Role of Medicaid in Pediatric Cochlear Implantation

Donna L. Sorkin, Executive Director
American Cochlear Implant Alliance
Disclosure Statement

I have no conflict of interest in relation to this presentation
Medicaid Overview

• Health care for persons of all ages whose income and resources are insufficient to pay for healthcare
• Medicaid created in 1965 as part of *War on Poverty* programs / Expanded in 1967
• Joint program, funded primarily by federal government and carried out at state level (Av Federal contribution=63% in FY2016)
• CI coverage specifics determined by each state and they do vary
Optional vs. Mandatory Services

- Original law listed Mandatory services: hospital (in and outpatient), physician services, birthing centers, federally qualified health centers

- Optional: Everything else including prescription drugs; PT; prosthetics; hospice; eyeglasses; dental; speech, hearing & language disorder services; respiratory care for ventilator dependent individuals (not an exhaustive list)

- States may offer optional services to populations that they are not required to cover
State Medicaid Policies Affect CI Access and Nature of Services

• Adults (whether or not they are covered)
• Children (candidacy and aftercare rules)
• Providers (especially when reimbursement is extremely low)
Children, Cochlear Implants, Medicaid
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

• EPSDT services were part of a broad effort to comprehensively address children’s healthcare
• Added to original Medicaid Act of 1965 (1967)
• Special needs of low income children at risk for conditions that could impose lifelong disabilities
• Looked beyond adult treatments—*issues that impact on growth and development of children*
• Hearing services including CI covered everywhere at present
Study Method

- CI center audiologists sent Survey Monkey in May 2017
- Focus on Medicaid and CI at their center
- Responses from CI centers in 35 states / 36 centers responded on pediatric CI
- Respondents from all regions, diversity of clinics (university, private practice, hospital based), varying program size
- Collected # surgeries for 2 years (2015, 2016)
- Asked about access challenges under Medicaid
States Participating in Survey n=35
Pediatric Medicaid % by CI Clinic n=36
Mean % Medicaid by Clinic=55% / Median=59%
Access Challenge #1: Low Reimbursement

- Majority identified reimbursement well below cost. Low reimbursement for entire continuum of care: surgery, device, programming, (re)habilitation, equipment replacement
- Threatens viability of clinics
- One center indicated they sometimes are given nothing on invoice
“We do not accept Medicaid because reimbursement is so poor”
Access Challenges: #2 Equipment Replacement/Upgrades

- No upgrade of processor if still working
  - Many state Medicaid agencies won’t upgrade unless lost, broken and obsolete, or stolen
  - If lost multiple times, won’t replace
- Some approve upgrade if equipment is 5 years+
- May require that recipient shows improvement with new equipment
- Prior approval required & can take time, leaving kids “off the air” if device is broken
- Parts reimbursement sometimes difficult, particularly if multiple replacements
Access Concern #3: Gaining Authorization

• Noted by 10 respondents as burdensome process that can interfere with service delivery and takes time away from clinical care

• Pre-authorization for therapy and equipment noted as sometimes taking > three months
Access Challenge #4: Medicaid Managed Care

- Hospital must be a provider for the particular MCO—finding a clinic that is a provider may make travel restrictive for Medicaid family
- Greater restrictions on aftercare (# of sessions for programming, (re)habilitation), not covering adults for rehabilitation, equipment replacement even worse than regular Medicaid
- States are encouraging managed care
Therapy Caps Initially Mentioned

- Upon direct review of Medicaid rules, few cases of caps
- One clinic was able to reverse a restrictive cap in their state by meeting with Medicaid
- You can change Medicaid rules
Other Access Challenges Noted

• Not covering adults who have been implanted as children and now don't have access to services (even those still in school)
• No coverage for teletherapy
• Simultaneous bilaterals “allowed” but Medicaid only reimburses for one implant
• Pre-authorization for therapy required every 90 days; time-consuming and can result in service lapses
You can change Medicaid

- ACI Alliance held discussions with CMS officials and with Congressional staff about access concerns
- State Champions and others have contacted their state Medicaid and share their concerns
- Reimbursement is harder but it can be improved
- We can bring specific concerns to CMS which can be discussed with Medicaid personnel during state reviews

http://www.acialliance.org/page/StateCommittees