

Medicaid AHCCCS Health Care

Arizona Legal Services
Statewide Conference

May 29, 2008
4:00 – 5:30 p.m.

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Training Goals

- To provide substantive information so participants can:
 - “Issue spot” health care issues
 - Analyze legal issues in health care cases
 - Represent clients in Medicaid appeals
- Understand
 - Medicaid
 - AHCCCS
 - Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) for children

Outline of Training

- Medicaid Program for adults and children
 - Medical Services
- Arizona Health Care Cost Containment System (AHCCCS)
 - Basic Eligibility Requirements
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children
 - Due Process and Appeals

OVERVIEW OF MEDICAID

Medicaid Act

- Enacted in 1965
 - Provides health care for persons with low incomes and limited resources
- Medicaid is Title 19 of the Social Security Act, 42 U.S.C. §1396-1396v
- Requires States to meet minimum standards regarding administration, eligibility, scope of services and procedural protections
 - Consists of acute care, long term care, and mental health services

Entitlement to Medicaid

- The number of people who can enroll in Medicaid cannot be limited.
- “An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives.” *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981).
- Constitutional due process protections attach to eligibility and benefits. *Goldberg v. Kelly*, U.S. 397 U.S. 254 (1970).

Medicaid Funding

- Medicaid is jointly financed by the federal government and the state
- Federal Financial Participation or money is given to states for services covered under the State Plan and for administrative costs

- The federal government reimburses states for a substantial portion of their Medicaid costs

- In Arizona, the federal contribution is 67.25% and the state contribution is 32.75%

Federal Medicaid Administration

- U.S. Health and Human Services (HHS) is the federal agency responsible for the Medicaid program
 - CMS
 - Governs the administration of the Medicaid program
 - Promulgates regulations to implement the Medicaid statute
 - Issues guidelines that interpret the statute and regulations through the State Medicaid Manual
 - Provides guidance to States
- The Centers for Medicare & Medicaid Services (CMS), formally HCFA, administers the Medicaid program under HHS

State Medicaid Administration

- States must designate a single state agency to administer the Medicaid program
- States must submit a “State Plan” to CMS, which outlines how the state will comply with Medicaid requirements
- States are not required to participate in the Medicaid program, but once they do, they are bound by Medicaid’s statutory and regulatory requirements, unless “waived”

Waiver of Medicaid Requirements

- Federal law allows States to ask for waivers of certain Medicaid requirements
- States seek waivers to:
 - Provide different kinds of services
- CMS grant waivers to exempt States from compliance with specific Medicaid requirements
 - Provide Medicaid eligibility to new groups
 - Implement new service delivery and management models
- Reduce state spending and/or make state spending more predictable

Arizona's Waiver

– Arizona has a Section 1115 Research and Demonstration Project Waiver

– Arizona was first granted a waiver in 1982, when AHCCCS started as a managed care system

– Some waivers in AZ:

- Restrict freedom of choice of provider because of managed care
- Add Medicaid coverage up to 100% of FPL for certain eligibility groups
- Provide retroactive eligibility to 1st day of application month
- Use “PAS” standard for long term care

Basic Medicaid Principles

- Statewideness: All Medicaid services must be available on a statewide basis
 - Comparability: The same level of services must be available to all recipients
- Amount, Duration and Scope: States must cover each service in amount, duration and scope that is “reasonably sufficient.” States may not arbitrarily limit services for specific illnesses or conditions
 - Exception: Under the EPSDT program, children are entitled to a broader range of medical services than adults

Medicaid Eligibility Groups

- There are three Medicaid eligibility groups:

- Mandatory Categorically Needy:

- Automatically qualify for Medicaid because fit into a specified low-income group
- States must cover this group

Optional Categorically Needy:

- Meet financial requirements for Medicaid but do not meet other eligibility criteria
- States can cover this group

Medically Needy:

- Meet federal benefit program category such as aged, blind or disabled but income and resources exceed categorically needy limits
- States can cover this group

Medical Services under Medicaid

- Once a state opts to provide a service, the state is bound by the Medicaid Act and regulations in the provision of that service, unless waived

- Types of medical services under Medicaid:
 - Mandatory services MUST be provided
 - Optional services MAY be provided
 - EPSDT services for children MUST be provided

Mandatory Services

- Medicaid mandatory services include:
 - Inpatient and outpatient hospital services
 - Physician services
 - Medical and surgical services furnished by a dentist if a physician could also provide such services
 - Laboratory and x-ray services
 - Skilled nursing facility services for persons over 21
 - Home health care services for persons entitled to receive nursing facility services
 - Rural Health Clinic services
 - Federal Qualified Health Centers (FQHC) services
 - Nurse midwife services
 - Prenatal care
 - Family planning services
 - Certified Pediatric Nurse Practitioner services
 - Immunizations for children
 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children
- See 42 U.S.C. § 1396d; 42 C.F.R. §§ 440.1 to 440.185.

Optional Services

- Medicaid optional services include:
 - Podiatrists
 - Optometrists and eyeglasses
 - Chiropractors
 - Private duty nursing services
 - Clinic services
 - Dental services and dentures
 - Physical, occupational, speech, hearing and language therapy
 - Prescription medications
 - Prosthetic devices
 - Diagnostic, screening, preventative and rehabilitation services

- Respiratory care services
- Transportation services
- Emergency hospital services
- Hospice care
- Services for persons 65 and older in mental institutions
- Inpatient psychiatric hospital services for persons under 21
- Nursing facilities for persons under 21
- Primary case management
- Personal care services
- Home and community care for disabled elderly persons
- Intermediate care facilities for persons with developmental disabilities and other persons

Early and Periodic Screening, Diagnostic and Treatment Program for Children

EPSDT for Children

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 42 U.S.C. § 1396d(r)(5)
 - Standard for EPSDT Services:
 - All necessary health care to “correct or ameliorate” physical or mental problems or conditions
 - Covers all medically necessary services, even if the service is not in the State Plan and/or is not provided to adults
- Purpose of EPSDT is early detection and treatment of childhood health conditions
- Covers all Medicaid eligible children and youth under age 21

EPSDT Services for Children

- EPSDT is a preventative health care program for children
- States must periodically “screen” children for health and developmental issues
- If health problems are discovered during these screenings, corrective treatment must be provided
- In addition to EPSDT services required by federal law at 42 U.S.C. §1396d(r)(5), states must provide:
 - All mandatory and optional services that the state can cover under Medicaid pursuant to 42 U.S.C. § 1396d(a), whether or not the medical services are covered for adults

EPSDT Mandatory Services for Children

- Vision, medical, dental, and hearing screening services pursuant to a periodicity schedule
 - Vision services
 - Diagnosis and treatment for defects in vision
 - Eye examinations
 - Prescriptive lenses
- Comprehensive health and developmental history
- Comprehensive unclothed physical examinations
- Appropriate immunizations according to age and health history
- Laboratory tests including lead blood level testing
 - See 42 U.S.C. 1396d(r)(5); 42 CFR § 441.50 *et seq.*; Ariz. Admin. Code, R9-22-213

EPSDT Mandatory Services for Children

- Dental services
 - Emergency dental services
 - Preventive services including screening, diagnosis, and treatment of dental disease
 - Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices
- Nutritional assessment and nutritional therapy
- Behavioral health services
- Orthognathic surgery
- Incontinence Briefs
- Hospice services
- Outreach
- Health education
- Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5)
- See 42 U.S.C. 1396d(r)(5); 42 CFR § 441.50 et seq.; Ariz. Admin. Code, R9-22-213

EPSDT Issues

- AHCCCS health plans must provide EPSDT services to all Medicaid eligible children under age 21
- AHCCCS also requires health plans to provide health care services similar to EPSDT services to children eligible for the KidsCare program
- The Institute believes that AHCCCS has failed to provide services to children consistent with EPSDT laws and regulations
- Some EPSDT issues in Arizona:
 - AHCCCS health plans often do not apply the broader EPSDT standard for children to “correct or ameliorate” health conditions when they determine if a child is eligible for a treatment or service
 - AHCCCS health plans list the adult standard in notices when denying a service to a child
 - AHCCCS health plans do not sufficiently inform families about EPSDT services

Medicaid Statute, Regulations and Policies

- **Statute:** 42 U.S.C. §§1396-1396v
- **Regulations:** 42 C.F.R. § 400 *et seq.*
- **Policy:** State Medicaid Manual and
“Dear State Medicaid Directors”
Letters found at www.cms.hhs.gov.
- **CMS Website:** www.cms.hhs.gov.

Arizona Health Care Cost Containment System (AHCCCS)

AHCCCS Basics

- AHCCCS is Arizona's single state Medicaid agency
 - Section 1115 waiver program
- Statewide managed care system
- The last state to join Medicaid in 1982
- Prop 204 expanded coverage to 100% of Federal Poverty Level
 - 1,084,360 AHCCCS recipients today

AHCCCS Health Plans

- AHCCCS is a statewide managed care system that contracts with health plans to deliver medical services to recipients.

- Health Plan Responsibilities:

- Contract for health services
- Ensure adequate network of providers
- Provide case management
- Process and pay claims
- Conduct monitoring and oversight
- Provide grievance and appeals process

- AHCCCS refers to Health Plans as Program Contractors

Acute Care Health Plans

- There are 8 Acute Care Health Plans in Arizona:
 - Arizona Physicians IPA
 - Care 1st Arizona
 - Health Choice
 - Maricopa Health Plan
 - Mercy Care Plan
 - Phoenix Health Plan
 - Pima Health System
 - University Family Care
- Acute Care Plans:
 - Are private entities or counties
 - Can make a profit on the contracts
 - Provide medical services to 895,365 AHCCCS recipients

ALTCS Health Plans

- There are 9 Long Term Care Health Plans in Arizona:
 - Cochise
 - DES/DDD
 - Evercare
 - Mercy Care Plan
 - Pima Health System
 - Pinal/Gila
 - Bridgeway
 - Yavapai
- Arizona Long Term Care System (ALTCS) Plans:
 - Serve Elderly and Physically Disabled (EPD) and Developmentally Disabled (DD) populations
 - Provide ALTCS members with behavioral health and acute care services (Exception: DD)
 - Serve 43,159 ALTCS members

Native American Health Services

- Native Americans can choose to receive Medicaid services from AHCCCS Health Plans or from Indian Health Services (IHS)
- AHCCCS fee-for-service (FFS) program provides Medicaid reimbursements to IHS
- 7 tribal governments have signed intergovernmental agreements (IGAs) to provide ALTCS case management
- Other tribal members receive case management through the Native American Community Health Center

AHCCCS Payment Methods

- Managed Care
 - “Capitated payments” to health plans
 - Pay health plans a set amount per person for each person served by the health plan
- Fee-for-Service
 - Direct payment to providers
 - Pay providers for medical services actually provided

AHCCCS Cost-Sharing

- AHCCCS may impose nominal deductibles or co-payments for services on categorically needy and medically needy groups.
- Currently, AHCCCS' co-payments are:
 - \$1 for doctor's visits
 - \$5 for non-emergency use of emergency room
- BUT providers cannot deny a medical service if a person cannot pay the co-payment

AHCCCS Cost-Sharing

- For certain groups, AHCCCS wants to impose higher co-payments and deny services for nonpayment
 - Proposed co-payments:
 - \$4 - \$10 for prescriptions
 - \$5 for a doctor visit
 - \$30 for non-emergency use of emergency room
- Groups include persons with incomes at 100% FPL and persons eligible under the MED program
 - Currently enjoined by Newton-Nations v. Rodgers, 316 F. Supp.2d 883 (D. Ariz. 2004).

AHCCCS Programs for Children

- AHCCCS programs for families with children under age 19:

- AHCCCS Care: 100% FPL

- Sixth Omnibus Budget Reconciliation Act (S.O.B.R.A) for children:

- Under age 1: 140% FPL
 - Ages 1-6: 133% FPL
 - Over 6: 100% of FPL

- KidsCare: 200% FPL
 - Medical Expense Deduction: spend down to 40% FPL
 - ALTCS: 300% of SSI amount
 - Youth Adult Transition Insurance (YATI) for children who turned age 18 in foster care: no income limit.

Other AHCCCS Programs

- Acute Care for Individuals
- Pregnant women
- Family Planning Services
- Medicare Cost Sharing
- SSI-Cash
- SSI-Medical Assistance Only
- SSDI-Temporary Medical Coverage
- Medical Expense Deduction (MED)
- Freedom to Work
- Breast and Cervical Cancer Treatment
- Federal Emergency Services (FES) for immigrants who do not meet immigration requirements for full service AHCCCS

AHCCCS Acute Care Services

- Routine services for illnesses and health conditions include:

- Physician services
- Prescription drugs
- Hospital services
- Durable Medical Equipment
- EPSDT services for children

- Physical, occupational and Speech therapy
- Mental health services
- Emergency care
- Pregnancy care
- Dialysis
- X-rays
- Lab work
- Organ transplants
- Surgery
- Medical transportation

ALTCS Covered Services

- All acute care services
- Mental health services
- EPSDT services for children
- Nursing home services
- Home health care services such as personal care, attendant care and case management
- ICF/MR (Intermediate care facility for the mentally retarded)

Covered Services Standard for Adults

- AHCCCS covered services for adults must be:
 - Medically Necessary
 - Cost-effective
 - Federally reimbursable
 - Non-experimental
 - A “covered service” under the State Plan
- Note: The standard for EPSTD services for children is broader than this standard.
 - See Ariz. Admin. Code, R9-22-201(B) and R9-22-213(A)(9)

Medically Necessary

- No federal definition

- State definition

- Medically necessary means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health condition or their progression, or to prolong life.

- Ariz. Admin. Code, R9-22-101(B).

Definition of Experimental

- Experimental
 - Services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless: The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.
 - See Ariz. Admin. Code, R9-22-101(B)

Definition of Standard of Care

- Standard of Care

- Means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.
- See Ariz. Admin. Code, R9-22-101(B)

Legal References for AHCCCS

Covered Services

- AHCCCS Acute Care Services
 - A.R.S. § 36-2907
 - Ariz. Admin. Code, R9-22-201 to 218
 - AHCCCS Policy Manual at www.ahcccs.az.state.us.
- ALTCS Long Term Care Services
 - A.R.S. § 36-2939
 - Ariz. Admin. Code, R9-28-201 to 206
 - AHCCCS Policy Manual at www.ahcccs.az.state.us.

Eligibility Requirements

Application Process

- The Department of Economic Security (DES) processes most Medicaid applications for children and families.
- AHCCCS processes applications for:
 - KidsCare
 - Long Term Care (ALTCS)
 - Medicare Cost Sharing
 - SSDI-Temporary Medical Coverage
 - SSI-MAO (aged, blind and disabled)

Applications

- AHCCCS universal application at www.ahcccs.state.az.us
 - Right to apply in-person, by mail or by fax
- DES joint application for Food Stamps, Cash Assistance and AHCCCS at www.azdes.gov
 - Decisions must be made within:
 - 7 days (hospital)
 - 20 days (pregnant)
 - 45 days (most)
 - 90 days (disability-related)
- E-applications at Federally Qualified Health Centers
 - Retroactive eligibility to 1st day of application month (except MED)

Application Process

- Interview
 - In-person, by phone or home visit
 - Can be waived
- Verification Process
 - Must provide proof of certain eligibility factors
 - Must be given 10 days to provide or help if requested
- Renewal Applications
 - Depending on program, must file a renewal application every 6 to 12 months

Basic Eligibility Requirements

- Arizona Resident
- Citizen or Qualified Immigrant (unless FES)
- Income Limit
- Resource Limit (ALTCS and MED)
- Provide or apply for a Social Security Number
- Age (some programs)
- Assignment of 3rd Party Coverage

ALTCS Eligibility Requirements

- Basic eligibility requirements +
 - Income limit is 3 x SSI amount (\$1911 month)
 - Parent's income is not attributed to child applicant
 - \$2000 resource limit, unless community spouse
 - Transfer of resource look-back period
- Pre-Admission Screening (PAS) Test
 - Must pass the PAS for nursing home and home health care
 - Medical, social and functional test components
 - Must be at risk of institutionalization

Arizona Residency and SSN

- Arizona Resident
 - Currently lives in Arizona and intends to remain in Arizona indefinitely
- Social Security Number
 - Only persons applying for AHCCCS must provide or apply for a SSN
- SSN used to verify information such as income
- Special rules for establishing a child's residency
 - Immigrants who cannot legally obtain a SSN are not required to provide one

Citizenship & Identity

- US Citizenship & Identity
 - Must document US citizenship and identity pursuant to recent change in federal law
- Examples:
 - Birth Certificate
 - Naturalization Certificate
 - U.S. Passport
 - Final Adoption Decree
 - Medical or school records
 - 3rd party affidavits (strict requirements)
- Four levels of acceptable documentation
 - (See AHCCCS handout on U.S. citizenship requirements)
- Exceptions:
 - Supplemental Security Income (SSI)
 - Social Security Disability Insurance
 - Social Security Retirement
 - Medicare
 - Foster Care
 - Adoption Subsidy

Qualified Immigrants

- To get full coverage AHCCCS benefits, immigrants must meet requirements at A.R.S. § 36-2903.03

- Qualified Immigrants

- Lawful Permanent Resident;
- Refugee or Asylee;
- Cuban & Haitian Entrant;
- VAWA (battered spouses and children);
- Persons granted withholding, conditional entrance, or parole;
- Indians; and

- Be designated as a member of an exception group pursuant to 8 U.S.C. § 1613(b); or
- Been a qualified immigrant for 5 years; or
- Been continuously living in the U.S. since before 8/22/96 (in any status including no immigration status)
- (See Handout for Qualified Immigrant Eligibility)

Due Process Requirements

Due Process

- Medicaid is an entitlement program protected by the Due Process Clause of the Constitution
 - Right to:
 - Notice of Adverse Action
 - Fair hearing (appeal)
- DES and AHCCCS are required to provide applicants and recipients with a written notice of denial, termination, or change in eligibility status or medical service
 - Continued benefits if appeal within 10 days
 - Retroactive eligibility or reimbursement of payment for services if wrongly denied

Other Due Process Rights

- Right to:
 - Expedited hearing in medical service cases
 - Be represented at the hearing
 - Reasonable accommodations & language interpreters
 - Review agency's evidence prior to hearing
 - Get copies of relevant documents
 - Get notice of hearing date, time and place
 - Present testimony, evidence and witnesses at hearing
 - Cross-examine agency's evidence and witnesses
 - Get timely, written decision with further appeal rights

Eligibility Appeals

- Right to Notice of Adverse Action
 - Agency must send a notice of adverse action to the applicant or recipient to deny or terminate Medicaid eligibility

- If DES denies or terminates eligibility, the DES Office of Appeals conducts hearing using the hearing rules applicable to the Cash Assistance program. Ariz. Admin. Code, R9-22-1441 and R6-12-1001 *et seq.*

- Eligibility Appeals

- File appeal with agency that made written decision within 30 days of agency's Notice of Adverse Action

- If AHCCCS denies or terminates eligibility, the Office of Administrative Hearings (OAH) conducts the hearing. Ariz. Admin. Code, R9-34-101 *et seq.*

Medical Services Appeals

- Medical Service Appeals
 - Appeal medical service denial or termination with Health Plan within 60 days of notice of adverse action
 - If AHCCCS Health Plan denies appeal, file written appeal for AHCCCS hearing within 30 days of decision
- Office of Administrative Hearings (OAH) conducts the hearing
 - The OAH Administrative Law Judge (ALJ) sends a recommended decision to the AHCCCS Director
 - The AHCCCS Director sends final decision to the petitioner affirming, modifying, or rejecting the OAH ALJ's recommended decision within 90 days of the request for hearing
- See chart entitled AHCCCS/ALTCS Service Appeal Process Flow Chart

Establishing Medical Necessity

- A physician's letter may be needed to support a request for a medical service or an appeal
- Physician's letter of medical necessity should include:
 - Health care professional's relationship with patient
 - Exact diagnosis and duration of medical condition
 - Functional limitations and abilities (if applicable)

- Description of prescribed service or item
- Reason requested service is medically necessary (using appropriate adult or EPSDT child standard)
- How service will help patient function independently
- Limitations or health problems if service is not provided
- Explanation any other rationale that supports service request, i.e. cost effective, no alternate treatment.

Further Appeal

- Superior Court Review
 - Can request review of AHCCCS final administrative decision in Superior Court pursuant to A.R.S. §12-901 et seq.
- Section 1983 Action
 - Can go directly to court and sue to enforce provisions of the Medicaid Act pursuant to 42 U.S.C. § 1983
 - Exhaustion of administrative remedies usually not required
 - To be enforceable, Medicaid provision must intend to benefit the beneficiary, written with sufficient clarity, and create binding obligation on the state

Legal References for Appeals

- Federal Statute
 - 42 U.S.C. § 1396a(a)(3)
 - DES
 - Ariz. Admin. Code, R6-12-1001 *et seq.*
- Federal Regulations
 - 42 C.F.R. §§ 431.200 and 438.400 *et seq.*
 - AHCCCS
 - Ariz. Admin. Code, R9-34-101 *et seq.*
- State Statute
 - A.R.S. § 41-1092 *et seq.*
 - Office of Administrative Appeals (OAH)
 - Ariz. Admin. Code, R9-34-101 *et seq.*

Advocacy Tips for Parents

- File an application
- Follow up with the agency that is handling your application
- Follow up when your case is referred to another agency
- Keep good records
- Take good notes of who you talk to at the agencies, with dates
- Give agencies the information they ask for by the deadline or ask the agency for help or more time before the deadline
- Keep copies of the documents you give to the agencies
- On your copy, write the date and name of the person or agency that you gave the information to
- Keep notices, decisions and other documents you get from the agencies
- Read the agencies' notices and documents carefully for deadlines
- Call Legal Aid for advice or help with dealing with the agencies

Tips for Advocates

- Ask every client if everyone in their household has health insurance
- If no, download an application to apply right away
- Explain what to expect during the application process
- Emphasize the importance of meeting deadlines to provide information or file appeals
- Explain the consequences of missing a deadline
- If the last application was denied, ask for the denial date, if it was appealed and if a hearing is scheduled
- If client does not know, call the agency or appeals office to find out right away
- If not appealed, decide if the appeal can be filed in a timely manner or if there is a “good cause” reason to file it late
- File an appeal with the agency that made the decision, if meritorious
- Explain the appeal process and your role in the appeal to the client
- If it cannot be appealed, have the client file a new application, if appropriate