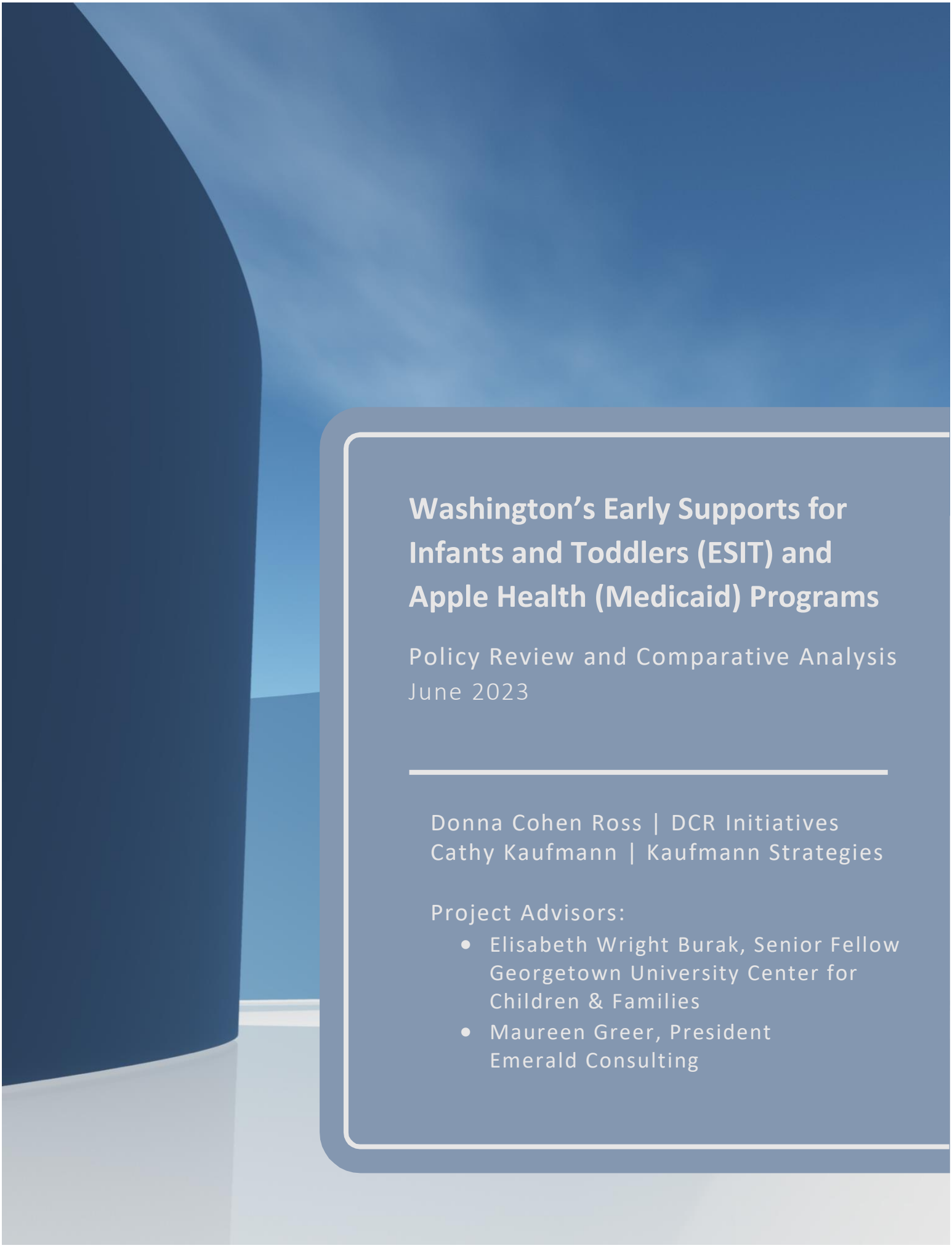

Washington's Early Supports for Infants and Toddlers (ESIT) and Apple Health (Medicaid) Programs

Policy Review and Comparative Analysis

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Table of Contents

Introduction

This comparative policy analysis examined service requirements outlined in the Washington State Early Support for Infants and Toddlers (ESIT) Program Policies and Procedures and Part C of the Individuals with Disabilities Education Act (IDEA) along with the comparative requirements in Washington's current Medicaid State Plan and model Medicaid managed care contract.

Based on this analysis, the consultants have determined that nearly all the services identified in the ESIT Program Policies and Procedures are allowable as covered services under Washington's Medicaid (Apple Health) program for Medicaid/CHIP enrollees. This is primarily due to the State's application of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Exceptions to this are ESIT services that are educational, rather than health-related. In addition, service coordination efforts focused on health needs could be covered under Medicaid, but further work would be required to develop billing mechanisms and assure there is no duplication of services particularly if Medicaid Managed Care Organizations (MCOs) are concurrently providing care coordination to the child.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit
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. Anyone under age 21 enrolled in Medicaid must receive coverage for EPSDT benefits and services—at regular intervals and whenever a possible problem appears—to identify physical, dental, developmental, and mental health conditions. In addition to health services, benefits include scheduling appointments, arranging for treatment, and financing transportation to keep appointments. (42 U.S.C. Sections 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)).

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 prevent, treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in the state's Medicaid plan. Services not otherwise covered under the Medicaid program are available to children under EPSDT, as long as medical necessity for these services is established.

EPSDT services are also exempt from any specific coverage or service limitations imposed on the rest of the Apple Health program. As described in federal rules, states are required to: "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly, … that informing methods are effective, … [and] that services covered under Medicaid are available." (CMS, State Medicaid Manual Sections 5010, 5121, 5310)

Apple Health Integrated Managed Care (IMC) contract (Section 17.1.31.1.5) requires MCOs be "responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, including evaluating the safety and

effectiveness of the requested service and to establish it is not experimental. If a non-covered healthcare service is determined to be medically necessary under the EPSDT benefit, the Contractor shall provide the service, unless it is specifically addressed in the Excluded and Non-Contracted Services section of this Contract. If any EPSDT service exceeds the 'soft' limit placed on the scope, amount or duration of a service, the Contractor shall use p procedures in accordance with WAC 182-501-0169 to determine medical necessity of the requested services and authorize the additional services as indicated.
If the Contractor receives a request for an Excluded Service for which the Contractor believes there may be medical necessity under EPSDT, the Contractor shall route the request to hcamcprograms@hca.wa.gov for technical assistance."

Medical Necessity
Washington Administrative Code (WAC 182- 500-0070) defines **"medically necessary"** as "a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, 'course of treatment' may include mere observation or, where appropriate, no medical treatment at all."

This definition is referenced and reflected in the Apple Health IMC contract definition (Section 1.79): " Medically Necessary Services means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, 'course of treatment' may include mere observation or, where appropriate, no medical treatment at all (WAC 182- 500-0070)."

In addition to the definitions of medical necessity, the Apple Health IMC contract requires MCOs to have a Utilization Management Program that uses "board-certified consultants to assist in making medical necessity determinations" (Section 11.1.4.4), as well as "assurance that a physician, doctoral level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any behavioral health denial based on medical necessity (Section 11.1.4.4)."

Furthermore, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a "Health Care Professional who has appropriate clinical expertise in addressing the Enrollee's medical or behavioral health condition or long-term services and supports (Section 11.1.2)."

Recommendations

The following recommendations are the result of an in-depth Comparative Analysis of Early Intervention and Medicaid policies at the federal and Washington State levels, a set of key informant interviews designed to understand Medicaid billing practices for ESIT services, and a detailed survey of ESIT providers to gather specifics on commonly used Medicaid billing codes for ESIT services and information on the experiences of different types of provider organizations. These recommendations provide options for the Health Care Authority to consider in the interest of maximizing Medicaid claims and payments and relieving administrative burdens for ESIT provider organizations.

In the near-term, Washington HCA and DCYF ESIT should consider the following:

1. **Help ESIT providers and MCOs better understand current requirements and appropriate billing codes:**
   - **Develop a consolidated Medicaid billing guide for all billable ESIT services to make Medicaid billing easier and more accessible for ESIT providers.** Complicated billing for ESIT services increases the administrative burden for ESIT providers and poses barriers to maximizing Medicaid financing of covered services. Simplifying and streamlining billing codes can make the billing process easier for the array of ESIT providers to navigate and for MCOs to understand. The majority of Medicaid covered ESIT services can be found in the existing NDC, Outpatient Rehabilitation, Habilitative Services, Mental Health Services and Medical Nutrition Therapy billing guides. The small billing survey conducted as part of this study revealed one ESIT provider is not billing for nutrition services – which are part of the Medicaid benefit – because they lacked information about appropriate billing codes.

   - **Assure ESIT providers (and MCOs) are aware of all relevant Medicaid reimbursable services and their appropriate billing codes.** Along with a consolidated billing guide, investments in training for ESIT providers, pediatric Medicaid providers, and MCOs on topics such as the basics of Medicaid's EPSDT benefit, Medicaid-covered ESIT services, and who can deliver such services would also support efforts to maximize Medicaid financing. Our billing code survey indicates MCOs are not fully informed of EPSDT requirements that apply to ESIT services. ESIT providers report that MCOs are inappropriately limiting certain ESIT services, including occupational, physical and speech therapy, and some services are denied completely, despite having been determined medically necessary. Service limitations or denials violate EPSDT requirements when these services are medically necessary for a child.

   - **Establish a training and technical assistance program focused on Medicaid billing "best-practices" for ESIT services:**
     - Require training for individuals and organizations that deliver ESIT services so providers can fully benefit from HCA efforts to streamline the process for ESIT providers and maximize Medicaid reimbursement.
     - Make technical assistance available to trained ESIT providers to respond to questions and concerns, and to help troubleshoot problems that may arise.

   In addition to the billing process improvements identified above, Washington should consider the following strategies to improve Medicaid reimbursement for allowable ESIT services and maximize alignment between ESIT and Medicaid programs:

2. **Simplify and streamline billing codes used most frequently for ESIT services.**

- Other states have opted to simplify and consolidate Medicaid billing codes for ESIT services in order to make the billing process easier to administer.
    - A given discipline could have just a few codes to choose from, depending on whether the service is delivered in a clinical setting, at home, etc.
    - ESIT providers could attach an "ESIT modifier" to billing codes to differentiate between a Medicaid-covered service delivered as an early intervention service or for another reason. (For example, an ESIT PT provider would use the ESIT modifier to distinguish delivery of an ESIT service from PT to aid in recovery for an injury.)

  An ESIT modifier would also allow the state to better track and understand Medicaid-covered ESIT service utilization and inform future policy development.
- Administering the billing codes survey designed for this project with additional ESIT providers could inform what codes should be included in this guide. Survey results along with an analysis of Medicaid claims to verify codes most commonly used by ESIT providers, the state could identify opportunities for clarification and simplification.

3. <u>Clarify and/or develop new policies to support ESIT and Medicaid alignment.</u>

- **Establish the Individualized Family Service Plan (IFSP) as the authorizing document for billable Medicaid services** included in it, thereby eliminating the need to obtain "prior authorization" for those services. This would not only preclude unnecessary delays in providing needed services, but also would avoid service limitation barriers in violation of EPSDT requirements.

- **Develop new Apple Health policies or clarify existing policies to ensure ESIT providers and MCOs understand how to bill for services covered under the current Medicaid state plan that appear to pose real or perceived barriers for ESIT providers.** Such services include:
    - ESIT Eligibility Determination
    - IFSP Development
    - Special Instruction Therapists *(Much of their work is clinical/ health-related and should be covered by Medicaid; however appropriate billing codes are not clear. Other states may characterize these services as "developmental therapy" for Medicaid billing)*
    - Family Resource Coordinators (FRCs) who provide clinical as well as social services and navigation services.

4. <u>Act as or engage a "third party administrator" (TPA) to manage Medicaid billing for all ESIT services.</u>

- Engaging a TPA would make Medicaid billing possible for smaller ESIT providers who do not have the staff and infrastructure capacity to ensure that Medicaid is billed and is paying for all covered services. Numerous ESIT providers, particularly smaller providers, lack the administrative capacity to bill Medicaid. This means ESIT services that should be covered by Medicaid go unreimbursed. Centralized billing through a TPA could help:
    - Ensure Medicaid claims are completed and submitted with consistency, accuracy, and efficiency.
    - Position HCA and its DCYF partners to track and manage how young children with developmental needs and their families are being served by two state agencies charged with supporting their health, development, and well-being.
    - Enable HCA and DCYF to pinpoint system inequities and pivot to make corrections and/or connections as needed.

  [Note that either HCA or DCYF could act as the TPA or either entity could contract with a private firm to provide this service. While the mechanics of implementation might differ depending on the choice, the

value of adding capacity and generating data to help guide program decision-making and systems improvements remain important potential outcomes, regardless.]

Recommendations for the Next Medicaid Managed Care Re-procurement and MCO contracts:

5. Leverage the upcoming Apple Health/Medicaid managed care re-procurement to emphasize the importance of early intervention. Strategies could include (but are not limited to):

- Requiring MCO bidders to respond to questions about how they will ensure the connection to ESIT services in pediatric primary care.
- Direct MCOs to engage in at least one Performance Improvement Project (PIP) related to boosting support for ESIT services covered under Medicaid.
- Allow MCOs that invest in community organizations or activities related to boosting ESIT services covered under Medicaid to count a portion of their investment toward their obligation to ensure at least 85% of capitation payments focus on improving health outcomes (i.e. the MCO investment can count in the numerator of the Medical Loss Ratio (MLR) equation.)
- Support a similar approach for investing in advancing equity and reducing disparities in screening for and enrollment in ESIT services.

6. Consider changes to the Medicaid managed care contract to encourage, incentivize, and/or require greater focus on young children (birth to age 3) with developmental needs. Options to consider include:

- **Add language clarifying EPSDT requirements related to the ESIT program.**
    - Our billing codes survey findings suggest that some MCOs have imposed inappropriate limits on Medicaid-covered services regardless of medical necessity.

- **Require training for MCOs at several levels:**
    - Require training for MCO leadership and other appropriate staff to ensure their understanding and proper execution of EPSDT and early intervention needs of young children with developmental needs.
    - Require MCOs to provide training for key internal staff on issues related to developmental needs, the importance of early intervention services, the benefits of Washington's ESIT program, and its connection to Medicaid priorities.

- **Require staff with specialized training in leadership role:** Require MCOs to deploy a high-level "early childhood/early intervention specialist" with the knowledge, skills and training needed to sharpen the MCO's focus on ensuring the healthy development of newborns, infants and toddlers in its interaction with clinicians, clinic staff, community liaisons, billing departments, and others.

- **Direct MCOs to engage in at least one Performance Improvement Project (PIP) related to boosting support for ESIT services.**

- **Encourage MCO investment into early intervention community resources.** Allow MCOs that invest in community organizations or activities related to boosting ESIT services covered under Medicaid to count a portion of their investment toward their obligation to ensure at least 85% of capitation payments focus on improving health outcomes (i.e. the MCO investment can count in the numerator of the Medical Loss Ratio (MLR) equation.). The state could also support a similar approach for investing in advancing equity and reducing disparities in screening for and enrollment in ESIT services.

Longer-Term Strategies for HCA to explore:

Longer-term strategies for HCA to explore including concerns that may not be in the direct control of HCA, including solutions that may require legislative action, cooperation and partnership with commercial health insurance plans, or other longer-term activities.

- **Avoid undue financial burdens for families of young children covered under commercial health insurance plans who qualify for Medicaid as secondary coverage**:
    - State legislation could be adopted that would require all health insurance companies under the purview of the state insurance agency to pay for EI services, with premiums, copays and/or deductibles for these services waived.
        - Alternatively, state legislation could require the health insurers to allow state ESIT payment of copays and deductibles on behalf of families with children needing EI services.

- **Streamline enrollment into Medicaid (as secondary coverage) for children with identified developmental needs who have commercial health insurance coverage**.

Overview of Comparative Analysis Tables

The comparative analysis that follows presents each of the 18 required services identified in Section 2.A.12 Early intervention services (EIS) of the ESIT Policies and Procedures Manual in a table along with the comparative language in Washington Administrative Code (WAC) 182-534-0100, the Washington Medicaid State Plan and/or Medicaid managed care model contract. Various relevant Medicaid provider billing guides are also referenced when they provide additional information on allowable services and/or provider types. Note: The comparative tables below do not cite federal requirements for Part C of the Individuals with Disabilities Education Act (IDEA) nor federal Medicaid requirements from Title 42 in the Code of Federal Regulations (CFR) as these federal requirements are reflected in the state requirements for ESIT and Washington's Medicaid program (Apple Health). It should be noted that nearly all the ESIT services below (with the exception of educational and some of the family coordination services) are required to be covered by Medicaid through federal and state general EPSDT requirements. As reflected in the table, some of the services have explicit coverage language as part of or outside of EPSDT requirements.

Format of ESIT and Medicaid Services Comparative Tables

The color-coded table below provides a guide to the format used for the service comparison tables on the pages that follow.

ESIT Service Name
The purple section includes the required ESIT service name and definition, taken from the *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021).*
ESIT Service Name: Associated Medicaid Coverage Requirements
The blue section identifies language related to the ESIT service identified in the purple box above from the Washington State Plan, Apple Health Integrated Manage Care contract, Washington Administrative Code and relevant language from HCA Billing guides.
ESIT Service: Comparative Analysis
The green section is where the consultant team provides a summary and assessment of the service comparison, noting the extent of Medicaid coverage for the ESIT service and any discrepancies in definitions.

Table 1: Assistive Technology Device and/or Assistive Technology Service

Assistive Technology Device and/or Service
Assistive Technology Device means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain, or improve the functional capabilities of infants and toddlers with disabilities. The term assistive technology device does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device. **Assistive Technology Service** means any service that directly assists an infant or toddler with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include: (i) The evaluation of the needs of an infant or toddler with a disability, including a functional evaluation of the child in the child's customary environment; (ii) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for infants or toddlers with disabilities; (iii) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (iv) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; (v) Training or technical assistance for an infant or toddler with disabilities or, if appropriate, that child's family; and (vi) Training or technical assistance for professionals, including individuals providing education or rehabilitation services, or other individuals who provide services too rare otherwise substantially involved in the major life functions of infants and toddlers with disabilities. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Assistive Technology Device and/or Service: Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) as well as the durable medical equipment and physician services/home health sections of Washington's State Plan and the Apple Health Integrated Managed Care contract. Relevant services from 17.1 Provider Services include: • 17.1.10.13 Fitting prosthetic and orthotic devices. • 17.1.22 Medical Equipment and Supplies and any applicable sales tax including, but not limited to: Medical Equipment; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for Enrollees over 3 years of age; medical supplies; and bed and pillow covers for Enrollees under age 21 diagnosed with asthma and dust mite sensitivity. Incontinence supplies shall not include non-disposable diapers unless the Enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax. • 17.1.36 Habilitative Services: Limited to Enrollees in the Medicaid expansion population that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME (Durable Medical Equipment) benefit.   ○ 17.1.36.1 **For Children: No limitation**. From the Medicaid Equipment and Supplies Billing Guide: HCA evaluates a request for any medical equipment, related supplies, and related services under the provisions of WAC 182-501-0160 (Exception to rule—Request for a noncovered health care service).When EPSDT applies, HCA evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 (Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment) to determine if it is: medically necessary; safe; effective; and not experimental.
Assistive Technology Device and/or Service: Comparative Analysis

Medicaid Coverage and Eligibility for Services

All ESIT Assistive Technology Device and/or all of the identified elements of Assistive Technology Services are covered by Medicaid through EPSDT requirements provided they are *medically necessary*, safe, effective and not experimental.

> **Apple Health IMC contract, section 1.179 Medically Necessary Services (Definition):** "Medically Necessary Services" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182- 500-0070).

Comparing Service Definitions

Assistive Technology Device and *Assistive Technology Services* are not terms used in Washington Administrative Code pertaining to the Medicaid program, Washington's State Plan nor the Apple Health Integrated Managed Care contract. Instead, the terms, *Medical Equipment* (including *Durable Medical Equipment*), *Medical Equipment and Appliances*, and *Auxiliary Aids and Services* are used.

Apple Health IMC contract, section 1.178 Medical Equipment (Definition)

"Medical Equipment" means medical equipment and appliances, and medical supplies as defined in WAC 182-543-1000:

"**Medical equipment"** - Includes medical equipment and appliances, and medical supplies.

"Medical equipment and appliances" - Health care-related items that:

(a) Are primarily and customarily used to serve a medical purpose;

(b) Generally are not useful to a person in the absence of illness or injury;

(c) Can withstand repeated use;

(d) Can be reusable or removable; and

(e) Are suitable for use in any setting where normal life activities take place.

Apple Health IMC contract, section 1.23 Auxiliary Aids and Services (Definition)

"Auxiliary Aids and Services" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Contractor. Auxiliary Aids and Services includes:

> 1.23.1 Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;
>
> 1.23.2 Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;
>
> 1.23.3 Acquisition or modification of equipment or devices; and
>
> 1.23.4 Other similar services and actions.

Further detail on billing for audiology services are covered in the HCA billing guides for Habilitative Services.

Table 2: Audiology Services

Audiology Services
Audiology Services includes: (i) Identification of infants and toddlers with auditory impairment, using at risk criteria and appropriate audiologic screening techniques; (ii) Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; (iii) Referral for medical and other services necessary for the habilitation or rehabilitation of infants and toddlers with disabilities who have an infants and toddlers who are deaf or hard of hearing; (iv) Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services; (v) Provision of services for prevention of hearing loss; and (vi) Determination of the infant's or toddler's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Audiology Services: Associated Medicaid Coverage Requirements
Audiology services are covered through EPSDT (see Appendix A) and the audiology benefit described in Washington's State Plan and the Apple Health Integrated Managed Care contract: **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** **17.1.31.1.1** Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health conditions, developmental disorders, autism and SUDs, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory guidance for both the child and caregiver, and **screenings for**: vision, dental, substance use conditions, mental health and **hearing**. 17.1.31.1.2 Diagnostic and treatment services include vision, dental and **hearing services** and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.1.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, **hearing**, and dental services they need to treat health problems and conditions. 17.1.31.1.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Washington State Plan Section 4b EPSDT covered services (p, 16b)** **(iv)Audiology-hearing evaluations and treatment services:** Assessments of children with hearing loss, determination of the range, nature and degree of hearing loss, including the referral to medical or other professional services for restoration and rehabilitation due to hearing disorders. Provision of rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification. Hearing aids are covered on the basis of minimal decibel loss.

WAC 182-531-0375 Audiology services

(1) The agency covers, with prior authorization, cochlear devices for clients twenty years of age and younger with the following limitations:
(a) The client meets one of the following:
(i) Has a diagnosis of profound to severe bilateral, sensorineural hearing loss;
(ii) Has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to forty percent correct in the best-aided condition on recorded open-set sentence recognition tests);
(iii) Has the cognitive ability to use auditory clues;
(iv) Is willing to undergo an extensive rehabilitation program;
(v) Has an accessible cochlear lumen that is structurally suitable for cochlear implantation;
(vi) Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; or
(vii) Has no other contraindications to surgery; and
(b) The procedure is performed in an inpatient hospital setting or outpatient hospital setting.
(2) The agency covers BAHAs for clients twenty years of age and younger with prior authorization.
(3) The agency covers replacement parts and batteries for BAHAs and cochlear devices for clients twenty years of age and younger only. See WAC 182-547-0800.
(4) The agency considers requests for removal or repair of previously implanted BAHAs and cochlear devices for clients twenty-one years of age and older only when medically necessary. Prior authorization from the agency is required.
(5) For audiology, the agency limits:
(a) Caloric vestibular testing to four units for each ear; and
(b) Sinusoidal vertical axis rotational testing to three units for each direction.

Audiology Services: Comparative Analysis

Medicaid Coverage and Eligibility for Services

All ESIT Audiology Services are covered by Medicaid through EPSDT requirements. Hearing screening and services are explicitly called out in the State Plan as well as the Apple Health Integrated Managed Care contract. MCOs are accountable for conducting hearing screenings on the periodicity schedule identified in the EPSDT requirements as well as for making referrals and coordinating care when there is a need for a diagnostic and/or treatment service.

Comparing Service Definitions

ESIT and Medicaid audiology service definitions are aligned.

Further detail on billing for audiology services are covered in the HCA billing guides for Habilitative Services and Hearing Hardware.

Table 3: Family Training, Counseling and Home Visits

Family Training, Counseling and Home Visits
Family Training, Counseling, And Home Visits means services provided, as appropriate, by social workers, psychologists, educators, and other qualified personnel to assist the family of an infant or toddler with a disability, in understanding the child's special needs and enhancing the child's development. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Family Training, Counseling and Home Visits: Associated Medicaid Coverage Requirements
<u>*Medically necessary*</u> Family Training, Counseling and Home Visits are covered through EPSDT (see Appendix A). **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, **as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice** (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 **The Contractor shall be responsible for all EPSDT** screening, diagnostic, and **treatment services found to be medically necessary**. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Mental health services as part of the EPSDT benefit in the WA State Plan, Attachment 3.1-B, Page 16b** *Mental health services* – Includes diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions. Mental health services include, but are not limited to, mental health evaluations, psychological testing, and individual and group counseling as specified in the child's IEP or IFSP. **Apple Health IMC contract, section 17.1.10 Provider Services** **17.1.10.15** Enrollee Health Education **Washington State Plan Section 6 Other Practitioner Services (Attachment 3.1A p, 20)** (3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advance Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors. To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must: a) Meet state requirements for a Children's Mental Health Specialist; or b) Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist. <u>And from **page 21c** of this same section:</u> **10) Social Work Services to Enhance the Effectiveness of Home Health Services** Licensed social workers are covered within their scope of practice in accordance with state law. Medical Social Services are provided as part of an authorizing practitioner-ordered Home Health service. **Apple Health IMC contract, section 1.142 Home Health Care** "Home Health Care" means a range of services provided in an Enrollee's home for treatment of an illness or injury.

Examples of home health care include wound care, education, IV or nutrition therapy, injections, and monitoring health status.

Home health care services
a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.
1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.
2) Approval required when period of service exceeds limits established by the single state agency.
3) Nursing care services are limited to:
(a) Services that are medically necessary;
(b) Services that can be safely provided in the home setting;
(c) Two visits per day (except for the services listed below);
(d) Three high risk obstetrical visits per pregnancy; and
(e) Infant home phototherapy that was not initiated in the hospital setting.

4) Services must be ordered by a physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) as part of a written plan of care. 5) Exceptions are made on a case-by-case basis.

Family Training, Counseling and Home Visits: Comparative Analysis

Medicaid Coverage and Eligibility for Services

Any family training, counseling and home visiting services that are *medically necessary*, safe, effective and not experimental are covered through the EPSDT requirement. However, services that are not medically necessary are not required to be covered by Medicaid. Specific requirements for the provision of home health services for children 3 and under are limited; however, EPSDT requirements mandate coverage of services outside the benefit package in the State Plan as long as they meet the medically necessary threshold.

Comparing Service Definitions

The "Family Training, Counseling and Home Visits" category of ESIT services is an extremely broad category of services without detailed definition; therefore, it is impossible to compare with Medicaid service definitions without further detail about the specific services offered in this category of ESIT services.

Table 4: Health Services

Health Services
"Health Services" means services necessary to enable an otherwise eligible child to benefit from the other EIS under Part C of IDEA, during the time that the child is eligible to receive EIS. (i) The term includes: (A) Such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and (B) Consultation by physicians with other service providers concerning the special health care needs of infants and toddlers with disabilities that will need to be addressed in the course of providing other EIS. (ii) The term does not include services that are: (A) Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); (B) Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or (C) Related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant. 1.Nothing in this part limits the right of an infant or toddler with a disability with a surgically implanted device (e.g., cochlear implant) to receive the EIS that are identified in the child's IFSP as being needed to meet the child's developmental outcomes. 2.Nothing in this part prevents the EIS provider from routinely checking that either the hearing aid or the external components of a surgically implanted device (e.g., cochlear implant) of an infant or toddler with a disability are functioning properly; (D) Devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; and (E) Medical-health services (such as immunizations and regular "well- baby" care) that are routinely recommended for all children. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Health Services: Associated Medicaid Coverage Requirements
All medically necessary health services are covered through EPSDT (see Appendix A) and the benefit package described in Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.

Health Services: Comparative Analysis

Medicaid Coverage and Eligibility for Services

All *medically necessary* health services are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract.

Medicaid covers all the services not included in the ESIT definition of health services: surgery, purely medical services, and services related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.

Because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract.

Comparing Service Definitions

The ESIT definition of health services does not include services included in Medicaid definitions. Medicaid is designed to cover medical services and goes far beyond the ESIT definition.

Table 5: Medical Services

Medical Services
Medical Services means services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for EIS. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Medical Services: Associated Medicaid Coverage Requirements
All services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for EIS are covered through EPSDT (see Appendix A). **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.
Medical Services: Comparative Analysis
Medicaid Coverage and Eligibility for Services All services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for EIS are covered through EPSDT (see Appendix A). Diagnosis and evaluation are essential elements of the EPSDT requirements. Medicaid must cover the cost of all EPSDT screening, diagnostic, and treatment services found to be medically necessary. **Comparing Service Definitions** The ESIT definition of Medical Services does not align with Medicaid definitions. Medicaid definitions are much broader and encompass a wide array of treatment, services and supports beyond the diagnosis and evaluation definition provided by ESIT.

Table 6: Nursing Services

Nursing Services
Nursing Services include: (i) The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems; (ii) Provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and (iii) Administration of medications, treatments, and regimens prescribed by a licensed physician. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Nursing Services: Associated Medicaid Coverage Requirements
All *medically necessary* health services, including nursing services, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.4.1 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)).
Nursing Services: Comparative Analysis
Medicaid Coverage and Eligibility for Services All *medically necessary* health services, including nursing services, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. Medicaid covers all the services not included in the ESIT definition of Nursing Services. In addition, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract. **Comparing Service Definitions** The ESIT definition of nursing services does not align with Medicaid definitions. Medicaid is designed to cover health/medical services and goes far beyond the ESIT definitions provided for these types of services. These services may be provided by an array of providers, including advanced registered nurse practitioners and nurse services/delegation (see provider chart in Appendix C).

Table 7: Nutrition Services

Nutrition Services
"Nutrition Services" include: (i) Conducting individual assessments in (A) Nutritional history and dietary intake; (B) Anthropometric, biochemical, and clinical variables; (C) Feeding skills and feeding problems; and (D) Food habits and food preferences. (ii) Developing and monitoring appropriate plans to address the nutritional needs of children eligible under Part C of IDEA based on the assessment findings in this subsection; and (iii) Making referrals to appropriate community resources to carry out nutrition goals. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Nutrition Services: Associated Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) as well as the physician services/home health sections of Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Apple Health IMC contract, section 17.1.10.16** Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia. Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary. The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness. **Limitations described below do not apply to the Medical Nutrition Program for clients under age 21 under EPSDT**. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on medical necessity. • Initial assessments limited to 2 hours (or 8 units) per year. • Reassessments limited to no more than 1 hour (or 4 units) per day. • Training and education provided to groups limited to 1 hour (or 4 units) per day. Again, the limitations identified above **do not** apply to children under age 21 under EPSDT.

Apple Health IMC contract, section 17.1.19
Enteral nutrition products, including the following:
Parenteral nutritional supplements and supplies for all clients.
Enteral nutrition products and supplies for tube-feeding are covered for all clients.
Medically necessary oral enteral nutrition products, including prescribed infant formulas not covered by WIC or additional quantities beyond amounts allowed by WIC, for clients 20 years of age and under.

WAC 182-554-300 Eligibility for WIC Clients:
A child who qualifies for supplemental nutrition from the women, infants, and children (WIC) program must receive supplemental nutrition directly from that program. The child may be eligible to receive enteral products from the agency if:

(a) The child's need for a product exceeds WIC's allowed amount; or
(b) The product is not available through the WIC program.

Nutrition Services: Comparative Analysis

Medicaid Coverage and Eligibility for Services
All *medically necessary* health services, including nutrition services, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. Medicaid covers all the services not included in the ESIT definition of Nutrition Services without limitations for children under age 21.

Nutrition services are also identified as services that may be provided by NDCs in the NDC Billing guide (this does not mean NDCs are the only permissible providers of these services).

In addition, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract.

Comparing Service Definitions
The ESIT definition of nutrition services generally aligns with Medicaid definitions.

Table 8: Occupational Therapy

Occupational Therapy
"Occupational Therapy" includes services to address the functional needs of an infant or toddler with a disability related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include: (i) Identification, assessment, and intervention; (ii) Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and (iii) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Occupational Therapy: Associated Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) as well as the physician services/home health sections of Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Apple Health IMC contract, section 17.1.10.16** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided when medically necessary and in accordance with 42 C.F.R. § 440.110. Includes Neurodevelopmental Centers (NDC) for Enrollees age 20 and under. May be provided by a home health agency or medical rehabilitation facility. **Apple Health IMC contract, section 17.1.17** Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability. 17.1.17.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.

Occupational Therapy: Comparative Analysis

Medicaid Coverage and Eligibility for Services

All *medically necessary* health services, including occupational therapy, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. Medicaid covers all the services not included in the ESIT definition of occupational therapy without limitations for children under age 21.

Occupational Therapy is identified as services that may be provided by NDCs in the NDC Billing guide (this does not mean NDCs are the only permissible providers of these services).

In addition, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract.

Comparing Service Definitions

The ESIT definition of occupational therapy generally aligns with Medicaid definitions. Medicaid includes occupational therapy in its definition of "Rehabilitation Services"

Apple Health IMC contract, section 1.248 Rehabilitation Services means services focused on improving an Enrollee's physical and mental strength, skills or functions, lost or impaired due to illness, injury or disability. Rehabilitation services include physical or occupational therapy and speech-language pathology.

Comparative table continued on the next page.

Table 9: Physical Therapy

Physical Therapy
"Physical Therapy" includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include: (i) Screening, evaluation, and assessment of children to identify movement dysfunction; (ii) Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and (iii) Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Physical Therapy: Associated Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) as well as the physician services/home health sections of Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Apple Health IMC contract, section 17.1.10.16** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided when medically necessary and in accordance with 42 C.F.R. § 440.110. Includes Neurodevelopmental Centers (NDC) for Enrollees age 20 and under. May be provided by a home health agency or medical rehabilitation facility. **Apple Health IMC contract, section 17.1.17** Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability. 17.1.17.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.

Physical Therapy: Comparative Analysis

Medicaid Coverage and Eligibility for Services

All *medically necessary* health services, including physical therapy, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. Medicaid covers all the services not included in the ESIT definition of occupational therapy without limitations for children under age 21.

Physical Therapy is identified as services that may be provided by NDCs in the NDC Billing guide (this does not mean NDCs are the only permissible providers of these services).

In addition, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract.

Comparing Service Definitions

The ESIT definition of Physical Therapy generally aligns with Medicaid definitions. Medicaid includes physical therapy in its definition of "Rehabilitation Services"

Apple Health IMC contract, section 1.248 Rehabilitation Services means services focused on improving an Enrollee's physical and mental strength, skills or functions, lost or impaired due to illness, injury or disability. Rehabilitation services include physical or occupational therapy and speech-language pathology.

Comparative Table continued on the next page.

Table 10: Psychological Services

Psychological Services
Psychological Services include: (i) Administering psychological and developmental tests and other assessment procedures; (ii) Interpreting assessment results; (iii) Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning mental health, and development; and (iv) Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Psychological Services: Associated Medicaid Coverage Requirements
Medically necessary Family Training, Counseling and Home Visits are covered through EPSDT (see Appendix A) and the benefit package in Washington's State Plan and the Apple Health IMC contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.5 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, **mental, psychological,** medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.6 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.7 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Mental health services as part of the EPSDT benefit in the WA State Plan, Attachment 3.1-B, Page 16b** *Mental health services* – Includes diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions. Mental health services include, but are not limited to, mental health evaluations, psychological testing, and individual and group counseling as specified in the child's IEP or IFSP. **Washington State Plan Section 6 Other Practitioner Services (Attachment 3.1A p, 20)** (3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advance Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors. To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must: • Meet state requirements for a Children's Mental Health Specialist; or • Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist.
Psychological Services: Comparative Analysis
Medicaid Coverage and Eligibility for Services All Psychological Services that are *medically necessary*, safe, effective and not experimental are covered through the EPSDT requirement. Parent training and education programs are included in this requirement if they meet the medical necessity and evidence-base thresholds.
Comparing Service Definitions Psychological services as defined by ESIT are included in the mental health services definition for Medicaid.

Table 11: Service Coordination

Service Coordination
Service Coordination – See Family Resources Coordination. Service coordination means services provided by a service coordinator to assist and enable an infant or toddler with a disability and the child's family to receive the services and rights, including required procedural safeguards, and is referred to as Family Resources Coordination in Washington State. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Service Coordination: Associated Medicaid Coverage Requirements
All medically necessary Training, Counseling and Home Visits are covered through EPSDT (see Appendix A) and the benefit package in Washington's State Plan and the Apple Health IMC contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.4 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the **Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions**. **14.16 Children's Health Care Coordination** The Contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under age 21 from receiving any other care coordination activity described in this Contract. The Contractor shall have a dedicated phone line for use by Enrollees and providers seeking ABA services. This phone line shall be monitored, and messages responded to within one Business Day to ensure direct access to care coordination staff who can assist with connecting Enrollees to necessary ABA services. When the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary: • Coordinate mental health treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider; • Follow-up to ensure an appointment has been secured; and • The Contractor will submit a report to HCA of children who have been identified as needing mental health care and appointment status. The quarterly Children's Mental Health report is due on the last Business Day of October, January, April, and July. • The Contractor will collaborate with Seattle Children's to receive Washington's Mental Health Referral Service for Children and Teens consultation letters. When Enrollee consultation letters are received, the Contractor will contact the Enrollee to ensure the Enrollee's needs are met and follow the provisions in this subsection as indicated.
Service Coordination: Comparative Analysis
Medicaid Coverage and Eligibility for Services Service coordination for health needs is an accountability of managed care organizations and covered through EPSDT (see section above) and physician services/home health section of State Plan/ Medicaid managed care contract. Some of the service coordination activities of a Family Resources Coordinator could be covered by Medicaid under EPSDT but this would require an agreement with the MCO to avoid duplication of services. MCOs may choose to maintain their accountability to coordinate all health care needs rather than delegate to an ESIT provider. In addition, a billing mechanism does not currently appear to exist for this service.

Comparing Service Definitions

ESIT's definition of service coordination is generally defined as "care coordination" in Medicaid.

Apple Health IMC contract, section 1.35 Care Coordination

"Care Coordination" means an Enrollee's healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Enrollee and the Enrollee's caregivers, and works with the Enrollee to ensure that the Enrollee receives the most appropriate treatment, while ensuring that health care is not duplicated.

Apple Health IMC contract, section 1.37 Care Coordinator (CC)

"Care Coordinator (CC)" means a health care professional or group of professionals, licensed in the state of Washington, who are responsible for providing Care Coordination services to Enrollees. Care Coordinators may be:
A Registered Nurse, Social Worker, Mental Health Professional or Substance Use Disorder Professional (SUDP) employed by the Contractor or primary care provider or Behavioral Health agency; and/or
Individuals or groups of licensed professionals, or paraprofessional individuals working under their licenses, located or coordinated by the primary care provider/clinic/Behavioral Health agency.
Nothing in this definition precludes the Contractor or care coordinator from using allied health care staff, such as Community Health Workers or Certified Peer Counselors and others to facilitate the work of the Care Coordinator or to provide services to Enrollees who need assistance in accessing services but not Care Coordination services.

Comparative Table continued on the next page.

Table 12: Signed Language and Cued Language

Sign Language and Cued Language
Sign Language and **Cued Language** services include teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Sign Language and Cued Language: Associated Medicaid Coverage Requirements
All interpretation services necessary for accessing and receiving health care services are required as part of the benefit package in Washington's State Plan and the Apple Health IMC contract. **Apple Health IMC contract, section 3.3 Equal Access for Enrollees and Potential Enrollees with Communication Barriers** The Contractor shall assure equal access for all Enrollees and Potential Enrollees when oral or written language communications creates a barrier to such access. (42 C.F.R. § 438.10 and 45 C.F.R. § 92.8). 3.3.1 Oral Information: The Contractor shall ensure interpreter services are provided free of charge for Enrollees and Potential Enrollees with a primary language other than English or those who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. § 438.10(d)(4)). Interpreter services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and the Contractor or any of its providers including, but not limited to: • Customer service, • All interactions with any provider for any covered service, • Emergency Services, and • All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535 and chapter 284-43 WAC). The Contractor is responsible for payment for interpreter services for Contractor administrative matters, including, but not limited to, handling Enrollee Grievances and Appeals. HCA is responsible for payment of interpreter services provided when the interpreter service is requested through, authorized, and provided by HCA's Interpreter Services program vendor and complies with all program rules. Hospitals are responsible for payment for interpreter services during inpatient stays. Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites. American Sign Language Instructors are included in the list of "licensed, registered or certified providers, or appropriately qualified providers who participate in one of the home and community-based services programs, or providers who are employed by a Regional Support Network may furnish the items, equipment, systems, or services described above in accordance with relevant state law and within their scope of practice"
Sign Language and Cued Language: Comparative Analysis
Medicaid Coverage and Eligibility for Services All interpretation services necessary for accessing and receiving health care services are required as part of the benefit package in Washington's State Plan and the Apple Health IMC contract. Nothing in the Washington State Plan nor Apple Health IMC contract indicate teaching sign language or cued language is a covered service. That said, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract. **Comparing Service Definitions** Medicaid definitions for Sign Language and Cued Language are limited to interpretation / access services, not educational services.

Table 13: Social Work Services

Social Work Services
Social Work Services include: (i) Making home visits to evaluate a child's living conditions and patterns of parent-child interaction; (ii) Preparing a social or emotional developmental assessment of the infant or toddler, within the context of the family; (iii) Providing individual and family-group counseling with parents and other family members; and appropriate social skill-building activities with the infant or toddler and parents; (iv) Working with those problems in the living situation (home, community, and any center where EIS are provided) of an infant or toddler with a disability and the family of that child that affect the child's maximum utilization of EIS; and (v) Identifying, mobilizing, and coordinating community resources and services to enable the infant or toddler with a disability and the family to receive maximum benefit from EIS. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Social Work Services: Associated Medicaid Coverage Requirements
Medically necessary Social Work Services are covered through the Medicaid mental health benefit and EPSDT (see Appendix A). **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.8 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, **as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice** (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.9 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.10 **The Contractor shall be responsible for all EPSDT** screening, diagnostic, and **treatment services found to be medically necessary**. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Mental health services as part of the EPSDT benefit in the WA State Plan, Attachment 3.1-B, Page 16b** *Mental health services* – Includes diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions. Mental health services include, but are not limited to, mental health evaluations, psychological testing, and individual and group counseling as specified in the child's IEP or IFSP. **Apple Health IMC contract, section 17.1.10 Provider Services** **17.1.10.15** Enrollee Health Education **Washington State Plan Section 6 Other Practitioner Services (Attachment 3.1A p, 20)** (3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advance Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors. To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must: c) Meet state requirements for a Children's Mental Health Specialist; or d) Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist.

And from **page 21c** of this same section:

10) Social Work Services to Enhance the Effectiveness of Home Health Services

Licensed social workers are covered within their scope of practice in accordance with state law. Medical Social Services are provided as part of an authorizing practitioner-ordered Home Health service.

Apple Health IMC contract, section 1.142 Home Health Care

"Home Health Care" means a range of services provided in an Enrollee's home for treatment of an illness or injury. Examples of home health care include wound care, education, IV or nutrition therapy, injections, and monitoring health status.

Home health care services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

2) Approval required when period of service exceeds limits established by the single state agency.

3) Nursing care services are limited to:

(a) Services that are medically necessary;
(b) Services that can be safely provided in the home setting;
(c) Two visits per day (except for the services listed below);
(d) Three high risk obstetrical visits per pregnancy; and
(e) Infant home phototherapy that was not initiated in the hospital setting.

4) Services must be ordered by a physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) as part of a written plan of care. 5) Exceptions are made on a case-by-case basis.

Social Work Services: Comparative Analysis

Medicaid Coverage and Eligibility for Services

Any Social Work Services that are *medically necessary*, safe, effective and not experimental are covered through the EPSDT requirement. However, services that are not medically necessary are not required to be covered by Medicaid. Furthermore, EPSDT requirements mandate coverage of services outside the benefit package in the State Plan as long as they meet the medically necessary threshold.

Comparing Service Definitions

Social Work Services as defined by ESIT are included in the mental health services definition for Medicaid.

Comparative Table continued on the next page.

Table 14: Special Instruction

Special Instruction
Special Instruction includes: (i) The design of learning environments and activities that promote the infant or toddler's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; personnel, materials, and time and space) that leads to achieving the outcomes in the IFSP for the infant or toddler with a disability; (iii) Providing families with information, skills, and support related to enhancing the skill development of the child; and (iv) Working with the infant or toddler with a disability to enhance the child's development. (ii) Curriculum planning (including the planned interaction of **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Special Instruction: Associated Medicaid Coverage Requirements
N/A
Special Instruction: Comparative Analysis
Medicaid Coverage and Eligibility for Services **Education services are not covered by Medicaid**; however, services related to health are covered under EPSDT requirements even if it is a service not identified in the State Plan and/or Apple Health IMC contract. **Comparing Service Definitions** Medicaid does not include definitions for special instruction.

Table 15: Speech Language Pathology Services

Speech-Language Pathology services
Speech-Language Pathology services include: (i) Identification of children with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; (ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and (iii) Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Speech-Language Pathology services: Associated Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) as well as the physician services/home health sections of Washington's State Plan and the Apple Health Integrated Managed Care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.

Apple Health IMC contract, section 17.1.10.16
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided when medically necessary and in accordance with 42 C.F.R. § 440.110.
Includes Neurodevelopmental Centers (NDC) for Enrollees age 20 and under.
May be provided by a home health agency or medical rehabilitation facility.

Apple Health IMC contract, section 17.1.17
Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.

> 17.1.17.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above but may also choose to contract for any other services the COE offers to children.

Limitations do not apply for clients under age 21 under EPSDT.

Speech-Language Pathology services: Comparative Analysis

Medicaid Coverage and Eligibility for Services
All *medically necessary* health services, including speech-language pathology services, are covered through EPSDT (see Appendix A) and the benefit packed described in Washington's State Plan and the Apple Health Integrated Managed Care contract. Medicaid covers all the services not included in the ESIT definition of occupational therapy without limitations for children under age 21.

Speech Therapy is identified as services that may be provided by NDCs in the NDC Billing guide (this does not mean NDCs are the only permissible providers of these services).

In addition, because of the EPSDT requirement, any service deemed medically necessary for a child under 21 is required to be covered by Medicaid even if it is a service not identified in the State Plan and/or Apple Health IMC contract.

Comparing Service Definitions
The ESIT definition of occupational therapy generally aligns with Medicaid definitions. Medicaid includes speech therapy in its definition of "Rehabilitation Services"
Apple Health IMC contract, section 1.248 Rehabilitation Services means services focused on improving an Enrollee's physical and mental strength, skills or functions, lost or impaired due to illness, injury or disability. Rehabilitation services include physical or occupational therapy and speech-language pathology.

Table 16: Transportation and Related Costs

Transportation and Related Costs
Transportation and Related Costs includes the cost of travel and other costs that are necessary to enable an infant or toddler with a disability and the child's family to receive EIS. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Transportation and Related Costs: Associated Medicaid Coverage Requirements
Transportation for ***medical*** appointments is covered through the Non-Emergent Medical Transportation benefit (NEMT) benefit in Medicaid. **WAC 182-546-5500 Nonemergency transportation—Covered trips.** (1) The Medicaid agency covers nonemergency transportation for a Washington apple health client to and from health care services if all of the following apply: (a) The health care services are: (i) Within the scope of coverage of the eligible client's benefit services package; (ii) Covered as defined in WAC 182-501-0050 through 182-501-0065 and the specific program rules; and (iii) Authorized, as required under specific program rules. (b) The health care service is medically necessary as defined in WAC 182-500-0070; (c) The health care service is being provided: (i) Under fee-for-service, by an agency-contracted provider; (ii) Through an agency-contracted managed care organization (MCO), by an MCO provider; (iii) Through a behavioral health organization (BHO), by a BHO contractor; or (iv) Through one of the following providers, as long as the provider is eligible for enrollment as a Medicaid provider (see WAC 182-502-0012): (A) A Medicare enrolled provider; (B) A provider in the network covered by the client's primary insurance where there is third-party insurance; (C) A provider performing services paid for by the Veteran's Administration, charitable program, or other voluntary program (Shriners, etc.). (d) The trip is to a local provider as defined in WAC 182-546-5100 (see WAC 182-546-5700(3) for local provider exceptions); (e) The transportation is the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities; (f) The trip is authorized by the broker before a client's travel; and (g) The trip is a minimum of three-quarters of a mile from pick-up point to the drop-off point (see WAC 182-546-6200(7) for exceptions to the minimum distance requirement). (2) Coverage for nonemergency medical transportation is limited to one roundtrip per day, with the exception of multiple medical appointments which cannot be accessed in one roundtrip.
Special Instruction: Comparative Analysis
Medicaid Coverage and Eligibility for Services Transportation for ***medical*** appointments is covered through the Non-Emergent Medical Transportation benefit (NEMT) benefit in Medicaid. **Comparing Service Definitions** Medicaid's definition for transportation and related costs pertains to medical appointments/ services only.

Table 17: Vision Services

Vision Services
Vision Services means: (i) Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development; (ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and (iii) Communication skills training, orientation and mobility training for all environments, visual training, and additional training necessary to activate visual motor abilities. **Source:** *Washington Early Support for Infants and Toddlers Program Policies and Procedures (July 2021)*
Vision Services: Associated Medicaid Coverage Requirements
Covered through EPSDT (see Appendix A) and physician services/home health of State Plan/ Medicaid managed care contract. **Apple Health IMC contract, section 17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** 17.1.31.2 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)). 17.1.31.3 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions. 17.1.31.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child. **Apple Health IMC contract, section 17.1.10.23** Eyeglass and contact lens fitting fees. **17.1.13 Vision Care:** Eye examinations once every twenty-four (24) months for adults and once every twelve (12) months for children under age 21. (WAC 182-531- 1000. These limitations do not apply to additional services needed for medical conditions.
Vision Services: Comparative Analysis
Medicaid Coverage and Eligibility for Services All vision services are covered under the EPSDT requirement in Medicaid. Eye examinations are covered in the periodicity outlines by EPSDT (once every 12 months), but service limitations do not apply for children with additional services needed for medical conditions. **Comparing Service Definitions** ESIT and Medicaid definitions for vision services are aligned, though the Medicaid benefit includes eyeglasses.

APPENDIX A: Key Informant Interview Summary

Below is a summary of the **Key Informant Interviews** conducted to help ensure that our policy comparisons of ESIT and Apple Health/Medicaid are tethered to the experience of ESIT stakeholders and providers from across Washington State. For this aspect of the project, we set out to learn more about the needs and concerns of stakeholders and focused attention on the Medicaid billing practices currently used by ESIT providers. In doing so, we hoped to understand how billing policies and procedures may support greater efficiency and reliability with respect to payment. We also anticipated that our conversations would elevate "on-the-ground" issues and validate, to the extent possible, the initial findings for the Comparative Analysis of Early Intervention (ESIT) and Apple Health/Medicaid in Washington State.

As a result of the interviews, we will be able to flag additional data that may be needed to validate the status of billing for ESIT services and inform the viability of actionable recommendations for systems improvements and administrative changes to policy and practice.

Purpose of the Interviews

Two sets of Key Informant Interviews were undertaken to gain a fuller understanding of the environment in which ESIT and Apple Health/Medicaid operate in Washington State, and to help distinguish between "the policy" and "the practical" with respect to how these two systems may or may not be aligned or coordinated. The interviews were designed to elicit from ESIT providers (billers and non-billers) a sense of perceived barriers to Medicaid billing and understand what changes may be needed to increase Medicaid billing. During the interviews, we gathered information about:

- Medicaid billing practices for ESIT services across Washington State, and the types of providers that are eligible to bill Medicaid;
- some of the practical aspects of how ESIT providers relate to Apple Health/Medicaid and where providers may have experienced successes and/or challenges; and
- additional "on-the-ground" perspectives related to the concerns of stakeholders and ESIT providers.

At various points in the discussions, we were able to probe for potential practical solutions, shedding light on issues and recommendations that could be elevated in the final report.

Methodology

During March 2023 we conducted two sets of interviews:

- **Stakeholders,** such as program administrators, early childhood and/or clinical providers, parents/caregivers, advocates, and others, and
- **ESIT Providers/Billing Staff,** to hear directly from ESIT providers familiar with Medicaid billing issues.

Finding informants to interview: Members of the State Team suggested a cohort of potential informants (Stakeholders and ESIT providers) for interviews. Once we began, informants led us to their colleagues and others in their professional networks.

We included, where possible, the perspectives of parents/caregivers. In addition to the potentially high needs of their babies, their own needs and expectations and those of other family members are likely to have changed significantly since their child has been found to need Early Intervention services. The extent to which the systems are equipped to provide support and guidance to them is intertwined with their infant's health, growth, and development.

Duration and scope of each interview: Each interview was approximately 30-45 minutes, depending on whether it was a group or individual conversation. All were conducted virtually via zoom. While the

questionnaires we prepared guided the interviews, flexibility (especially for group interviews) led to more robust conversations and allowed key informants to describe their experiences and express their viewpoints more freely.

Interviewees and Discussion Guide

The consultant team conducted interviews with the following individuals:

- Rene Denman, Executive Director, Toddler Learning Center, Whidbey Island & San Juan Counties
- Stephanie Schmitt, Finance & Admin. Director, Whatcom Center for Early Learning, Bellingham
- Heidi Sechrengost, Billing & Insurance Coordinator, Whatcom Center for Early Learning,
- Elizabeth Espinosa-Snow, Program/Project Manager II, Developmental Disabilities and Early Childhood Supports Division, King County
- Debi Donelan, Early Supports for Infants and Toddlers, Lead, Department of Community and Human Services, Developmental Disabilities and Early Childhood Supports Division , King County
- Eileen Duenas-Reyes, Healthy Families Program Manager, Spokane Regional Health District
- Brayde Wilson, Early Support Program Lead, Pierce County
- Trisa Harris, ESIT Program Manager/Supervisor, Snohomish County
- Michelle LaMotte, Pediatric occupational therapist/ co-owner, Stepping Stones Pediatric Therapy, LLC (Spokane)
- Maryanne Barnes, Executive Director, Birth to Three Developmental Center, King County
- Janelle Bersch, Social Worker, Special Education Early Childhood Services, North Central Educational Services District, Wenatchee
- Lisa Greenwald, CEO, Kindering Center, (Bellevue, Bothell, Redmond, Renton)
- Angela Raught, Insurance Administrator, Kindering Center (Bellevue, Bothell, Redmond, Renton)
- Vanessa Allen, ESIT Family Engagement Coordinator, Dept of Children Youth and Families (DCYF)
- Lou Olson, Infant Mental Health Mentor-Clinical, HopeSparks Family Services, Tacoma
- Vianeth Zubrod, Director of Children's Developmental Services, HopeSparks Family Services

Discussion Guide

General stakeholder interviews:

- Please begin by describing your organization and your role. Please tell us about the population you serve, members of the care team, caseload, etc.
- Can you tell us how you first connect with families? How do they get to Medicaid and/or ESIT? What are your thoughts on how families experience this process?
- Is there anything we haven't asked about that should be the focus of more attention?

ESIT Provider Interviews:

- Are you a Medicaid provider? (Many of our questions will focus on billing practices)
- Are there particular Medicaid policies/rules that have posed billing challenges (including Medicaid denials or delays in payment) for the early intervention services you provide? If so, how have you worked to address them?
- What billing codes do you most commonly use? What documentation is most frequently required to ensure successful billing?
- Are there any resources or tools you have found particularly helpful in navigating the Medicaid billing process for ESIT services? Would you recommend them to other providers?

Is there anything we haven't asked about that should be the focus of more attention?

Key Findings

- Many of the ESIT providers interviewed shared that children with Medicaid coverage account for a disproportionately large share of their caseload, yet the revenue from Medicaid is a very small portion of the total amount of the provider organization's funding. The interviewees shared their perspectives on the reasons for this apparent "mismatch", including:
    - Low Medicaid reimbursement rates
    - Need for information and training on how to submit approvable claims
    - Not all ESIT providers have the credentials needed to bill Medicaid (and/or the certification process can take time
    - Delays due to inconsistencies across managed care plans (timeliness of payments, credentialing, etc.)

Note: More focused research on this issue was beyond the scope of the current project, however a better understanding of the data related to ESIT services and Medicaid claims, reimbursements, timeliness and other performance issues could shed light on specific systems improvement needs.

- The Key Informant Interviews helped identify the factors that can make Medicaid billing for ESIT services a relatively smooth process, as well as the factors that may impose barriers to Medicaid billing.

Advantages for Medicaid Billing for ESIT Services

Of the ESIT providers interviewed, two types of organizations reported experiencing advantages when it comes to Medicaid billing, particularly, in the managed care environment:

- Neurodevelopmental Centers
    - ESIT provider organizations that are Neurodevelopmental Centers (NDCs) reported having an easier time billing and securing Medicaid reimbursement for ESIT services covered under Medicaid, as compared to organizations that are not NDCs. Interviewees gave the following examples, which may or may not be supported in the NDC Billing Guide or other materials:
        - NDCs are not subject to coverage limitations. (According to the HCA Neurodevelopmental Centers Billing Guide (p.12), coverage is unlimited for services provided in an NDC for Medicaid enrollees age 20 and younger, with the exception of Medicaid enrollees, ages 19 through 20 in Medical Care Services (MCS) who are eligible for limited outpatient rehabilitation services.)
        - NDCs do not need *prior approval* from MCOs to deliver covered services.
        - NDCs get paid for services not covered in the Medicaid State Plan, such as certain services performed by registered dietitians. (This provision is not unique to NDCs. Under EPSDT, States are required to provide any health care services that are covered under the federal Medicaid program and found to be "medically necessary" … regardless of whether the service is covered in that state's Medicaid plan.)
    - A perceived administrative burden may be preventing more ESIT organizations from becoming NDCs, although some interviewees indicated it need not be so challenging. For example, several NDCs rely on volunteer Medical Directors and do not need to hire for that position, which could be costly.
    - Existing NDCs may see reduced administrative funds if those resources need to be stretched across a wider number of entities.

- Behavioral Health agencies
    - Advantages are similar to those enjoyed by NDCs.
    - Providers interviewed noted that in the behavioral health arena, where the system is geared towards adults, adjustments in how services are billed are often in order when children need care. Behavioral health providers with previous contracts and experience billing MCOs did not experience such stumbling blocks.

Barriers to Medicaid Billing for ESIT Services

- **Medicaid as Secondary Coverage.** ESIT providers flagged a need for additional clarity billing rules and procedures, especially when it comes to services delivered to children covered under private coverage with Medicaid as a secondary payor. ESIT services related to evaluation/assessment must be delivered at no cost to the child's family, yet health insurance rules require providers to collect copayments and other out of pocket payments. Until the child's Individualized Family Service Plan (IFSP) is "active" (meaning the evaluation and assessment is completed) providers expressed concerns about properly executing their contractual obligations as well as meeting their responsibilities to children and families.
- **Inconsistent Medicaid managed care processes and timelines.** For example:
    - If a child needs specialized equipment, it may take multiple attempts to get approval, prompting caregivers to switch MCOs.
    - Securing approval (either from HCA or a given MCO) to become a Medicaid provider (even when credentials are in order) can take a long time (sometimes months); retaining Medicaid provider status is an ongoing challenge.
- **Billing for Family Resource Coordinators.** Family resource coordinators are providing care coordination and family support services that should be covered by Medicaid as part of the EPSDT benefit, but a possible billing mechanism is unclear to providers.

APPENDIX B: Billing Codes Survey

Four ESIT providers (three of which are NDCs) with experience billing Medicaid for ESIT services completed a survey on their top billing codes in all ESIT service categories, noting any particular challenges. These ESIT providers were asked to identify any prior authorization, service limitations, payment challenges and/or provider requirements for each service. The survey indicates that there are no unnecessary barriers to reimbursement for the majority billing codes identified below, though it should be noted there are challenges with certain codes and/or particular MCOs (highlighted in yellow).

ESIT Service Category	CPT Code	Description	Notes from Survey Respondents
Assistive Technology Device and/or Service	92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	Assistive Technology Services are billed to the Discipline that does the service using the appropriate procedure codes. Assistive Technology is not a provider type. For Devices, the Speech or Physical Therapist would complete an assessment and work with a device vendor to trial devices. After a device is chosen, they would write the letter of Medical Necessity that is needed for the family to get the device. We also measure for splints and orthotics.
	92607	Evaluation for prescription of speech-generating AAC device; first hour.	
	92608	Evaluation for prescription of speech-generating AAC device; each additional 30 minutes. This is an add-on code for 92607.	
	92609	Therapeutic services for the use of speech-generating device, including programming and modification	
	92618	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; each additional 30 minutes.	
	97542	Management of a patient using a wheelchair, including an assessment (e.g., positioning needs)	
	97755	Assistive Technology assessment	
	97760	Physical Medicine and Rehabilitation Evaluations, Orthotic Management and Training and Prosthetic Training	
	97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes.	
Audiology Services	N/A	None of the survey respondents indicated any billing codes for this category for ESIT Services.	

ESIT Service Category	CPT Code	Description	Notes from Survey Respondents
Family Training, Counseling, and Home Visits	90791	Integrated biopsychosocial assessment, including history, mental status, and recommendation	No limits - Medicaid covers these services at 100% of the allowed, and MCO payers have not applied limitations to these types of services
	90832	Psychotherapy without medical evaluation and management services (30min)	
	90834	Psychotherapy without medical evaluation and management services (45min)	
	90837	Psychotherapy without medical evaluation and management services (60min)	
	90846	Family psychotherapy without the patient present	
	90847	Family psychotherapy with the patient present	
	90853	Group Therapy	
Health, Medical and/or Nursing Services	96125	Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing), Assessment of Aphasia and Cognitive	*These services are billed by only one of the four survey respondents.*
	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making	
	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making	
	99215	Established patient, spending up to 55 minutes caring for a patient	
Nutrition Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	One respondent noted, "We do have a nutritionist on staff but are unable to bill for her services because there is not a nutritionist provider type in the NDC billing codes." The consultants note these services should be covered by Medicaid regardless of what is included in the NDC billing guide (and other survey respondents are successfully billing for these codes).
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face to face with the patient each 15 minutes	

ESIT Service Category	CPT Code	Description	Notes from Survey Respondents
Occupational Therapy	97110	Therapeutic Exercises	**Prior Authorization:** For three of the five MCOS: after 12 visits, regardless of age - HCA does not place visit limits on these services for our client base (ages 0-3) After the arbitrary visit limits placed by MCO payers, have been breached, these payers will inconsistently deny services (some process for payment, many do not) - HCA, as well as WAC 182-545-200, state that, for clients under the age of 20, Occupational Therapy is covered at an "unlimited rate", yet MCO payers continue to append PA requirements after an arbitrary visit limit is placed. Occasionally, maybe twice per quarter we will get a denial stating we need prior auth. We call and let them know we are an NDC, and they correct the denial.
	97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."	
	97165	OT Eval - Low Comp	
	97166	OT Eval - Mod Comp	
	97167	OT Eval - High Comp	
	97168	OT Re-Eval	
	97530	Therapeutic Activities	
	97533	Sensory eval/ Sensory Integrative Techniques **often deemed not necessary/ denied coverage	
	97535	Self-care/ Home management	
	97750	Physical performance test or measurement	
Physical Therapy	97110	Therapeutic Exercises	**Prior Authorization:** For three of the five MCOS: after 12 visits, regardless of age - HCA does not place visit limits on these services for our client base (ages 0-3) After the arbitrary visit limits placed by MCO payers, have been breached, these payers will inconsistently deny services (some process for payment, many do not) - HCA, as well as WAC 182-545-200, state that, for clients under the age of 20, Occupational Therapy is covered at an "unlimited rate", yet MCO payers continue to append PA requirements after an arbitrary visit limit is placed. Occasionally, maybe twice per quarter we will get a denial stating we need prior auth. We call and let them know we are an NDC, and they correct the denial.
	97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."	
	97116	Gate training	
	97161	L eval	
	97162	M eval	
	97163	H eval	
	97164	PT re-eeval	
	97165	OT Eval - Low Comp	
	97166	OT Eval - Mod Comp	
	97167	OT Eval - High Comp	
	97168	OT Re-Eval	
	97530	Therapeutic Activities	
	97533	Sensory eval/ Sensory Integrative Techniques **often deemed not necessary/ denied coverage	
	97535	Self-care/ Home management	
	97750	Physical performance test or measurement	
	97760	Orthotic fitting/training	

ESIT Service Category	CPT Code	Description	Notes from Survey Respondents
Service Coordination	N/A	None of the survey respondents indicated any billing codes for this category for ESIT Services.	
Psychological or Social Work Services	90791	Integrated biopsychosocial assessment, including history, mental status, and recommendation	*No comments on survey*
	90846	Family BH Therapy without patient	
	90847	Family BH Therapy with patient present	
Special Instruction	N/A	None of the survey respondents indicated any billing codes for this category for ESIT Services.	
Speech Language Pathology	92507	Treatment of speech-language services	**Prior Authorization:** For three of the five MCOS: after 6 visits, regardless of age - HCA does not place visit limits on these services for our client base (ages 0-3) MCO plans: 6 visits, regardless of age of client After the arbitrary visit limits, placed by MCO payers, have been breached, these payers will inconsistently deny services (some process for payment, many do not) - HCA, as well as WAC 182-545-200, state that, for clients under the age of 20, Occupational Therapy is covered at an "unlimited rate", yet MCO payers continue to append PA requirements after an arbitrary visit limit is placed
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals*One respondent indicated this code isn't reimbursed	
	92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	
	92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	
	92523	Speech eval	
	92524	Behavioral and qualitative analysis of voice and resonance	
	92526	Treatment of swallowing dysfunction and/or oral function for feeding	
	92610	Feeding/ Swallowing eval *One respondent indicated this code isn't reimbursed	
	97532	Cognitive Skills	
Transportation	N/A	None of the survey respondents indicated any billing codes for this category for ESIT Services.	
Vision	N/A	None of the survey respondents indicated any billing codes for this category for ESIT Services.	

APPENDIX C: EPSDT Requirements in MCO Contract

Washington State Health Care Authority
Apple Health - Integrated Managed Care Contract 1/1/23

17.1.31 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):
The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and HCA WAC 182-534-0100.

17.1.31.1.1 Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health conditions, developmental disorders, autism and SUDs, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory guidance for both the child and caregiver, and screenings for: vision, dental, substance use conditions, mental health and hearing.

- The Contractor shall conduct outreach efforts with Enrollees to promote completion of EPSDT services and coordinate EPSDT screening services both at established times and as requested (https://www.hca.wa.gov/assets/billers-and- providers/EPSDT-bi-20180101.pdf). The Contractor may implement Enrollee and Primary Care Provider incentives to ensure that Enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at other times, when medically necessary (42 U.S.C. § 1396(r)(1)).
- Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)).
- When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.
- The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.

17.1.31.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, including evaluating the safety and effectiveness of the requested service and to establish it is not experimental. If a non-covered healthcare service is determined to be medically necessary under the EPSDT benefit, the Contractor shall provide the service, unless it is specifically addressed in the Excluded and Non-Contracted Services section of this Contract.

- If any EPSDT service exceeds the "soft" limit placed on the scope, amount or duration of a service, the Contractor shall use LE procedures in accordance with WAC 182-501-0169 to determine medical necessity of the requested services and authorize the additional services as indicated.
- If the Contractor receives a request for an Excluded Service for which the Contractor believes there may be medical necessity under EPSDT, the Contractor shall route the request to hcamcprograms@hca.wa.gov for technical assistance.

17.1.31.3 If a child with special health care needs is assigned to a specialist for primary care, the assigned specialist is responsible for ensuring the child receives EPSDT services.

17.1.31.4 The Contractor may enter into contractual agreements with school- based health centers and family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. Such contracts shall:

- Require providers to follow EPSDT requirements;
- Coordinate identified needs for specialty care, such as referrals for vision, mental health or SUD evaluation and treatment services with the Primary Care Provider;
- Not deny payment for EPSDT services delivered by more than one (1) provider (Primary Care Provider, school-based provider or family planning clinic) within a calendar year;
- Ensure the policies and procedures for accessing
- such services by contracting school-based health centers and family planning clinics are compliant with applicable federal and state statutes; and

17.1.31.5 The Contractor shall coordinate with school-based health centers and other appropriate entities to assure activities performed by the Contractor are not duplicated.

EPSDT requirements in Washington Administrative Code

WAC 182-534-0100: EPSDT

(1) Persons who are eligible for Medicaid are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) **EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program**. Examples of service limits which do **not** apply to the EPSDT program are the specific numerical limits in WAC **182-545-200**.

(c) **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:**

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 C.F.R. 441, Subpart B are met through a contract with transportation brokers throughout the state.

APPENDIX D: ESIT Required Providers and Medicaid Allowable Providers

Washington State Health Care Authority

Note: Standards for all of the provider types listed below are the same for both ESIT and Medicaid.

ESIT Required Providers	Medicaid Allowable Provider Types
(1) **AUDIOLOGISTS**	WAC 182-502-0002 (Eligible provider types) identifies Audiologists as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 29** *Audiologist* – A 'licensed audiologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2). Audiology services may be provided by non-licensed personnel under the direction of a licensed audiologist per federal regulations and professional practice standards. **42 CFR § 440.110 (c) *Services for individuals with speech, hearing, and language disorders*** 3. A "qualified audiologist" means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions: (i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services. (ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions: (A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association. (B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.
(2) **FAMILY THERAPISTS**	WAC 182-502-0002 (Eligible provider types) identifies the following relevant allowable Medicaid provider types: Marriage and family therapists; Mental health counselors; and Mental health care providers. (*Note that other provider types, such as licensed clinical social workers and psychologists are about to provide family therapy services*). **Washington State Plan Section 6 Other Practitioner Services (Attachment 3.1A p, 20)** (3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advance Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors. To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must:

	a) Meet state requirements for a Children's Mental Health Specialist; or b) Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist. **From HCA Mental Health Services Billing Guide 2023, pp.34-35** Except for licensed psychiatrists and psychologists, qualified health care professionals who treat clients up to age 18 and younger must Submit a *Mental Health Professionals Attestation* form HCA 13-951. To be eligible to provide and bill HCA fee-for-service (FFS) for mental health outpatient treatment services, all mental health professionals must meet all the following: • Be independently licensed by the Department of Health. • Be in good standing without restriction. • Have a current core provider agreement (CPA) with HCA and a national provider identifier (NPI). **WA State Plan, Attachment 3.1A, p. 29** (viii) *Mental Health Counselor* – A 'licensed mental health counselor' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by a 'licensed mental health counselor associate' or non-licensed personnel under the direction of a licensed mental health provider per federal regulations and professional practice standards. **42 CFR § 440.130 Diagnostic, screening, preventive, and rehabilitative services.** (a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. (c) "Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized 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. (d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.
(3) **NURSES**	WAC 182-502-0002 (Eligible provider types) identifies the following relevant allowable Medicaid provider types: Advanced registered nurse practitioners and Nurse services/delegation. **WA State Plan, Attachment 3.1A, p. 29** *(v) Advanced Registered Nurse Practitioner (ARNP), Registered Nurse (RN), or Licensed Practical Nurse (LPN)* – An 'advanced registered nurse practitioner,' 'registered nurse,'

	or 'licensed practical nurse' is an individual who meets the requirements set forth in 42 CFR 440.60. Nursing and health services may be provided by non-licensed personnel under the direction of an ARNP or RN per professional practice standards. **42 CFR § 440.60 Medical or other remedial care provided by licensed practitioners.** (a) "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law. **42 CFR § 440.166 Nurse practitioner services.** (a) Definition of nurse practitioner services. Nurse practitioner services means services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. (b) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section. (1) If the State specifies qualifications for pediatric nurse practitioners, the practitioner must— (i) Be currently licensed to practice in the State as a registered professional nurse; and (ii) Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. (2) If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must— (i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and (ii) Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (c) ***Requirements for certified family nurse practitioner.*** The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. (1) If the State specifies qualifications for family nurse practitioners, the practitioner must— (i) Be currently licensed to practice in the State as a registered professional nurse; and (ii) Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. (2) If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must— (i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and (ii) Have a family nurse practice limited to providing primary health care to individuals and families. (d) ***Payment for nurse practitioner services.*** The Medicaid agency must reimburse nurse practitioners for their services in accordance with § 441.22(c) of this subchapter.
(4) **OCCUPATIONAL THERAPISTS**	WAC 182-502-0002 (Eligible provider types) identifies occupational therapists as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 16** *Occupational Therapist* – A 'licensed occupational therapist' is an individual who has

	met the requirements set forth in 42 CFR 440.110(b). Occupational therapy services may be provided by a 'licensed occupational therapy assistant' or non-licensed personnel under the direction of an occupational therapist per federal regulations and professional practice standards. **WA State Plan, Attachment 3.1A, p. 29** Under 42 CFR 440.110(b), occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers. **42 CFR § 440.110** ***Services for individuals with speech, hearing, and language disorders*** ***Occupational therapy*** — (1) ***Occupational therapy*** means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. (2) A "qualified occupational therapist" is an individual who meets personnel qualifications for an occupational therapist at § 484.115. **42 CFR** § 484.115.Standard: Occupational therapist. A person who— (1)(i) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, unless licensure does not apply; (ii) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and (iii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
(5) **ORIENTATION AND MOBILITY SPECIALISTS**	*No corresponding provider type in Medicaid outside occupational/physical therapists is identified*
(6) **PEDIATRICIANS** and **other physicians** for diagnostic and evaluation purposes	WAC 182-502-0002 (Eligible provider types) identifies pediatricians and other physicians as an allowable Medicaid provider type. **42 CFR § 440.130 Diagnostic, screening, preventive, and rehabilitative services.** (a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

	(c) "Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized 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. (d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.
(7) **PHYSICAL THERAPISTS**	WAC 182-502-0002 (Eligible provider types) identifies physical therapists as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 16** (i) *Physical Therapist* – A 'licensed physical therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(a). Physical therapy services may be provided by a 'licensed physical therapy assistant' or non- licensed personnel under the direction of a physical therapist per federal regulations and professional practice standards. ***Physical therapy*** — (1) ***Physical therapy*** means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. (2) A "qualified physical therapist" is an individual who meets personnel qualifications for a physical therapist at § 484.115.
(8) **PSYCHOLOGISTS**	WAC 182-502-0002 (Eligible provider types) identifies psychologists as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 16a** (vi) *Psychologist* – A 'licensed psychologist' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed psychologist per federal regulations and professional practice standards
(9) **REGISTERED DIETITIANS**	WAC 182-502-0002 (Eligible provider types) identifies Dietitians or nutritionists as an allowable Medicaid provider type.
(10) **SOCIAL WORKERS**	WAC 182-502-0002 (Eligible provider types) identifies Social Workers as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 16a** *Social Worker* – A 'licensed social worker' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed social worker per federal regulations and professional practice standards. **42 CFR § 440.130 Diagnostic, screening, preventive, and rehabilitative services.** (a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of

	one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. (c) "Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized 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. (d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.
(11) **SPECIAL EDUCATORS**, including teachers of the deaf and hard of hearing and teachers of children with visual impairments	Special Educators are not identified as an allowable Medicaid provider.
(12) **SPEECH AND LANGUAGE PATHOLOGISTS**	WAC 182-502-0002 (Eligible provider types) identifies Speech/language pathologists as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 16a** (iii) Speech-Language Pathologist – A 'licensed speech-language pathologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2), has passed the Speech and Hearing Association examination, and who is currently licensed according to the Washington State Board of Hearing and Speech. Speech-language pathology services may be provided by a 'certified speech-language **42 CFR § 440.110** ***Services for individuals with speech, hearing, and language disorders*** ***Occupational therapy*** — (b)Services for individuals with speech, hearing, and language disorders — (1) Services for individuals with speech, hearing, and language disorders means 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. It includes any necessary supplies and equipment. (2) A "speech pathologist" is an individual who meets one of the following conditions: (i) Has a certificate of clinical competence from the American Speech and Hearing Association. (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
(13) **VISION SPECIALIST**, including **OPHTHALMOLOGISTS** and **OPTOMETRISTS**	WAC 182-502-0002 (Eligible provider types) identifies Ophthalmologists and Opticians as an allowable Medicaid provider type. **WA State Plan, Attachment 3.1A, p. 18b** (11) All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether performed by a physician or an optometrist in accordance with 42 CFR 441.30.

	Optometric physicians are subject to Washington scope of practice laws and are held to the same standards as are people licensed as physicians to practice medicine and surgery by the Washington Medical Board. Optometric physicians are eligible providers for the Electronic Health Records (EHR) incentive program to the extent they provide services to children under age 21 and meet EHR participation criteria.
According to feedback received in interview, not permitted as a ESIT service.	(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531A-0800: (i) Licensed behavior analyst; (ii) Licensed assistant behavior analyst; and (iii) Certified behavior technician