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NATIONAL HEALTH LAW PROGRAM

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National Health Law Program[1]

To: Health Advocates
From: Jane Perkins
Date: September 25, 2006

Re: September Q&A – EPSDT "wraparound" services

Question: My client is a 14-year-old girl who has serious emotional disturbances. Over the years, she has been in and out of the child welfare system, including institutional placement. She would be able to live in a home-based setting if she received wraparound services; however, Medicaid has denied our request. What can we do?

Short Answer: Medicaid may be required to cover many of the wraparound services that your client needs. However, that coverage will depend on whether the services, unbundled and separately described, can be fit within a Medicaid coverage box.

Discussion

Wraparound defined. Wraparound generally refers to an individually designed set of services and supports provided to children who have multiple needs due to serious emotional disturbance or serious mental illness. Wraparound services include diagnostic and treatment services, personal support services, and other supports needed to maintain the child/youth in home and community-based settings. These services are developed using a team that includes the child, parents or guardians, health care providers, other service providers/agencies, schools, extended family and friends, and others whom the child and/or family identify. This is a particularly effective approach in assisting children who are being served by multiple systems.

EPSDT background. The Medicaid Early and Periodic Screening, Diagnostic and Treatment service (EPSDT) can be an important source of funding for children who need wraparound services. Most Medicaid-eligible children under age 21 are entitled to receive EPSDT. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43),1396d(a)(4)(B), and 1396d(r).

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[1] **Error! Main Document Only.**Produced by the National Health Law Program with a grant from the Training Advocacy Support Center (TASC), which is sponsored by the Administration on Developmental Disabilities, the Center for Mental Health Services, the Rehabilitation Services Administration, the Social Security Administration, and the Health Resources Services Administration. TASC is a division of the National Disabilities Rights Network (NDRN).

EPSDT is a comprehensive benefit that requires states, among other things, to provide for "arranging for (directly or through referrals to appropriate agencies, organizations, or individuals) corrective treatment" found to be needed during an examination. *Id.* at § 1396a(a)(43)(C). Treatment benefits are defined to be "such other necessary health care, diagnostic services, treatment, and other measures described in § 1396d(a)," whether or not such services are covered in the state's Medicaid plan. *Id.* at § 1396d(r)(5). Such items and services need to be covered when "necessary … to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." *Id.*

CMS' August 2006 Letter to California. In connection with ongoing litigation in California, the federal Centers for Medicare & Medicaid Services (CMS) has recently discussed how the Medicaid EPSDT requirements apply to coverage of wraparound services. *See* Letter from Gale P. Arden, Director, Department of Health and Human Services, CMS Services, Center for State Operations, Disabled and Elderly Health Programs Group, to Stan Rosenstein, Deputy Director, Department of Health Services, Medical Care Services (Aug. 16, 2006) (on file with author) ("CMS Letter of August 2006"). The letter states:

> Since the term "wraparound services" is not used in the [Medicaid] law to describe covered benefits, it is necessary to define the term before it is possible to determine if these services are within the scope of Medicaid coverage…. For coverage purposes, CMS does not recognize "bundles" of services, except to the extent that the list of Medicaid services contains a bundled service (for example, "inpatient hospital services"…). Otherwise, CMS must compare each component service individually to the benefits set forth in section 1905a [1396d(a)] of the Act.

Id. at 1-2. The position taken by federal agency in the August 2006 letter is similar to its previous statements on the issue. *See, e.g.*, Letter from Pamela Caron and Barbara J. England, Department of Health and Human Services, Health Care Financing Administration, Health Insurance Specialist, Division of Medicaid, to Patricia MacTaggert, Director, Health Care Purchasing, Minnesota Department of Human Services (Sept. 20, 1995) (on file with author) (stating "[w]raparound services are not listed as a covered service in section 1905(a) of the Social Security Act and only those components of 'wraparound' services which clearly meet the definition and requirements of the listed services may be covered under Medicaid").[2]

But while the CMS Letter of August 2006 reflects a consistent agency policy, it may impose a more exacting degree of description and "proof" upon the entity seeking coverage. For instance, CMS Letter of August 2006 classifies the plaintiffs' descriptions of the component services as "very general" and refuses to recognize coverage without more information. By contrast, CMS approved a state plan amendment from West

[2] *See* Jane Perkins, National Health Law Program, *Fact Sheet: Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Intervention Services* (June 20, 2002) (on file with author and NDRN) (discussing CMS position and "fitting" various early intervention services into a Medicaid box).

Virginia in 1993 that included descriptions similar to those used by the California plaintiffs, finding that they qualified as "rehabilitation" services.[3] In addition, CMS claims for itself (and impliedly not the courts or the states) the authority to make the ultimate coverage decision: "The kind of detailed review that is necessary to make final determinations on whether these services are within the scope of Medicaid coverage is one of the functions of the CMS review and approval process for Medicaid state plan amendments." CMS Letter of August 2006 at 2.

Recommendations. Because it was produced for litigation, the deference due to the CMS Letter of August 2006 in the case may be questionable.[4] Nevertheless, the CMS policy will affect advocates engaged in other litigation or state plan advocacy. In addition, this method of analyzing whether a requested service is covered by Medicaid is increasingly being applied by states to individual claims for medical assistance. In the last three months, the National Health Law Program has worked with advocates for children in Florida, North Carolina, and Washington whose clients have been denied Medicaid coverage of services that providers and case workers have described as wraparound services.

To maximize Medicaid coverage of services through the EPSDT program, child advocates can take the following steps:

First, work with clients' treating providers and case workers to break down (unbundle) services to determine the extent to which each component can be fit within a Medicaid box – that is, described as a benefit listed in § 1396d(a) of the Medicaid Act. For example, a service component may fit the definition of a "diagnostic," "preventive," or "rehabilitative" service that is for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level. *See* 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130.

A service component may also qualify as a "case management." However, advocates should be aware that the Medicaid Act was recently amended to more specifically define this service. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6052 (amending 42 U.S.C. § 1396n(g)(2)).[5] Case management now includes: (1) assessment of a Medicaid-eligible individual to determine service needs (e.g. taking client history, gathering information from other sources such as family, providers, and educators), (2) development of a specific care plan, (3) referral and related activities to

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[3] *Compare* CMS Letter of August 2006 (finding that CMS was unable to determine whether "immediate crisis stabilization" as described by plaintiffs could be covered by Medicaid) *with* Letter from Robert J. Taylor, Associate Regional Administrator, to Ann Stottlemyer, Director, West Virginia Office of Medicaid Services Approving State Plan Amendment (July 8, 1993) (on file with author) (approving coverage of "individual and family crisis intervention services" as rehabilitation service).

[4] For a discussion of the deference issues, *see* Sarah Somers, *Deference to the Federal Agency in Medicaid Case* (July 31, 2006) (on file with author and NDRN).

[5] A DRA provision provides that CMS will publish regulations regarding case management services. The CMS Letter of August 2006 states that these regulations are currently in the clearance process within the agency.

help the individual obtain needed services, and (4) monitoring and follow up activities, including those to insure that the service plan is effectively implemented. Case management does *not* include the direct delivery of medical, education, social or other services to which the individual has been referred. With respect to foster care services, activities *excluded* from case management include: research gathering and completion of paper work required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster parents, serving legal papers, home investigations, providing transportation, administrating foster care subsidies, or making placement arrangements. *See* 42 U.S.C. § 1396n(g)(2)(A)(iii). Contacts with individuals who are not eligible for Medicaid do not count as case management unless the purpose of the contact is directly related to managing the eligible individual's care. *Id.* at § 1396n(g)(3). Moreover, federal Medicaid funds are only available for case management if there are no other third parties liable for the services, such as another medical, social, or educational program. *Id.* at § 1396n(g)(4)(A); *see also* CMS Letter of August 2006 at 5 (stating that case management services for children in foster care "may not be used to replace or supplant payments that the law recognizes as administrative expense of the foster care program"). Thus, in its Letter of August 2006, CMS states that the development, tracking and adapting of a child's treatment plan may be precluded by the newly-added DRA language. *Id.*

Advocates can use CMS's previous pronouncements as a guide. The following table provides some examples of CMS's previous responses to service requests:

"Wraparound" component service	**CMS statement**
Engagement of the child and family	Elements may qualify as targeted case management so long as the "engagement" is confined to activities that directly support the child as opposed to benefiting family members and other natural supports
Immediate crisis stabilization	Could be covered a rehabilitation service; however, coverage is limited to medical needs and does not extend to cover unsafe living arrangements and safety issue
Strength and needs assessment	Cannot be covered as a Medicaid service if it is part of other Medicaid services furnished to the child. Moreover, assessing the need for services and the appropriate services is ordinarily an integral part of any service provider's planning process
Wraparound team formation	To the extent these activities are administrative elements of the planning process in which a Medicaid provider engages as part of furnishing a covered service, the cost may be recognized by Medicaid as a component part of the covered service

"Wraparound" component service	CMS statement
Tracking and adapting wraparound service plan	May qualify as case management or may be an integral part of another service[6]
Mobile crisis intervention team services	Could be covered as a rehabilitation service
Independent living skills training	Could be covered as a rehabilitation service, based on medical necessity criteria
Paying for a home addition to keep a child at home	Could be covered through a Medicaid home and community based waiver
Behavioral aide to assist at home and school to prevent out-of-home placement	Might be covered as a rehabilitation service in specifically described circumstances
Respite services	Could be covered through a Medicaid home and community based waiver
Buying an auto repair part to provide transportation to therapy or a washing machine for child with enuresis	Could not be covered
Therapeutic camp services	Excluding room and board, specific components could be covered such a group or occupational therapy
Counseling, psychology and therapy services offered in a student support center	Could be covered
Social skills development	May be covered, provided services are directed exclusively to the effective treatment of the recipient
Parenting education	Services delivered to family of an eligible child can be covered to improve the physical and mental well-being of a child who is failing to thrive if the services are directed exclusively to the effective treatment of the child, not someone other than the child, and are medical in nature, not social services

Second, keep in mind that the service must be for the treatment of the child. While family members may be included in, for example, therapy services that are directed to the treatment of the child, the services cannot extend to the point where they become a means of treating persons other than the Medicaid-eligible child. *See, e.g.,* Medicaid Regional Memorandum, Region IX, No. 92-80, *Re: Rehabilitation Services for the Mentally Ill* (Aug. 10, 1992) (on file with author) (stating concern that rehabilitation service not "devolve to a point where it becomes a means of treating others rather than, or in addition to, the primary recipient").

[6] However, with respect to the delivery of foster care services, CMS states that the following activities are not components of case management: research gathering and completion of documentation required by the foster care program; assessing adoption placements, recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; or making placement arrangements. CMS Letter of August 2006 at 6.

Finally, it must be clear to the Medicaid agency that the service has been prescribed by a licensed professional acting within their scope of practice, is necessary to "correct or ameliorate" a physical or mental condition of the individual child, and will be provided by a health care provider participating in the state Medicaid program.