (3) Within standards of professional practice and given at the appropriate time and in the appropriate setting.
- (4) Not primarily for the convenience of the Enrollee, the Enrollee's physician or other Provider, and
- (5) The most appropriate level of Covered Services, which can safely be provided."

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MEDICAID PROCESS

- Case by case determination of medical necessity based on physician's recommendation, evidence, and criteria
- Re-review(s) of original determination within a reasonable amount of time, e.g., 30 days, 60 days
- Exception policy for certain services, e.g., experimental treatments
- Right to a fair hearing in case of denials

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Examples of Children Who Benefit From EPSDT

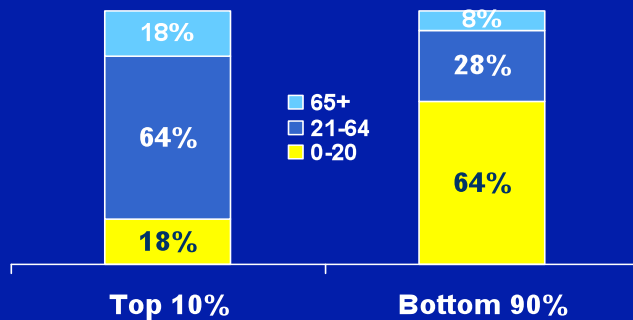
- Healthy infants and toddlers with "primary prevention" needs
 - Regular and "as needed" checkups, complete vision, dental and hearing care, parenting support
- Children born extremely prematurely (<1000 g) and at-risk for lifelong disabilities
- Foster care children and children in the child welfare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

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Only 18% of Medicaid High Cost Cases are Children



Source: Schneider A, Lambrew J, & Shanouda Y. Medicaid Cost-Containment: The Reality of High-Cost Cases. Center for American Progress. 2005.

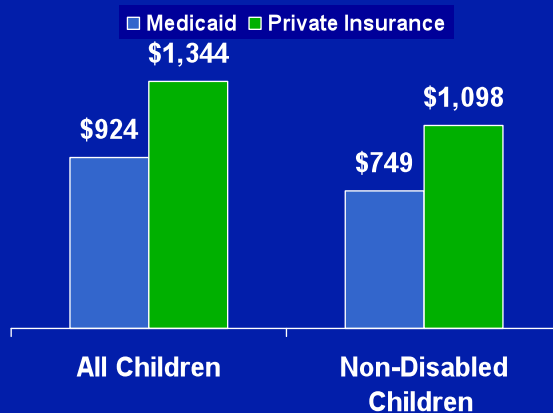
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Spending, including Medicaid Spending, on Children is Low

PC Spending (in 2001 dollars) on Medicaid and Privately-Insured Children, 1996-1999



Source: Kaiser Family Foundation, Medicaid: A Lower-Cost Approach to Serving a High-Cost Population, March 2004

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Issue(s) to Consider in the Era of Health Reform

Seamless transitions between Medicaid/CHIP and private insurance products in HIE as children's family incomes rise and fall so that coverage decisions are more aligned and children, especially CSHCN, have access to, and continue to have access to, needed medical care

'Macro-level' (ACA provisions)

- EPSDT for Medicaid expansion enrollees who are children, BHPs and benchmark benefit packages in HIE have to cover EHBs, including pediatric services
- Certificate of comparability of coverage of benefits and cost-sharing between CHIP and HIE products for children moving from CHIP to HIE

'Micro-level'

- Explicit definition of the medical necessity standard and determination process to support a thorough evidentiary review of the child's medical needs as part of benefit and coverage design
- Managed care contracting and the "cascade" of requirements

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