The Network for Public Health Law

NHeLP NATIONAL HEALTH LAW PROGRAM

MODEL MEDICAID MANAGED CARE CONTRACT PROVISIONS: EPSDT VISION AND HEARING SERVICES

INTRODUCTION

Children enrolled in Medicaid are entitled to a comprehensive array of preventive and ameliorative care through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.[1] As states have increasingly turned to managed care entities to fulfill their Medicaid administrative obligations, these companies are charged with affirmative duties to ensure that children receive EPSDT benefits. This report suggests model contract provisions for coverage of vision and hearing services in Medicaid managed care.

OVERVIEW

Medicaid managed care may increase the number of children who receive all required vision and hearing screening and improve coordination with specialty providers. This potential is most likely to be realized when the responsibilities of the state agency, managed care entity (MCE), and providers are clear; the content of vision and hearing screening is specified; MCEs and states use robust record-keeping and tracking systems; and states monitor MCEs appropriately to ensure all obligations are met. When Medicaid managed care contracts do not address these issues, the probability is increased that children will not receive the EPSDT services they need and to which they are entitled. The need for clarity in MCE contracts is particularly acute for vision and hearing screening, since these screens are not among the federally mandated components of an EPSDT medical screen and are not reported separately to CMS.[2]

The model provisions set forth here are based upon our previous work surveying and assessing state-level provisions addressing EPSDT coverage of vision and hearing services. Initially, we assessed the legal landscape by surveying Medicaid statutes, regulations, policies, and guidelines that govern EPSDT vision and hearing services in

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[1] For more information on EPSDT, see CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), http://www.healthlaw.org/issues/medicaid/EPSDT-CMS-Guide#.VUfBExdGx-U.

[2] *See* 42 U.S.C. § 1396d(r)(1)(B) (listing the mandatory components of an EPSDT medical screen, which do not include hearing and vision); Accountability Guide, *supra* note 2, at 25-26 (listing information states must report on CMS's mandatory Form 416, which does not include vision and hearing screenings).

50 states and the District of Columbia.[3] Because the vast majority of low-income children who are on Medicaid are enrolled in managed care delivery systems, we also reviewed and assessed the responsibilities for vision and hearing care set forth in the contracts between state Medicaid agencies and their MCE contractors. We reviewed Medicaid managed care contracts from 39 states and DC to determine the extent to which they address EPSDT vision and hearing care.

In reviewing MCE contracts and state guidance documents to assemble or create these model contract provisions, we noted the variability across contracts. Some states and MCEs have agreed upon extensive, specific requirements for children's vision and hearing services and established clear lines of communication and accountability. Other contracts lack the detail to offer assurance that EPSDT hearing and vision services will be provided to enrollees. We anticipate that these model provisions will serve as building blocks and resources for advocates, state policymakers, MCEs, and health care providers as future Medicaid managed care contracts are developed and negotiated.

We have selected or formulated model provisions addressing (1) the EPSDT periodicity schedule, (2) inter-periodic screens, (3) content of screens and requirements for referral, (4) provider qualifications, (5) provider network adequacy, (6) monitoring and reporting, and (7) coordination with outside entities. We based these provisions on the following principles: States should include detailed, required content for EPSDT vision and hearing screens in their contracts with MCEs and should regularly evaluate reported data to ensure they are fulfilling this obligation. MCEs, in turn, should perform regular medical record audits to ensure the providers are complying with these requirements as well. Ultimately, the MCE must remain responsible for ensuring these services are provided.

While many of these activities are also subject to federal and state regulation, having such provisions in the contract between a state and its managed care contractors helps to ensure obligations are clearly understood by all parties. The model provisions are based largely on provisions that exist in contracts today; however, where there were gaps, we have suggested model language. Moreover, it should be kept in mind that the contracts are only one aspect of the state's Medicaid program, and the model provisions suggested here should be assessed in conjunction with provisions that exist in state law, regulation and other written policies.

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[3] *See* Jane Perkins & Catherine McKee, *Vision Services for Children on Medicaid: A Review of EPSDT Services*, NAT'L HEALTH LAW PROGRAM 13 (May 11, 2015), *http://www.healthlaw.org/publications/browse-all-publications/vision-screening-epsdt#*; Catherine McKee & Jane Perkins, *Hearing Services for Children on Medicaid: A Review of EPSDT Services*, NAT'L HEALTH LAW PROGRAM 11 (Oct. 21, 2014), http://www.healthlaw.org/publications/Issue-brief-hearing-services-for-children-on-medicaid#.VUen6BdGx-U

MODEL CONTRACT PROVISIONS

EPSDT VISION AND HEARING PERIODICITY SCHEDULES

Contractors must ensure that providers perform the age-specific vision and hearing screenings as specified in the most current periodicity schedule developed by the American Academy of Pediatrics (AAP).[4] The Contractor shall educate new providers on the use of the AAP periodicity schedule, which will be included in Contractor's contracts with providers for ease of reference.[5]

INTER-PERIODIC SCREENS

The Contractor shall provide inter-periodic screens, which are screens that occur between the complete periodic screens and are medically necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing services.[6]

CONTENT SPECIFIED FOR VISION AND HEARING SCREENINGS

Objective vision screening and objective hearing screening using valid, age-appropriate instrument(s) are to be provided in the primary care medical home according to the AAP periodicity schedule. If the provider does not perform such objective screenings, a referral for the relevant screening should be made in accordance with the periodicity schedule and child's health history, and that referral should be recorded in the child's medical record. The provider should request a copy of the screening results for inclusion in the medical record and should ensure appropriate follow-up and care coordination.[7]

VISION

Birth to 3 years: Eye evaluation should occur at the newborn and all subsequent well child exams and be conducted by the primary care physician (PCP), nurse practitioner or physician assistant using the following procedures:

- Ocular history

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[4] BRIGHT FUTURES/AMERICAN ACADEMY OF PEDIATRICS, 2014 PERIODICITY SCHEDULE RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE (2014), *available at* http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

[5] Provision formulated by NHeLP.

[6] Quoting Georgia Sample Contract, pp. 86-87.

[7] Adapted from ILL. DEP'T OF HEALTHCARE & FAMILY SERVS., *Handbook for Providers of Healthy Kids Services* HK-203(23) (Jan. 2015), http://www2.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf. [hereinafter "Illinois Healthy Kids Handbook"].

- Age appropriate vision assessment
- External inspection of the eyes and lids
- Ocular motility assessment
- Pupil examination
- Red reflex examination
- Age appropriate test of alignment (light reflex test, cover test, or quantitative test of depth perception)
- Photo screening is an acceptable quantitative method to screen children who are not yet ready for visual acuity testing.[8]

For children younger than age 3, or in any non-verbal child, providers may use non-quantitative vision assessment by evaluating the child's ability to fix and follow objects: whether each eye can fixate on an object, maintain fixation, and then follow the object into various gaze positions. Failure to perform these maneuvers indicates significant visual impairment. A binocular as well as monocular assessment should be performed. If poor fix and following are noted in both eyes after 3 months of age, a significant bilateral eye or brain abnormality is suspected, and the provider should make a referral for more formal vision assessment. It is important to ensure that the child is awake and alert, because disinterest or poor concentration can mimic a poor visual response.

In addition, providers should inquire regarding the child's progress in achieving certain vision-related developmental milestones, which include:

- 0-3 months: turns eyes and head to look at light sources; briefly holds gaze on bright light or objects; stares at surroundings; blinks at camera flash; moves eyes and head together; tracks vertically and horizontally; begins eye contact at 6-8 weeks; focuses 8-12 inches away; eyes wander, occasionally cross; prefers black/white, or high contrast patterns; prefers human face to all other patterns.
- 4-7 months: follows adults or moving objects with eyes across midline; begins moving eyes with less head movement; watches own hands before face; looks at hands, food, bottle when sitting; watches faces when spoken to; briefly fixes still objects; reaches for small objects.
- 8-12 months: orients to objects in home; notice small objects, like cereal; interested in pictures; enjoys hide and seek (recognizes partially hidden objects); inspects toys held in hand; responds to smiles and voices; sweeps eyes across room.
- 1-1.5 years: uses "pincer grasp" to hold objects between forefinger and thumb; looks for toys that fall out of sight; builds tower with 3 blocks; enjoys picture books and points to pictures; uses both hands; holds objects close to eyes to inspect.
- 2-3 years: builds tower with 6 blocks; imitates vertical line; recognizes people in photographs; begins to inspect objects without touching objects; smiles

[8] Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(25).

and face brightens when looking at favorite people or objects; likes to watch movements of objects, such as wheels on toy vehicle; watches and imitates other children; "reads" pictures in books; begins to control hand movement while coloring or drawing.[9]

3-5 years: Children aged 3 to 5 must be screened annually for amblyopia ("lazy eye"), strabismus ("crossed eyes" or "wall eyes"), and defects in visual acuity. If amblyopia is not treated early – generally before age 5 – the child's vision will be permanently impaired.

PCPs and staff must perform formal visual screening for distance, visual acuity, ocular alignment, and stereovision at each visit from age 3 to 5 years using valid, age-appropriate tests. PCPs and staff may:

- Use the Snellen Notation 20/40-symbol size for 3- and 4-year-old children at a distance position of 20 feet
- Use the Snellen Notation 20/30-symbol size for 5-year-old children at a distance position of 20 feet
- Use the HOTV or Lea charts for 3- to 5-year-old children at a distance of 10 feet.

Vision screening tests are presented first on both eyes to train the child and then tested for each eye. Referrals should be made for children aged 3 through 5 who do not pass the 20/40 symbol sizes or who have a 2-line or more difference between each eye, even if in passing range.[10]

6-18 years: Vision screening must evaluate visual acuity (how a child sees with each eye independently), hyperopia (whether child has excessive farsightedness), and muscle balance (phoria; how the two eyes are used together). PCPs and staff may use the Snellen Notation 20/30-symbol size at 10 feet. Referrals should be made if vision is less than 20/30 or if there is a 2-line or more difference between each eye, even if in passing range.[11]

The red reflex test should be used at each visit. Boys ages 5 and over should be screened at least once for color discrimination.[12]

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[9] Quoting and adapted from Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(26)-(27).
[10] Quoting and adapted from Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(27).
[11] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(28).
[12] Adapted from UTAH DIV. OF MEDICAID & HEALTH FIN., *Utah Medicaid Provider Manual: CHEC Services* 5 (Jan. 2015), https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Child%20Health%20Evaluation%20And%20Care%20%28CHEC%29/CHEC1-15.pdf [hereinafter "Utah CHEC Manual"].

The above detailed approved tests and preschool vision screening procedures are applicable to testing children with special needs, including children with developmental disabilities, learning disabilities and hearing impairment, as well as children who use English as a second language. Many children with special needs should have an optometrist or ophthalmologist on their Individualized Family Service Plan team or their Individualized Education Program team.

If the child cannot participate in objective vision screening and the child is not under the care of an eye professional, the child may be screened by photorefraction alone. If photorefraction is unavailable, refer the child to an optometrist or ophthalmologist appropriately trained to test and treat pediatric patients.[13]

Referrals: Specific risk factors for vision problems that may require earlier or more frequent referrals to a specialist include extreme prematurity; family history of congenital cataracts, retinoblastoma or metabolic or genetic diseases; significant developmental delay or neurologic disease; and systemic disease associated with eye abnormalities.[14]

In addition to the referrals noted above, refer a child with any of the following conditions to an ophthalmologist or optometrist:

1. History or clinical observation of head tilt, squinting, nystagmus or other clinical finding consistent with a possible vision problem.
2. Avoidance of covering one eye or non-conjugate ocular movement in uncovered eye during the cover/uncover test or visual acuity screening.
3. Any abnormalities observed with the corneal light reflex test or cover test.
4. Abnormalities observed with the ophthalmoscopic exam (e.g. white reflex) should be referred to an ophthalmologist.
5. In the event that the child over age 3 is unable to cooperate for vision testing, a second attempt should be made 4 to 6 months later. For children 4 years and older, the second attempt should be made in 1 month. When vision testing is unsuccessful, children should be referred to an ophthalmologist or optometrist experienced in the care of children for an eye evaluation.[15]

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[13] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(30).
[14] Adapted from CAL. DEP'T OF HEALTH CARE SERVS., *CHDP Health Assessment Guidelines Revision: Section 61, Vision Screening* 1-3 (Oct. 25, 2011), http://www.dhcs.ca.gov/services/chdp/documents/letters/chdppin1111.pdf [hereinafter "California Vision Screening"].
[15] Quoting California Vision Screening, *supra* note 12, at 2-3.

HEARING

All newborns must receive an objective hearing screening, using an electro-physiological testing methodology, otoacoustic emission (OAE) or auditory brainstem (ABR), for identifying congenital hearing loss.[16]

Regular surveillance of auditory skills, parental concern, and middle ear status should be a part of every well child visit consistent with the AAP periodicity schedule. Infants who do not pass the speech language portion of a medical home screening, or for whom there is a concern regarding hearing or language, should be referred for speech-language evaluation and audiology assessment.[17]

Hearing Assessment Procedure	Birth to 6 mos	6 mos to 4 years	4 years to under 21 years
Newborns will be screened using physiological techniques such as auditory brainstem response (ABR) or otacoustic emissions (OAE).	X		
Medical history, physical and developmental assessment	X	X	X
Middle ear examination by otoscopy	X		
Middle ear examination by otoscopy and/or acoustic impedance		X	X
Screen using age appropriate behavioral techniques provided by or under the supervision of a licensed audiologist. Visual response audiometry (VRA), conditioned orientation response (COR) or play audiometry is required. ABR and OAE screening may also be used.		X	
Conventional bilateral puretone screening under earphones[18]			X

Under 3 years: At 0-1 months or any initial visit with a new provider, review results of the infant's newborn hearing screen.

- If they did not receive newborn hearing screening:19 If risk factors exist, refer to audiology for diagnostic ABR. If no risk factors exist, provide OAE screening (if available) or refer to audiology.

[16] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(30).
[17] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(31).
[18] Quoting Utah CHEC Manual, *supra* note 10, at 5.
[19] Add reference to near universal newborn hearing assessment.

- If they received but did not pass newborn hearing screening: If risk factors exist or if OAE rescreening is not available, refer to audiology. If no risk factors exist, provide OAE rescreening (if available); refer to audiology if OAE screening is not available or they do not pass the OAE rescreen.[20]

Infants who exhibit one or more of the following risk criteria should be screened as soon as possible and within 3 months after the risk is identified:

1. Parent/caregiver concern regarding hearing, speech, language and/or developmental delay;
2. History of bacterial meningitis;
3. History of neonatal events associated with hearing loss (e.g., cytomegalovirus, prolonged mechanical ventilation, and inheritable disorders);
4. History of head trauma, especially with fracture of the temporal bone;
5. History of ototoxic medications, such as aminoglycocosides used for more than five days (Some medications contribute to hearing disorders.);
6. Presence of neurodegenerative disorders;
7. History of childhood infectious diseases associated with hearing loss (e.g., mumps or measles);[21]
8. Recognizable syndromes associated with progressive hearing loss, such as neurofibromatosis, osteopetrosis, and Usher's syndrome;[22]
9. Family history of childhood or delayed-onset hearing loss;
10. Birthweight < 1500 grams;
11. Apgar scores of 0 to 4 at 1 minute or 0 to 6 at 5 minutes;
12. Recurrent or persistent otitis media with effusion (OME) > 3 months;
13. Craniofacial or temporal bone anomalies;
14. Physical findings associated with sensorineural or conductive hearing loss;
15. Repeated exposure to potentially damaging noise levels;
16. Chemotherapy.[23]

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[20] Quoting MINN. DEP'T OF HUMAN SERVS., *C&TC Fact Sheet – Hearing Screening* 2-3 (Aug. 2014), http://www.health.state.mn.us/divs/fh/mch/ctc/factsheets/hearingscreening.pdf [hereinafter "Minnesota Hearing C&TC Fact Sheet"].

[21] Quoting D.C. DEP'T OF HEALTH, *HealthCheck Medical Assistance Administration Manual* 18-19, http://dchealthcheck.net/resources/healthcheck/manual/HCmanual.pdf [hereinafter "D.C. HealthCheck Manual"].

[22] Quoting Utah CHEC Manual, *supra* note 10, at 6.

The timing and number of hearing re-evaluations for children with risk factors should be customized and individualized depending on the relative likelihood of a subsequent delayed-onset hearing loss. Infants who pass the neonatal screening but have a risk factor should have at least one diagnostic audiology assessment by 24-30 months of age. Early and more frequent assessment may be indicated for children with [cytomegalovirus] infection, syndromes associated with progressive hearing loss, neurodegenerative disorders, trauma, or culture-positive postnatal infections associated with sensorineural hearing loss; for children who have received extracorporeal membrane oxygenation (ECMO) or chemotherapy; and when there is a caregiver concern or a family history of hearing loss.

Every infant with confirmed hearing loss should be evaluated by an otolaryngologist with knowledge of pediatric hearing loss and have at least one examination to assess visual acuity by an ophthalmologist experienced in evaluating infants. A genetics consultation should be offered to families of children with congenital hearing or vision deficits.[24]

Over 3 years: Refer to the AAP periodicity schedule and the chart above for frequency of screens. The purpose of objective screening is early detection of a prompt referral for congenital abnormalities, central auditory problems, sensorineural hearing loss, and conductive hearing impairments. Temporary hearing loss is common among school-age children, usually as a complication of otitis media with middle ear effusion. A PCP can perform an objective test using the pure-tone audiometer, Welsh Allyn Audioscope, or other approved instruments.

The pure-tone audiometry test should be performed in a quiet environment using earphones since ambient noise can significantly affect test performances, particularly at the lower frequencies (i.e., 500 and 1000Hz). Each ear should be tested separately.[25] For a pure tone audiometry sweep screening, tones are presented at the following levels: 25dB at 500Hz; and 20dB at 1000 Hz, 2000Hz and 4000 Hz. To pass the screening, the child must respond to all 4 tones in each ear. Play audiometry is a recommended modification of standard pure tone audiometry when the child is not developmentally able to provide a hand-raising response to presented tones.[26]

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[23] Quoting D.C. DEP'T OF HEALTH CARE FIN., *HealthCHECK Requirements – Comprehensive Hearing Screening*, http://www.dchealthcheck.net/trainings/screenings/hearing.html (last visited May 5, 2015).
[24] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(32).
[25] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(32).
[26] Quoting Minnesota Hearing C&TC Fact Sheet, *supra* note 17, at 2-3.

Air-conduction hearing threshold levels of greater than 20db at any of these frequencies indicate possible impairment. The audiometer must have double earphones and meet American National Standards Institute (ANSI) standards. The audiometer or audioscope should be calibrated yearly. The operator should listen to it each day of use to detect gross abnormalities.[27]

Subjective screening includes questions about the individual's ear and hearing history and speech development. Sample questions include:

- Ear history – has your child ever had trouble with his ears? What kind of trouble? (e.g., draining ears, ear infections) How often has this been noticed? When was the last time this occurred? How has this been treated?
- Hearing history – did your child have a newborn hearing screening test? Did your child pass the test? (If the response is no, or I don't know, refer the child for electrophysiological testing through an audiologist.) Do you feel your child hears adequately? If not, what problems have you noticed, how long have you noticed a problem, are there times when you notice this more than other times?[28]

Referrals: When hearing impairment or progressive hearing loss is suspected, the PCP should promptly refer the child to an approved speech and hearing center. If a successful evaluation cannot be made due to behavioral difficulties or other factors, a prompt referral for assessment and treatment should be made to a facility that provides audiological services.[29] Children with unilateral or mild hearing loss also should be further evaluated. Studies show such children to be similarly at risk for adverse communication skills as well as difficulties with social, emotional, and educational development.[30]

VISION AND HEARING PROVIDER QUALIFICATIONS

GENERAL

EPSDT health assessment and evaluation services shall be delivered under the supervision of skilled medical personnel: physicians, physician assistants, nurse practitioners, public health nurses or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an in-service training course on physical assessments approved by the department. Individual procedures may be completed by paraprofessional staff who are supervised by skilled medical

[27] Quoting D.C. HealthCheck Manual, *supra* note 18, at 18-19.
[28] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(33).
[29] Quoting D.C. HealthCheck Manual, *supra* note 18, at 18-19.
[30] Quoting Illinois Healthy Kids Handbook, *supra* note 5, at HK-203(31).

personnel. Registered nurses who perform EPSDT physical assessments shall have satisfactorily completed a curriculum for pediatric physical assessments approved by the department.[31]

The Contractor shall attend and shall require that Providers attend trainings as directed by the state Medicaid agency. Within twelve months of the Start Date of the contract (and within the first year of a Provider joining Contractor's network), Contractor shall, at a minimum, provide training on the following topics … an overview of EPSDT, the periodicity schedule, and compliance requirements, an overview of the IDEA and the roles and responsibilities of the schools, Providers, and Contractor, as well as [any other relevant state programs].[32]

VISION

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained:

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee;
- Employee verbalizes an understanding of the steps required to perform a vision screening;
- Employee performs a vision screening under supervision on a minimum of three patients successfully.[33]

All pediatric health care providers should be familiar with the most recent version of eye examination and screening guidelines of the American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics.[34]

HEARING

All personnel performing infant hearing screening must be supervised and trained in the performance of infant hearing screening. Training shall include the following:

1. the performance of infant hearing screening;
2. the risks including psychological stress for the parent;
3. infection control practices;

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[31] Adapted from WIS. ADMIN. CODE DHS § 105.37(1)(b)(2) (2015).
[32] Adapted from D.C. MCO Contract, p. 134.
[33] Quoting ALA. MEDICAID AGENCY, *Medicaid Provider Manual* Appendix A-13 (Apr. 2015), http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2015/6.7.1.2_April_2015/Apr15_A.pdf.
[34] Quoting California Vision Screening, *supra* note 12, at 2.

4. the general care and handling of infants in hospital settings according to established hospital policies and procedures;
5. the recording and documentation of screening results as directed; and,
6. procedures for communicating screening results to parents.

Personnel other than licensed audiologists may perform infant hearingscreening provided that:

1. the screening equipment and protocol used are fully automated;
2. equipment parameters are not accessible for alteration or adjustment by such personnel; and,
3. the results of the screening are determined without clinical decision-making and are reported as pass or fail.

Equipment that requires clinical decision-making shall be used to conduct infant hearing screenings only by personnel licensed … and authorized to perform infant hearing screening.[35]

VISION AND HEARING PROVIDER NETWORK

The Contractor must demonstrate adequate provider networks as follows.

1. The Contractor shall ensure a minimum 1:2000 Physician specialist to member ratio for all specialist Physicians designated to practice otolaryngology/ENT; ophthalmology; and audiology.[36]
2. The Contractor shall submit documentation demonstrating that the Contractor's Primary Care, Specialty Care, Dental Service, and Behavioral Health networks comply with travel distance standards as set forth below. For any demonstrated access that differs from these standards, the Contractor must submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.[37]
3. The following chart lists the maximum number of miles from home that an enrollee must travel to access a given type of provider in urban [population 200,000 or more], basic [population of 50,000 to 199,999], and rural counties [population under 50,000, all based on the latest reported census data] for vision care/primary eye care, ophthalmology, otolaryngology, and audiology:

[35] Quoting N.Y. COMP. CODES R. & REGS. tit. 10, § 69-8.3(c)-(f) (2015).
[36] Adapted from Colorado Denver Contract Amendment 9, p. 5; Rocky Mountain Contract Exh. A, p. 17.
[37] Adapted from Missouri RFP, p. 181.

	Urban County Distance Standard	Basic County Distance Standard	Rural County Distance Standard
Vision care/ primary eye care	15	30	60
Ophthalmology	25	50	100
Otolaryngology	25	50	100
Audiology	50	50	50[38]

Only providers who regularly perform routine vision and hearing exams can be used to meet the vision care and hearing care provider panel requirements, respectively. If optical dispensing is not sufficiently available in a region through the Contractor's contracting ophthalmologists/optometrists, the Contractor must separately contract with an adequate number of optical dispensers located in the region.[39]

Reporting and Monitoring System for Vision and Hearing Services

The importance of documentation and accurate record keeping for all members in the EPSDT Program cannot be overemphasized. Incomplete documentation results in lack of evidence that a complete screen occurred. All screens must be documented in the child's medical record.

It is imperative that all eligible children receive all screens – including vision and hearing – as indicated on the EPSDT periodicity schedule. *These screens are not considered to have taken place if they are not documented in the child's medical record*.[40]

The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. [41] A member's medical record shall include, at a minimum, the following:

1. Reason for the visit;
2. The date screening services were performed, the specific tests or procedures performed, the results of these tests and the person who provided the service;

[38] Adapted from Mo. Code Regs. Ann. tit. 20, § 400-7.095 (2015). While the population that classifies a county as urban, basic, or rural may vary by state, having such classifications for distance standards is recommended.
[39] Adapted from Ohio Contract Appendix H, p. 6.
[40] Adapted from D.C. HealthCheck Manual, *supra* note 18, at 10.
[41] Adapted from Kentucky Anthem, Humana, and Passport Contracts, pp. 98-99; Coventry Contract, pp. 108-09; Wellcare Contract, p. 106.

3. Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening;
4. Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as the medical screening;
5. Documentation of declination of screening services by the parent;
6. Referrals made for diagnosis, treatment or other medically necessary health services for conditions found in the screenings; and
7. Date the next screening is due.

The provider should make referrals for diagnostic testing after discussing the need for such services with the recipient and (if relevant) his/her parent/legal guardian during a post-screening interview. The physician's progress notes should indicate the need for such testing.

A dated written referral should be given to the recipient or parents or forwarded to the referral service provider. The referral should include the following information:

1. The name of the child;
2. The Medicaid ID number of the child;
3. The date of the screening;
4. The abnormality noted;
5. The name, address, telephone and fax numbers of the child's primary physician if different from the screening provider; and
6. The physician to whom the referral applies if known.

The provider should advise recipients of possible resources for obtaining testing as appropriate.[42]

In addition, the Contractor shall require PCPs to meet the following requirements:

1. PCPs who serve members under the age of 21 are responsible for conducting all EPSDT screens for individuals on their Panel under the age of 21. Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the member's PCP Medical Record.

[42] Quoting NEV. DIV. OF HEALTH CARE FIN. & POLICY, *Medicaid Services Manual* § 1503.1B (Oct. 9, 2014), https://dhcfp.nv.gov/MSM/CH1500/MSM%20Ch%201500%20Packet%2011-01-14.pdf.

2. PCPs who serve members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by the State Department of Health, to the Contractor within ninety (90) calendar days from the date of service.

3. PCPs are responsible for contacting new members identified in the quarterly encounter lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of enrollment. The Contractor must require the PCP to:

   a) Contact members identified in the monthly lists as not complying with EPSDT periodicity and immunization schedules for children;

   b) Identify to the Contractor any such members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the Contractor; and

   c) Document the reasons for noncompliance, where possible, and to document its efforts to bring the member's care into compliance with the standards.[43]

Although PCPs must be given responsibility for the above tasks, the Contractor must agree to retain responsibility for monitoring PCP activities to ensure they comply with the Contractor's and the State's requirements. The Contractor is prohibited from imposing restrictions on the above tasks.[44]

Contractor shall submit to the State Department of Health a monthly EPSDT report, including – the number and percent of a) members who have received all required EPSDT services and b) children who received vision and hearing screening in accordance with the AAP vision/hearing periodicity schedules.[45]

The Contractor must establish a tracking system to monitor EPSDT services. The use of health information technology can help the Contractor meet this requirement: for instance, a comprehensive database that incorporates information from the Contractor's telephone customer service staff, physician's offices, and claim submission systems. Such a database, when paired with the AAP periodicity schedule and other evidence-based clinical practice guidelines, should be used to prompt automatic reminders for upcoming and overdue screening services, referrals, and follow-up appointments. If an enrollee calls the Contractor's customer service line, a representative should also provide a reminder for needed services about that enrollee and any other members of his/her household enrolled

[43] Quoting Mississippi CCO Contract, p. 72; Pennsylvania MCO Contract Exh. CCC-2 has substantially the same language.
[44] Quoting Nevada RFP, Amerigroup VI-142; similar provision in Pennsylvania MCO Contract, p. 106.
[45] Quoting D.C. CASSIP Contract, p. 106.

with that MCE. During the same call, the representative should also assist the enrollee in scheduling any needed medical appointments and arranging for transportation as necessary. [46]

The Contractor's tracking system must provide information on compliance with EPSDT service provision requirements in the following areas: (1) Initial visit for newborns (the initial EPSDT screen shall be the newborn physical exam in the hospital); (2) EPSDT screenings (including vision and hearing) and reporting of all screening results; and (3) diagnosis and/or treatment, or other referrals for children.

The Contractor must also have an established process for reminders, follow-ups and outreach to members that includes:

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of members.
2. Telephone protocols to remind members of upcoming visits and follow-up on missed appointments within a set time period (calling them repeatedly over several days, at different times of day or night as needed).
3. If requested, any necessary assistance with transportation to ensure that recipients obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination.
4. Protocols for conducting outreach with non-compliant members, including home or school visits, as appropriate.
5. A process for outreach and follow-up to members under the age of twenty-one (21) with Special Needs, such as homeless children.
6. A process for outreach and follow-up with County Children and Youth Agencies and Juvenile Probation Offices to assure that they are notified of all members under the age of 21 who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

The Contractor may develop alternate processes for follow up and outreach subject to prior written approval from the Department. The Contractor shall submit to the Department reports that identify its performance in the above four required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach).[47]

In addition, each month, the Contractor will provide network PCPs with a report that includes all of their assigned members due an EPSDT visit the upcoming month as well as members who are past due for services. The Contractor will also educate all new PCPs regarding the EPSDT program, including the periodicity

[46] Adapted from Nebraska Arbor Contract, pp. 583-84 of PDF.
[47] Quoting Pennsylvania MCO Contract Exh. J-2 to J-3.

schedule and required components of each EPSDT visit (which include vision and hearing screening). The Contractor will compare individual provider practices to normative data, so that providers can improve their practice patterns, processes, and quality of care in alignment with evidence-based clinical practice guidelines and State Department of Health goals. The Contractor will also provide PCPs with lists of panel members in need of recommended EPSDT services and their contact information. As a part of the Provider contract, participating practitioners can increase their overall compensation by demonstrating improvements in EPSDT scores (e.g., percentage of enrollees who are up to date on hearing and vision screenings per the AAP periodicity schedule).

The State will also annually audit files from a random sample of providers to ensure that all required EPSDT visit elements are present. Low-performing providers receive education regarding required elements, are targeted for other education and collaboration efforts to increase compliance, and are re-evaluated in six months. If efforts remain unsuccessful, the provider is subject to corrective action.[48]

Coordination with Other Entities

The State considers school-based clinics to be an important part of the health care delivery system for children. The Contractor is required to include all State-approved school-based clinics in its network for delivery of EPSDT services available at the school-based clinics by the effective date of this Agreement.[49]

The services provided at school-based clinics may include a wide variety of preventive services including general health screening or assessments, EPSDT screenings, laboratory and diagnostic screenings, patient education and other services. The Contractor must ensure that the results of any screening services provided at a school-based health center are incorporated into the child's primary medical record; the child and his/her parent(s) or guardian are notified of the need for any resulting diagnosis or treatment services; and that the child's PCP receives a reminder to schedule any follow-up or referral services needed.

Contractors must

1. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC and Head Start; services, classes, and supplies for pregnant women and newborns; housing assistance and homeless shelters; services for disabled adults; services for children with special needs (e.g., Early Intervention Program and Child Protective Services, as relevant); disease specific services;

[48] Quoting and adapted from New Hampshire Granite State Health Plan, pp. 352-54.
[49] Quoting Rhode Island NHP and United Contracts, p. 53.

and organizations providing services to designated [racial and] ethnic groups.[50]

2. Develop agreements to coordinate care with governmental entities including, but not limited to, County Office of Drug and Alcohol Programs; Office of Children, Youth, and Families; County Children and Youth Agencies; Office of Developmental Programs; Office of Mental Health and Substance Abuse Services; County Mental Health Agencies; County and Municipal Health Departments; School Districts and Intermediate Units; Juvenile Detention Centers; Juvenile Probation Offices; Area Agency on Aging; and Public Housing Authorities.[51]
3. Include language in PCP contracts that requires PCPs to
    a. Assist members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure that members receive appropriate support services.
    b. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes.
    c. Refer eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Medically necessary nutritional supplements are covered by the Contractor.
    d. Coordinate with Head Start programs to ensure eligible members receive appropriate EPSDT services to optimize child health and development.[52]
4. Establish a Community Advisory Council (CAC) that:
    a. Includes, as a majority of the CAC membership, representatives of the community and of the government of each county served by the Contractor.
    b. Ensures diverse membership, with a specific emphasis on those representing populations who experience health disparities.

[50] Quoting Nebraska United Contract, p. 279 of PDF.
[51] Adapted from Pennsylvania MCO Contract Exh. OO.
[52] Quoting ARIZ. HEALTH CARE COST CONTAINMENT SYS., *AHCCCS Medical Policy Manual* 430-21 to -26 (Aug. 1, 2011), http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf.

c. Has its membership selected by a committee composed of equal numbers of county representatives from each county served by the Contractor and members of Contractor's governing body.

d. Meets no less frequently than once every three months.

e. Posts a report of its meetings and discussions to the Contractor's CCO website and other websites appropriate to keeping the community informed of the CAC's activities.

f. Includes, among its duties,

(1) Identifying and advocating for preventive care practices to be utilized by the Contractor;

(2) Overseeing a Community Health Assessment (CHA) and adopting a Community Health Improvement Plan (CHP) to serve as a strategic plan for addressing health disparities and meeting health needs for the communities in the Service Area(s); and

(3) Publishing an annual report on the progress of the CHP.[53]

CONCLUSION

Vision and hearing screening is a crucial part of a robust child health benefit – and a legal entitlement for Medicaid-eligible children. These children are more likely to get the screening they need, when they need it, when the responsibilities of the state agency, managed care plans, and providers are clearly set forth in the contracts that govern the provision of care. Detail matters, too – medically appropriate specifications for the content of screenings, affirmative specifications for outreach, monitoring, and tracking should be included. Accordingly, providers, public health workers, state agency personnel, and child health advocates have a common interest in ensuring that Medicaid managed care contracts meet the highest standards possible.

SUPPORTERS

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[53] Quoting Oregon Contract Exh. B, pp. 27-28.