EPSDT: Guaranteeing Comprehensive Pediatric Benefits for over 50 Years

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Health Policy Office

Colorado Department of Health Care Policy and Financing

EPSDT

- What is EPSDT and how does it work?
- EPSDT Components
  - Screenings
  - Diagnostic services
  - Treatment services
- Medical Necessity and scope of services
- Required services to support access
- Data from this past fiscal year

Our Mission:

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Part One: EPSDT

What is it and how does it work?

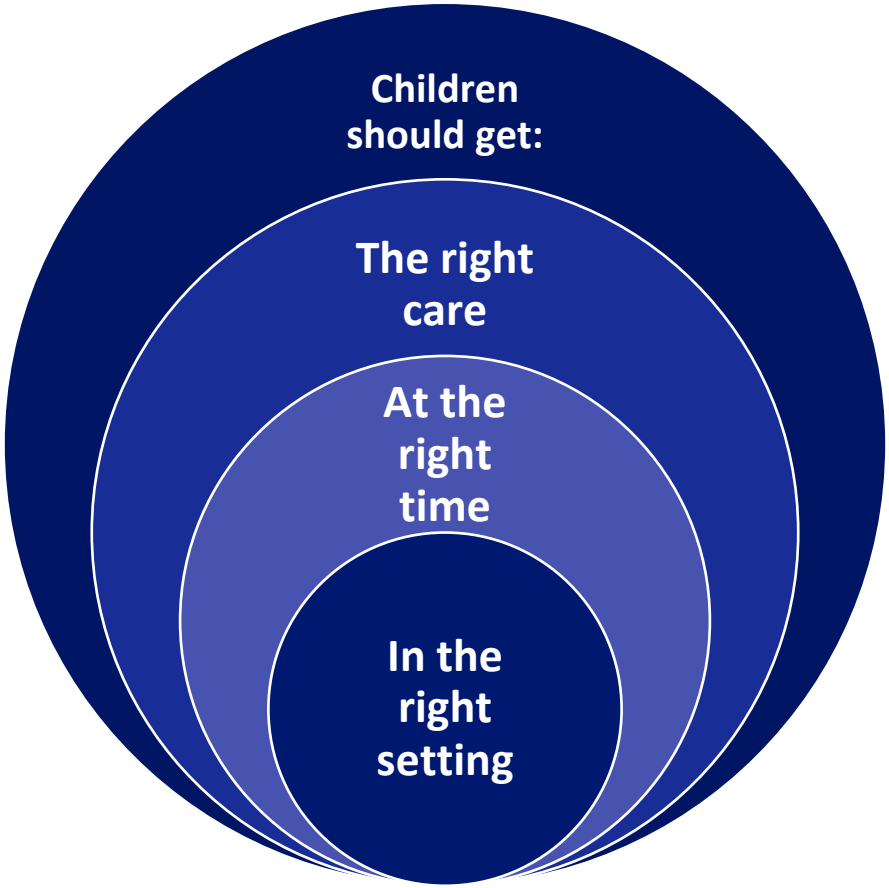
EPSDT Definition

EPSDT is the **Early** and **Periodic** **Screening**, **Diagnostic**, and **Treatment** benefit for individuals under 21 who are enrolled in Medicaid

- ✓ **Early**: Assessing and identifying problems as early as possible
- ✓ **Periodic**: Checking children's health at periodic, age-appropriate intervals
- ✓ **Screening**: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- ✓ **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified
- ✓ **Treatment**: Control, correct or reduce health problems found

EPSDT Design and Philosophy

- Federal EPSDT law under the Social Security Act:
  - Requires the delivery of comprehensive pediatric healthcare services to all Medicaid-enrolled children and youth under 21
  - Provides comprehensive array of prevention, diagnostic, and treatment services as specified in Section 1905(r) of the Social Security Act
- Covered benefits for children are more robust than Medicaid benefit for adults;
  - screenings, coverage requirements, and definition of medical necessity are unique to children
- EPSDT is designed so that children and youth under 21 receive early detection and medically necessary care to help them grow up as healthy as possible.



EPSDT is a Federally Guaranteed Benefit Package

Early and Periodic Screenings

- Comprehensive health and developmental screenings
- Physical exams
- Vision and hearing tests
- Immunizations
- Lab tests
- Dental screenings and referrals
- Health education

Diagnostic Services

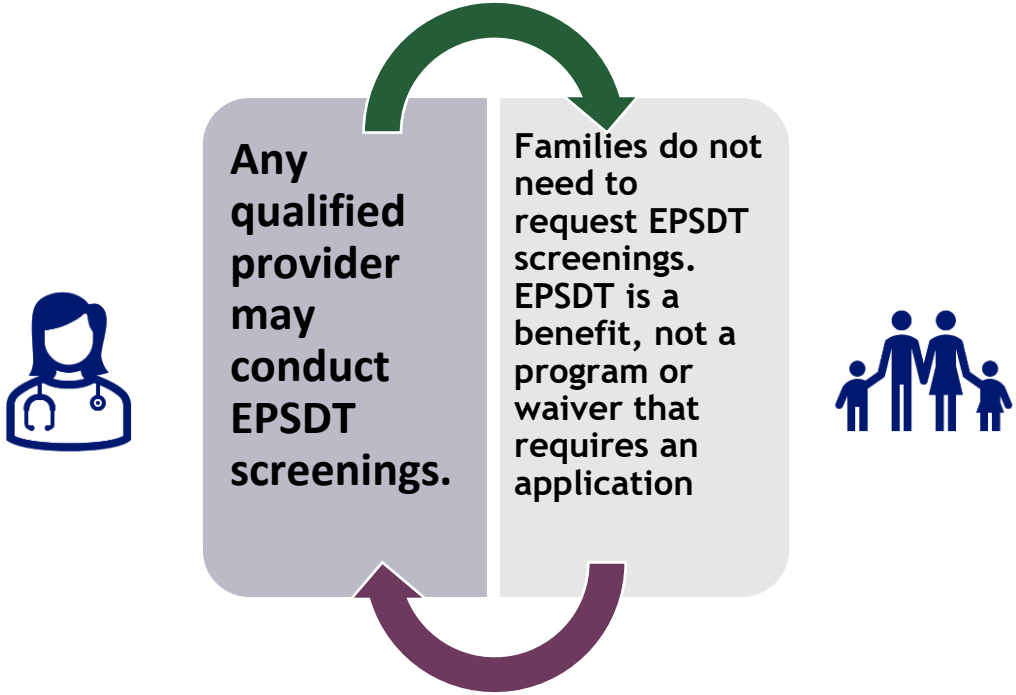
- Medically necessary diagnostic services when a risk is identified
- Follow-up testing
- Psychosocial/behavioral assessment, including depression, alcohol, tobacco or drug screenings
- Referrals

Treatment Services

- Timely treatment services determined by screenings
- Medically necessary services to correct or ameliorate defects and address physical and behavioral health conditions

EPSDT Screenings

States must provide or arrange for EPSDT screening services both at established times (periodic) and on an as-needed (inter-periodic) basis to identify health and developmental issues as early as possible. Screenings may be provided in a variety of settings such as providers offices, school health clinics or community health centers.



EPSDT Diagnostic Services

- When a screening identifies a risk, the child must be promptly referred for diagnostic services

- A screening service provided before a child enrolls in Medicaid is sufficient to trigger EPSDT coverage after enrollment, for follow-up diagnostic services and necessary treatment

The Periodicity Schedule

The periodicity schedule sets the frequency by which screening services are provided and covered, it provides preventive care that consists of AAP schedule of well-visits, vaccines, developmental and sensory testing.

Periodic screenings may not require prior authorization

Colorado's EPSDT Periodicity Schedule

Age:	Days		Months										Years																	
	New born	3-5	1	2	4	6	9	12	15	18	24	30	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
History, Measurement, Physical Exam, Lab Tests, and Anticipatory Guidance, etc.	*Follow the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care*																													
Mandatory Blood Lead Test								★			★		*Between 36 and 72 months*																	
Immunizations	*Follow American Committee on Immunization Practices (ACIP) for immunizations*																													
Vision Screen													★	★	★	★		★		★		★			★			★		
Hearing Screen	★													★	★	★		★		★										
Psychosocial/Behavioral Assessment	*Follow the AAP Recommendations for Preventive Pediatric Health Care*																													
Developmental Testing							★			★	★	★																		
Refer to Dental Home/ Assess Oral Risks								★			★	★	*Refer to dental services by age 1 Provide dental exams every 6 months*																	

When are Dental Services Required?

Dental periodicity Is different than a medical periodicity schedule.

States must consult with dental organizations involved in child health care.

CMS encourages consistency with the American Academy of Pediatric Dentistry's recommended schedule.

Inter-Periodic Screenings

Inter-periodic screenings are outside of the State's periodicity schedule and are conducted based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled (periodic) screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services

Inter-periodic Screening Requirements:

- May not be limited in number nor require prior authorization
- Any qualified provider operating within the scope of practice, as defined by state law, can provide a screening service
- Medical necessity of inter-periodic screening may be determined by child's physician, dentist, health, developmental, or educational professional who comes in contact with the child

Example of Inter-Periodic Screening

Age 6

- Child receives regularly scheduled periodic vision screening, at which no issue is detected

Age 7

- School nurse suspects child has vision issue and recommends the child see an optometrist**. Child receives inter-periodic vision screening**

Age 8

- Child receives next regularly scheduled vision screening

Scope of Services Covered by EPSDT

- EPSDT covers all medically necessary services included within any category of Medicaid services listed in Section 1905(a) and is not limited to services included in the Colorado Medicaid State Plan
- Services must be deemed effective to correct or ameliorate a diagnosed condition
- States are not required to do so, but Colorado Medicaid has opted to cover experimental services for individuals under 21 if it is determined that it would be effective to correct or ameliorate a child's condition. (ie We may not cover the experimental drug, but we can cover other services around the trial.)
- These requests will be reviewed on a case-by-case basis
- If the analysis results in a full or partial denial, the reviewer must conduct a secondary review applying the EPSDT correct or ameliorate standard

Medical Necessity Standards Under EPSDT

- Services or devices that are medically necessary to correct or ameliorate a physical or mental condition must be provided, even if the service is not covered by the Medicaid State Plan
- Medical necessity is different under EPSDT compared to the regular Medicaid definition of medical necessity. EPSDT's medical necessity standard is whether the service corrects or ameliorates a condition
- If application of the standard medical necessity criteria results in a denial, in whole or in part, for an individual under 21, then a secondary, individualized review must be done applying the correct or ameliorate standard
- Medical necessity must be determined on a case-by-case individual basis and must fully consider EPSDT criteria
- HCPF and its contracted vendors may require prior authorization in order to safeguard against unnecessary use of services
- Prior authorization cannot delay or deny medically necessary services
- Hard or fixed limits may not be imposed

In Other Words…

- ✓ The service or item is a reasonable, appropriate, and effective method for meeting the client's medical need;
- ✓ The expected use is in accordance with current medical standards or practices (clinical guidelines exist);
- ✓ It is cost effective; and
- ✓ It provides for a safe environment or situation for the client

Medical Necessity does not take the place of clinical guidelines or evidence-based medicine. A single provider cannot write an order and override the lack of evidence-based medicine.

Medical Necessity Is NOT Demonstrated for an Item or Service That:

Is experimental or investigational

Is primarily to enhance the personal comfort of the member

Is primarily for the convenience of the member or the members' caretaker

Has not shown it could help the member

Behavioral Health Services

Medicaid is required to cover services that are in our State Plan. The term "Behavioral Health" includes both mental health (MH) and substance use disorder (SUD) services. Behavioral Health services included in the State Plan include:

- MH Inpatient Services (psychiatric hospitalization)
- SUD Inpatient and Residential
- Outpatient Services
  - Emergency/Crisis Services
  - Physician services (medication management)
  - Individual, Group, Family therapy
  - Pharmacy
  - Day Treatment/Partial Hospitalization (PHP)
  - SUD screening, monitoring, Medication Assisted Treatment (MAT) services
  - Targeted Case Management (TCM)
  - School-based BH services

Behavioral Health Waiver Services

Because Colorado has a 1915(b)(3) waiver, we are allowed to provide additional ("B3" or "alternative") services that significantly expand the BH services we provide to members. B3 services that are covered include:

- Prevention/Early Intervention
- Respite Care
- Intensive Case Management
- Clubhouse and Drop-In Services
- Recovery Services - services provided by peers
- Vocational Services - job training, and support obtaining and maintaining employment
- Assertive Community Treatment (ACT)
- MH Residential Services - 24-hour services not provided in a hospital

Special Considerations for Justice Involved Members

- Medically necessary court ordered services are covered by Medicaid. Other payment sources are needed for services that are not deemed medically necessary.

Crisis Services

Colorado has been building out a full crisis continuum over the last several years.

The Behavioral Health Administration (BHA) has some funding and piloting of programs.

- Colorado Crisis Hotline
- Mobile Crisis Response (MCR) and Behavioral Health Secure Transport (BHST) as covered benefits

Inpatient Psychiatric Care Under 21

- Regulations at 42 CFR 440.160 and 42 CFR 441.150
  - Optional benefit but covered by Colorado.

- Services are provided in psychiatric hospitals or psychiatric units in a hospital, or psychiatric facilities

- Many states provide psych under 21 service through psychiatric residential treatment facilities (PRTFs).
  - PRTF programs are designed to offer a short term, intense, focused mental health treatment program to promote a successful return of the youth to the community.

Just Ask!

Providers who feel a service or item is medically necessary can and should ask for that service even if it is not listed as a covered services – this is possible because of the EPSDT program!

Follow the direction on the ColoradoPAR website for how to make an EPSDT request or ask the RAE how to wrap services around to the appropriate payer (DentaQuest, Magellan etc)

What is EPSDT?

EPSDT is Medicaid

No separate eligibility

No application

No separate release of information

Not a separate funding source

Part Two: EPSDT Outreach

When is it required and what do we do?

Required Outreach and Communications

Colorado is required to inform families about the EPSDT benefit and how to access care – within 60 days of eligibility determination

The Social Security Act (§ 1902(a)(43)) requires that the State plan for medical assistance provide for:

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(r) and the need for age-appropriate immunizations against vaccine- preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment, the need for which is disclosed by such child health screening services.

Required Services to Support Access

Scheduling Assistance for Appointments	If a family requests help with scheduling appointments for EPSDT services, Medicaid managed care plans must provide this assistance via case managers or other members of the care team.
Necessary Transportation to and from Appointment	Emergency, urgent, and non-emergency medical transportation (NEMT) to ensure that members have access to and from providers of EPSDT services. A parent/guardian can transport members to their Medicaid covered services and receive gas and/or mileage reimbursement.
Related Travel Expenses	The cost of meals and lodging for the member and a parent/guardian/caretaker/relative/friend/attendant to and from medical care and while the member is receiving medical care.
Language Assistance Services for Individuals with Limited English Proficiency	**States must offer services to promote access to preventive, screening, diagnostic, and treatment services.**

Key Takeaways

EPSDT is the benefit package for Medicaid-enrolled children and youth under 21

The benefit covers periodic and inter- periodic screening, diagnosis and treatment services

Under EPSDT, all medically necessary services that correct or ameliorate a condition, even those not included in the State Plan, must be covered by Medicaid

The EPSDT definition of medical necessity and the coverage requirements are unique to children and youth under 21

Part Three:

EPSDT and Waivers

What are Home and Community Based Services waivers and how does EPSDT fit in?

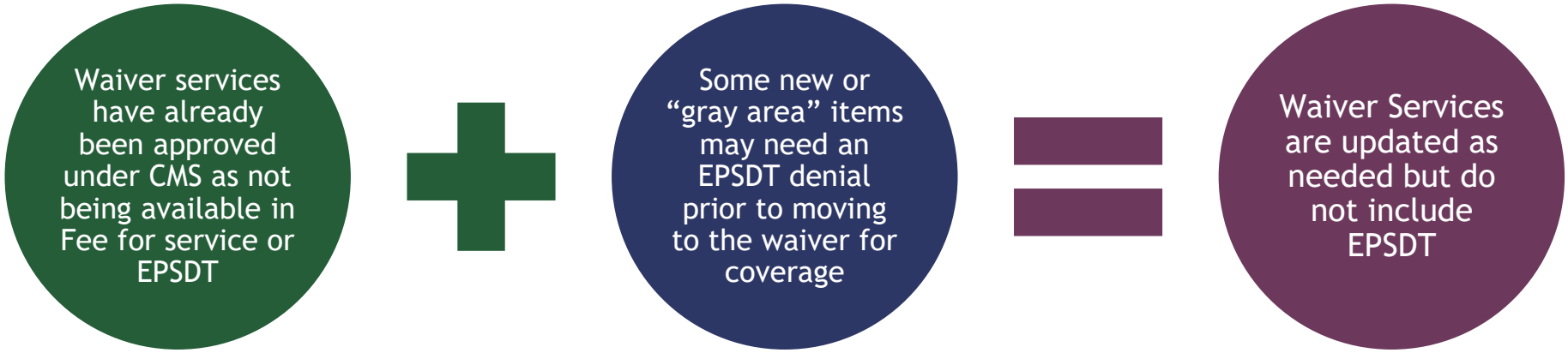
EPSDT and HCBS Waivers

- Children covered in Home and Community Based Services waivers under Section 1915 (c) are still covered under the state Medicaid plan and entitled to the EPSDT benefit.

- HCBS waivers are the primary vehicle used by states to offer non-institutional services to individuals with significant disabilities.

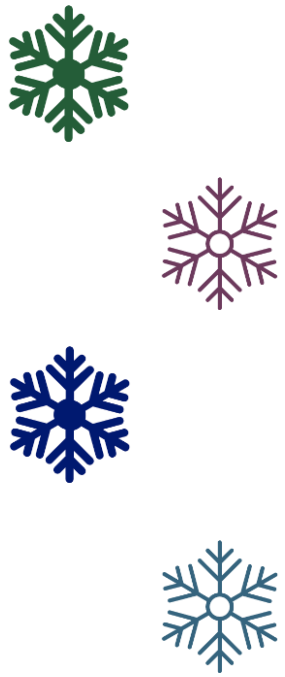
- To be enrolled, individuals must meet an institutional level of care.

Is EPSDT Available as a Part of Waiver Services?



Relationship of HCBS Waiver Services to EPSDT and State Plan Services

- If a service is available to a child under the State plan or could be furnished as an EPSDT benefit under the provisions of §1905(r), it **may not** be covered as a waiver service for child waiver participants.
  - Provider qualifications and the exact nature of the service (service definition) can differ from the State plan service
- Waiver services cannot duplicate a State plan service!



Part Four:

EPSDT and Child Welfare

What are Home and Community Based Services waivers and how does EPSDT fit in?

Child Welfare and EPSDT

Volume 7 – specifically requires counties to follow EPSDT periodicity schedule

Bright Futures has a separate periodicity schedule for children who are in out of home placement

- Testing, well care, etc. can be provided as often as medically necessary.
- Medicaid will not deny a well child visit because one was completed 3 months ago.

EPSDT and DHS

"14.5.7.1.5.1. The Contractor shall not be financially responsible for covering residential treatment services for children and youth in the custody of the Colorado Department of Human Services—Division of Child Welfare or the Division of Youth Corrections who are placed by those agencies into either a Psychiatric Residential Treatment Facility (as defined in C.R.S. 25.5-4-103) or a Residential Child Care Facility (as defined in C.R.S. 26-6-102)."

This **doesn't** say that the county pays for all services....it should be wrapped to Waivers, FFS or EPSDT if there is a medical need and not a placement need.

RAEs and Child Welfare

- RAEs are the primary care coordination team for these youth, even when out of state or when there is a CMA or County DHS office involved.
- Parties can divvy up coordination work but its not the counties or CMA responsibility to complete and carry out a discharge plan
- RAEs may need to prior authorize services or arrange wrap around services prior to or at discharge.

Payment of Services While Out of State

Medicaid does not cover services across state lines. However, if a Health First Colorado member is temporarily out of the state but still a resident of Colorado, they may receive some Health First Colorado (Colorado's Medicaid Program) benefits under three conditions:

- It is a medical emergency.
- Health would be endangered if they were required to return to Colorado for the medical care/treatment.
- The treating health care provider enrolls in the Health First Colorado program.

What Happens When Child Welfare Is Involved?

- If all three conditions are not met for out of state treatment, the services will not be covered.
- Any child leaving the state should look for a contracted provider in the area they are visiting and use that provider if at all possible.
- If a child is placed out of state, the county should look at ICAMA or other CDHS programs for local coverage.

Remember…

- A required component of a properly requested service is the requestor's rationale for medical necessity by EPSDT standards.
- Documentation that the service is standard of medical care, safe and evidence-based treatment for the child and his/her unique medical conditions must accompany the request.
- It is the responsibility of the ordering practitioner to provide documentation for medical necessity per EPSDT criteria.

What to Do With a Denied Claim

If the denial is for not being medically necessary, follow the appeal process through the RAE and to the State Administrative Law Judge

If the denial is for not being a covered benefit or covered service, wrap the request around to Health First Colorado as a payer

Notice of Decision

- The notice must reflect that a Secondary Review was done using the EPSDT correct or ameliorate standard and explain how it was applied to the facts
- "Show your work"
- If a service is being denied or partially denied, the notice must explain the service is:
  - Not a covered service under 1905(a) of the Act, or
  - It is a covered service under 1905(a) but is not medically necessary and why it is not medically necessary for the individual
- This includes addressing any opinion submitted by a treating physician or other medical evidence submitted by the individual

Appeal of Service Denial

- If an EPSDT covered child is denied a treatment service, an appeal can be made through the state Medicaid agency's fair hearing process, as described in the state plan.
- If the child is enrolled in a managed care plan, the first line of appeal is through the managed care plan.
- If the child was denied services by a RAE, the first line of appeal is through the RAE.
- A notice of denial will include:
  - ✓ Reason for denial
  - ✓ Right to file an appeal and request a state fair hearing, if applicable
  - ✓ Procedures for appeal
  - ✓ Expedited resolution, if appropriate
  - ✓ Right to continuation of benefits pending resolution of appeal.

Part Five:

EPSDT Monitoring

What does the data show?

CMS-416 Form: Assessing Children's Utilization of EPSDT Services

- To assess the effectiveness of each state's EPSDT benefit, the Federal Centers for Medicare and Medicaid Services (CMS) collects children's enrollment and utilization data from each state Medicaid program through the CMS-416 Form

- HCPF submits a completed CMS-416 Form to CMS on an annual basis.

- Each managed care organization submits an annual report to HCPF, which are used to monitor and track their EPSDT performance.

Data Definitions

The following data definitions are drawn from *Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report*

Effective for the reporting period federal fiscal year 2023 (October 1, 2022 through September 30, 2023)

Which can be found at this link: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Data Definitions [1]

- EPSDT Eligible vs 90 continuous day eligibility. Members can be eligible within the year but cycle on and off.

- Expected Screenings are the number of screenings on the periodicity schedule for that age range multiplied by the number of members in that are eligible.

Data Definitions Cont.

- Screening ratio is defined as the number of initial and periodic screening services received out of the number of expected services.
- Participant ratio is defined as the number of children eligible for any initial and periodic screenings who received at least one screening
- Blood lead test is defined as the percentage of children ages 0-5 receiving a blood lead test of kids eligible for blood lead tests

Data Definitions Cont.[2]

- Total Eligibles Receiving Any Dental Services is at least one dental service by or under the supervision of a dentist. Defined by a code set on all types of claims.

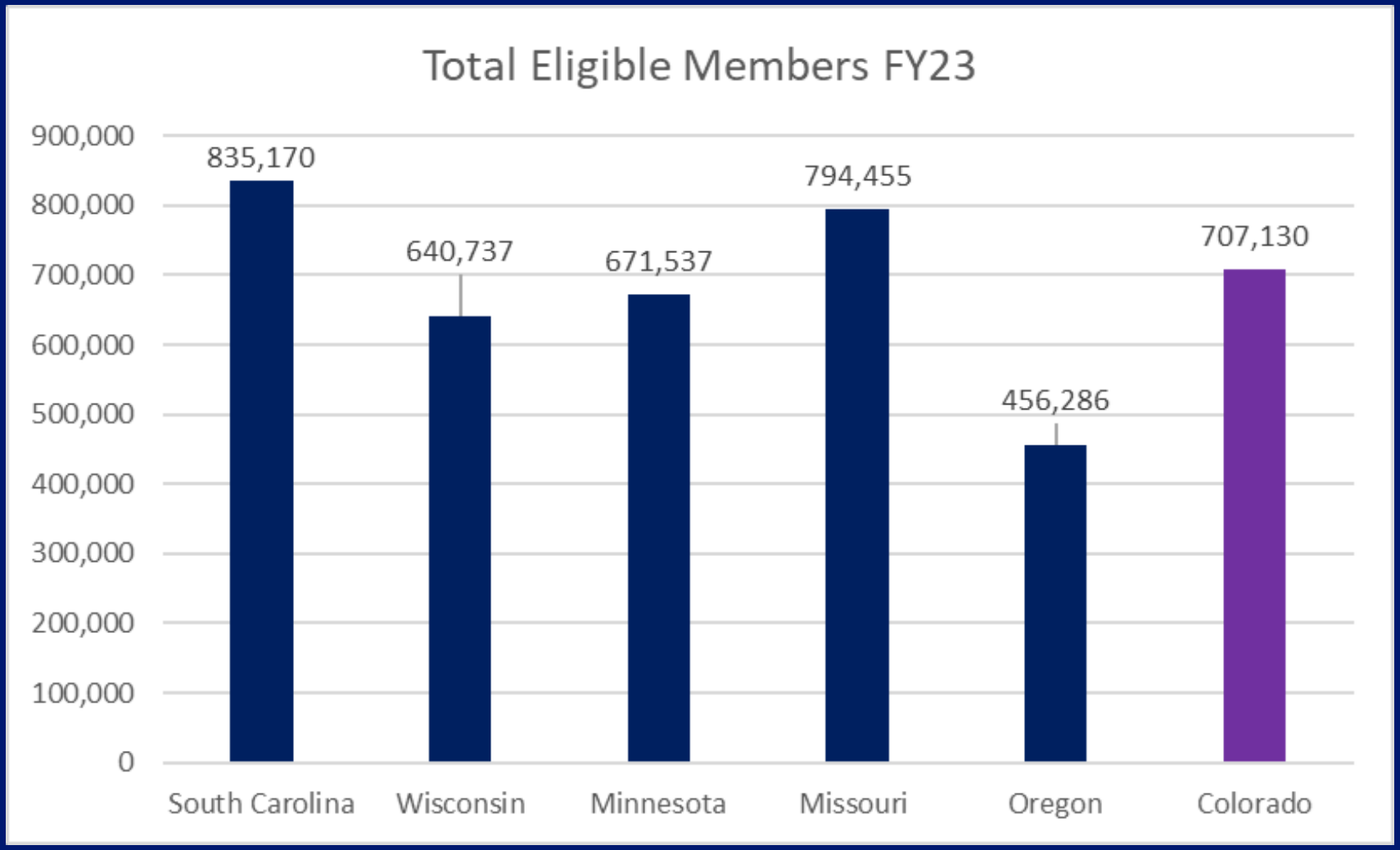
- Total Eligibles Receiving Any Preventive Dental or Oral Health Service is either a preventive dental service by or under the supervision of a dentist **or** a preventive oral health service by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist.

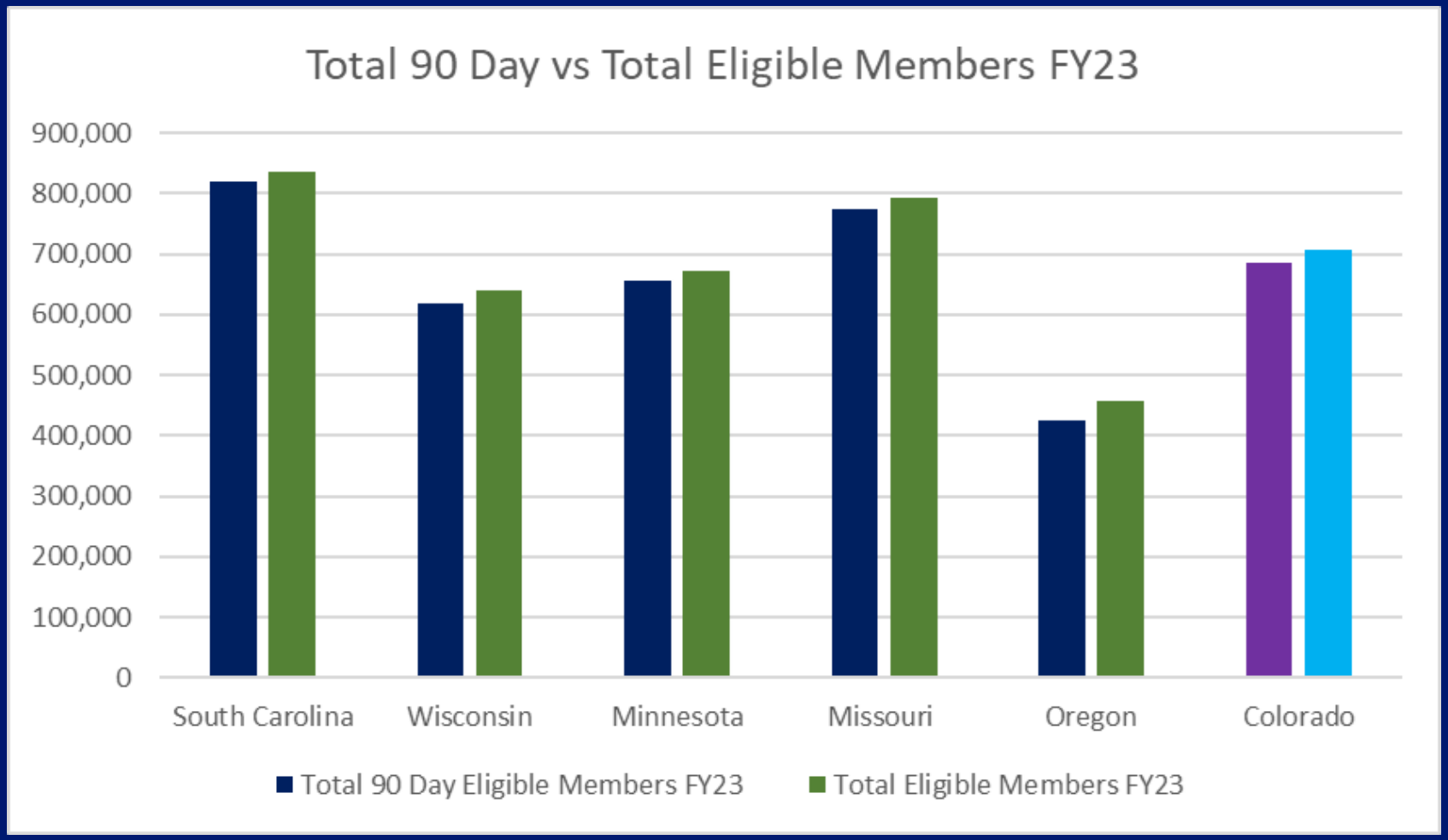
Comparison Criteria

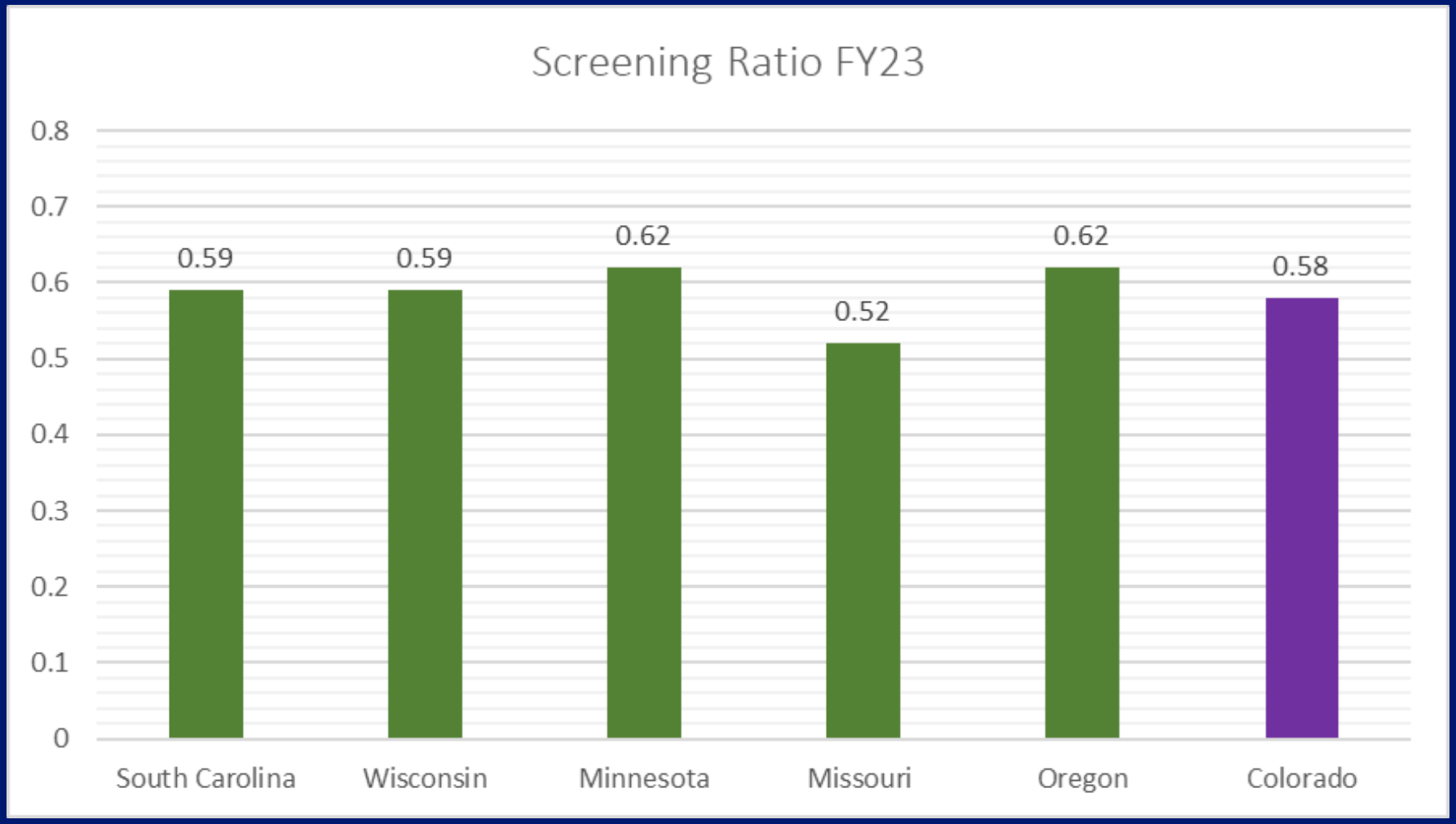
- Similar population size
- Similar Medicaid enrollment size
- Similar total Medicaid spending

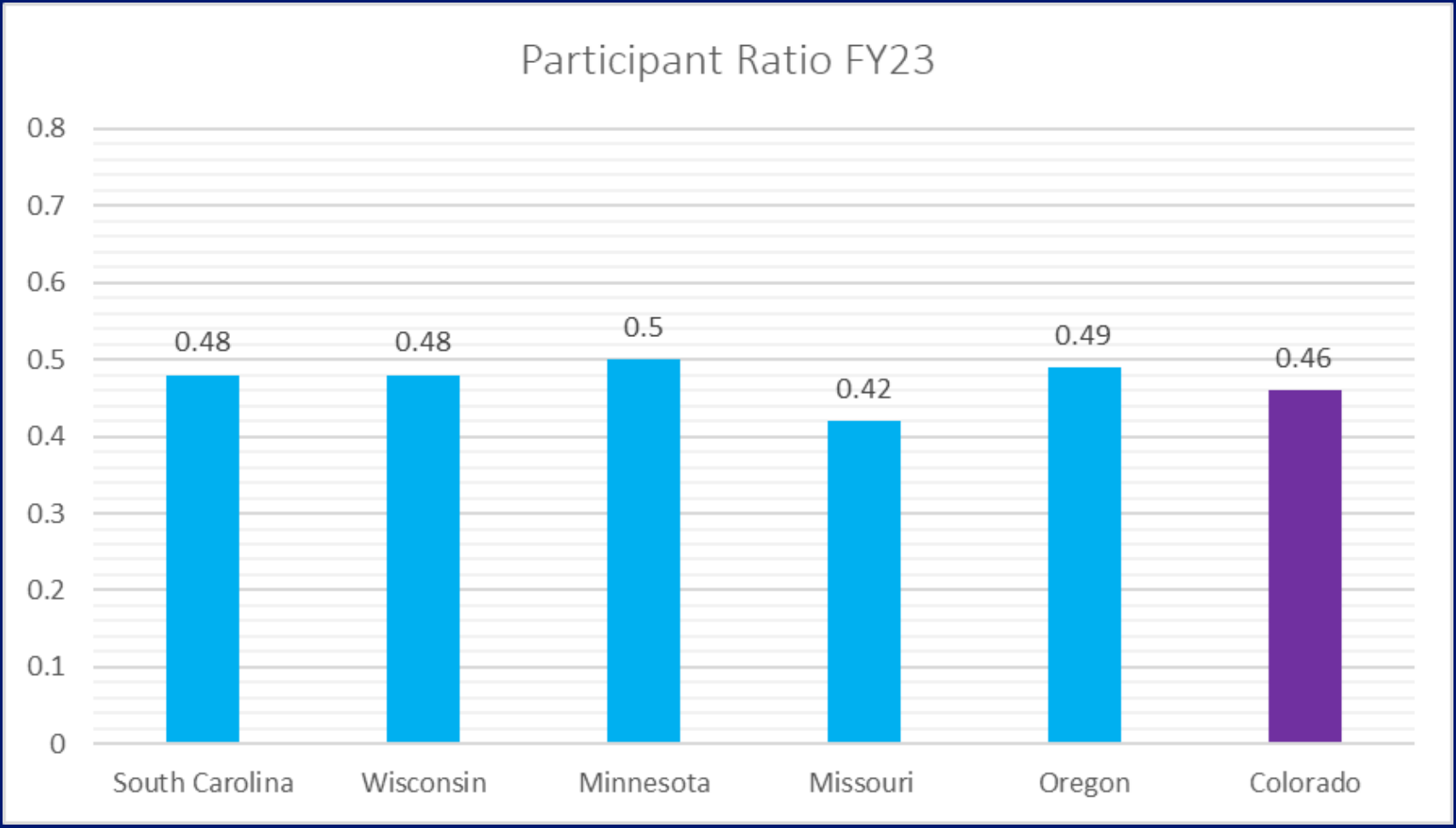
- What states are close?
  - South Carolina
  - Wisconsin
  - Minnesota
  - Missouri
  - Oregon

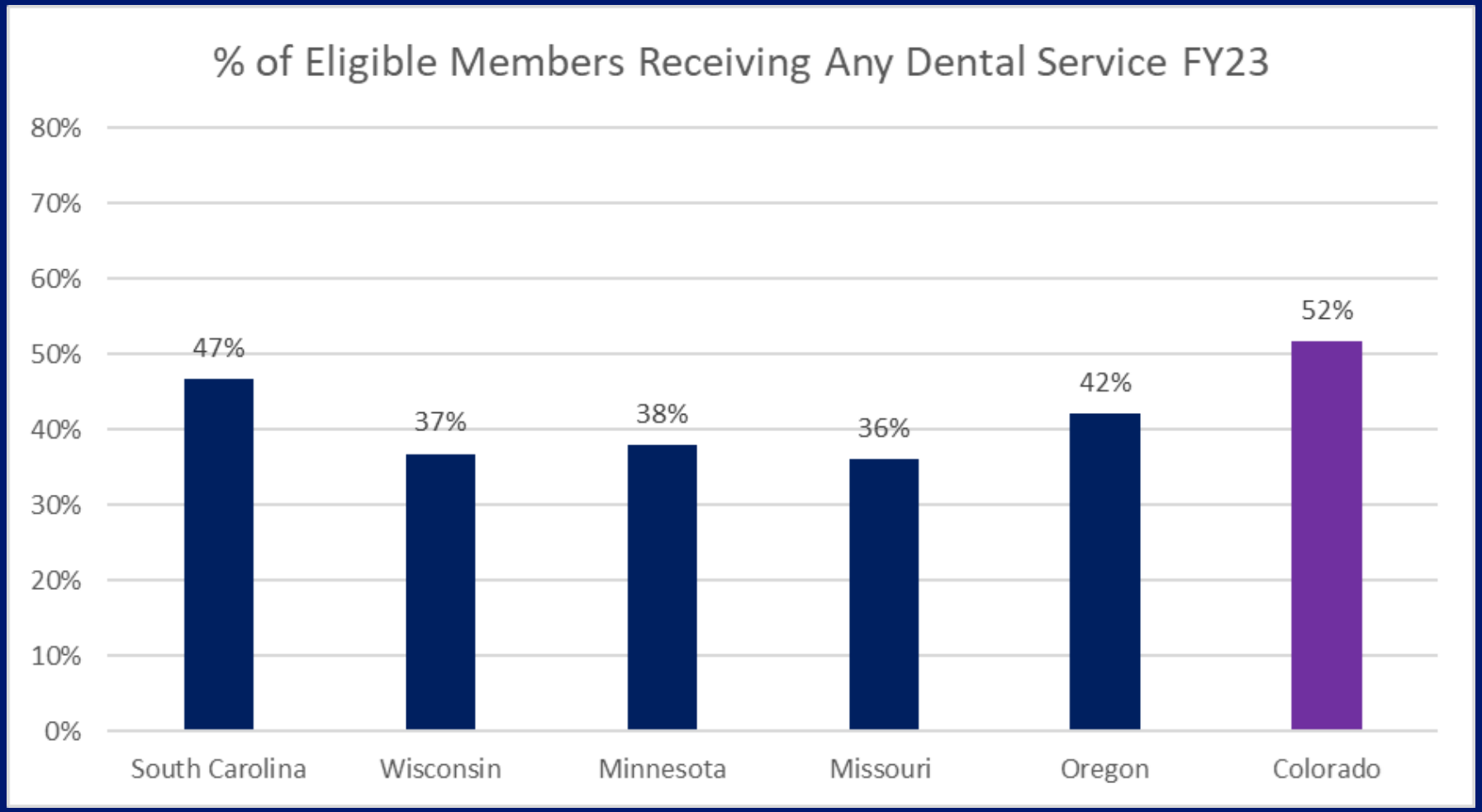
Total Eligible Members

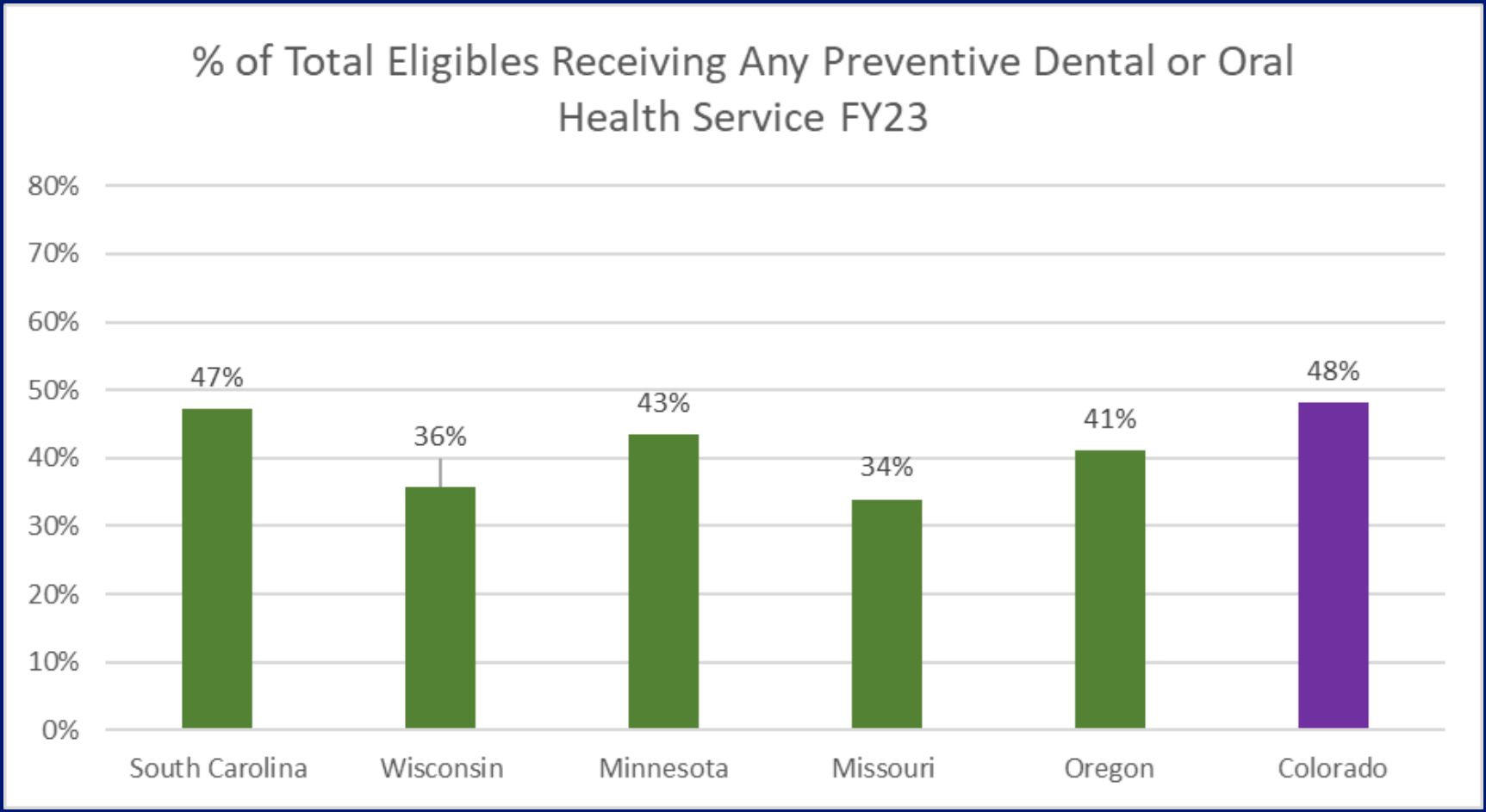


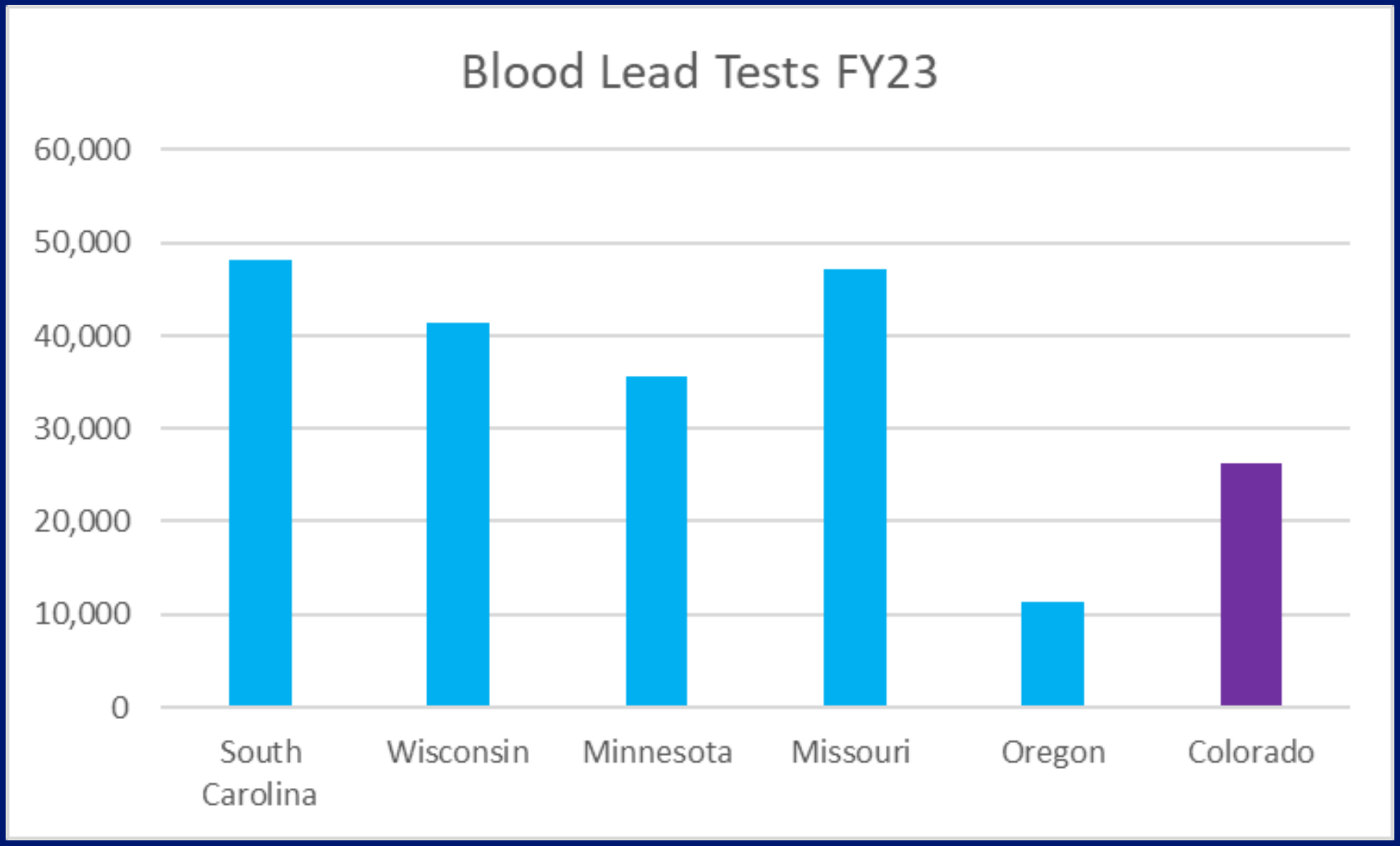

Total 90 Day vs Total Eligible Members FY23
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado
Total 90 Day Eligible Members FY23
Total Eligible Members FY23


Screening Ratio FY23
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.59
0.59
0.62
0.52
0.62
0.58
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado


Participant Ratio FY23
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.48
0.48
0.5
0.42
0.49
0.46
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado


% of Eligible Members Receiving Any Dental Service FY23
80%
70%
60%
50%
40%
30%
20%
10%
0%
47%
37%
38%
36%
42%
52%
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado


% of Total Eligibles Receiving Any Preventive Dental or Oral Health Service FY23
80%
70%
60%
50%
40%
30%
20%
10%
0%
47%
36%
43%
34%
41%
48%
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado


Blood Lead Tests FY23
60,000
50,000
40,000
30,000
20,000
10,000
0
South Carolina
Wisconsin
Minnesota
Missouri
Oregon
Colorado

Part Six:
What Do You Know About EPSDT?

Everyone Ready for a Quiz?

QUESTIONS AND ANSWERS

Why doesn't the EPSDT benefit include CHP+?

- Medicaid is governed under Title XIX of the SSA and CHP+ is governed by Title XXI of the SSA (Children's Health Insurance Program).
- EPSDT is a federally mandated Medicaid benefit and it does not extend to benefits available under other Titles.

EPSDT seems to allow for everything, so why are there prior authorizations?

- All requests for services for individuals under 21 must be reviewed through the EPSDT lens, considering the correct or ameliorate criteria, and decisions must be individualized and be based on the individual's condition at that time
- Services must still be determined to be medically necessary
- EPSDT cannot override 1905 of the Act and approve items not coverable under that statute

How would correct or ameliorate apply to preventive services (no current condition so how would it apply)?

- Some preventive services are built into periodicity schedules. Some of these services may be required at a higher frequency than contemplated by periodicity schedules if such need has been a determination by a qualified provider.
- For example, a child determined by a qualified provider to be at moderate or high risk for developing tooth decay could be covered to receive dental exams and preventive treatments more frequently than the twice-yearly periodicity schedule

EPSDT Key Takeaways

1. No limits or caps in services are allowed even if the limits is in state rules
2. All services that could be provided under Medicaid regardless of whether they are covered in the state plan
3. EPSDT applies to all XIX eligibility categories for those 20 and under (not CHP+)
4. Case management and outreach required
5. Quality and Measurement of EPSDT services

Send questions or comments to:

HCPF_EPSDT@state.co.us

Any Final Questions?

Where is EPSDT Defined?