



## State Approaches to Providing Home Health Services to Children with Medical Complexity Enrolled in Medicaid

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States are implementing new and enhanced strategies to improve the delivery and quality of home health services (e.g., nursing, home health aides, therapies) for children with medical complexity enrolled in Medicaid. This policy brief examines how six states structure, finance and provide home health services that are designed to provide important home-based care and family supports, improve quality of care, and avoid costly, hospitalizations and institutionalized care.

### Background

State Medicaid agencies can use home health services to improve the quality of care and life for Medicaid enrollees and reduce costs.

Today, many states are renewing their focus on this critical set of services as part of their Medicaid delivery system reforms, including managed care delivery arrangements and value-based care. Home health services are important for individuals with complex needs, especially for children with chronic, serious, and complex conditions.

Quality home health care can help children avoid emergency department use and prolonged hospitalization or institutional care.<sup>1</sup> Access to high-quality home health services can improve the outcomes and health of children and their families.<sup>2</sup>

States seeking new ways to improve health outcomes for Medicaid enrollees with complex needs have been challenged by longstanding policy

barriers and workforce shortages. Few policy studies have analyzed state approaches to coverage and delivery of home health services for children and youth with special health care

**Methodology:** NASHP studied how six states (CT, DE, IA, MD, OH, and WA) structure and provide home health services to children in their Medicaid programs. Selections were based on states':

- Diversity of Medicaid delivery systems;
- Priority for improving systems of care for CYSHCN; and
- Collaboration between state Title V Maternal and Child Health programs and Medicaid.

Authors conducted a literature review of articles on home health services, state documents including Medicaid agencies' policy guidance, managed care contracts, and state plan amendments.

Using a structured questionnaire for each group, NASHP interviewed representatives from both state Medicaid agencies and Title V CYSHCN programs.

This work builds on NASHP's [50-state analysis](#) of Medicaid Managed long-term services and supports (MLTSS) programs for children.

needs (CYSHCN). This brief describes how six states structure and provide home health services to children enrolled in Medicaid.

Nearly 20 percent (14.6 million children) of US children from birth to age 18 have chronic or complex health care needs that require physical and behavioral health care services and supports beyond what children normally require.<sup>3</sup> CYSHCN often depend on home health services as part of primary and specialty care, and other services and supports.<sup>4</sup> Of CYSHCN in the United States, 52 percent are white, 21 percent are Latinx, and 18 percent are African American.<sup>5</sup> A subset of CYSHCN – children with medical complexity – who comprise approximately 0.5 percent of US children, are even more likely to require home health services.<sup>6</sup> In 2016, nearly 500,000 families of CYSHCN reported needing home-based medical and therapeutic services.<sup>7</sup>

Medicaid plays a crucial role in providing coverage for CYSHCN, serving almost half of the CYSHCN population (48 percent).<sup>8</sup> CYSHCN are eligible for Medicaid through a variety of coverage pathways, some of which are mandatory under federal Medicaid law and others are optional at the state level. These pathways include Medicaid coverage for children:

- Based solely on their household income;
- Enrolled in the Medicaid Aid to the Aged, Blind and Disabled (ABD) category of assistance;
- Receiving Supplemental Security Income (SSI);
- Enrolled in foster care or receiving adoption assistance;
- Enrolled through a Medicaid waiver, including the Katie Beckett waiver that provides home-based services for children with complex health care needs

### **How Home Health Services Are Defined, Delivered, and Covered**

Federal regulations broadly define home health services to include a range of specific services for adults and children that are provided at a “beneficiary’s place of residence,”<sup>9</sup> including:

- Nursing services;
- Home aide services provided by a home care agency;
- Medical supplies and equipment for use in home-based settings; and
- Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency.<sup>10</sup>

These services are outlined in federal regulations, but state Medicaid programs have the discretion to deliver them in varying ways, with unique policies and procedures. For example, a state may offer home nursing services through Medicaid managed care delivery systems but provide home-based therapies through a fee-for-service system. Prior authorization policies may also vary for different home health services within a state.

Home nursing care in particular can be an important service for children with medical complexity (CMC). CMC often face a range of conditions and diagnoses that require care in a home-based setting and without access to home health services they would face higher

hospitalization rates.<sup>11</sup> Community-based care is also considered a best practice for children with special health care needs and is typically more cost effective than institutional care.<sup>12</sup>

Home health services are provided by a range of providers including nurses, home health aides, personal care assistants, and others. Additionally, families play a critical role in delivering home health services to children. Family caregivers provide over 1.5 billion hours annually of health care for their children, according to a recent report.<sup>13</sup> Several states have begun to recognize the invaluable role families play and, as a result, provide training support and reimbursement to family caregivers for certain home health services, such as personal care services.<sup>14</sup>

### **Medicaid Coverage of Home Health Services for Children**

Medicaid coverage of home health services for children is established by the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit. Medicaid EPSDT mandates coverage of all services that are medically “necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions.”<sup>15</sup> Coverage of these services includes all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults.<sup>16</sup>

The EPSDT benefit is mandated for all children enrolled in Medicaid under age 21. Determining if a service is medically necessary is a key step for states when establishing whether a service is covered under the EPSDT benefit.<sup>17</sup> States are required to determine medical necessity, but they do so in a variety of ways depending on the delivery system providing the service.<sup>18</sup> The table in [Appendix A](#) details how the six states define medical necessity under Medicaid EPSDT and the prior authorization processes states use to determine medical necessity for all services, including home health services.

Federal law underscores the role of states in providing community-based and home-based services for children enrolled in Medicaid. Most notably, the US Supreme Court case, *Olmstead v. L.C.*, established that unjustified institutionalization of Medicaid beneficiaries violates the Americans with Disabilities Act. As a result of the ruling, states must cover services in their programs, including Medicaid, in the community rather than institutions.<sup>19</sup>

State Medicaid programs are using a variety of strategies to improve access to home health services, particularly for CYSHCN. Some strategies are unique to home health services and others focus on improving care overall. The six study states (WA, OH, IA, MD, DL, CT) use a variety of delivery systems to provide home health services. Their strategies include addressing provider capacity, advancing the person-centered medical home model, streamlining prior authorization processes, collaborating with Title V CYSHCN programs, and promoting stakeholder collaboration.

### **Innovations to Address Home Health Services Workforce Shortages**

The availability of well-trained providers is foundational to the timely delivery of high-quality home health services for CYSHCN. The extensive needs of CYSHCN and children with medical complexity often require ongoing skilled care by nurses and therapists. The design of service

delivery models, provider education and training, and the adequacy of home health provider payment rates are all important factors affecting the home health workforce for CYSHCN.

Lack of sufficient home health provider capacity is one of the most significant challenges for states. States are experiencing shortages of pediatric nurses, licensed practical nurses (LPNs), and physical, occupational, and speech therapists. As a result, CYSHCN and their families can often experience barriers and wait lists for home health services.

### **State Innovations**

Staff shortages are attributed to a variety of factors including geographic access challenges in rural areas, lack of home health services training programs, and payment rates that lag behind those of competing institutions or nearby regions. In **Ohio**, staff shortages are mostly concentrated in rural areas. **Maryland** has provider shortages in areas that are adjacent to Washington, DC where Medicaid payment rates are higher. Maryland also experiences home health care provider capacity challenges in certain areas due to competition from nursing facilities within the state.<sup>20</sup> In **Connecticut**, home health agencies that serve CYSHCN enrolled in Medicaid face competition for pediatric nurses from hospitals.

States are actively seeking solutions to address provider shortages. The Maryland Department of Health developed the Task Force to Study Access to Home Health Care for Children and Adults with Medical Disabilities using input from a variety of stakeholders in an effort to improve LPN training in home nursing skills and use of durable medical equipment.<sup>21</sup> The Maryland task force explored a range of options including:

- Partnerships between home health agencies and nursing programs at universities and community colleges to create training programs for LPNs interested in home health work;
- Opportunities for agency staff to participate in training simulation labs; and
- Preceptorships in which families would participate in training environments with providers in training.

The task force also recommended that provider agencies pool their resources to provide home health skills training and use a skills checklist to evaluate LPN competency on an annual basis to allow for a better understanding of how to continuously improve home health LPN skills, certifications, and competencies.

In an effort to improve the supply of home health nurses, Ohio's Medicaid agency has increased awareness of the state's workforce loan forgiveness and training programs.<sup>22</sup> In addition, an Ohio children's hospital has partnered with a home health agency serving CYSHCN enrolled in Medicaid to provide home health nurses with specialized training in pediatric nursing.

Several states have either considered or implemented increases in home health care provider payment rates as a strategy to increase the number of providers participating in the Medicaid delivery system. Given the substantial fiscal impact of increasing payment rates, states have had to weigh the impact that these rate increases would have compared to other strategies for addressing workforce shortages. Ohio increased payment rates for home health nurses in 2017.

Maryland's task force provided several recommended options for significant increases to Medicaid home- and community-based services waiver and other community-based nursing providers' payment rates. After an analysis of the fiscal impact of proposed increases, Maryland's task force suggested that a phased-in approach to increases could be a pathway to modifying rates. This approach was implemented, and in May 2018 Maryland announced a 3 percent payment increase.<sup>23</sup> In an effort to streamline the reimbursement methodology for home health agencies, Connecticut Medicaid proposed a structured fee schedule approved by the state legislature in 2017, which allows for improved fiscal monitoring and data collection. Delaware's Children with Medical Complexity Steering Committee, in studying how to improve the system of care for children with medical complexity,<sup>24</sup> recommended a workforce study to investigate possible shortages of private-duty nurses available to provide care to this population.

Recognizing the different levels of care that CYSHCN may need from home health care can also help make the best use of the limited number of pediatric home health providers. Maryland Medicaid allows for reimbursement of several tiers of service, with different payment rates to meet a range of needs within the fee-for-service (FFS) component of the program. For example, Medicaid covers certified nursing assistants (CNAs) and certified medical technicians (CMTs) to provide services, such as medication administration, that do not require an LPN level of care.

States are also acknowledging the crucial role that families play in understanding and supporting the unique needs of children as part of broader strategies to address shortages of home health providers. For children enrolled in Medicaid waivers, Ohio Medicaid allows family caregivers to be reimbursed for providing home-based personal care services to children. The Maryland task force recommended efforts to foster dialogue between parents and home care providers to increase feedback, manage expectations, and increase transparency about wait times. In Delaware, CYSHCN families were extensively engaged in the state's steering committee process that identified challenges and developed solutions for managing the health care needs of children with medical complexity.<sup>25</sup>

### **Innovations to Advance the Medical Home Model**

The American Academy of Pediatrics has identified medical homes as a core component of a comprehensive system of care for CYSHCN.<sup>26</sup> The medical home model can create the infrastructure needed for primary care provider (PCP) practices to engage with and coordinate home health and other providers involved in the care of CYSHCN. The model can help integrate home health services with all aspects of children's care and provide the care coordination support needed to monitor access to home health services, ensure that authorized services are delivered, and close gaps in care.

### **State Innovations**

In **Connecticut**, the medical home model is central to the state's managed fee-for-service approach to delivering care to all members, particularly CYSHCN. Primary care practices receive in-office, ongoing support to attain and maintain National Committee for Quality Assurance (NCQA) or The Joint Commission medical home recognition. In addition, care coordinators

employed by the state’s contracted Administrative Services Organizations support primary care providers and offer home visits and telephonic follow-up as needed. To the extent that PCMH practices have difficulty connecting families with home health care providers, they work closely with the state’s medical, behavioral, and dental administrative services organizations (ASO) to find qualified providers. ASOs are organizations that are contracted by the state to provide administrative services such as management of claims and benefits and provider delivery reform support. **Delaware’s** steering committee on medical complexity<sup>27</sup> recommended implementing the PCMH model as part of a comprehensive strategy to manage the health care needs, including home health services, of this population. Delaware found that the PCHM model could help ensure primary care provider leadership in coordination across all sectors of the health care system, including home health.

### **Innovations to Streamline Prior Authorization**

The prior authorization process within Medicaid is intended to hold providers accountable for delivering medically necessary care and achieving cost savings in the health care system. However, because CYSHCN often need home health and other services on an ongoing basis, requirements for repeated prior authorizations can have the unintended effect of impeding access.<sup>28</sup> Access to home health for CYSHCN can be further delayed because of administrative challenges associated with navigating multiple prior authorization processes and forms used by different managed care plans.

### **State Innovations**

To streamline the process and reduce unnecessary duplication of effort, **Delaware** managed care plans are working on a method to create a “system flag” within the Medicaid managed care data system for children with medical complexity. Using this system strategy will streamline and simplify the prior authorizations process, so that prior authorization processes can be simplified and not overly onerous. Additionally, to enable ongoing monitoring of managed care organization (MCO) prior authorization processes, Delaware Medicaid requires quarterly reporting on prior authorization decisions. **Iowa** Medicaid has recognized the challenges and delays associated with lack of uniformity in prior authorization requirements for MCOs. The state is working with managed care plans to develop a standard prior authorization form to be used across all plans. This will ease the burden on providers who were forced to be familiar with a wide assortment of forms and processes for multiple MCOs. State Medicaid officials anticipate that the form will be available in the next 18 months.

### **Improving Collaboration with Title V CYSHCN Programs and Stakeholders (Accordion tab #6)**

In some states, state Title V Maternal and Child Health Services Block Grant (Title V) CYSHCN programs partner with Medicaid agencies to coordinate home health services for CYSHCN. State Title V CYSHCN programs are mandated under federal statute to support coordinated, community-based care for CYSHCN. Additionally, state Title V programs have extensive data and expertise on the needs of the population, as well as connections to pediatric specialists who can facilitate access to home health and other needed services. In some states, Title V

programs provide important gap-filling services and supports, such as durable medical equipment, to supplement Medicaid or private insurance.<sup>29</sup>

### **State Innovations**

In **Ohio**, state Medicaid and state Title V CYSHCN program staff partnered to help ensure a smooth transition for CYSHCN who transitioned to Medicaid managed care in 2012, which included children who access home health services. Ohio Medicaid and Title V program staff meet monthly to review cases of CYSHCN who have reported issues with accessing services or experiencing barriers to care. For example, medical-necessity determinations have not always considered that, due to their development, children requiring durable medical equipment may need more frequent replacements than they were receiving. This case review process has allowed for better understanding of the unique needs of children with medical complexity and better implementation of EPSDT medical necessity policies by Medicaid managed care organizations.

The University of **Iowa**'s Child Health Specialty Clinics (CHSC), Health and Disease Management team helps coordinate care for a subset of Medicaid-enrolled CYSHCN who are served through Medicaid fee-for-service programs and are not part of the state's Medicaid managed care program. In Iowa, CHSC is part of the state's Title V CYSHCN program. Care coordinators help maintain ongoing communication with home health agencies to facilitate timely access to pediatric nursing services. CHSC also trains and certifies family navigators – individuals who have lived experience with CYSHCN – to support families on waiting lists for Medicaid waiver services. This work requires coordination and collaboration between CHSC and the state Medicaid program to ensure coordinate care for children who are served by both programs.

### **Creating Opportunities for Stakeholder Collaboration**

CYSHCN typically need services from many programs, organizations, and care systems, including Medicaid, public health, education, social services, behavioral health and substance use, foster care, and others. However, these agencies and systems historically have operated in silos, with minimal data sharing, collaboration, or integration.<sup>30</sup> The lack of collaboration across systems can lead to care gaps, duplication of services, fragmentation of care, and long delays in obtaining services. State officials increasingly are recognizing the need for communication and collaboration across multiple stakeholders within and outside of government to develop effective solutions for delivering home health services for children.

### **State Innovations**

**Delaware**'s Children with Medical Complexity Steering Committee convened for eight months in 2017 and 2018 to develop a comprehensive plan to manage the health care needs of children with medical complexity. The steering committee included Medicaid officials, as well as other state divisions and agencies, providers, health plans, and family representatives. The committee's goals were to strengthen the system of care, increase collaboration across agencies, encourage community involvement, and ensure adequate and appropriate access to

health services for Children with Medical Complexity.<sup>31</sup> The steering committee divided into four work groups to address key issues, including access, and submitted recommendations to the legislature. Families provided extensive input on the nature of challenges in access to services, the need for respite care, transportation, difficulties in obtaining durable medical equipment, appeal and fair hearings processes, and coordination among payers.

**Ohio** Medicaid officials also convened an interagency workgroup to identify potential gaps and duplication of services for CYSHCN served by both Medicaid and state Title V CYSHCN programs. This interagency effort has allowed for sharing of CYSHCN-specific knowledge from Title V CSYHCN staff about the needs of this population with Medicaid staff to better deliver services, including home health services.

## **Key Strategies and Conclusion**

The experiences of the six states featured in this report provide insights for other states interested in improving their coverage and delivery of home health services for children enrolled in Medicaid.

**Prioritize efforts to address provider shortages.** The shortage of qualified providers is the single greatest challenge for states seeking to optimize home health services for CYSHCN. The complexity of this issue requires creative and multi-faceted solutions. Stakeholder task forces and study committees, partnerships with state workforce agencies, innovative approaches to education and training, review of Medicaid payment rates, and exploration of credentialing and reimbursing family caregivers all play important roles in state strategies to improve and expand the home health care workforce for CYSHCN.

**Seek regular feedback from families.** Family experiences and satisfaction levels are the ultimate determinant of quality care for CYSHCN. States can leverage a variety of tools for beneficiary feedback, including annual surveys, focus groups, stakeholder advisory committees, regional forums, and one-on-one stakeholder meetings. Advisory committees may be time-limited or ongoing, depending on the nature of the issue and state agency capacity. Feedback from a range of stakeholders — including families, providers, health plans, and care coordinators — can be critical to learn from individuals with a variety of perspectives, identify the most pressing problems, and formulate effective solutions tailored to beneficiary needs.

**Leverage the benefits of cross-sector and stakeholder collaboration.** Delivery of comprehensive, high-quality home health services to CYSHCN requires active engagement of many entities and systems and state agencies have recognized the need to go beyond siloed approaches to policy and program development. Partnerships across state agencies, particularly between state Medicaid and Title V CYSHCN programs and with provider groups, families of CYSHCN, and other key stakeholders can expand the knowledge base of all participants, advance innovative approaches to training, facilitate data sharing, and help build the relationships and infrastructure needed to overcome access challenges.

**Adjust service delivery models to increase capacity.** States are considering and implementing a variety of creative approaches to address persistent provider shortages. These strategies include development of medical home models that rely on team-based care and use of non-licensed staff (e.g., certified nursing assistants and certified medical technicians) to provide services, such as medication administration, that do not require the involvement of nurses or LPNs. Changes to prior authorization and staffing rules, such as allowing multiple agencies to provide authorized services or adjusting pediatric nurse assignments, may help maximize staffing resources to mitigate capacity challenges.

**Strengthening oversight to improve quality and access to services.** Medicaid programs have a variety of tools to strengthen accountability for access to quality care in either fee-for-service or managed care delivery systems. States are using a range of strategies that include requiring flagging of CYSHCN in information technology systems for targeted support, establishing provider network requirements aligned with CYSHCN needs, and requiring regular managed care plan reporting to identify challenges in delivery of authorized services. Additionally, states are enhancing oversight of home health services through targeted external reviews to validate the availability of qualified provider panels and regular evaluation of service delivery.

**Customize fee-for-service and managed care approaches to improve access.** State officials in both fee-for-service and managed care environments have found effective ways to advance access to home health services for CYSHCN, and leadership in both systems have viewed the payment models as critical to their success. A fee-for-service model may offer the advantage of allowing home health providers a “one-stop shop” to receive prior authorization for home health and other services and can be simple for families to understand. A Medicaid managed care model may provide the infrastructure needed to achieve effective care coordination and cost savings.

Officials in Medicaid managed care states report using fee-for-service carve-outs for specific populations and/or services in a way that is seamless to CYSHCN families and helps advance access to home health and other needed services. In carve-out environments, close coordination between health plans and providers is critical to ensure access. The optimal mix of managed care, fee-for-service, and carve-out strategies to advance access to home health services for CYSHCN will vary depending on the unique populations, policy landscape, and health care delivery systems in individual states.

## **Conclusion**

Focusing on the unique needs of CYSHCN represents a key opportunity for states to increase quality and access to these services. The six states highlighted in this issue brief have each found unique ways of tackling both access and quality of home health services in different delivery system models. The efforts of these states demonstrate that by analyzing barriers to access, such as provider shortages, and collaborating with both stakeholders and families, states can improve the quality and delivery of home health services for children in Medicaid.

**Appendix A: Summary of State Characteristics Related to Delivery of Home Health Services within Medicaid**

| Home Health Services for Children and Youth with Special Health Care Needs (CYSHCN) Delivery Systems<br>Fee for Service (FFS) or Medicaid Managed Care (MMC)                  |  |
|---|--|
| <b>CT</b>   | Fee for service  |
| <b>IA</b>   | Medicaid managed care <sup>32</sup>  |
| <b>DE</b>   | Medicaid managed care <sup>33</sup>  |
| <b>MD</b>   | Medicaid managed care <sup>34</sup><br><br>Managed care organizations (MCOs) “may not” be required to cover a number of specified services covered under FFS, including personal care services (assistance with activities of daily living) pursuant to COMAR 10.09.20. <sup>35,36</sup>   |
| <b>OH</b>   | Medicaid managed care <sup>37</sup>  |
| <b>WA</b>   | Medicaid managed care <sup>38</sup>  |
| Populations of CYSHCN Enrolled in Medicaid Managed Care   |  |
| <b>CT</b>   | N/A  |
| <b>IA</b>   | Mandatory enrollment for all populations of CYSHCN<br>Voluntary enrollment for American Indians/Alaskan Natives (AI/AN) <sup>39</sup><br>Excludes children who are enrolled in the Health Insurance Premium Payment (HIPP) program from managed care.  |
| <b>DE</b>   | Mandatory enrollment in Medicaid managed care for all populations of CYSHCN.<br>AI/AN are exempt from managed care enrollment. <sup>40</sup>   |
| <b>MD</b>   | Mandatory enrollment for all populations of CYSHCN <sup>41</sup>   |
| <b>OH</b>   | Managed care enrollment is mandatory for: <sup>7</sup> <ul style="list-style-type: none"> <li>• Children receiving Title IV-E federal foster care maintenance;</li> <li>• Children receiving Title IV-E adoption assistance;</li> <li>• Children in foster care or other out-of-home placement; and</li> <li>• Children receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under the Social Security Act and is defined by the state in terms of either program participation or special health care needs.</li> </ul> <p>Managed care enrollment is optional/voluntary for:</p> <ul style="list-style-type: none"> <li>• American Indians who are members of federally recognized tribes; or</li> <li>• Individuals diagnosed with a developmental disability who have a level of care that meets the criteria specified in state regulations and receive services through a 1915(c) home- and community-based services (HCBS) waiver administered by the Ohio department of developmental disabilities (DODD).</li> </ul> |
| <b>WA</b>   | Mandatory enrollment for most populations of CYSHCN<br>Voluntary enrollment for children in foster care or receiving adoption assistance <sup>42</sup>   |
| Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Medical Necessity Definition in States’ Medicaid Managed Care Contract, Provider Manual, or Other State Documents |  |
| <b>CT</b>   | <a href="#">Definition of medical necessity</a>  |
| <b>IA</b>   | State regulations do not include a definition specific to EPSDT. IAC 79.9(2) includes an overall definition of medical necessity definition. <sup>43</sup><br>The Amerigroup Medicaid managed care contract similarly includes a general definition of medical necessity. <sup>44</sup>  |

|                  |  |
|------------------|--|
| <p><b>DE</b></p> | <p>Medical necessity is defined as the essential need for health care or services which, when delivered by or through authorized and qualified providers, will:</p> <ul style="list-style-type: none"> <li>• Be directly related to the prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the member’s condition), and be provided to the member only;</li> <li>• Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member’s family;</li> <li>• Be primarily directed to the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living (ADLs), but will not be solely for the convenience of the member, the member’s family, or the member’s provider;</li> <li>• Be timely, considering the nature and current state of the member’s diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;</li> <li>• Be the least costly, appropriate, available health service alternative, and represent an effective and appropriate use of funds;</li> <li>• Be the most appropriate care or service that can be safely and effectively provided to the member, and not duplicate other services provided to the member;</li> <li>• Be sufficient in amount, scope and duration to reasonably achieve its purpose;</li> <li>• Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner’s peer group, or the functional equivalent of other care and services that are commonly provided; and</li> <li>• Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.</li> </ul> <p>For members enrolled in Diamond State Health Plan - Plus (DSHP-Plus) long-term support services, provide the opportunity for members to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. In order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all-natural family, community and facility environments, and activities. The contractor shall not arbitrarily deny or reduce the amount, duration or scope of a medically necessary service solely because of member’s diagnosis, type of illness or condition. The contractor shall determine medical necessity on a case-by-case basis and in accordance with this section of the contract.<sup>45</sup></p> |
| <p><b>MD</b></p> | <p>Per Maryland EPSDT regulations,<sup>46</sup> MCOs must cover the following for Medicaid enrollees under age 21: Health care services that are medically necessary, which means that the service or benefit is:</p> <ul style="list-style-type: none"> <li>• Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;</li> <li>• Consistent with current accepted standards of good medical practice;</li> <li>• The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and</li> <li>• Not primarily for the convenience of the consumer, the consumer's family, or the provider.</li> </ul> <p>Health care services described in the regulation include (but are not limited to):</p> <ul style="list-style-type: none"> <li>• Chiropractic services;</li> <li>• Nutrition counseling services; and</li> <li>• Private duty nursing services including: <ul style="list-style-type: none"> <li>○ An initial assessment and development of a plan of care by a registered nurse;</li> <li>○ On-going private duty nursing services delivered by a licensed practical nurse or a registered nurse; and</li> </ul> </li> </ul>   |

|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>○ Durable medical equipment.</li> </ul>  |
| <b>OH</b>  | Per state regulations, medical necessity in EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability. <sup>47</sup>   |
| <b>WA</b>  | <p>Per state regulation,<sup>48</sup> the standard for coverage for EPSDT is that the services, treatment or other measures are:</p> <ul style="list-style-type: none"> <li>● Medically necessary;</li> <li>● Safe and effective; and</li> <li>● Not experimental.</li> </ul> <p>EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the Categorically Needy and the Medically Needy program. Services not otherwise covered under the Medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:</p> <ul style="list-style-type: none"> <li>● Nutritional counseling;</li> <li>● Chiropractic care;</li> <li>● Orthodontics; and</li> <li>● Occupational therapy (not otherwise covered under the MN program).</li> <li>● Prior authorization and referral requirements are imposed on medical service providers under EPSDT.</li> </ul> |
| <b>Entity Reviewing Prior Authorization Requests</b> |   |
| <b>CT</b>  | Most prior authorization requests are reviewed and processed by the department’s Administrative Services Organization (ASO), Community Health Network of Connecticut (CHNCT) <sup>49</sup>  |
| <b>IA</b>  | <p>In Medicaid fee for service, the Iowa Medicaid Enterprise (IME) Medical Services Unit reviews prior authorization requests and makes coverage determinations.<sup>50</sup></p> <p>In managed care:<sup>51</sup><br/> MCOs must use “appropriate licensed professionals” to supervise medical necessity determinations and specify the type of personnel responsible for each level of UM. MCOs must document access to board-certified consultants to help make medical necessity determinations. Any decision to deny long-term support services (LTSS) must be made by a long-term care professional with appropriate expertise providing LTSS.</p>  |
| <b>DE</b>  | <p>MCOs receive and review prior authorization requests for covered services including:</p> <ul style="list-style-type: none"> <li>● Home-based services: <ul style="list-style-type: none"> <li>○ Home health care</li> <li>○ Private-duty nursing, if covered under benefit category.</li> <li>○ Skilled nursing visits.</li> <li>○ Speech, physical, and occupational therapy.<sup>52</sup></li> </ul> </li> </ul>   |
| <b>MD</b>  | MCOs receive and review prior authorization requests for home-based services. <sup>53</sup>   |
| <b>OH</b>  | The Ohio Department of Job and Family Services reviews prior authorization requests for services other than those provided by MCOs. <sup>54</sup>   |
| <b>WA</b>  | <p>The state’s Developmental Disabilities Administration reviews prior authorization requests for private-duty nursing.<sup>55</sup></p> <p>The Washington Health Care Authority reviews prior authorization requests for durable medical equipment.<sup>56</sup></p>   |

Medicaid personal care is authorized by Home and Community Services and Developmental Disabilities administrations within the state's Department of Social and Health Services.<sup>57</sup>

## Notes

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<sup>1</sup> Simpser E, Hudak ML, AAP Section on Home Care, Committee on Child Health Financing. Financing of Pediatric Home Health Care. *Pediatrics*. 2017;139(3):e20164202

<sup>2</sup> Foster, C.C., Agrawal, R.K., & Davis, M.M. (2019). Home Health Care For Children With Medical Complexity: Workforce Gaps, Policy, And Future Directions. *Health affairs*, 38 6, 987-993 .

<sup>3</sup> Child and Adolescent Health Measurement Initiative. 2018 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

<sup>4</sup> MaryBeth Musumeci and Julia Foutz, "Medicaid's Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending," Kaiser Family Foundation, February 2018, <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-ateligibility-services-and-spending/>.

<sup>5</sup> Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

<sup>6</sup> Dennis Kuo et al., "A national profile of caregiver challenges among more medically complex children with special health care needs," *Archives of Pediatrics & Adolescent Medicine* 165, no. 11 (November 2011): <https://dx.doi.org/10.1001%2Farchpediatrics.2011.172>.

<sup>7</sup> Ibid.

<sup>8</sup> MaryBeth Musumeci and Julia Foutz, "Medicaid's Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending," Kaiser Family Foundation, February 2018, <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-ateligibility-services-and-spending/>.

<sup>9</sup> 42 CFR § 440.70

<sup>10</sup> Ibid.

<sup>11</sup> Gay, James C., Cary W. Thurm, Matthew Hall, Michael J. Fassino, Lisa Fowler, John V. Palusci, and Jay G. Berry. "Home health nursing care and hospital use for medically complex children." *Pediatrics* 138, no. 5 (2016): e20160530.

<sup>12</sup> CMCS, and SAMHSA. "Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions," May 7, 2013. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

- 
- <sup>13</sup> Romley, John A., Aakash K. Shah, Paul J. Chung, Marc N. Elliott, Katherine D. Vestal, and Mark A. Schuster. "Family-Provided Health Care for Children With Special Health Care Needs." American Academy of Pediatrics. American Academy of Pediatrics, January 1, 2017. <https://pediatrics.aappublications.org/content/early/2016/12/23/peds.2016-1287>.
- <sup>14</sup> Coleman, Cara L. "Not Just Along For The Ride: Families Are The Engine That Drives Pediatric Home Health Care." Not Just Along For The Ride: Families Are The Engine That Drives Pediatric Home Health Care | Health Affairs, April 18, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20190415.172668/full/>.
- <sup>15</sup> 42 U.S.C. § 1396d(r)
- <sup>16</sup> 42 U.S.C. § 1396d(a)
- <sup>17</sup> EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents: [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Downloads/EPSDT\\_Coverage\\_Guide.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf).
- <sup>18</sup> Clary, Amy, and Barbara Wirth. "State Strategies for Defining Medical Necessity for Children and Youth with Special Health Care Needs," October 2015. <https://nashp.org/wp-content/uploads/2015/10/EPSDT.pdf>.
- <sup>19</sup> U.S. Department of Justice. Civil Rights Division . "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.," n.d. [https://www.ada.gov/olmstead/q&a\\_olmstead.pdf](https://www.ada.gov/olmstead/q&a_olmstead.pdf).
- <sup>20</sup> Maryland Department of Health. Task Force Report on Access to Home Health Care For Children and Adults with Medical Disabilities. December 27, 2018. Baltimore, MD. Accessed on November 13, 2019. Available at: <https://mmcp.health.maryland.gov/Documents/JCRs/2018/Report%20on%20Access%20to%20Home%20Health%20Care%20for%20Children%20and%20Adults%20with%20Medical%20Disabilities.pdf>
- <sup>21</sup> Ibid.
- <sup>22</sup> Ohio Association of Community Health Centers. Benefits & Loan Repayment Programs. Accessed on November 27, 2019. Available at: <https://www.ohiochc.org/page/168>
- <sup>23</sup> Maryland Department of Health. December 27, 2018.
- <sup>24</sup> Delaware Health and Social Services Division of Medicaid and Medical Assistance. Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity. May 15, 2018. Newcastle, DE. Accessed on November 13, 2019. Available at: [https://dhss.delaware.gov/dhss/dmma/files/de\\_plan\\_cmc.pdf](https://dhss.delaware.gov/dhss/dmma/files/de_plan_cmc.pdf)
- <sup>25</sup> Ibid.
- <sup>26</sup> <https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx>
- <sup>27</sup> Delaware Health and Social Services Division of Medicaid and Medical Assistance. May 15, 2018.
- <sup>28</sup> Honsberger, K., et al. How States Structure Medicaid Managed Care to Meet the Unique Needs of Children and Youth with Special Health Care Needs. April 2018. Washington, DC. National Academy for State Health Policy. Accessed on November 28, 2019. Available at: <https://nashp.org/wp-content/uploads/2018/04/How-States-Structure-Medicaid-Managed-Care.pdf>.
- <sup>29</sup> Association of Maternal & Child Health Programs. National Title V Children and Youth with Special Health Care Needs Program Profile. April 2017. Accessed on November 29, 2019. Available at: [http://www.amchp.org/programsandtopics/CYSHCN/Documents/CYSHCN-Profile-2017\\_FINAL.pdf](http://www.amchp.org/programsandtopics/CYSHCN/Documents/CYSHCN-Profile-2017_FINAL.pdf).
- <sup>30</sup> Silow-Carroll, S., et al. Interagency, Cross-Sector Collaboration to Improve Care for Vulnerable Children: Lessons from Six State Initiatives. Health Management Associates. Prepared for the Lucile Packard Foundation for Children's Health. February 2018. Accessed on November 28, 2019. Available at: [https://www.lpfch.org/sites/default/files/field/publications/hma\\_interagency\\_collaboration\\_national\\_report\\_02.15.2018.pdf](https://www.lpfch.org/sites/default/files/field/publications/hma_interagency_collaboration_national_report_02.15.2018.pdf)
- <sup>31</sup> Delaware Health and Social Services Division of Medicaid and Medical Assistance. May 15, 2018.
- <sup>32</sup> "Medicaid for Kids with Special Needs (MKSNS)." Iowa Department of Human Services. Accessed December 13, 2019. <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/MKSNS>.
- <sup>33</sup> Delaware Health and Social Services. "Division of Medicaid and Medical Assistance 2018 Medicaid Managed Care MASTER SERVICE AGREEMENT," December 19, 2017. [https://dhss.delaware.gov/dmma/files/mco\\_msa2018.pdf](https://dhss.delaware.gov/dmma/files/mco_msa2018.pdf).

- 
- <sup>34</sup> Code of Maryland Regulations (Last Updated: December 4, 2019), Title 10, Maryland Department of Health, Part two, Subtitle 09 Medical Care Programs, Chapter 10.09.63. Maryland Medicaid Managed Care Program: Eligibility and Enrollment.
- <sup>35</sup> Code of Maryland Regulations (Last Updated: December 4, 2019), Title 10, Maryland Department of Health, Part two, Subtitle 09 Medical Care Programs, Chapter 10.09.70. Maryland Medicaid Managed Care Program: Non-Capitated Covered Services
- <sup>36</sup> Code of Maryland Regulations (Last Updated: December 4, 2019), Title 10, Maryland Department of Health, Part two, Subtitle 09 Medical Care Programs, Chapter 10.09.20. Community Personal Assistance Services
- <sup>37</sup> “The Ohio Department of Medicaid, Medicaid Ohio Medical Assistance Provider Agreement for Managed Care Plan,” n.d. [https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed Care/Provider Agreements/Medicaid-Managed-Care-Generic-PA.pdf](https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf)
- <sup>38</sup> Washington State Health Care Authority. “Washington Apple Health Managed Care Contract,” n.d. [https://www.hca.wa.gov/assets/billers-and-providers/model\\_contract\\_ahmc.pdf](https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf).
- <sup>39</sup> Iowa Department of Human Services. Iowa Health Link contract with Amerigroup, effective January 2016. [http://dhs.iowa.gov/sites/default/files/AmeriGroup\\_Contract.pdf](http://dhs.iowa.gov/sites/default/files/AmeriGroup_Contract.pdf)
- <sup>40</sup> Delaware Health and Social Services. “Division of Medicaid and Medical Assistance 2018 Medicaid Managed Care Master Service Agreement,” December 19, 2017. [https://dhss.delaware.gov/dmma/files/mco\\_msa2018.pdf](https://dhss.delaware.gov/dmma/files/mco_msa2018.pdf).
- <sup>41</sup> Code of Maryland Regulations (Last Updated: December 4, 2019), Title 10, Maryland Department of Health, Part two, Subtitle 09 Medical Care Programs, Chapter 10.09.63. Maryland Medicaid Managed Care Program: Eligibility and Enrollment.
- <sup>42</sup> “Health Care Services and Supports.” Apple Health managed care | Washington State Health Care Authority. Accessed December 13, 2019. <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-managed-care#changes-to-apple-health-managed-care>.
- <sup>43</sup> Iowa Department of Human Services. “General Provisions for Medicaid Coverage Applicable to All Medicaid Providers and Services.,” n.d. <https://www.legis.iowa.gov/docs/iac/rule/441.79.9.pdf>.
- <sup>44</sup> Amerigroup RealSolutions in Healthcare. “Medical Policy: Medical Necessity Criteria.” Accessed July 10, 2019. [https://medicalpolicies.amerigroup.com/medicalpolicies/policies/mp\\_pw\\_a044145.htm](https://medicalpolicies.amerigroup.com/medicalpolicies/policies/mp_pw_a044145.htm)
- <sup>45</sup> Delaware Health and Social Services. “Division of Medicaid and Medical Assistance 2018 Medicaid Managed Care Master Service Agreement,” December 19, 2017. [https://dhss.delaware.gov/dmma/files/mco\\_msa2018.pdf](https://dhss.delaware.gov/dmma/files/mco_msa2018.pdf).
- <sup>46</sup> <http://mdrules.elaws.us/comar/10.09.67.20>
- <sup>47</sup> Lawriter - OAC - 5160-1-01 Medicaid medical necessity: definitions and principles. Accessed December 13, 2019. <http://codes.ohio.gov/oac/5160-1-01>.
- <sup>48</sup> Chapter 182-534 WAC: Accessed December 13, 2019. <https://apps.leg.wa.gov/wac/default.aspx?cite=182-534&full=true#182-534-0100>.
- <sup>49</sup> Connecticut Department of Social Services (DSS). “Connecticut InterChange MMIS,” September 28, 2018. [https://www.ctdssmap.com/CTPortal/Information/Get Download File/tabid/44/Default.aspx?Filename=ch9\\_auth\\_v4.5.pdf&URI=Manuals/ch9\\_auth\\_v4.5.pdf](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch9_auth_v4.5.pdf&URI=Manuals/ch9_auth_v4.5.pdf).
- <sup>50</sup> Iowa Department of Human Services. “ALL PROVIDERS IV. BILLING IOWA MEDICAID,” February 1, 2018. <https://dhs.iowa.gov/sites/default/files/All-IV.pdf?080220190110>.
- <sup>51</sup> Iowa Department of Human Services. “Iowa Health Link MCO Contract ,” February 1, 2016. [https://dhs.iowa.gov/sites/default/files/AmeriHealth\\_Iowa\\_Contract.pdf?050820191355](https://dhs.iowa.gov/sites/default/files/AmeriHealth_Iowa_Contract.pdf?050820191355).
- <sup>52</sup> “Physical Health Prior Authorizations.” AmeriHealth Caritas Delaware. Accessed December 13, 2019. <https://www.amerihhealthcaritasde.com/provider/resources/physical-prior-auth.aspx>.
- <sup>53</sup> Division of State Documents. Accessed December 13, 2019. <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.04.06.htm>.
- <sup>54</sup> Lawriter - OAC - 5160-1-31 Prior authorization [except for services provided through medicaid contracting managed care plans (MCPs)]. Accessed December 13, 2019. <http://codes.ohio.gov/oac/5160-1-31>.
- <sup>55</sup> Chapter 182-551 WAC: Accessed December 13, 2019. <https://apps.leg.wa.gov/wac/default.aspx?cite=182-551&full=true#182-551-3400>.

---

<sup>56</sup> Washington Apple Health (Medicaid). “Medical Equipment and Supplies Billing Guide,” August 1, 2019.

<https://www.hca.wa.gov/assets/billers-and-providers/Med-Equip-Supplies-bi-20190801.pdf>.

<sup>57</sup> “Health Care Services and Supports.” Medicaid Personal Care | Washington State Health Care Authority, January 1, 2018. <https://www.hca.wa.gov/health-care-services-supports/program-administration/medicaid-personal-care>.