EPSDT Provider Education

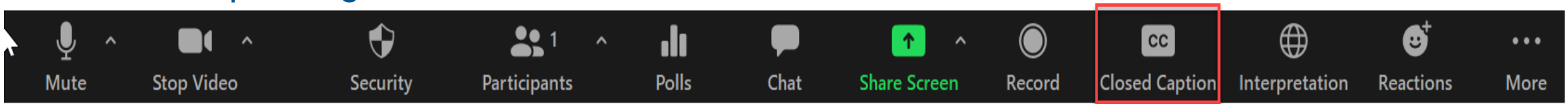
Early and Periodic Screening,
Diagnostic & Treatment Program (EPSDT) Overview
for Behavioral Health and BRS providers

February 15, 2023

Oregon Health Authority

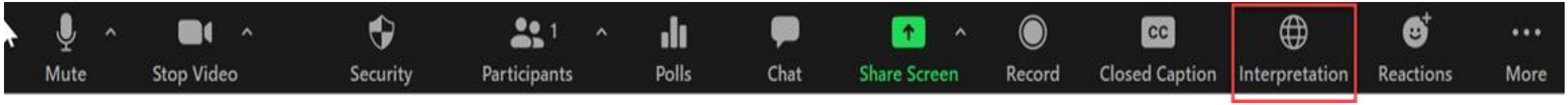
Webinar Logistics

- This session will be recorded
- Private chat or email Tom Cogswell (thomas.cogswell@dhsoha.state.or.us) with any Zoom issues
- Closed captioning is available:



- American Sign Language (ASL) interpretation is available. Pin the ASL Interpreter's video by clicking on the "More" button next to their name

- Todos los participantes que hablan español deberán seleccionar el botón Interpretación y luego el canal en español para que aparezca el sonido.



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OHA clinician leadership and EPSDT team

Margaret Cary, MD, MPH, OHP Fee For Service Clinical Director
Jessica Ickes, EPSDT/Children's Policy Analyst
Laura Sisulak, Health Policy Analyst

Not presenting, but on the team:
Dana Hargunani, MD, MPH, OHA Chief Medical Officer
Dawn Mautner, MD, MS, Medicaid Medical Director
Liz Stuart, Project Manager

Welcome and context

Meg Cary, MD, MPH, OHP Fee for Service Clinical Director

Objectives for the session

Providers, partners and advocates will:

- Understand the change to EPSDT policy, effective January 1, 2023
- Understand what has changed, and what hasn’t, with respect to historically non-covered services for children
- Understand requirements for OHA and CCOs that are the same, and which processes may remain different
- Address questions about specialty behavioral health services
- Know where to access detailed guidance and submit questions

EPSDT policy

What is changing?

First…what is EPSDT?

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid or the Oregon Health Plan (OHP).
- States must follow a periodicity schedule for children's services. Oregon follows the Bright Futures periodicity schedule.
- States are required to provide comprehensive services and **furnish all Medicaid coverable, medically appropriate, and medically necessary services needed to correct and ameliorate health conditions,** based on certain federal guidelines.
- **In Oregon, EPSDT constitutes the child and youth benefit within the Oregon Health Plan.** It is not necessary to enroll in a separate program to access these benefits.

Oregon.gov/EPSDT

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Who qualifies for EPSDT services?

- Oregon Health Plan (OHP) members under age 21 (members transition to adult coverage on their 21st birthday).
- In the future, youth with special health care needs (YSHCN) will be eligible until their 26th birthday.
    - This coverage expansion will not be implemented before July 2024 and guidance will be updated at that time.
    - This coverage expansion was approved by the Federal government as part of Oregon's 2022-2027 Medicaid 1115 waiver.

These policies apply to both Open Card (Fee for Service) and CCO enrolled members

EPSDT: Covered services

- All medically necessary and medically appropriate services needed to find or treat illness, injury, or other changes in health

- Well child visits and adolescent well visits following the Bright Futures Periodicity Schedule. These visits include:
    - Complete physical exam
    - Comprehensive health and developmental history (including assessment of both physical and mental health development)
    - Developmental screening
    - Preventive laboratory tests (including lead toxicity testing)
    - Appropriate immunizations
    - Assessment of nutritional status
    - Anticipatory guidance and health counseling for parents and children
    - Referrals for medically necessary health and mental health treatment

- Screenings for vision, hearing, and oral/dental health

EPSDT: Covered services

Medically appropriate and medically necessary services including:

- Behavioral health services
- Prescriptions
- Speech-language-hearing, occupational and physical therapy
- Eyeglasses, hearing aids, and augmentative communication
- Dental care
- Medical equipment and supplies
- School-based health services (such as services in an Individu
- Personal care services
- Rehabilitation services
- Nutritional supplements/medical foods

Until 2023, one element of the EPSDT benefit was waived

- Most EPSDT services have been provided in Oregon for many years.
- Oregon's 2017-2022 1115 Medicaid waiver and prior waivers allowed the state to *restrict coverage for treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments.*
- This means Oregon did not cover **treatment** services that were "below the line" on the Prioritized List of Health Services for kids between the ages of 1 and 21.

What changed on January 1, 2023?

- Now, no EPSDT requirements are waived in Oregon.
- Under EPSDT, OHP covers **all medically necessary and medically appropriate services for enrolled children and youth until their 21st birthday**, regardless of:
    - The location of the diagnosis on the Prioritized List of Health Services
    - Whether it pairs, or is a non-pairing service
    - Whether it is a “non-covered” ancillary service
    - Whether it is covered under the Oregon’s Medicaid State Plan

What is the Prioritized List?

- The Prioritized List of Health Services is a tool used to show which services are generally covered by the Oregon Health Plan.

- The Health Evidence Review Commission (HERC) uses medical evidence to provide guidance about coverage of services.
    - Historically, covered services appeared “above the line” on the Prioritized List, and services “below the line” were not covered by OHP.
    - **This is still true for adults (ages 21+)** but not for children and youth.

The policy change does NOT mean all services are covered in all cases

- CCOs and OHA may use appropriate utilization management processes and require prior authorization for some services
- Covered services must have a billable code – HCPCS or CPT codes.
- Services must be Medicaid-coverable. One example that is not: purely cosmetic procedures.
- CCOs and OHA may utilize a preferred provider network.
- In order to bill for services, the provider must be a Medicaid-enrolled provider and have an NPI (National Provider Identifier)
- Medicaid is required to be a good steward of resources, and may require least costly alternatives
- Services must be medically necessary and medically appropriate

CCO and Open Card implementation

OHA and CCOs must both:

- Comply with the EPSDT policy change and coverage requirements, effective January 1, 2023
- Ensure that services to OHP members under age 21 are **not** denied without an individual review for medical necessity and medical appropriateness.
- Abide by a definition of medical necessity and medical appropriateness that is not more restrictive than that listed in Oregon Administrative Rule 410-120-0000
- Follow the Bright Futures periodicity schedule.
- Follow guidance for the application of prior authorization to EPSDT services

CCOs and OHA may differ in:

- Prior authorization procedures.
- Billing procedures

Medically Necessary and Medically Appropriate

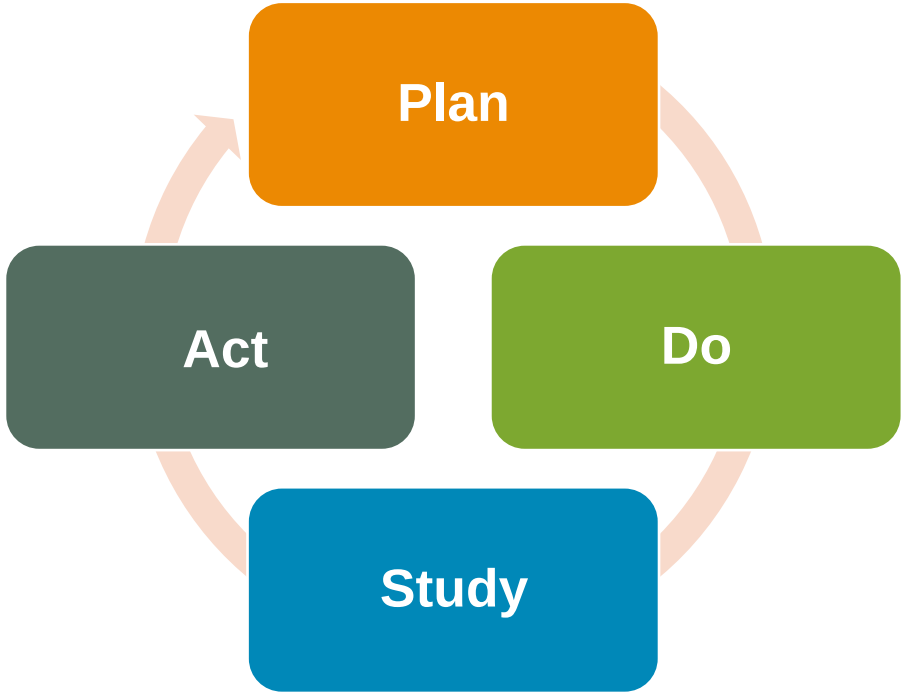
- Medically Necessary, Medically Appropriate and Dentally Appropriate are defined in Oregon Administrative Rule 410-120-0000.
- States are required to provide comprehensive medically appropriate and medically necessary services needed to correct and **ameliorate** health condition
- This includes services which, based on the child's individual circumstances, adversely affect the child's ability **to grow, develop, or participate in school** (Statement of Intent 4 on the Prioritized List).
- Documentation needed to demonstrate medical necessity and appropriateness are outlined in OHA's EPSDT Provider Guide.

Dos and don’ts under EPSDT

CCOs and OHA cannot:	CCOs and OHA can:
Deny a service or claim solely because it is below the funding line, non-pairing, or a historically “non-covered” ancillary service. **This includes automatic denial by claims processing systems of services that have historically not been covered.**	Deny a claim for administrative errors such as incorrect entries of diagnostic codes and other incorrectly entered factual information **without** first conducting an individual review for medical necessity and medical appropriateness.
Deny a claim solely due to a lack of chart notes or other documentation of medical necessity and medical appropriateness.	Deny a service or claim if it is not medically necessary and medically appropriate (or dentally appropriate, for a dental service) for the child/youth, based on individual review of clinical documentation.
Require prior authorization for all historically non-covered services (for example, those below the line on the Prioritized List) solely as a way to operationalize EPSDT coverage expansion.	Choose to automatically approve previously not covered services without a review for medical necessity.
Require prior authorization for any EPSDT screening services.	Use the Prioritized List as a guidance tool and not a denial tool.

Pathway to implementation

- **These requirements are effective January 1, 2023.**
- Full implementation is expected by the end of Q1 2023.



What does this mean for…..

Addressing specific service questions

The Prioritized List under EPSDT

- Under EPSDT, CCOs and OHA must cover **all medically necessary and appropriate (or dentally appropriate, in the case of a dental service) services for children and youth under age 21.**
- The Health Evidence Review Commission (HERC) reviews clinical evidence and update the Prioritized List. Guideline notes may be used to support the individual evaluation of medical necessity and medical appropriateness (or dental appropriateness) for members under 21. However, they must be considered based on the individual needs of the member and may not be applied to determine coverage for children across the board.
- Location of a service on the Prioritized List may **not** be a reason for denial of a service.
- Note for providers who also serve adults: These changes do not apply to adults (ages 21+). Services under the funding line on the Prioritized List are generally not covered for adults.

What *has* been moved on the Prioritized List?

The Health Evidence Review Commission has recently completed review of historically non-covered services with the unique needs of children and youth in mind to minimize the need for individual reviews prior to approval of services.

Examples of services moved above the line related to EPSDT:

- Treatment for conduct disorder and oppositional defiant disorder for children 18 or under.
- Treatment of tendon and ligament injuries (full tears)
- Orthodontic treatment for handicapping malocclusion. Review criteria that addresses this condition specifically may be found here.

For more information: Prioritized List of Health Services

Examples of treatment services that have been approved through individual review

- Additional therapy sessions beyond a defined threshold (e.g. 10 visits)
- Treatment of acne in some cases that affect child growth, development and participation in school
- Ancillary services that were previously not covered, such as durable medical equipment when determined to be medically necessary and medically appropriate.
- Removal of tonsils

Specialty behavioral health services

- Utilization management techniques used for mental health and substance use disorders should comply with the Mental Health Parity and Addiction Equity Act.
- Without denials based on a funding line on the Prioritized List, more referrals may be reviewed for medical necessity and medical appropriateness on a case-by-case basis.
- In 2023, there is work to align Behavioral Health rules, but implementation of EPSDT policy takes precedence over any conflicting guidance.

Medical Necessity

Medical Necessity means health services and items that are required by a client or member to address one or more of the following:

- The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;
- The ability for a client or member to achieve age-appropriate growth and development;
- The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
- The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;
- A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

Medical (and Dental) Appropriateness

Medical (and Dental) Appropriateness means health services, items, or supplies that are:

- Recommended by a licensed health provider practicing within the scope of their license;
- Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
- Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;
- The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;
- All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

Case example: Intensive In-home Behavioral Health Treatment

Prior to EPSDT policy change:

- Two mental health diagnoses above the line were required at intake
- Example: Anxiety and PTSD

Post EPSDT Policy Change:

- May meet medical necessity and medical appropriateness if they have Anxiety and a Z code
- Example: Anxiety and Problems Related to Negative Life Events in Childhood (Z61)
  - Z61.1 Removal from home in childhood

Case Example: Residential Services

Prior to EPSDT policy change:

- ADHD diagnosis was only approved for outpatient services

Post EPSDT policy change:

- ADHD may be approved for residential if determined to be medically necessary and medically appropriate

EPSDT & Pharmaceutical reviews

- **Pharmaceutical reviews** for coverage will be aligned with the requirements for individual review of medical necessity and medical appropriateness as required.
- There is no required change to prior authorization **processes** under EPSDT at this time.

- To encourage the submission of timely and complete documentation, the following language is being added to the Prior Authorization Request for Medications and Oral Nutritional Supplements (OHP 3978), effective January 1, 2023:

"List all applicable diagnosis codes or contributing factors causing or exacerbating a funded condition, including any relevant comorbid conditions or impacts on growth, learning or development."

- The addition of this language is intended to help facilitate individual reviews.

Pharmacy Prior Authorization

- Update all PA criteria to support individualized review for members younger than 21 years of age who have a historically unfunded diagnosis, to evaluate on a case-by-case basis whether the requested medication is medically appropriate and necessary
- Standard definitions for medically appropriate and necessary use will include:
    - FDA-approved or compendia-supported indication;
    - Trial and failure, contraindication, or intolerance to at least two preferred products (when available in the class); and
    - Documentation that the disease is of sufficient severity that it impacts the patient's health

EPSDT and school-based health services

- EPSDT does not change the hierarchy of who pays for services. If something is a Medicaid eligible services in schools, Medicaid pays for it.
- However, more treatment services may be deemed covered under EPSDT.
- Statement of Intent 4 on the Prioritized List specifies that medical necessity includes services which, **based on the child's individual circumstances**, adversely affect the child's ability to grow, develop, **or participate in school**.
- If a service is requested that relates to an Individualized Education Plan (IEP), OHA will consider the IEP as part of the documentation for medical necessity and medical appropriateness. Sharing the IEP documentation or information requires parental approval.

EPSDT and DME

- Durable Medical Equipment (DME) are some of the most-affected by the EPSDT policy change. The majority of services reviewed under the policy change in the Fee For Service (Open Card) program have been for DME.
- Statement of Intent 4 is a meaningful factor in reviewing DME.
- OHA and CCOs may still consider “least costly alternative” and whether alternatives have been tried.

Member rights and what if a requested service is denied?

Service denials

- Any denial of coverage must be in writing. **Providers should not refuse to render or refer for care.**
- OHP members must be provided a written Notice of Action (for FFS) or Notice of Adverse Benefit Determination (for CCOs) when denying a service.
    - Notices must contain:
        - A statement of the intended action and effective date
        - The specific reasons and legal support for the action
        - An explanation of the individual's appeal and/or hearing rights, and
        - The member's rights to representation.

What recourse do providers and members have?

- If a provider or member/guardian disagrees with a denial decision, they can appeal the decision.
    - Any denial notice should include instructions on how to appeal or request a hearing.
    - All OHP members have the right to a fair hearing for denials.
- If a provider submits additional clinical documentation, that will be reviewed as part of the appeal or hearing process.

Ensuring patient access to services

If you have concerns with patient access to services, please reach out to one of the following contacts:

- OHP Client Services Unit 1-800-273-0557
  - Email: OHP.ComplaintResolution@odhsoha.oregon.gov

- OHA Ombuds Program OHA.OmbudsOffice@odhsoha.oregon.gov
  - Phone: 1-877-642-0450 (message line only)

Resources for providers and advocates

Checklist: What should Providers do to prepare?

All providers should:

- ✓ NOT assume historically non-covered services continue to be non-covered. They MUST be considered for each individual child/youth.
- ✓ Monitor claims/prior authorizations in Q1, 2023 and be prepared to re-submit if need be.
- ✓ Review EPSDT Provider Guide and Member Fact Sheet
- ✓ Sign up for Provider Matters and the Transformation Center Resources email (sign up here: https://www.surveymonkey.com/r/OHATransformationCenterTA) to receive information about upcoming EPSDT webinars for providers
- ✓ Bookmark this page: **Oregon.gov/EPSDT**
- ✓ **Contact our team with questions: EPSDT.Info@odhsoha.oregon.gov**

What should Providers do to prepare?

Fee-for-Service providers should:

- ✓ Update contact info with Provider Enrollment at OHA to facilitate communication about post-service reviews
    - ✓ Provider Enrollment at 1-800-336-6016, Option #6 or provider.enrollment@odhsoha.oregon.gov
- ✓ Ensure the ability to send secure email (resources in OHA's EPSDT Provider Guide)

CCO providers should:

- ✓ Consult the specific CCO for its procedures for billing, authorization, and reimbursement

Webinar Recordings available

Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) Overview

Ensuring EPSDT access: Documenting medical necessity, prior authorization and related processes for fee-for-service (FFS, or "Open Card") patients

EPSDT for Behavioral Health and Behavior Rehabilitation Service Providers (this webinar)

Visit Oregon.gov/EPSDT for slides and recordings

Where to find more information

OHA has developed the following materials to share information about this change:

- EPSDT Guidance Document for CCOs
- EPSDT Policy Change Memo for OHP providers
- EPSDT Guidance for OHP Providers (webinars available)
- EPSDT Fact Sheet for OHP members (available in 13 languages)

Oregon.gov/EPSDT

All guidance documents and EPSDT communication materials will be available and updated on this page.

EPSDT Regulations and Resources

- Oregon Administrative Rule 410-130-0245 – Early and Periodic Screening, Diagnostic and Treatment Program
- Code of Federal Regulations 42 CFR § 441 Subpart B – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of Individuals Under Age 21
- EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- Medicaid.gov
- Health Resources & Service Administration – Maternal & Child Health Bureau
- Medicaid and CHIP Payment and Access Commission

Questions?

EPSDT.Info@odhsoha.oregon.gov

Dialogue with collaborators and partners, including families and members, helps us center equity. Thank you for your ongoing participation, and for providing us with the partnership and insights that help us better serve Oregon's communities.

Thank you