

PROJECT THRIVE



Linking Policies for Child Health,
Early Learning, and Family Support

www.nccp.org/thrive

thrive@nccp.org

Project THRIVE *Short Takes* highlight topics of interest and importance to state maternal and child health leaders and their partners building State Early Childhood Comprehensive Systems (ECCS). Each *Short Take* summarizes the issue, relevant research, and related resources. Project THRIVE is a public policy analysis and education initiative for infants and young children at the National Center for Children in Poverty (NCCP) funded through a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, of the U.S. Department of Health and Human Services.

The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

SHORT TAKE NO. 2

Maximizing the Use of EPSDT to Improve the Health and Development of Young Children

The Issue

In every state, assuring access to health care and a medical home is a core component of the Early Childhood Comprehensive System (ECCS) initiative. Medicaid finances health, mental health, and developmental services for approximately one-third of U.S. children under age 6. This Project THRIVE *Short Take* discusses the importance of Medicaid's child health benefit—the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT is in essence the child health benefit plan for Medicaid. (See box on page 6 for federal guidance regarding the EPSDT child health benefit under Medicaid.) *Short Take 2* reviews research about the role of EPSDT in improving early childhood health and development and opportunities for ECCS leaders to use EPSDT in collaborative efforts to improve child health.


What Research Says About Medicaid, EPSDT, and Young Children

- An estimated 35-40 percent of births are financed by Medicaid, with coverage continuing throughout the first year of life for infants. In some states, approximately half of all births are covered. Virtually all of the infants whose births were financed by Medicaid will have automatic and continuous coverage until age 1 year.
- Approximately one-third of children ages 1 to 5 years are covered by Medicaid.¹ This means that many early childhood health and developmental services in each state will be financed by Medicaid. (See maps on page 4 for EPSDT state performance rates for young children.)
- With Medicaid, poor children's access to health care is similar to that of nonpoor, privately insured children. Moreover, child Medicaid beneficiaries use care in approximately the same pattern as their privately insured counterparts.²
- Children are half of all Medicaid enrollees, but represent less than 20 percent of the total spending—primarily because they use less expensive primary and preventive services.³

The Role of EPSDT in Early Childhood Comprehensive Systems

Promoting Child Health

Young children's health status is assessed through comprehensive well-child exams known as EPSDT screens. Offering health education and anticipatory guidance to parents is an important component of these visits. Ideally, each state's periodic visit schedule will reflect the recommendations of the American Academy of Pediatrics and Bright Futures guidelines for health supervision.⁴

 **TIP:** Check to see if your state's periodicity schedule meets professional guidelines for young children. If not, encourage a professional review of the schedule.


Promoting Healthy Child Development

For ECCS leaders, understanding this aspect of EPSDT is important. Medicaid primarily finances such services for young children through EPSDT screening, diagnosis, and treatment benefits. No Medicaid benefits category is specifically called "child development"⁵ or "early intervention" services.⁶ Intervention and treatment services are more likely to be covered when they are considered medical rather than educational.⁷

Age-appropriate developmental screening is one component of a comprehensive EPSDT screening visit. Having age-appropriate and evidence-based screening tools is critical to the success of such efforts. The federal Medicaid rules state that:


"Screening for developmental [status]... is a part of every routine initial and periodic examination. Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process.... In younger children, [screener must] assess at least the following elements: gross motor development, focusing on strength, balance, locomotion; fine motor development, focusing on eye-hand coordination; communication skills or language development, focusing on expression, comprehension, and speech articulation; self-help and self-

care skills; social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and cognitive skills, focusing on problem solving or reasoning."⁸

 **TIP:** Make sure that your state recommends two or three age-appropriate, validated, specific developmental screening tools that providers should use when serving young children.

Promoting Healthy Mental Development

EPSDT calls for mental health screening; however, special efforts to assure age-appropriate screening and intervention related to social and emotional development for the youngest children may be required. For example, through the ABCD II Initiative, five states (California, Illinois, Iowa, Minnesota, and Utah) are using Medicaid pilot projects to finance care that supports the healthy mental development of young children ages birth to 3, particularly in primary health care services. In early childhood mental health projects in Vermont and Colorado, Medicaid is a partner financing screening and interventions in larger efforts to promote mental health systems of care.⁹

 **TIP:** Make sure that your state recommends age-appropriate, validated screening tools to assess the social-emotional development of infants, toddlers, and preschoolers.

Using Interperiodic Screening

So called "interperiodic" screening visits are used to monitor suspected problems even when a routine EPSDT screen is not on the state schedule and can also be provided whenever a condition is suspected. Parents, teachers, child care providers, and others may identify a problem that calls for an interperiodic screen. In addition, a pediatric primary care provider who suspects a developmental problem or identifies risk may ask the parent to return for a comprehensive interperiodic screening visit in order to monitor the child's condition. Providers also might conduct developmental screening alone in a separate "interperiodic" visit, to follow up on concerns of a parent, teacher, or health professional.

TIP: Find out if your state permits pediatric primary care providers to bill separately for developmental screening of young children as an interperiodic visit. If not, encourage the state Medicaid agency to adopt this approach and pediatric providers to use it.

Financing Early Interventions and Treatment

EPSDT law requires coverage of medically necessary treatment services. If a service has been approved as a Medicaid one under federal law and qualifies for federal matching funds, it is a covered service under EPSDT. In other words, for an individual child, a service is covered if it is determined (by a provider, managed care organization, or the state) to be medically necessary. How the service is defined and who determines medical necessity varies from state to state.¹⁰ Generally, however, medically necessary care must be consistent with standard accepted practice to: (1) help restore or maintain health; (2) prevent deterioration or ameliorate a condition; or (3) prevent the likely onset of a health problem.¹¹

TIP: Identify problems providers report in financing interventions for young children and engage in strategic planning and action to address them. One way to start the review is with hypothetical case examples of young children with developmental and behavioral challenges.

Interagency Collaboration to Improve EPSDT Performance and Child Health Outcomes

ECCS leaders across the country are working to assure health access and a medical home. While few states have new resources to finance health care, most can do more to promote health care access and medical homes for children in Medicaid. One important step is to find out about EPSDT performance rates for young children in your state. Next, learn more about the role of EPSDT in financing early childhood services such as newborn screening, early intervention, home visiting, and early childhood mental health treatment. ECCS leaders also might convene an interagency discussion regarding the role of EPSDT and how to improve its performance. States such as Alaska, Colorado, and Iowa have started interagency discussions and collaboration to improve EPSDT in the context of ECCS.

TIP: ECCS might convene leaders from Medicaid, Maternal and Child Health, Children with Special Health Care Needs, Part C Early Intervention, Mental Health, and other agencies to discuss ways that EPSDT can be used to assure health care access, medical homes, mental health, and healthy development for young children in your state.

Every state has a ready-made opportunity to use its Title V Programs for Maternal and Child Health and for Children with Special Health Care Needs (CSHCN) to improve the performance of EPSDT. Federal law requires collaboration between state Medicaid and Title V agencies to improve child health, and most states do more than what is required.¹² For example, state Title V agencies:

- Offer toll-free hotlines to assist families with information about and enrollment in Medicaid.
- Jointly develop EPSDT screening tools, periodicity schedules, and managed care contracts.
- Employ EPSDT care coordinators who work in local agencies to support families and providers in effective use of EPSDT resources.
- Provide training and support services for EPSDT providers, including “medical home” initiatives.
- Provide EPSDT screening through child health clinics operated by local health departments.
- Use home visiting programs as a strategy for EPSDT outreach, information, and screening.
- Employ public health nurses in projects to assure EPSDT screening for children entering foster care.
- Promote EPSDT dental screening and preventive oral health services in pediatric care settings, as well as direct referral to a dentist beginning at age 1.

TIP: Identify opportunities for your state to increase participation and referral ratios for EPSDT as part of the ECCS strategic planning process, with particular focus on the role of Title V.

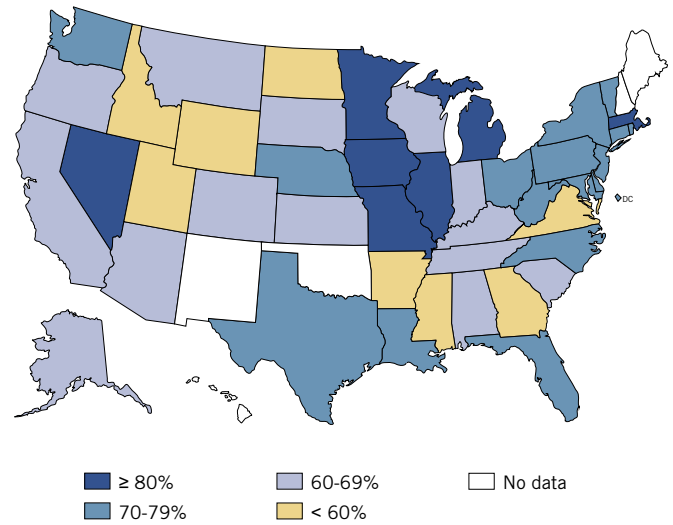
EPSDT State Program Performance for Young Children

In theory, EPSDT guarantees children coverage for the full range of screening, diagnostic, and medically necessary treatment services. In practice, however, screening and referral rates fell short of the 80 percent screening performance benchmark set in 1989 under the last major federal law changes to the program. Figure 1 shows states' participation ratios (percent who received at least one well-child EPSDT screening visit during the year) for infants and toddlers (that is, children ages 1-3) in Fiscal Year 2003.¹³ While most states' periodicity schedules call for two or three visits for toddlers in this age group, only a small number of states had reached the 80 percent performance goal for even one visit.

- Seven states (Illinois, Massachusetts, Missouri, Minnesota, Nevada, Iowa, and Michigan) reported an EPSDT participation (screening) ratio of 80 percent or more for children ages 1-3.
- A larger number of states (17) achieved ratios of 70-79 percent for this age group. This included two states (Connecticut and Rhode Island) that were at 79 percent.
- Eight states had ratios for toddlers of less than 60 percent, with five of these below 50 percent.

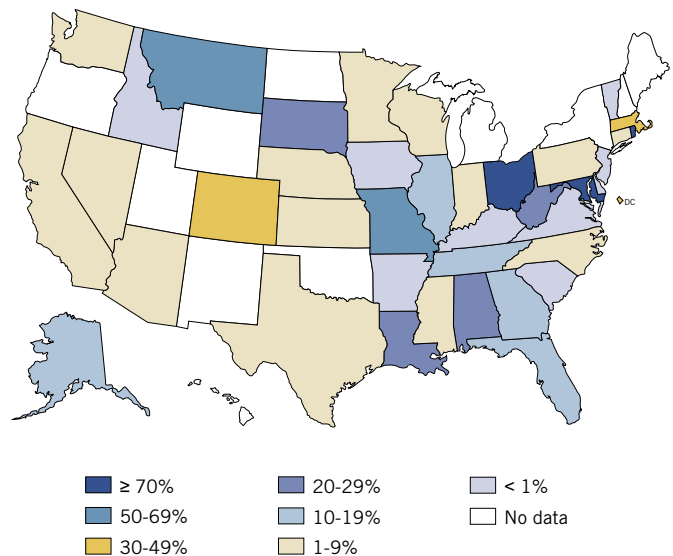
In addition, data reported by states regarding referrals for further diagnostic evaluation or treatment as a result of an EPSDT screen show low rates. Figure 2 shows referral rates (the percent whose providers noted referrals subsequent to an EPSDT screening visit where a problem is identified). Nearly half of the states (23) had less than 10 percent of children ages 1-3 referred for diagnosis and treatment services, with nine states reporting less than 1 percent referrals. Given national data on the developmental needs of young children, expected rates would be somewhat higher.¹⁴ Several factors may contribute to these low referral rates. Recent state demonstration projects indicate that many pediatric primary care providers do not use age-appropriate or sensitive tools for early childhood developmental screening.¹⁵ In addition, more detailed state studies (such as those using audits and record reviews) indicate that low rates may reflect both low numbers of referrals and inadequate provider reporting.¹⁶

Figure 1: EPSDT Participation Ratios,* Children Ages 1-3, FY 2003



* Percent of one- and two-year-olds who had at least one EPSDT screen.
Source: Data from the U.S. Centers for Medicare and Medicaid Services <www.cms.gov>.

Figure 2: EPSDT Referral Ratios,* Children Ages 1-3, FY 2003



* Percent of one- and two-year-olds who had a referral subsequent to EPSDT screen.
Source: Data from the U.S. Centers for Medicare and Medicaid Services <www.cms.gov>.

Conclusion

As ECCS leaders and partner stakeholders take action to assure access to health care and a medical home, they have choices about Medicaid policy and implementation. Every state should look to EPSDT, the child health benefit plan for Medicaid, to improve the health outcomes of young children in low-income families. Title V federal law currently requires that state MCH programs work with Medicaid agencies in the following ways:

- Assist with coordination of EPSDT.
- Establish coordination agreements with their state Medicaid programs.
- Provide a toll-free number for families seeking Title V or Medicaid providers.
- Provide outreach and facilitate enrollment of Medicaid-eligible children and pregnant women.
- Share data collection responsibilities.
- Provide services for children with special health care needs and disabilities not covered by Medicaid.

States also have opportunities to do the following:

- Encourage adoption of best practices in outreach and enrollment for Medicaid and SCHIP.¹⁷
- Assist with administration of EPSDT, particularly with assuring the quality of care and appropriateness of periodicity schedules and screening tools.
- Develop standards of care and policies to support quality improvement in EPSDT, including development of managed care contract provisions.
- Assist Medicaid agencies in tracking the screening ratio, with the goal of reaching 80 percent.
- Collaborate with the Academy of Pediatrics, Academy of Family Physicians, Primary Care Association, and other professional organizations to train about and promote participation in EPSDT.
- Promote use of the “medical home” approach and Bright Futures guidelines, especially for young children.
- Evaluate and/or monitor EPSDT program performance.
- Inform state policymakers about the potentially positive and negative effects on child health coverage of the DRA changes to Medicaid (see *Short Take 1*).

Federal Guidance for the EPSDT Child Health Benefit under Medicaid

The Early and Periodic Screening, Diagnosis, and Treatment benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. As described by the federal Centers for Medicare and Medicaid Services (CMS): "The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources."¹

The Deficit Reduction Act (DRA) gives states the option to use "benchmark" benefit plans in lieu of the full Medicaid benefit package.² (See Project THRIVE Short Take No. 1.)³ For children, benchmark plan coverage would be less than EPSDT requires, but CMS has stated that states are required to finance EPSDT services not covered through the benchmark plan as "wraparound" services.⁴ This would be similar to some states' Medicaid managed care approaches that pay on a fee-for-service basis for services outside the managed care contract for such items as hearing aids, dental care, and developmental services. While understanding EPSDT is important in every state, it will be particularly important in states that adopt a benchmark benefit plan.

The EPSDT benefit includes the following services:

A. Screening through Comprehensive Well-Child Exams.

Schedules for periodic screening (known as "periodicity schedules") of medical (including physical and mental health), dental, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice. For young children, this means more frequent screening visits (for example, five exams in the first year of life). States are required to consult with recognized medical and dental professional organizations involved in child health care in developing periodicity schedules and visit protocols.

CMS rules inform state Medicaid agencies that EPSDT screening must include all of the following services:

- **Comprehensive health and developmental history**—including screening of both physical and mental health development.
- **Comprehensive unclothed physical exam.**
- **Appropriate immunizations**—according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.

- **Laboratory tests**—including lead toxicity screening for all Medicaid-eligible young children.
- **Health education**—Health education is a required component of screening visits and includes anticipatory guidance. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- **Vision, hearing, and dental screening in primary care**—Primary care providers are expected to conduct screening tests for vision, hearing, and dental services. For these service areas, however, referral to other providers is expected. A direct referral to a dentist is required for every child beginning at age 1 year.

The following services are to be provided by appropriately trained professionals according to appropriate periodicity schedules:

- **Dental services**—At a minimum, include screening, preventive care, relief of pain and infections, restoration of teeth, and maintenance of dental health.
- **Vision services**—At a minimum, include screening, diagnosis, and treatment for defects in vision, including eyeglasses.
- **Hearing services**—At a minimum, include screening, diagnosis, and treatment for defects in hearing, including hearing aids. This might include follow-up to newborn hearing screening for Medicaid-recipient children.

B. Diagnosis. When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services. The referral should be made without delay, with follow-up to make sure that the recipient receives a complete diagnostic evaluation.

C. Treatment. Health care must be made available for treatment or other measures to correct or ameliorate disabilities and physical and mental illnesses or conditions discovered by the screening services.

D. Other Necessary Health Care. Provide other necessary health care, diagnosis services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

1. See <www.cms.gov>.

2. Rosenbaum, S. & Markus, A. (In press). *The Deficit Reduction Act of 2005: An overview of key provisions and their implications for early childhood development*. New York, NY: Commonwealth Fund.

3. For more about the impact of the DRA on early childhood comprehensive systems, see Project THRIVE Short Take No. 1. NCCP, June 2006 <www.nccp.org/pub_tst.html>.

4. Smith, D. (2006, March 31). *Dear State Medicaid Director Letter* (SMDL #06-008). Baltimore, MD: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. This letter clarifies the DRA intent that enrolled mandatory and optional categorically needy children under age 19 must receive "wraparound" benefits to the benchmark or benchmark-equivalent plan to assure that in combination with the plan, these children receive the full range of EPSDT benefits.

Endnotes

1. Kaiser Commission on Medicaid and the Uninsured. (2004). *Health coverage for low-income children*. Washington, DC: Henry J. Kaiser Family Foundation <www.kff.org/uninsured/2144-04.cfm>.
2. Kaiser Commission on Medicaid and the Uninsured. (2005). *Early and Periodic Screening, Diagnosis, and Treatment*. Washington, DC: Henry J. Kaiser Family Foundation <www.kff.org/medicaid/upload/Early-and-Periodic-Screening-Diagnostic-and-Treatment-Services-Fact-Sheet.pdf>.
3. Henry J. Kaiser Family Foundation <www.statehealthfacts.org>. Accessed May 5, 2006.
4. See Bright Futures, a “national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice” <www.brightfutures.org>.
5. VanLandeghem, K.; Curtis, D.; & Abrams, M. (2002). *Reasons and strategies for strengthening childhood development services in the health-care system*. Portland, ME: National Academy for State Health Policy; Johnson, K. (2003). *Finding the ways: Medicaid financing for early intervention and child development services in Vermont*. Burlington, VT: Vermont Parent-Child Centers.
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11. Rosenbaum, S. & Sonosky, C. (2000). *Federal EPSDT coverage policy: An analysis of state Medicaid plans and state Medicaid managed care contracts*. Washington, DC: Center for Health Services Research and Policy, George Washington University School of Public Health and Health Services.
12. A web site of the federal Health Resources and Services Administration provides more information about required collaboration and additional opportunities. See <www.hrsa.gov/epsdt>.
13. Data are from: Centers for Medicare and Medicaid Services <www.cms.gov>. These are the most recent data posted for all states. Individual state Medicaid agencies and regional offices may have data available for 2004 and 2005.
14. Institute of Medicine; Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press; Brown, B. & Weitzman, M. (2004). *Early child development in social context: A chartbook*. New York, NY: Commonwealth Fund.
15. Pelletier, H. (2006). *How states are working with physicians to improve the quality of children's care*. Portland, ME: National Academy of State Health Policy; Rosenthal, J. & Kaye, N. (2005). *State approaches to promoting young children's healthy mental development*. Portland, ME: National Academy of State Health Policy.
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SHORT TAKE No. 2: Maximizing the Use of EPSDT to Improve the Health and Development of Young Children prepared by Kay Johnson, Project Director, Project THRIVE

NCCP National Center for
Children *in* Poverty

Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

215 West 125th Street, 3rd floor, New York, NY 10027
TEL 646-284-9600 • FAX 646-284-9623

www.nccp.org