Medicaid **EPSDT Overview**

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What is EPSDT?

"EPSDT" is the common abbreviation for Federal Medicaid's Early and Periodic Screening Diagnosis and Treatment benefit. [1] Under federal Medicaid law, States must provide comprehensive and preventive health care services to youth under the age of 21 who are enrolled in Medicaid.[2] The EPSDT provisions of the federal Medicaid Act, mandate States seeking federal match for Medicaid expenditures to cover all "necessary health care, diagnostic services, treatment and other measures described in [42 U.S.C. § 1396(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State [Medicaid] plan*."[3] While the scope of EPSDT services is broad, States have considerable discretion in how they choose to administer the program.

How EPSDT functions in NH

As New Hampshire's single state Medicaid agency, the Department of Health and Human Services (DHHS) is responsible for establishing, maintaining, implementing and coordinating NH's EPSDT benefit.[4] DHHS is guided in its execution of federal Medicaid law by state statute and administrative rules. In the context of EPSDT, New Hampshire's Medicaid Office is guided by He-W 546. [5]

He-W 546 provides direction for billing purposes and outlines which services can be administered under EPSDT without an independent review of medical necessity from DHHS.[6] If a physician performs an EPSDT screen or service outside of those listed in He-W 546, and has not gained prior approval, DHHS may refuse the physician reimbursement for those services.

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[1] *See* U.S.C. § 1396a(a)(1); 42 U.S.C. § 1396d(1)(4)(B); and He-W 546
[2] *Id. see also* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
[3] 42 U.S.C. § 1396(r)(5)
[4] *See* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf
[5] N.H. CODE ADMIN. R. ANN He-W 546 (1992) *available at* http://www.gencourt.state.nh.us/rules/state_agencies/he-w500.html
[6] N.H. CODE ADMIN. R. ANN He-W 546.05 (1992).

Why recent changes to He-W 546 are significant

Until very recently, the screening services listed under He-W 546 were keyed to an outdated March 2000 "Recommendations for Preventative Pediatric Health Care" document from the American Academy of Pediatrics. This fifteen-year-old document contained stale periodicity schedules and an incomplete list of currently recommended youth medical screenings.

This flaw in He-W 546 required providers administering substance misuse and SBIRT screens to apply for EPSDT coverage via an independent review by DHHS for each patient and screen administered. The administrative burden of this requirement led some physicians to forgo performing youth SBIRT altogether.

Fortunately, DHHS recognized this problem within the rule and worked with advocates on a rule change to He-W 546. The final rule change updated the list of approved screenings and services to coincide with the most recent recommendations of the American Academy of Pediatrics; reflecting current recommendations to screen youth for behavioral health and substance use disorders.[7] On May 15, 2015, New Hampshire's Joint Legislative Committee for Administrative Rules accepted the proposed changes to He-W 546, eliminating previous barriers to universal SBIRT screening of Medicaid youth in NH.

Why EPSDT is important for youth with Substance Use Disorders in NH

As mentioned above, the EPSDT provisions of the federal Medicaid Act mandate States to cover all "necessary health care, diagnostic services, treatment and other measures described in [42 U.S.C. § 1396(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan" for enrolled beneficiaries under the age of 21.[8] The New Hampshire State Medicaid plan does not include a Substance Use Disorder benefit for traditional Medicaid populations; so, for Medicaid youth with Substance Use Disorders, the EPSDT mandate fills an important gap in health coverage.

If a Substance Use Disorder is detected in a Medicaid youth through an EPSDT SBIRT screen, DHHS is required to arrange for (whether directly or through referral to appropriate agencies, organizations [MCOs] or individuals) any "necessary" treatment.[9] While States are not required to pay for services that are not "medically necessary," they cannot arbitrarily deny or reduce the amount, duration, or scope of services based on the diagnosis, type of illness or condition.[10] The standards used by DHHS to determine the "medical necessity" of services, must be also keyed to accepted clinical criteria.[11] For

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[7] *See* http://www.dhhs.state.nh.us/oos/aru/documents/hew546ip.pdf
[8] 42 U.S.C. § 1396(r)(5)
[9] 42 U.S.C. § 1396a(a)(43)(C); *See also* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
[10] 42 C.F.R. §440.230(c)(1)
[11] 42 U.S.C. § 1396(a)(17); N.H. CODE ADMIN. R. ANN He-W 546.01(e) (1992).

Medicaid youth with Substance Use Disorders, accessing services through EPSDT can help to ensure proper and timely treatment.

How to access coverage for Substance Use Disorder Treatment when medically necessary for a Medicaid youth

To access Substance Use Disorder Treatment under EPSDT, families and providers must first request prior authorization from the appropriate state contractor, Managed Care Organization (MCO) or MCO contractor. Because Substance Use Disorder Treatment is not currently included in New Hampshire's State Medicaid Plan, the request for prior authorization must be submitted according to the EPSDT provisions and detail the medical necessity of the treatment for the particular child.

As previously explained, New Hampshire defines "medically necessary" as "reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service."[12] The EPSDT request for prior authorization should be as specific as possible (e.g. X hours of Intensive Outpatient Treatment per week) and reference EPSDT and the standard for coverage described above. Additionally, the request should include any applicable diagnostic evaluations, a letter of medical necessity from the child's treating physician or therapist, and any other documentation supporting the medical necessity of the requested service at the requested level.[13]

If the child has Fee-for-Service Medicaid (i.e. the child's Medicaid is administered by the New Hampshire Department of Health and Human Services), the EPSDT request for prior authorization must be submitted through KEPRO[14], the State's contractor for Medicaid utilization management. A different process must be followed for EPSDT requests for prior authorization when the child has Medicaid through one of the State's two MCOs, Well Sense or New Hampshire Healthy Families. Well Sense contracts with Beacon Health Strategies[15], LLC and New Hampshire Healthy Families contracts with Cenpatico to manage behavioral health services. The EPSDT request for prior authorization based on medical necessity for coverage of Substance Use Disorder Treatment must be submitted through the appropriate MCO contractor, either Beacon or Cenpatico.

How to appeal a denial or limited authorization of Substance Use Disorder Treatment

Medicaid recipients and their providers have a right to appeal any denials, limited authorizations, or termination of treatment that they believe is medically necessary.

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[12] *See* N.H. CODE *supra* note 5 *at* He-W 546.01(e).
[13] For detailed instructions about what must be included in an EPSDT request for prior authorization based on medical necessity, please review He-W 546.06. (*See attached)*
[14] *See* https://nhmedicaid.kepro.com/
[15] *See* http://beaconhealthstrategies.com/ and http://www.cenpatico.com/

Appeals may be filed with the New Hampshire Department of Health and Human Services' Administrative Appeals Unit (AAU).[16]

If the service coverage dispute is with a MCO or MCO contractor, the MCO's appeal process must first be exhausted before further appeal to the AAU is permitted. To ensure treatment services continue pending appeal, the appeal and a request for continuation of benefits must be made no later than 10 days from the receipt of the MCO's written notice. After receiving notice of appeal, an MCO has 30 days to issue a decision. If waiting 30+ days for a resolution would seriously jeopardize the life or health of the Medicaid beneficiary, an expedited appeal may be requested. An MCO must issue a decision on an expedited appeal within 3 calendar days. If the result of the MCO appeal is unfavorable, a request a fair hearing before an impartial hearing officer at the AAU may be filed as mentioned above.[17]

For more information on the new EPSDT rules or accessing EPSDT coverage in NH, please contact New Futures at 603-225-9540 x109 or visit http://www.new-futures.org/.

For more information on appeals to the AAU or MCO appeals, please contact the Disabilities Rights Center- NH at 800-834-1721 or visit http://drcnh.org/.

[16] For more information on appeals to the AAU see "Fair Hearing Rights Under Medicaid," http://www.drcnh.org/medicaidhearings.html

[17] For more information on MCO appeals, see "Know Your Rights: New Hampshire Medicaid Managed Care Health Plans - Your Right to Appeal or File a Grievance," available at www.drcnh.org/MMCappealsgrievances.html

Appendix

He-W 546.06 Prior Authorization for Coverage Based on Medical Necessity.

(a) Prior authorization shall be required for services described in He-W 546.05(c) and (e).

(b) Requests for prior authorization shall include the following:

(1) The recipient's name, address, and Medicaid identification number;

(2) The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;

(3) An estimation of the effect on the recipient if the requested service is not provided;

(4) The medical justification for the services or equipment being requested;

(5) The recommended timetable of the prescribed treatment;

(6) A discussion of why the service is medically necessary as relates to He-W 546.01(e);

(7) The expected outcome of providing the requested service;

(8) The recommended timeframe to achieve the expected outcome;

(9) A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested service is being recommended;

(10) Listings of individuals or agencies to whom the recipient is being referred; and

(11) Assurance that the requested service is the least restrictive, most cost-effective service available to meet the recipient's needs.

(c) Requests for prior authorization shall include a statement signed by at least one of the following indicating that they concur with the request:

(1) Treating physician or primary care provider;

(2) Treating advanced practice registered nurse; or

(3) Primary treating psychotherapist.

(d) Prior authorizations for coverage of services requested in accordance with He-W 546.06 shall be approved by the department if the department determines that the information provided in (b) above demonstrates medical necessity.

(e) Confirmation of department approvals shall be sent to the treating physician in writing.

(f) Providers shall be responsible for determining that the recipient is Medicaid eligible on the date of service.

(g) If the requested service is denied, or denied in part, by the department, the department shall forward a notice of denial to the recipient and the treating provider with the following information:

(1) The reason for, and the legal basis of, the denial; and

(2) Instructions that a fair hearing on the denial may be requested by the recipient within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

(h) Decisions made by the department in accordance with (d) and (g) above shall not be superseded by the treating or consultative health care professional's prescription, orders, or recommendations