

EPSDT Screening Requests

The Magistrate's recommendation relies on his interpretation of 42 U.S.C. § 1396a(a)(43)(B), the requirement that states screen EPSDT-eligible children to determine whether they need treatment and what treatment they needed. He found that the Plaintiffs had not stated a claim because they "fail[ed] to request the screening" that precedes the State's obligation to provide treatment. Magistrate Judge's Report and Recommendations, Docket No. 55, at 10.² According to the plain language of the statute, this screening obligation is incumbent upon a state only when it is requested. However, a child's visit to a medical professional to address a behavioral problem is in fact a screening encounter related to that behavioral problem. The family need not use the term "EPSDT screen" when requesting such services. Rather, as both the federal and state agencies administering the Medicaid Act have made clear, any such visit or contact with a qualified medical professional is sufficient to satisfy EPSDT's screening requirement. Plaintiffs have pled that they presented themselves to medical professionals and received mental health services. *See* Complaint ¶¶ 45-46 (J.B. was in custody of the Department of Mental Health at the time the Complaint was filed and had an intake interview at the state's treatment facility, including an examination by a physician), ¶53 (L.P. entered a state hospital and was transferred to a secure treatment facility), ¶55-57 (L.M. was hospitalized for mental health treatment and committed to the state hospital for five months), and ¶61 (L.S. received limited outpatient counseling and medication management). These contacts with medical professionals constitute screenings for the purposes of EPSDT.

The Department of Health and Human Services' regulations define screenings as "regularly scheduled examinations and evaluations of the general physical and mental health,

² To the extent that the Court finds that alleging a request for a screening is necessary to state a claim under EPSDT, that could easily be rectified with the filing of an amended complaint.

growth, development, and nutritional status of infants, children, and youth.” 42 C.F.R. § 441.56(b)(2001). Guidance from the Centers for Medicare and Medicaid Services (“CMS”), the federal agency charged with administering the Medicaid Act, indicates that EPSDT screening requests need not be different than other interactions with medical providers. In 2001, CMS explained, “[W]e have long considered any encounter with a health care professional practicing within the scope of his/her practice [to be] inter-periodic screening.” CMS Letter to State Medicaid Directors #01-006, 11 (Jan. 10, 2001) (attached as Exhibit 1).³ Similarly, the State of Mississippi has created both a periodic schedule for EPSDT screening, and it has also identified visits to the doctor other than for periodic screens as “interperiodic screens.” See Mississippi Division of Medicaid, MS Cool Kids FAQs, available at: https://msmedicaid.acs-inc.com/msenvision/AMA_ADA_licenseAgreement.do?strUrl=MS%20Cool%20Kids%28EPSDT%29&method=accept. Thus, both the federal government and the State of Mississippi recognize that when a Medicaid eligible child visits his or her medical professional seeking guidance and treatment, the encounter qualifies as a request for an EPSDT screening.⁴

Conclusion

A screening under EPSDT need not be a formal event separate from a child’s normal assessment and treatment interactions with his or her medical providers. To the extent that the Magistrate’s recent recommendations rely on an interpretation of the Medicaid Act that would

³ Courts have afforded CMS’ interpretations of the Medicaid Act respectful consideration because of the authority delegated to the Secretary of the Department of Health and Human Services under the Act and because of the agency’s expertise. *Katie A. v. Bonta*, 481 F. 3d 1150, 1154-55 n. 11 (9th Cir. 2007); see also *S.D. v. Hood*, 391 F.3d 581, 590 n.6 (5th Cir. 2004); *Wis. Dep’t of Health & Family Servs. v. Blumer*, 534 U.S. 473, 497 (2002).

⁴ The State’s argument in its Motion to Dismiss rested on the premise that Plaintiffs must provide a “particularized allegation that there is any particular corrective treatment, any particular services that these individuals think they are entitled to that Medicaid hasn’t provided or has not provided for.” (H. Pizzetta, Motion Hearing Transcript, August 19, 2011, p. 14). However, as the Magistrate correctly held, EPSDT does not require that Plaintiffs identify the particular service necessary to treat their condition, only that the State “arrange for corrective treatment of conditions discovered through the screening provided under Subsection (43)(B).” Report and Recommendations, p. 6.

require a parent or caretaker to make a formal request for an “EPSDT screening,” the recommendations should be rejected. Any visit to a medical provider seeking a Medicaid diagnosis and/or treatment would necessarily include a screening as to the condition identified and would qualify the child for medically necessary EPSDT services necessary to address that condition.

Dated: September 6, 2013

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on September 6, 2013, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all parties.

/s/ Ryan Wilson



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
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SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at <http://www.hcfa.gov/medicaid/olmstead/olmshome.htm>.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

Attachment 4-B “EPSDT and HCBS waivers”

State Medicaid Director – 2

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Attachment 4-A

Subject: Allowable Limits and State Options in HCBS Waivers

Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?
2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?
3. ***Access to Services Within a Waiver:*** May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?
4. ***Sufficiency of Amount, Duration, and Scope of Services:*** What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?
5. ***Amendments that Lower the Potential Number of Participants:*** May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?
6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statutes, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

Avoiding or Minimizing Adverse Effects on Current Participants: Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- ❖ The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.
- ❖ The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.
- ❖ The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- ❖ The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B

Subject: EPSDT and HCBS Waivers

Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.
- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.