Managed Care Contract Provisions—Beefing Up EPSDT During Contract Renegotiations (March 2024)

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NHeLP maintains a bank of states' Medicaid managed care contracts. In February and March 2024, we reviewed contracts from selected states for provisions addressing EPSDT. The provisions excerpted below are examples of language that can be suggested, as appropriate and with needed modifications, when states are renegotiating their managed care contracts.

States

The following states' contracts were selected for review based on our understanding of their past coverage of EPSDT and/or litigation focusing on EPSDT: Arizona, California, Washington D.C., Florida, Kansas, Maine, Massachusetts, Michigan, Minnesota, North Carolina, Ohio, Oregon, Tennessee, Texas, Washington, and Wisconsin.

Focus of the Search

Our review focused on the following:

- Definitions
- Well child screening, e.g. periodicity, separate assessments for vision, hearing, & dental services
- Informing & outreach, e.g. scheduling and transportation
- Treatment, i.e. the "correct or ameliorate" standard and 1396d(a) scope of benefits
- Form 416 reporting, the Child Core data set
- Provider network adequacy, including pediatric specialists, pediatric ratios, travel/time distance, wait times, secret shopper
- Designed EPSDT coordinator/staff

EPSDT Defined

Arizona

A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the Arizona State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost-effectiveness, do not apply to EPSDT services.

D.C.

The health benefit for individuals under age 21, combined with informational, scheduling and transportation services required under federal law. The EPSDT benefit is defined in 1905(r) of the Act. The EPSDT benefit encompasses regularly scheduled assessments beginning at birth and continuing through age twenty (20) interperiodic (as needed) assessments when a physical, developmental, or mental condition is suspected, comprehensive vision care (including regularly scheduled and as needed eye exams and eyeglasses), hearing care (including regularly scheduled and as-needed exams and hearing aids and batteries), dental care needed to treat emergencies, restore the teeth and maintain dental health and the items and services set forth in Section 1905(a) of the Act that are needed to ameliorate or correct any physical or mental condition identified through a periodic or inter-periodic assessment, whether or not included in the District's State Medicaid Plan.

Well-child screenings: vision, hearing, and dental services

Michigan

Section 1.1, VI.F. Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services.
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit (42 USC Sec. 1396D(R)(5), 1396D(A)), also referred to as a well-child visit, is a federal mandate that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. States are required to provide comprehensive services

including appropriate preventive, dental, behavioral health, and developmental, and specialty services needed to correct and ameliorate health conditions, based on federal guidelines. EPSDT provides for coverage of all medically necessary services included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act, regardless of whether such services are covered under the State Plan. Refer to EPSDT- A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014 for more information on the administration of this benefit.

1. Contractor must provide EPSDT services as Medically Necessary in accordance with 42 USC Sec. 1396D(R)(5), 1396D(A)), 42 CFR part 441, Subpart B, [NB: Citations to the EPSDT regulations should be checked for content. These regulations have not been revised to reflect major statutory changes since 1989, leaving some of the provisions out of synch with the statute.] and MSA 16-01 whether or not such services are covered under the State Plan and without regard to established limits.
2. Contractor must have a process that provides services to Enrollees for services not covered under the State Plan that have been determined to be Medically Necessary.
3. Contractor must ensure screenings and laboratory services are provided to Enrollees under 21 years of age according to the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule (see Appendix 6)
4. Contractor must provide outreach to Enrollees due or overdue for well-child/ EPSDT visits, including phone, mail, home-visiting or other means of communication acceptable to the Enrollee; the Contractor may meet this requirement by contracting or collaborating with community-based organizations and providers.

North Carolina

The PHP shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.

Pursuant to 42 C.F.R. § 457.410(b)(1), the PHP shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents" including:

1. Screening for developmental delay at each visit through the 5th year;

2. Screening for Autistic Spectrum Disorders per AAP guidelines;

b) Comprehensive, unclothed physical examination;
c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
d) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
e) Health education and anticipatory guidance for both the child and caregiver.

Vision

Arizona

Vision Services/Ophthalmology/Optometry.
The Contractor shall provide emergency eye care, and all medically necessary vision examinations, prescriptive lenses, frames, repair, or replacement of broken or lost eyeglasses without restriction, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition. In addition, cataract removal, medically necessary vision examinations, and prescriptive lenses and frames are covered if required following cataract removal. Members shall have full freedom to choose, within the Contractor's network, a practitioner in the field of eye care, acting within the scope of their practice, to provide the examination, care, or treatment for which the member is eligible. A "practitioner in the field of eye care" is defined to be either an ophthalmologist or an optometrist.

Minnesota

Vision care services are covered and include vision examinations, eyeglasses, optician, and optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the MCO Network physicians or Network optometrists. The MCO must make available a reasonable selection of eyeglass frames, but is not required to make available an unlimited selection. Replacement of lost, stolen or irreparably damaged eyeglasses, sunglasses, and contact lenses may be covered upon a showing of Medical Necessity and may be limited to replacement by the same frames. [Minnesota Statutes, §256B.0625, subd. 12; Minnesota Rules, Part 9505.0277]

North Carolina

Vision Services: Clinical Coverage Policy 6A: Routine Eye Exam and Visual Aids for Recipients Under Age 21.
Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.

Tennessee

Amendment 14 Vision Services.
Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements;

Amendment 11 Vision Services.
1. Annual vision exam including refractive exam and glaucoma screening.
2. Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair.
3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair.
4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair.

Washington

Section 17.1.31.1.3
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)).

Exhibit M-4, Scope of Benefits.
Vision Exams/ Optometrists/ Ophthalmic Services Medically necessary eye examinations, refractions and eyeglass/contact lens fitting fees.

Managed Care Contract Provisions—Beefing Up EPSDT During Contract Renegotiations

For Enrollees age 20 or younger, services will be provided in accordance with EPSDT requirements, subject to determination of medical necessity.

Hearing

Arizona

Audiology Services.
The Contractor shall provide medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids are covered only for members under the age of 21 receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

North Carolina

Hearing Screening Program.
1. Consistent with N.C. Gen. Stat. § 130A-125 and 10A NCAC 43F, the PHP shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program including reporting to the Early Hearing Detection and Intervention (EHDI) Program at https://wcs.ncpublichealth.com.
2. The PHP shall establish a joint plan with the Department to implement the requirement of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or time otherwise defined by the Department.

Dental

California

Section 4.3.17 Dental.
A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.
B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic

assessment, with annual dental referrals beginning with the eruption of the Member's first tooth or at 12 months of age, whichever occurs first.
C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to, laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures. If a Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

D.C.

Section C.5.28.5.3.3.4
Dental screening services in accordance with the District of Columbia Dental Periodicity Schedule (Attachment J.19) and at such other intervals as may be needed to identify the existence of a suspected illness or condition, including relief of pain and infection, restoration of teeth and maintenance of dental health. Contractor shall reimburse for up to four (4) applications of fluoride varnish per year, furnished either by a dentist or, for Enrollees under the age of three (3) years, by a PCP who has completed the fluoride varnish training approved by DHCF through the HealthCheck Training and Resource Center.

Minnesota

Medical Assistance covers dental services for children and pregnant women that are Medically Necessary. The following guidelines also apply:
(1) Posterior fillings are paid at the amalgam rate;
(2) Application of sealants once every five years per permanent molar for children only; and
(3) Application of fluoride varnish once every six months; and

(4) Orthodontia is eligible for coverage for children only, and in limited circumstances described in Minnesota Rules, Part 9505.0270, subp. 2a, item F

Washington

Attachment 5-C.
ABCD Program - The Access to Baby and Child Dentistry (ABCD) Program was established to increase access to dental services for all Apple Health-eligible clients through age 5. The ABCD Program will be extended to Apple Health-eligible clients through age 12 with a disability who are enrolled in the Developmental Disabilities Administration (DDA) waiver program and possess a DDA indicator on their Medicaid file, effective January 1, 2022. The Program's goal is to ensure positive dental experiences in early childhood will lead to lifelong practices of good oral health. The ABCD Program is a partnership between the public and private sectors, such as the Washington State Health Care Authority (HCA), the Washington State Department of Health, the University of Washington School of Dentistry (UW), Arcora, the Washington State Dental Association, local dental societies, and local health jurisdictions. The design of the ABCD Program is to develop competency in dental practices to deliver dental services to children and, in primary medical care practices, to provide oral health education, oral assessments and treatments, or referrals for treatment.

Informing and Outreach

North Carolina

Member Handbook.
g. Information on the EPSDT benefits, for members under the age of twenty-one (21), including:

1. The benefits of preventive health care;
2. Services available under the EPSDT program and where and how to obtain those services;
3. That EPSDT services are not subject to cost-sharing; and
4. That PHP will provide scheduling and transportation assistance for EPSDT services upon request by the Member.

EPSDT
n. The PHP shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:

i. Regular preventive care, and
ii. Scope of services, products and treatments available when medically necessary to correct or ameliorate a health condition or problem.

o. The PHP shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) calendar days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in Section V.B.3. Member Engagement.
q. The PHP shall effectively inform Members and/or their parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the Section V.B.3. Member Engagement.

Ohio

vi. With respect to Healthchek services, the MCO must:
1. Inform each new member under the age of 21 about Healthchek services as prescribed by ODM and as specified by 42 CFR 441.56 within five calendar days of receipt of the Health Insurance Portability and Accountability Act (HIPAA) 834C daily enrollment file;
a. The MCO may meet this requirement by including information with the new member materials as specified in Appendix E, Marketing and Member Materials.
2. Communicate and coordinate with the member's local county Department of Job and Family Services (CDJFS) agency about any requests made by the member for county-coordinated services and supports (e.g., social services);
3. Provide members with accurate information in the member handbook regarding Healthchek;
a. The MCO must provide member handbooks to members within the timeframes specified in Appendix E, Marketing and Member Materials, and must include verbatim the model language developed by ODM.
b. The model language, at a minimum, includes:
i. A description of the types of screening and treatment services covered by Healthchek, such as that provided on the ODM 03528 "Healthchek and Pregnancy Related Services Information Sheet";
ii. A list of the intervals at which members under the age of 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;
iii. Information that Healthchek services are provided at no additional

cost to the member; and

iv. Information that providers may request prior authorization for:

1. Coverage of services that have limitations; and
2. Services not covered for members under the age of 21 if the services are medically necessary.

4. Provide the information included in the member handbook above regarding Healthchek on the MCO's member website as specified in Appendix E, Marketing and Member Materials;
5. Deliver Healthchek information as provided, or as approved, by ODM to its members at the following intervals:
   a. When the member is 9 months old;
   b. When the member is 18 months old;
   c. When the member is 30 months old;
   d. January of each calendar year (CY) to all members under the age of 21;
   e. In July of each CY for members from age 4 to under 21; and
   f. When the member is identified as pregnant, regardless of the member's age.
6. Use the mailing templates provided by ODM not to exceed two 8x11 pages for each mailing with most mailings being one page or less in length. The MCO must populate the materials with appropriate Healthchek information as required (e.g., type of service, rendering provider, date of service, and age of member on the date of service).

vii. The MCO must inform members about Pregnancy Related Services.

1. Upon identifying a member as pregnant, the MCO must deliver a Pregnancy Related Services form as designated by ODM to the member within five calendar days.
2. The MCO may communicate with the member's local CDJFS agency for any requests made by the member for county-coordinated services and supports (e.g., social services).

viii. The MCO must inform and educate providers about Healthchek.

1. The MCO must provide Healthchek education to all network providers on an annual basis that must include, at a minimum:
   a. The required components of a Healthchek exam pursuant to OAC rule 5160-01-14;
   b. A list of the intervals at which members under the age of 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;
   c. A statement that Healthchek includes a range of medically necessary

screening, diagnostic, and treatment services; and
d. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

2. The MCO must provide the above information on the MCO's provider website as specified in Appendix A, General Requirements.

ix. The MCO must maintain documentation to verify members and providers were informed of Healthchek and Pregnancy Related Services as specified by ODM.

Oregon

Federal guidelines and CCO contracts require that all EPSDT-eligible members are informed of EPSDT services and how to access them (this includes pregnant members and foster and adoptive parents).

1. New members must be informed within 60 days of enrolling.
   a. CCOs meet this requirement by sending member handbooks within 14 days of enrollment.
   b. The 2023 CCO Model Member Handbook has been updated to include EPSDT information and is located on the CCO Contract Forms webpage.
   c. A fact sheet for OHP members is available on the OHA EPSDT webpage.
2. Members must be informed immediately following birth for newborn infants.
3. Members who have not used EPSDT services must be re-informed annually.

Communication of EPSDT benefits must include:

1. The benefits of preventive healthcare;
2. What EPSDT services are available;
3. Age of eligibility for services;
4. Availability of transportation & scheduling assistance;
5. Availability of translation services; and
6. That members are able to request a case-by-case review of a denied service/claim.

Outreach

D.C.

Section C.5.28.9 EPSDT Outreach Activities.
C.5.28.9.1 The Contractor shall be responsible for outreach activities and for informing Enrollees who are under the age of twenty-one (21), or their parent or caretaker relative, of the availability of EPSDT services, including services that are due and

overdue. In addition to targeted EPSDT outreach to specific Enrollees, the Contractor shall provide Enrollee education and outreach in the community settings.

C.5.28.9.2 The Contractor shall have the ability to conduct EPSDT outreach in formats appropriate to Enrollees who are blind, deaf, illiterate or have limited English proficiency (LEP). Outreach attempts identified above shall advise Enrollees how to request and/or access such assistance and information. The Contractor shall collaborate with agencies that have established procedures for working with special populations in order to develop effective EPSDT outreach and materials.

C.5.28.9.3 The Contractor shall have policies and procedures, including an electronic tracking tool, to monitor children's compliance with EPSDT, including EPSDT periodicity schedules, and shall conduct outreach activities to assist Enrollees under age 21 to make and keep EPSDT appointments. The outreach activities shall include every reasonable effort, including a telephone call or mailed reminder prior to the due date of each EPSDT screening service. In the case of a first missed appointment, the Contractor shall contact the Enrollee by telephone or mailed reminder. If there is no response, a home visit shall be conducted to urge the parent(s) and/or caregiver(s) to bring the child for his or her EPSDT appointment. When appropriate, such contacts shall be directed to *sui juris* teenagers.

C.5.28.9.4 The Contractor shall have policies and procedures, including an electronic tracking tool, in a format as determined by DHCF, that monitors compliance with IDEA. The Contractor shall ensure staff attend the Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) planning meetings. The Contractor shall, on a quarterly basis, provide to DHCF, a summary of the information contained in the tracking tool with a summary of the number of staff and beneficiaries attending IEP and IFSP meetings, along with the number and percentage of meetings that staff and beneficiaries did not attend due to circumstances such as late notice to the MCO or the Enrollee fails to attend the meeting.

California

Section 2.2.10 Quality Care for Children.
2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and Bright Futures/American Academy of Pediatrics (AAP) preventive services to Members and their families. Additionally, Contractor must ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or Bright Futures/AAP preventive services, and ensure outreach to these Members in a culturally and linguistically appropriate manner;

Scheduling and Transportation

California

E. EPSDT Services.
2) Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

D.C.

Section C.5.28.9.5 The Contractor shall offer scheduling and transportation assistance, such as paying for Enrollees' transportation costs, prior to the due date of each Enrollee's periodic examination and shall provide this assistance when requested and necessary.

Tennessee

Section 2.7.6.2.2.1 If the CONTRACTOR's TennCare Kids screening rate is below ninety percent (90%), as determined in the most recent CMS 416 report, the CONTRACTOR shall conduct New Member Calls or Digital Outreach (for example, but not limited to, text messages) for all new members under the age of twenty-one (21) to inform them of TennCare Kids services including assistance with appointment scheduling and transportation to appointments.

Reporting

Arizona

CMS-416: AHCCCS utilizes the methodology established within the CMS Instructions for Completing Form CMS-416: Annual EPSDT Participation Report for reporting EPSDT

Participation. The aggregate rate for Title XIX, as well as the aggregate rate for Title XXI, are generated one time per year and reported to CMS within specified timeframes. AHCCCS may, in lieu of generating the rates, opt to utilize CMS-generated rates for reporting purposes. AHCCCS may require the Contractor to implement a CAP or participate in mandatory workgroup activities when statistically significant declines in the Title XIX and/or Title XXI aggregate rates are identified.

Child Core Data Set

North Carolina

Section VII. Attachment E. Required PHP Quality Metrics.
Child Core measures:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates) - priority measure
- Dental Sealants for 6-9 Year Old Children at Elevated Carries Risk
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Childhood Immunization Status (Combination 10) - priority measure
- Follow-Up for Children Prescribed ADHD Medication (Both Rates)
- Prenatal and Postpartum Care (Both Rates) - priority measure
- Immunizations for Adolescents (Combination 2) - priority measure
- Adolescent Well-Care Visit
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life - priority measure
- Percentage of Low Birthweight Births - priority measure

Network Adequacy:

Pediatricians and Pediatric Specialists

California

Exhibit A, Attachment III
5.2 Network and Access to Care.
5.2.1 Access to Network Providers and Covered Services
2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section

14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

5.2.3 Network Composition.
A. Network must include at a minimum adult and pediatric PCPs, adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and Long-Term Care (LTC) Providers

Provider Ratio

California

Section 5.2.4 Network Ratios.
A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:
1) FTE PCPs that are Physicians: Member: 1:2,000
2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

Florida

NB: This listing of pediatric specialists is singular among states in this review; however, the ratios should be verified with the appropriate pediatric specialists.

Cardiology (PEDS) 1:16,667 enrollees
Endocrinology (PEDS) 1:20,000 enrollees
Nephrology (PEDS) 1:39,600 enrollees
Neurology (PEDS) 1:22,800 enrollees
Pediatrics (including Adolescent Medicine) 1:1,500 enrollees
Therapists, Pediatric (Occupational, Speech, Physical, Respiratory) 1:1,500 enrollees

Massachusetts

Section 2.9: Accessibility and Availability

C. Availability
The Contractor shall execute and maintain written contracts with Providers to ensure that Enrollees have access to MCO Covered Services within a reasonable distance and travel time from the Enrollee's residence, as provided below. The Contractor shall take into account both walking and public transportation.
1. PCPs
b. The Contractor shall maintain a sufficient number of PCPs, defined as one adult PCP for every 200 adult Enrollees and one pediatric PCP for every 200 pediatric Enrollees throughout the Regions, provided that, EOHHS may approve a waiver of the above ratios in accordance with federal law.

Michigan

Pediatric PCP Provider Ratio 1:500

Wisconsin

Pediatric PCP Provider Ratios
- Urban Counties: 1:100
- Rural Counties: 1:120

Time & Distance

NB: The following provisions are noted for their existence and not necessarily for the standards they announce.

Florida

ATTACHMENT II - EXHIBIT II-A
Section VIII. Provider Services
A. Network Adequacy Standards
4 Specialists and other providers.
b. For pediatric specialists not listed on the Managed Medical Assistance Provider Network Standards Table, Table 4, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at an agreed upon location or at a PCP's office within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's

residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability

Pediatrics (including Adolescent Medicine) Time and Distance:

- Urban Counties: 50 maximum minutes; 35 maximum miles
- Rural Counties: 75 maximum minutes; 60 maximum miles

Pediatric specialists Time and Distance:

- Urban Counties: 100 maximum minutes; 75 maximum miles
- Rural Counties: 110 maximum minutes; 90 maximum miles

Pediatric therapists Time and Distance:

- Urban Counties: 30 maximum minutes; 20 maximum miles
- Rural Counties: 60 maximum minutes; 45 maximum miles

Pediatric Respiratory Therapist Time and Distance:

- Urban Counties: 60 maximum minutes; 45 maximum miles
- Rural Counties: 75 maximum minutes; 60 maximum miles

Michigan

Pediatric PCPs Time and Distance:

- Non-rural: 30 maximum minutes; 30 maximum miles
- Rural: 40 maximum minutes; 40 maximum miles

Ohio

NB: Ohio's contact is unique in this review because its time and distance standards are broken down into four distinct types of geographic region whereas many states only delineate into Urban and Rural.

Large Metro: 20 max minutes;10 max miles
Metro: 30 max minutes; 20 max miles
Micro: 50 max minutes; 35 max miles
Rural: 75 max minutes; 60 max miles

Wisconsin

Time and Distance to Pediatric PCPs

- Urban Counties: 15 maximum minutes; 10 maximum miles
- Rural Counties: 40 maximum minutes; 30 maximum miles

Wait Time

D.C.

Section C.5.29.18 Appointment Time Standards for Services.
C.5.29.18.2 The Contractor shall ensure that Enrollees with appointments who arrive by their scheduled appointment time shall not routinely be made to wait more than forty-five (45) minutes from their scheduled appointment time to see a PCP. The Contractor shall monitor Enrollee wait times to make an appointment with the Provider, as well as the length of time the Enrollee actually spent waiting to see the Provider.;

C.5.29.18.10 The Contractor's Providers shall offer appointments for initial EPSDT screenings to new Enrollees within sixty (60) days of the Enrollee's enrollment date with the Contractor or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the Enrollee's case indicates a more rapid assessment is needed or a request results from an Emergency Medical Condition. The initial screening shall be completed within three (3) months of the Enrollee's enrollment date with the Contractor, unless the Contractor determines that the new Enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screenings, laboratory tests, and immunizations shall take place within thirty (30) days of their scheduled due dates for children under the age of two (2) and within sixty (60) days of their due dates for children age two (2) and older. Periodic EPSDT screening examinations shall take place within thirty (30) days of a request by an Enrollee or parent/guardian.

North Carolina

Preventive Care Services – child, birth through 20 years of age examinations, immunizations, mammograms and pap smears

- Within fourteen (14) Calendar days for Member less than six (6) months of age
- Within thirty (30) Calendar days for Members six (6) months or age and older.

Texas

Section 8.1.3.1 Appointment Accessibility.
Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first.
10. Preventive health services for Members less than 6 months of age must be provided within 14 Days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. CHIP Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment.

Secret shopper

D.C.

Section C.5.29.1.23 The Contractor shall at least annually conduct access and availability audits to validate Provider Network access of individual Providers within the Contractor's Provider Network. The Contractor may coordinate with other MCOs to conduct these audits to avoid duplicate contacts to Providers. Reviews shall include the use of "secret shopper" calls and activities

EPSDT Coordinator

Arizona

Section D.15 Staffing Requirements:
EPSDT Coordinator who is located in Arizona and who is an Arizona licensed nurse, physician or physician's assistant in good standing; or has a Master's degree in health services, public health, health care administration or other related field, and/or a Certified Professional in Healthcare Quality (CPHQ) or Certified in Health Care Quality and Management (CHCQM) certification. Staff reporting to this position shall be appropriate to meet the AHCCCS Maternal and Child Health (MCH)/EPSDT contractual and policy requirements, and quality and performance measure goals, and shall be located in Arizona. EPSDT staff shall either report directly to the EPSDT Coordinator or the EPSDT Coordinator shall have the ability to ensure that AHCCCS EPSDT requirements are met. The EPSDT Coordinator may also serve as the MCH Coordinator.

The primary functions of the EPSDT Coordinator are:
a. Ensure receipt of EPSDT services,
b. Promote preventive health strategies,
c. Promote access to oral health care services,
d. Identify and coordinate assistance for identified member needs, and
e. Interface with community partners.

Ohio

Early and Periodic Screening, Diagnosis, and Treatment/Maternal Child Health Manager:
1. The early and periodic screening, diagnosis, and treatment (EPSDT)/Maternal Child Health Manager must be an Ohio licensed registered nurse, physician, or physician's assistant; or has a master's degree in health services, public health, or health care administration or another related field, and/or is a Certified Professional in Health Care Quality or CHCQM.

2. The primary functions of the EPSDT/Maternal Child Health Manager are to:
a. Ensure member receipt of all EPSDT services;
b. Ensure member receipt of maternal and postpartum care;
c. Promote family planning services;
d. Promote preventive health strategies;
e. Identify and coordinate assistance for identified member needs specific to maternal/child health and EPSDT;
f. Interface with community partners and pregnancy related services coordinators; and
g. Participate in EPSDT and maternal child quality and performance improvement efforts.

Two states with less detailed examples in their contracts are Washington, D.C. and Tennessee:

D.C.

Section C.5.4.2.9 Manager or employee who oversees EPSDT services for Enrollees under age 21, along with services provided to children under the IDEA; manages all EPSDT/court -related reports; coordinates with the DHCF Division of Children's Health Services; serves on the EPSDT Working Group and other child-related initiatives.

Managed Care Contract Provisions—Beefing Up EPSDT During Contract Renegotiations

Tennessee

Amendment 14
Section 2.29.1.3.37 A full-time staff person dedicated to and responsible for all TennCare Kids services and related issues, including but not limited to, all TennCare Kids activities and EPSDT screening events. This person shall report to the local health plan.

For questions or additional information, please contact:

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