

MANAGING THE “T” IN EPSDT SERVICES

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EXECUTIVE SUMMARY

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the child health component of Medicaid. Federal statutes and regulations specify that children under 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that states must cover a broad array of prevention and treatment services. All types of conditions—medical, mental, developmental, acute, and chronic—must be treated, including conditions not newly discovered or those detected outside of an EPSDT comprehensive well-child “screening” visit. Moreover, for EPSDT, the medical necessity standard used to approve treatment services must assure a level of coverage sufficient not only to treat an already-existing illness or injury but also to prevent the development or worsening of conditions, illnesses, and disabilities.

Despite EPSDT’s broad benefits, studies and state policymakers’ experience suggest that not all children are receiving the services to which they are entitled. While many stakeholders understand the requirements that define EPSDT well-child visits (commonly called screening visits) and their importance in supporting and promoting child health, the requirements that define EPSDT coverage for treatment (the “T” in EPSDT) are not as well understood. This is especially true when treatment extends beyond what is typically covered through private insurance and Medicaid adult coverage.

This brief explores states’ efforts and opportunities to improve access to treatment services in EPSDT. Strategies include:

- Collecting and using data on referrals and treatment
- Focusing on quality improvement
- Identifying children with special needs and better managing their care in order to prevent a child’s condition from worsening
- Maximizing the medical home concept and care coordination/case management
- Clarifying and communicating with providers and families about what treatment services are covered by EPSDT and how to obtain approval for qualified services
- Modifying and adapting their policies to clarify treatment coverage using appropriate definitions of pediatric medical necessity

By managing the T in EPSDT, states can add value to their investments in screening through well-child visits, reduce long-term costs for chronic conditions, and reduce the harm related to untreated child health conditions.

INTRODUCTION

EPSDT was enacted in 1967 to build on the vision of President Johnson and Congress in order to “discover, as early as possible, the ills that handicap our children” and to provide “continuing follow up and treatment so that handicaps do not go neglected.” During the past 40 years, federal EPSDT law has been amended and state efforts have evolved to match changes in standards of pediatric care, structures in the health care system, and our understanding of the physical, emotional, and developmental needs of low-income children.

Federal statutes and regulations specify that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that states must cover a broad array of prevention and treatment services. States have responsibility for key policy and implementation decisions, including provider qualifications, payment levels, benefit definitions, and medical necessity determinations. How states implement and manage EPSDT is important to millions of children, particularly the youngest and most vulnerable.¹

While many stakeholders understand the requirements that define EPSDT well-child visits (commonly called screening visits) and their importance to supporting and promoting child health, the requirements that define EPSDT coverage for treatment (the “T” in EPSDT) are not as well understood. This is especially true when treatment extends beyond what is typically covered through private insurance and Medicaid adult coverage.

This brief explores states efforts and opportunities to improve access to treatment services in EPSDT. The strategies summarized here are being used by Medicaid agencies and their partners to improve child health outcomes and manage health care costs. They are not, however, being used consistently across the country. The information in this brief should be particularly helpful to state agency staff administering EPSDT programs as well as state staff from other agencies endeavoring to improve the delivery of services to young children. It may also help to guide the actions of providers, health plans, family advocates, and others concerned about improving the health of low-income children.

WHAT TREATMENT IS COVERED UNDER EPSDT?

A. TREATMENT BROADLY DEFINED

The array of treatment services covered by EPSDT is too great to describe in this brief. Most EPSDT treatment services needed by children fall within the usual Medicaid benefits categories. (See Appendix I.) Common EPSDT treatment and intervention services beyond most states' Medicaid coverage for adults include: eyeglasses, hearing aids, orthodontia, wheelchairs and prosthetic devices, occupational and physical therapy, prescribed medical formula and nutritional supplements, assistive communication devices, personal care, therapeutic behavioral services (TBS), behavioral rehabilitation, and substance abuse treatment.

Compared to commercial insurance, Medicaid/EPSDT covers more services in a number of categories.² For example, compared to the Federal Employees Health Benefit Plan, Blue Cross/Blue Shield option, EPSDT covers more developmental services, occupational and physical therapy, home health, and speech therapy as needed.³

B. PEDIATRIC MEDICAL NECESSITY UNDER EPSDT

Medicaid, like commercial insurers, will not pay for treatment unless it is considered to be medically necessary. For most private plans, this means the service must be justified as reasonable, necessary, and/or appropriate, using evidence-based clinical standards of care.

For children, federal Medicaid law requires coverage of “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions.”⁴ Thus, the EPSDT medical necessity standard assures a level of coverage sufficient not only to treat an already-existing illness or injury but also to prevent the development or worsening of conditions, illnesses, and disabilities.^{5 6} States face challenges in meeting this coverage standard. They must balance this broad standard of pediatric medical necessity with the need for reasonable administrative practices (e.g., to avoid instances of fraud) to exercise sound fiscal management of Medicaid—maintaining the capacity to apply evidence-based coverage standards and make appropriate decisions regarding what is medically necessary for an individual child.

In order to simplify administration and keep costs down, some states have tried to limit coverage across the board (e.g., on types of wheelchairs, number of physical therapy visits, or on coverage of formula foods). However, as described by Sara Rosenbaum, Chair of the Department of Health Policy and Harold and Jane Hirsh Professor of Health Law and Policy at George Washington University: “A sizable body of federal case law, nearly all of it decided in favor of children, underscores the problems that can arise when states attempt to apply across-the-board treatment limitations...”⁷

Federal Medicaid law also requires that coverage must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Yet, while states have the authority to limit the amount, duration and scope of services based on medical necessity, such limits generally need to be determined case-by-case. For example, one child's condition may require weekly speech therapy over a period of years, while another child may need only three visits while adapting to a new hearing aid device.

Exemplary Medicaid managed care contract purchasing specifications proposed by the George Washington University offer guidance to states about the types of evidence to be considered in making EPSDT treatment coverage determinations. They suggest that in making a coverage determination, Medicaid managed care contracts should require that contractors take into account factors such as the health provider's

recommendation, the child's health status, research evidence, and professional standards. (See Appendix III for further details).

WHY SOME CHILDREN DO NOT RECEIVE COVERED TREATMENT

Despite EPSDT's broad benefits, studies suggest that not all children are receiving the services to which they are entitled.⁸ While most studies discuss low rates for comprehensive, well-child "screening" visits, some researchers have looked specifically at utilization of treatment services. For example, one study used medical records to assess whether health problems were identified and whether treatment, follow-up, or referral care was provided within six months of an EPSDT screening visit. Health problems were identified for 43% of the children; 22% received treatment, and 18% were referred for specialty care. Almost one-third of the children referred for specialty care did not receive such care.⁹

Barriers that inhibit use of screening, diagnosis, and treatment services include:

- **Low provider participation in Medicaid, particularly among dentists, mental health providers, and pediatric specialists.** Families may face challenges in finding a provider who accepts Medicaid. This may be due to providers' perceptions of the adequacy of payment levels, the level of administrative burden associated with participation, or the type of patients who are covered by Medicaid.¹⁰
- **Services are fragmented and poorly coordinated.** In most communities, health and related providers are not organized in a coordinated or transparent manner.¹¹ Providers are more likely to be organized through fiscal structures such as managed care or other network arrangements. Families receiving a referral for specialty pediatric care may face barriers as a result of fragmentation and limited coordination. Without a medical home, families and their children may have no health professional who takes responsibility for following up on referrals for treatment or coordinating medical records.
- **Discontinuous coverage is a barrier to effective treatment.** Changes in coverage status (i.e., being in and out of Medicaid), health plans, or providers can lead to disruptions during a course of treatment or a long-range care plan. A variety of studies have documented the negative impact of discontinuous coverage on utilization of needed pediatric care. For example, a study of infants enrolled in Medicaid in South Carolina found those that experienced a health plan change had significantly less preventive health care, less treatment for illness in physicians' offices, more preventable hospitalizations, and more costly medical care.¹²
- **Parents face different barriers for treatment than for well-child care.** Low-income families seeking care for their children are more likely than middle/high income families to have a "big problem" getting necessary care (2.4 vs. 1.0 percent) and have trouble getting a referral to a specialist (11.5 vs. 5.3 percent).¹³ In terms of treatment services, access barriers are commonly stated reasons for not receiving care (e.g., geographic access or availability of appointments with providers who accept Medicaid). Parents' perceptions of quality and their satisfaction with a child's health provider also have an influence on use of services. For example, one study used Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and found that parents' perceptions of timeliness, family centeredness, and realized access were associated with lower use of emergency departments.¹⁴
- **Unequal treatment by racial/ethnic status also appears to be a factor.** National survey data suggest a need for improved access and quality for children who are racial and ethnic minorities.^{15 16 17} A national study found rates of specialist use by non-Hispanic blacks and

Hispanics were lower than for non-Hispanic whites, even after controlling for chronic condition/disability status and socioeconomic status.¹⁸ Using the Agency for Healthcare Research and Quality's five pediatric quality measures for potentially avoidable hospitalizations (asthma, short-term complications of diabetes, gastroenteritis, urinary tract infection, and perforated appendix), another study found that black children and children insured by public programs had significantly different discharge rates for potentially avoidable hospitalizations than their white or commercially insured counterparts.¹⁹

STRATEGIES STATES USE TO IMPROVE APPROPRIATE USE OF EPSDT TREATMENT

States have opportunities to better manage the “T” in EPSDT services. This section highlights improvement strategies related to data, quality improvement, identification of special needs, medical home, care coordination/case management, and communication with providers and families. Most of the strategies discussed are within reach of state Medicaid administrators, at relatively low cost. At the same time, successful use of these approaches requires partnerships with health plans, providers, and/or families.

A. COLLECT AND REPORT DATA TO SUPPORT TREATMENT REFERRALS

States are required to routinely report EPSDT-related data to the Centers for Medicare and Medicaid Services (CMS). The standard reporting document is known as the CMS 416 form.

One element called for on the 416 form is “*Total Eligibles Referred for Corrective Treatment.*” This counts the unduplicated number of individuals, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic EPSDT well-child (screening) visit—including vision and hearing screenings—were scheduled for another appointment with the screening provider or referred to another provider for further diagnostic or treatment services.

States have not always been successful in tracking the number of referrals or the number of children who have a follow-up appointment or visit for EPSDT treatment. Yet some progress has been made in collecting and reporting this information. National EPSDT statistics from CMS for 2007 indicate that 18.6 percent of child Medicaid beneficiaries who were eligible for EPSDT and 32.5 percent of those received at least one EPSDT well-child (screening) visit were referred for corrective treatment.

When states and providers have a method to routinely track EPSDT referrals, the information can be used to support families, monitor completed referrals (or “close the loop,”) as well as for federal reporting. Some states have adopted approaches such as referral forms (paper or electronic) that can be used by providers or care coordinators (e.g., Maine). Other states have enlisted the support of health plans. For example, Anthem Blue Cross Blue Shield in Ohio has a form and a process specifically for reporting on EPSDT referrals. (http://www.anthem.com/provider/oh/f3/s4/t1/pw_ad089753.pdf)

B. FOCUS ON QUALITY IMPROVEMENT

Quality measurement informs and encourages quality improvement in child health care. Currently, most measures gauge only whether care is received (e.g., receipt of a well-child care visit), providing little information about the actual content of care. Recently, a new measurement framework for comprehensive well-child care was proposed. This framework seeks to improve assessment of children’s health care, take a more efficient approach to data collection, and seek opportunities for eliciting families’ views on the quality of well-child care.²⁰ In the Child Health Insurance Program Reauthorization Act (CHIPRA), Congress called for systematic study and design of child health quality measures. States also have opportunities to augment existing approaches using this new measurement framework.

In particular, some measures from the Health Plan Employer Data and Information Set (HEDIS®) can be used to assess treatment for key, sentinel events and processes. (See text box.) Some states also commission or conduct special reports focused on Children with Special Health Care Needs (CSHCN) or a subset of child health measures that go beyond counting well-child visits. For example:

- North Carolina has developed a special report tracking a subset of HEDIS measures specific to CSHCN. These measures, in addition to focused care studies, are used to assess quality of care and for reporting to state and federal agencies. <http://www.dhhs.state.nc.us/DMA/quality/hedistrendscshcn.pdf>
- In Colorado, the CHIP program—known as Child Health Plan Plus (CHP+)—contracts with managed care organizations to deliver services. The state External Quality Review Organization (EQRO) is charged with calculating performance on a subset of HEDIS measures related to child health and then developing a composite report. The CHP+ selected HEDIS measures for 2008 included: (a) Lead Screening in Children, (b) Access to Primary Care Practitioners, (c) Well-Child Visits in the First 15 Months of Life, (d) Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and (e) Follow-Up Care for Children Prescribed ADHD Medication. <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1234499395789&ssbinary=true>

Medicaid programs can enhance the value and maximize the use of quality measurement resources by integrating patient/family-centered data into their overall quality improvement measurement strategy. For example, the Promoting Healthy Development Survey (PHDS) can help monitor the quality and content of EPSDT services (e.g., anticipatory guidance, developmental screening and follow up and family psychosocial assessment) and can be used by states to focus on and measure quality.²¹ The PHDS collects data on 10 health care quality topics related to clinical and patient-centered care and preventive and developmental services for young children, including coordination of care for children requiring multiple types of health care services or seeing more than one health care provider. Three state Medicaid agencies (Maine, Vermont, and Washington State) have administered the PHDS.

HEDIS® Quality Measures Related to EPSDT Treatment

- Children's Access to Primary Care Providers
- Use of Appropriate Medications for People with Asthma
- Follow-up care for children prescribed ADHD medication
- Children diagnosed with upper respiratory infection and were not dispensed an antibiotic on or within the three days after the episode date
- Average Length of [Hospital] Stay
- Inpatient Utilization-Non-acute Care
- Inpatient Utilization—General Hospital/Acute Care Discharges
- Ambulatory Care—Emergency Room Visits
- Mental Health Utilization (members receiving in-patient, intermediate & ambulatory care services)

C. IDENTIFY CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with special health care needs (CSHCN) are children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.^{22 23} An estimated 12-15 percent of children enrolled in Medicaid would likely qualify as CSHCN. By definition, CSHCN use a disproportionate amount of

treatment services; however, states have challenges in assuring appropriate treatment for CSHCN in Medicaid and EPSDT.^{24 25 26 27 28 29}

Nationally 10 percent of Medicaid and CHIP enrollees (two-thirds of whom have a chronic condition) account for 72 percent of the spending.³⁰ Almost half of the children in the top 10 percent for costs in one year continue to have high costs the next. Targeted programs (e.g., care coordination, case management, care management, medical home) to provide effective interventions and decrease expenditures for those with the greatest costs have the potential to save future health care dollars.³¹

Identification of CSHCN can help states anticipate ongoing costs and manage such costs by optimizing child health. It could also serve to automatically trigger the availability of “upper-tier” or “special” treatment services under EPSDT. The identification of a child’s special needs status can thus form the basis for all coverage, medical necessity decisions and subsequent treatment

A first step in identifying CSHCN is having a clear definition.³² Consensus recommendations for modernizing EPSDT encouraged consistent use of the Title V definition of CSHCN (stated above) because it focuses on developmental risk rather than specific underlying diagnoses, thereby aligning with current concepts of pediatric practice and ensuring that coverage is extended regardless of the nature of the underlying diagnosis.³³

Moreover, while a simple, standardized, and validated CSHCN screening tool exists, few state Medicaid agencies have used it. Use of the standardized CSHCN assessment tool is a practical means to identify those children who might require greater than normal levels of medical and other health-related services.

D. MAXIMIZE THE MEDICAL HOME AND CASE MANAGEMENT/CARE COORDINATION

Increasing Support For The Medical Home

Generally, the term “medical home” describes an enhanced model of primary care in which provider care teams address the multi-faceted needs of patients and provide comprehensive, coordinated, and patient-centered care.³⁴ The American Academy of Pediatrics first advanced the medical home concept to emphasize the importance of having a provider who accepts responsibility for coordination and overall management of health services. The consensus among child health leaders is that a pediatric medical home includes processes to provide continuous and comprehensive primary care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.³⁵ The medical home approach aims to assure that all providers of a child’s care operate as a team, that families are critical members of that team, and that all team members understand the importance of quality, coordinated medical, mental and oral health care.^{36 37} State policymakers recognize the important role the medical home model plays in ensuring that treatment services are appropriately delivered.

Every state Title V Maternal and Child Health program has made a commitment to advancing the medical home for children. Often, this work has been on a small, pilot basis and focused on CSHCN. In some cases, these Title V efforts have become larger partnerships aimed at system change. State Medicaid and CHIP also have played a key role in advancing medical homes and their financing. The medical home’s particular value for assuring treatment is that it places one provider—generally a primary care provider—in a position to develop and monitor care plans and coordinate care, as well assuring that medically necessary treatment services are received. For example:

- Minnesota’s work in assuring medical homes began in the late 1990s with the Title V CSHCN program and was formalized in 2008 with legislation that requires “health care homes” for all Medicaid

and CHIP beneficiaries, state employees, and privately insured in Minnesota. This law calls for standards and criteria that, among other things, emphasize: appropriate use of primary care; quality, patient-centered care; consistent contact with a clinician or team; appropriate care plans for complex or chronic conditions; care coordination services for individuals who have or are at risk for developing chronic health conditions; and use of quality measures, health information technology, and decision support tools. Medical home providers receive higher fees for care of patients with chronic conditions.

- The Colorado Medical Home Initiative for children began in 2001 with the Title V program in the Department of Public Health and Environment and currently brings together a group of more than 40 people representing various agencies, families, hospitals, organizations and policymakers. This public-private partnership has added strength to the approach statewide. In 2007, legislation designated Medicaid (in the Department of Health Care Policy and Financing) to take the lead in assuring a medical home for all Colorado children eligible for Medicaid and CHIP. Incentive payments to trained and certified medical home providers are in place, and more than 500 physicians are participating. At a minimum, medical homes for Colorado children must assure: preventive care, anticipatory guidance and health education, acute and chronic illness care, coordination of specialists and medications, linkage to hospital care, and 24-hour telephone care.

Although many pediatric primary care providers want to be a medical home for their patients, the cost of care coordination and other support mechanisms delivered in pediatric practice settings is substantial and often not covered by payers.^{38 39} Several states are using primary care case management (PCCM)—whether supported by a monthly fee or on a fee-for-service basis—as a way to improve the coordination and continuity of pediatric care and to support medical homes for Medicaid-enrolled children.

- Health Connect is a medical home program of the Illinois Department of Healthcare and Family Services (Medicaid). Illinois Health Connect is based on the American Academy of Pediatricians’ initiative to create medical homes to make sure preventive health care is provided in the best setting. People who are enrolled in Illinois Health Connect will have a “medical home” through a Primary Care Provider (PCP). Illinois reported \$34 million in net savings during fiscal year 2007 from the implementation of this PCCM program and a parallel Disease Management program launched in 2006.
- North Carolina Medicaid operates an enhanced PCCM program, Community Care of North Carolina (CCNC). Built on a traditional PCCM program (known as Access), CCNC aims to manage care across both health and social service providers, and focuses on the highest cost, highest need patients. It relies on a community team approach to care that engages physicians, hospitals, social service agencies, and local health departments. Case managers — often a social worker or nurse — support families and monitor care for beneficiaries with chronic conditions such as asthma or diabetes.

Using Care Coordination/Case Management To Support Delivery Of Treatment

In terms of children’s health, “care coordination” and “case management” are terms used to describe an array of activities that help link families to services, avoid duplication of effort, and improve communication between families and providers. The meaning of these terms varies depending on the provider, program, or payer. In practice today, the terms care coordination and case management are used interchangeably, without clear and distinct usage.⁴⁰ Specifically, Medicaid pays for services identified as case management. (The federal Medicaid statute and implementing regulations do not contain a “care coordination services” category).

Care coordination/case management services are generally used to support access to appropriate health services for two groups of children: 1) children with special health care needs, including chronic conditions and disabilities, who have a need for enhanced and specialty care; and 2) children who experience problems with access to care related to barriers such as language, culture, low health literacy, or geographic distance. Both groups are disproportionately represented in Medicaid eligible populations.⁴¹

EPSDT requires state Medicaid agencies to “arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment.” This means that state Medicaid programs can and should affirmatively assist families and providers in arranging for treatment. (42 U.S.C. § 1396a(a)(43)(C))⁴² Care coordination/case management is a crucial tool to ensure that appropriate treatment is arranged and provided.

E. COMMUNICATE WITH FAMILIES AND PROVIDERS

Informing Families

Informing families and providers about treatment covered under EPSDT is critically important to managing the “T”. This informing is also required by federal law. While all states have information materials to educate families and providers about the screening component of EPSDT, not all have readily available materials that describe the treatment benefits. A few innovative examples of language related to “T” used in communication materials (printed and/or web based) produced by EPSDT programs are below:

- *“If your doctor finds a health problem, he or she will make sure you get the care you need. You will be sent to another doctor or place if you need care your check-up doctor does not provide. If you are in the Medicaid Check-up Program, there are no limits on the number of doctor visits after you have had a well-child check-up (also called an EPSDT screening). Note: Some services may need special approval.”* http://www.medicaid.alabama.gov/documents/ROBIN_5_16_05/3B_EPSDT/3B-3-a-EPSDT-Brochure-for-Recipients.pdf
- *“If any illnesses or medical problems are found during a check-up, they will be treated by the doctor or clinic performing the examination. If necessary, a referral will be made to a special doctor for treatment.”* <<http://www.princegeorgeva.org/Index.aspx?page=499>>
- *“The program includes other child health services for finding and treating illnesses, including referrals for eyeglasses; dental care; and hearing aids, if needed.”* <http://sss.usf.edu/Resources/topic/medicaid/mac_tutorial/childhealthcheckupprogram.htm>
- *“The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program for children... divided into two components: EPSDT Screenings and EPSDT Special Services.... The EPSDT Special Services Program allows coverage for items or services which are medically necessary and which are not covered somewhere else in Medicaid. It is considered treatment. All EPSDT special services require prior authorization. EPSDT Special Services may be preventive, diagnostic or treatment, or rehabilitative. Examples of services covered through the EPSDT Special Services include...”* <http://chfs.ky.gov/dms/epsdt+special+services.htm>
- *“Your TennCare plan and Partner’s plan must provide treatment for any physical, mental or developmental problems that are found.”* <http://health.state.tn.us/factsheets/epsdt.htm>

In a smaller number of states, more innovative or comprehensive approaches to informing have been undertaken. For example:

- Iowa has created on-line resources for families and providers, adding to their toll-free family help line and the network of county-based EPSDT coordinators. <<http://www.iowaepsdt.org/>> <http://www.ime.state.ia.us/Members/AdditionalServices/EPSDT/Resources.html>

- The Oklahoma Health Care Authority has an EPSDT video on YouTube intended for physicians, physician's assistants, nurses and administrative staff. <<http://www.youtube.com/watch?v=MBVL5K-j7do>> <www.okhca.org>
- California has an information brochure specifically related to EPSDT and mental health services. It discusses treatment coverage and the interface with community mental health providers. Some counties have opted to post this information on local websites.
http://www.co.san-bernardino.ca.us/dbh/childrenservices/01-07_Enclosure_A.pdf
<http://www.co.fresno.ca.us/DepartmentPage.aspx?id=16237>

Informing Providers About The Process For Determining Medical Necessity

Pediatric providers commonly report that in addition to not understanding what services might be covered as EPSDT treatment, they also do not know how to seek approval for coverage. State policymakers can play a role in describing the processes providers should follow to obtain medical necessity determinations. States do so in a variety of ways, including managed care contract requirements, Medicaid policy manuals and provider communications. The AAP recommends that such communications include how to: provide clinical evidence supporting coverage of interventions that meet the needs of the individual child; incorporate appropriate pediatric expert opinion or testimony supporting coverage of interventions; assist families who wish to appeal in the case of denials; and determine when coverage decisions will be made.⁴³

Some states have a specific form that helps guide the process for determining medical necessity in EPSDT. For example, the North Carolina Division of Medical Assistance website advises that prior authorization may be required to verify medical necessity for some services. It also states that: "If a child's physician or another licensed clinician determines that a child needs a treatment service that is not normally covered by Medicaid, the provider must submit a "Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age" on behalf of the recipient...." <http://www.dhhs.state.nc.us/dma/epsdt/>

F. ADOPT IMPROVED POLICIES AND PROCEDURES

Studies suggest that when states modify policies with the goal of increasing appropriate utilization of a particular service, it can make a significant difference.⁴⁴ State Medicaid policy and procedure changes can be large (e.g., modifying the prior authorization process, clarifying coverage for child development services) or small (e.g., modified billing codes, updated provider letters).

The following examples illustrate different approaches.

- Wisconsin changed their Medicaid Policy to allow medical care (not just dental) providers to be reimbursed for fluoride varnish treatment (FVT) provided to enrolled children. Following the policy change, Medicaid claims for FVT increased from 3,631 in 2002-03 to 28,303 in 2004-06, with more than one-third submitted by medical care providers.⁴⁵
- The California EPSDT provider manual expanded and increased funding for Medicaid-financed mental health treatment. The expansion efforts had the greatest effect in rural and "underequity" counties that face the greatest barriers to mental health service use.⁴⁶

Florida reissued its EPSDT policy guidance for treatment services for young children (birth through five) in 2002. The updated guidance reflects more current practice in early childhood development and early childhood mental health practice. One important change was clarification of coverage for parent-child therapy in the case of infants and toddlers. Adoption of the age appropriate diagnostic codes (DC:0-3) was another important element. Built from a state-level strategic plan, these changes were piloted, evaluated, and then disseminated statewide. (<http://www.cpeip.fsu.edu/FAIMH/2008IMHPlan.pdf>)

CONCLUSION

The broadly defined EPSDT benefit aims to provide support for healthy growth and development for millions of low-income children— an estimated one in four. Some suggest that the open-ended nature of the EPSDT benefit leads to excess and high costs for state Medicaid agencies. While a small number of cases and anecdotes have been widely reported, researchers have concluded that the lack of reliable data makes it impossible to determine if EPSDT adds to what otherwise would have been covered under Medicaid. Children account for about half of the Medicaid enrollees but less than 20% of expenditures. Even CSHCN who have higher than average costs (greater than \$20,000 annually) account for only 3 percent of total Medicaid spending.⁴⁷

States have the primary implementation role in assuring that the goals and rules of EPSDT are met. Many states have focused administrative attention on assuring that children receive the comprehensive well-child (screening) visits defined under EPSDT, and more work remains to be done in that area. At the same time, states are actively engaged in supporting the use of medically necessary treatments and interventions that can provide long-term health and savings.

States are using the following strategies to improve and manage the delivery of treatment services (“T”) in EPSDT. States may want to consider those strategies they’ve not yet adopted as ways to improve child health outcomes, manage costs, and maximize the time of available providers.

- **Collect and report data:** Improved data on referrals and treatment can help states support families and assure completed referrals. Revised reporting forms, electronic reporting, and tools for providers are some options for improving data.
- **Focus on quality improvement:** Major new opportunities to measure child health quality are emerging through public and private sector projects. States also have opportunities to better use existing tools for quality improvement, such as HEDIS measures and improvement partnerships.
- **Identify Children with Special Health Care Needs:** By definition, CSHCN use an above average amount of health services. When enrolled in Medicaid, they account for a disproportionate share of EPSDT treatment services. States can better serve these children and their families, as well as better manage costs, through clear definitions, consistent identification of CSHCN, and use of mechanisms to manage care.
- **Maximize the medical home and case management/care coordination:** Medical homes and care coordination are important approaches for assuring receipt of appropriate and needed treatment. The medical home is an essential tool for assuring appropriate utilization of child health services, and state Medicaid agencies can do more to administratively and financially support medical homes. States also have an opportunity to use case management/care coordination to improve linkages among providers and to support families in their efforts to use appropriate treatment services.
- **Communicate with Families and Providers:** Lack of knowledge among families and providers is one of the widely reported reasons children do not receive the EPSDT treatment services to which they are entitled. Pediatric providers need information that can help them understand how to make referrals, what case management may be available, and how to traverse the process for determining the medical necessity of a recommended treatment. Families need to be informed about the benefits available to their children.
- **Adapt improved policies:** When an area of improvement is identified, states have an opportunity to make both small and large changes to Medicaid policy. Studies have shown that even small changes, such as clarifying billing codes or provider guidance, can help improve service delivery for children.

APPENDICES

APPENDIX I: EPSDT SCOPE OF BENEFITS (42 U.S.C. §§ 1396D(R)(5), 1396D(A))

MANDATORY SERVICES:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally-qualified health center services
- Laboratory and X-ray services
- Nursing facility services for adults
- EPSDT services
- Physician services
- Family planning services and supplies
- Physician services
- Medical and surgical services furnished by a dentist (with limitation)
- Nurse-midwife services
- Pediatric nurse practitioner or family nurse practitioner services
- Home health services for persons eligible to receive nursing facility services

SERVICES OPTIONAL FOR ADULTS; MANDATORY UNDER EPSDT WHEN NECESSARY TO CORRECT OR AMELIORATE AN ILLNESS OR CONDITION:

- Case management services
- Dental services, including orthodontia and dentures
- Prescribed drugs
- Physical therapy and related services
- Eyeglasses
- Home health care services (includes nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services)
- Private duty nursing services
- Clinic services
- Prosthetic devices
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Intermediate care facility for the mentally retarded services
- Inpatient psychiatric hospital services for individuals under age 21
- Hospice care
- TB-related services
- Respiratory care services
- Personal care services
- Primary care case management services
- Any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary of the Department of Health and Human Services.

APPENDIX II: FEDERAL LAW RELATED TO EPSDT TREATMENT

SUMMARY OF FEDERAL STATUTORY PROVISIONS

In 1989, Congress clarified that all treatments allowed under the federal definition of “medical assistance” in the Medicaid statute (that is, all mandatory and optional Medicaid services) are covered in all states for children enrolled in Medicaid. Treatment must include any “other necessary health care, diagnostic services, treatment, and other measures” that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act) that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.”

The Deficit Reduction Act of 2006 (DRA) revised federal Medicaid law related to eligibility and enrollment, benefit and coverage standards, patient cost-sharing, and case management activities. The DRA gives states the flexibility to provide “alternative” coverage, known as benchmark coverage. (42 U.S.C. § 1396w, added by § 6044 of the DRA) However, the EPSDT benefit standard for children continues under the DRA and must be met either under the benchmark package or so called “wrap-around” benefits. (42 U.S.C. § 1396w (1)(A)(ii) as added by § 6044 of P.L. 109-171).

REGULATIONS RELATED TO EPSDT TREATMENT

§ 5124(B)(1) “You [the states] must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in § 5122 F.”

§ 5122 F. “Limitation of Services.—The services available...are not limited to those included in your State [Medicaid] plan.... the services must be necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . . and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You [the states] make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.”

“42 CFR 440.230 allows you [the states] to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in § 1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.”

APPENDIX III. CONTRACT PURCHASING SPECIFICATIONS

Contract purchasing specifications proposed by the George Washington University make further suggestions regarding the type of evidence to be considered in making coverage determinations about treatment under EPSDT. These exemplary purchasing specifications are intended to guide Medicaid agencies in developing strong and effective contracts under managed care arrangements. They suggest that in making a coverage determination, Medicaid managed care contracts should require that contractors take into account the following evidence and information if offered on behalf of the enrolled child:

- Recommendation of the provider treating the enrolled child for whom the coverage determination must be made;
- Clinical evidence of the health status and needs of the child;
- Evidence and information that is provided by the child or child's family or caregiver;
- Opinions of medical, dental and other health care practitioners who are experienced in the treatment of children with similar mental or physical illnesses or conditions;
- Professional standards of medical, dental and other health care practice related to the care of children, as reflected in: (a) scientific literature published in peer-reviewed journals; (b) the results of clinical trials relevant to pediatric care; (c) government-sponsored studies; (d) professional consensus statements; and (e) other sources of valid and reliable evidence regarding the pediatric standard of care;
- Opinions of, and evidence supplied by, qualified individuals who are involved in the care of the enrolled child and who are affiliated with publicly-supported agencies, programs, or providers delivering health services to children residing in contractor's service area; and
- Provisions of an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA).

The Purchasing Specifications also recommend that state Medicaid managed care contracts specify that the contractor shall not deny, terminate, reduce or exclude coverage in part or in whole of an item or service covered for an enrolled child because the item or service sought is: (a) required to treat a condition rather than an illness or injury; (b) not expected to result in the restoration or achievement of normal functioning; (c) experimental, unless the service is available only through a clinical trial, or is not a generally accepted practice or procedure among pediatric specialists; (d) identified in a plan of care developed by another public agency, in an IEP or IFSP, or provided in a school setting; or (e) mandatory because of a failure of the family or caregiver of the enrolled child to ensure that the child has complied with a recommendation or prescription of the child's treating provider.

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