

Kay Johnson
ABCD Screening
Academy
July 10, 2007

EPSDT Overview

Since 1967, Medicaid has included a special child health benefit known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. From its beginning, its mission has included prevention and early intervention.

Most Important: The Three E's

- ❖ Eligible services for
- ❖ Eligible children delivered by
- ❖ Eligible providers

Why discuss EPSDT?

- ❖ EPSDT was designed to ensure comprehensive health coverage for children in Medicaid, related to preventive, acute and chronic medical problems.

Source: 42 U.S.C. Section 1396d(a)(4)(B); 42 U.S.C. Section 705(a)(1968).

- ❖ EPSDT has policy significance as the only U.S. entitlement to comprehensive child health services.



Overview of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit

EPSDT GOALS

- ❖ Created in 1967 during Johnson Administration
 - “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.”

- ❖ Sweeping guarantee for comprehensive health coverage unlike any other in US health policy
 - To locate poor children, assess their health status, and ensure that they received the continuous and comprehensive medical care they need. (Rosenbaum and Johnson, 1986)

What significant EPSDT policy events?

- ❖ Created in 1967, with major amendments in 1972.
- ❖ Recodified in 1989, with a strengthened federal definition of mandatory benefits.
- ❖ In 1993-94 health reform proposal called for EPSDT benefits to be limited to children living in poverty.
- ❖ In the 1996-97 policy debate that led to SCHIP, the EPSDT comprehensive benefit package was discussed, but rejected to serve as the SCHIP benefits.
- ❖ The Deficit Reduction Act of 2005 (DRA) revised Medicaid statutory requirements in several areas.

EPSDT Framework

Follow the letters:

- E**arly - starting before problems worsen
- P**eriodic - at regular intervals & as needed
- S**creening - comprehensive well child exams
 - with developmental, physical, and mental, plus separate vision, hearing, dental
- D**agnosis - as appropriate
- T**reatment - all services (covered under federal law) needed for diagnosed conditions

The Dual Nature of EPSDT

“The EPSDT program consists of two mutually supportive, operational components:

- assuring the availability and accessibility of required health care resources
- helping Medicaid recipient and their parents or guardians effectively use these resources.”

- ❖ Fulfilling each continues to be challenging.

Sources: Center for Medicare and Medicaid Services, *State Manual Part 5 EPSDT*.

Summary of EPSDT Core Elements

❖ **Benefits and services:**

- Periodic and “as needed” screening services
- Vision, hearing, and dental care
- All medically necessary diagnosis and treatment needed to “ameliorate” conditions
- A prevention-focused standard of medical necessity

❖ **Administrative services:**

- Informing families
- Transportation, scheduling and other assistance
- Linkages to other agencies
- Reporting

Medicaid Benefits

States must cover:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Nurse midwife and pediatric / family nurse practitioner services
- Medical & surgical dental care
- Laboratory & x-ray services
- EPSDT services
- Family planning services
- Rural health clinic and federally-qualified health center services
- Home health & nursing facilities

Optional, covered for children as necessary

- Prescription drugs
- Dental services
- Optometrist & eyeglasses
- Mental health services
- Prosthetic devices
- Intermediate nursing facility / mental retardation services
- Nursing facility for < age 21

EPSDT “Medical Necessity”

“Medically necessary” services covered

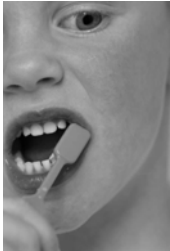
- EPSDT definition is broader than most private plans
- EPSDT covers prevention & early intervention
- Thus, a service is medically necessary:
 - if service will prevent condition,
 - if service will improve health or ameliorate condition, or
 - if service will cure or restore health.

Definition of Developmental Screening and Assessment under EPSDT

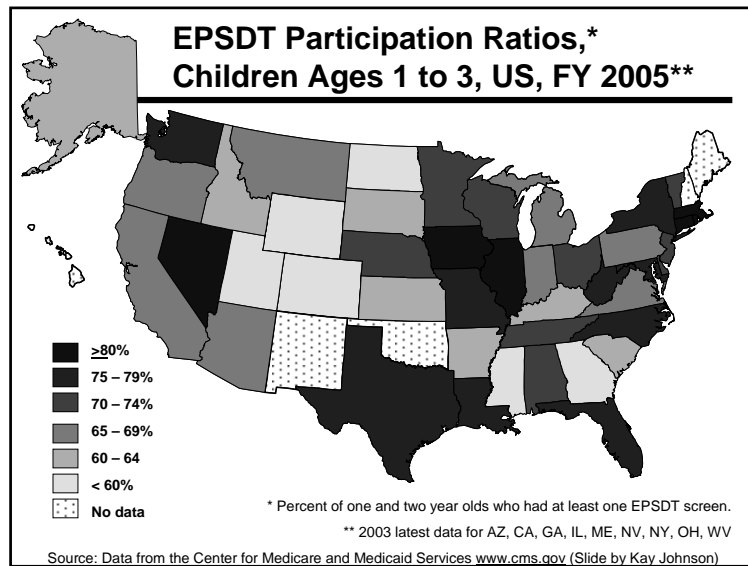
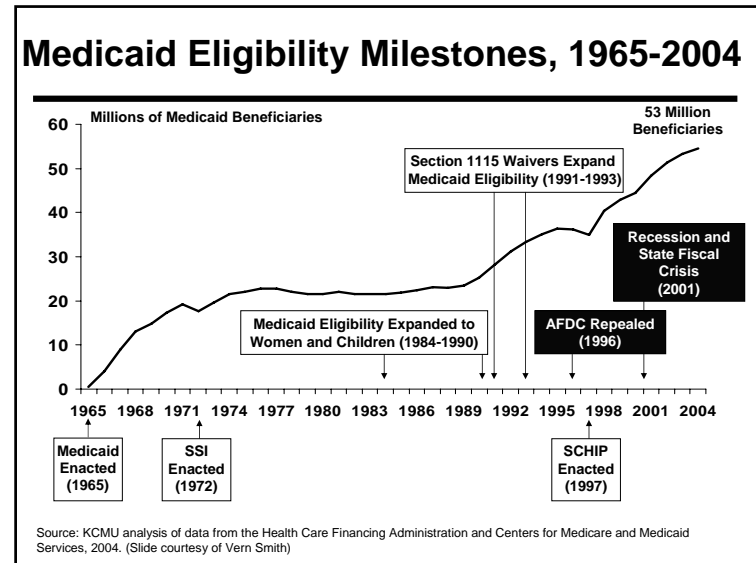
“Screening for developmental assessment is a part of every routine initial and periodic examination. Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process.... In younger children, 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.”

Source: CMS State Medicaid Manual, Part 5: EPSDT § 5123.2

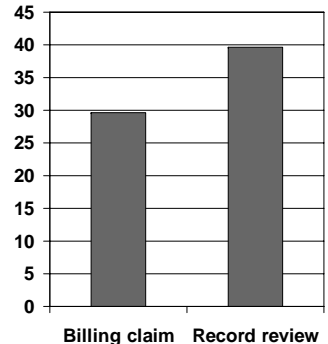


What do we know about EPSDT program performance?



Bad data &/or poor performance?

- ❖ Administrative data showed 30% of children received a well child visit.
- ❖ Medical record review showed 40% had a visit.
- ❖ EPSDT screens provided for only 68% of the children who had a claim or encounter billed as well child visit.



Billing claim Record review

Source: Schneider KM, Wiblin RT, Downs KS, O'Donnell BE. Methods for evaluating the provision of well child care. *Joint Commission Journal on Quality Improvement*. 2001;27(12):673-82.

National HEDIS Results for Measure: Well-Child Visits in the Early Childhood Years (Birth to 6), 2004

MEASURE	Mean	10th %tile	90th %tile	Difference/ Gap
Six or More Well-Child Visit in the first 15 Months of Life				
<i>Medicaid</i>	45.0	15.2	65.7	50.5
Commercial	68.7	47.9	85.7	37.8
One or More Well-Child Visits in the 3rd, 4th, 5th, & 6th Years				
<i>Medicaid</i>	62.0	48.6	76.7	28.1
Commercial	64.4	48.3	82.7	34.4

Source: NCQA: 2000 HEDIS® and HEDIS/CAHPS® www.ncqa.org

Success depends on linkages to other public programs for children & families

- ❖ Title V MCH primary child health care
- ❖ Title V Children with Special Health Care Needs (CSHCN)
- ❖ Immunization
- ❖ Child Welfare, particularly foster care
- ❖ IDEA Part C Early Intervention
- ❖ IDEA Part B Preschool and School-age Special Education
- ❖ Early Care and Education/Head Start

EPSDT and Title V Collaboration

Web-based Module www.hrsa.gov/epsdt

Content related to:

- EPSDT & Title V policy
- Opportunities for collaboration
- Examples of data, family support, provider and other collaborative projects
- Links to federal and other resources

Deficit Reduction Act of 2005 (DRA)



- Eligibility
- Premiums and cost-sharing
- Benefits coverage
- Case management



MEDICAID ELIGIBILITY

Eligibility

- **Federal law mandates:**
 - Infants and children to age 6 up to 133% of poverty
 - Children ages 6-18 up to 100% of poverty
- **State options to cover:**
 - Children in Medicaid at any income level
 - SCHIP ≥ 200% of poverty
 - Children with disabilities and special needs ≥ 300% of poverty

Mandated up to 133% of poverty

Birth to 6

Optional Medicaid for children with disabilities up to or above 300% of poverty

Ages 6 -18

Optional Medicaid and/or SCHIP up to or above 200% of poverty


Mandated up to 100% of poverty

Post DRA: Family Opportunity Act (Effective 1/1/2007)

- ❖ New State option allows families of children with severe disabilities to “buy-into” Medicaid
 - **Age:**
 - Target group children birth to age 19 (qualified for SSI)
 - Phased-in, starting with younger children under age 6
 - **Income:**
 - Up to 300% FPL;
 - At higher income levels with state funds only
 - **Premium caps:**
 - 5% cap <200% FPL, 7.5% cap 200-300% FPL
 - **Employer-sponsored family coverage:**
 - If eligible must enroll + 50% of premium paid by employer
 - Premium subsidy at option of state
- ❖ Parent-to-Parent Information Centers (Title V)

Eligibility: Post-DRA Documentation (Effective 7/1/2006)

- ❖ **Citizens:**
 - No self-declaration of U.S. citizenship
 - **Must present:**
 1. U.S. passport, certificate of naturalization, certificate of U.S. citizenship, valid driver’s license, or other ID document deemed valid, or
 2. birth certificate or other ID document deemed appropriate (e.g., school id, medical record)
 3. Other documents by special exception
- ❖ **Legal residents:**
 - No change



**MEDICAID
FINANCING:
FAMILY
CONTRIBUTIONS**

Medicaid Family Cost Sharing

❖ **PRIOR LAW**

- Children, all income levels:
 - No premiums, no cost-sharing
 - Demonstration waiver authority
- Pregnant women, all income levels:
 - No premiums
 - Pregnancy-related services: no cost-sharing
 - Non-pregnancy-related services: "nominal" cost-sharing (\$3 or 5% of cost of service, with special limits for institutional care)
 - Demonstration waiver authority


Post DRA: Premiums & Cost Sharing

Effective January 1, 2007

- For mandatory groups of children and pregnant women no premiums and cost sharing
- For child/family income below 150% FPL
 - No premiums
 - Cost sharing limited to 5% of income
 - Co-insurance to 10% of cost for service
- For child/family income above 150% FPL
 - Premiums and cost sharing limited to 5% of income
 - Co-insurance to 20% of cost for service
- For new disability optional group
 - For child family income 150-200% FPL, premiums and cost sharing limited to 5% of income
 - For child family income 200-300% FPL, premiums and cost sharing limited to 7.5% of income

Above 300% FPL no federal participation; family buy in at full cost anticipated	Optional Medicaid for children with disabilities up to or above 300% of poverty ↑
Optional Medicaid and/or SCHIP up to or above 200% of poverty ↑	Optional group to 150% has special cost sharing rules
Mandated up to 133% of poverty	Mandated up to 100% of poverty

Birth to 6 Ages 6 -18



**MEDICAID
BENEFITS**

Medicaid Benefits

❖ PRIOR LAW

- Some federally mandated
- Some optional, state selected
- Since 1989, more benefits required for children:
 - EPSDT is benefit package for children
 - Included all allowable under federal law, even if not in state plan

Post-DRA: Coverage Rules

(Effective 3/31/2006)

- ❖ States have the option to use a “benchmark” benefit package and require enrollment for certain groups.
 - No need for waiver; State Plan Amendment suffices
 - This is similar to what is used for State (non-Medicaid) SCHIP programs.
 - Cannot use for expansion groups

Post-DRA: Coverage Wrap-around

(Effective 3/31/2006)

- ❖ For children, states must supplement “benchmark” package with “wrap-around” EPSDT coverage
 - Required coverage of all benefits as defined since 1989 in Sec. 1905(r) of Medicaid law
 - Obligation to provide comprehensive children’s services is maintained.
 - Further CMS guidance expected

MEDICAID

CASE MANAGEMENT



Case Management: PRIOR LAW

TYPE	SAMPLE ACTIVITIES	MATCH RATE
EPSDT case management	<ul style="list-style-type: none"> • Outreach & informing • Arranging transportation 	50/50
Administrative case management	<ul style="list-style-type: none"> • Assisting with applications • Assisting providers 	50/50
Targeted case management	<ul style="list-style-type: none"> • Help in identifying services • Care coordination 	63/37 <small>(state's service match rate)</small>
Case management requiring expertise of skilled medical personnel	<ul style="list-style-type: none"> • Reviewing care plans • Approving provider payments • Certain referrals 	75/25

Post DRA: Case Management

(Effective 1/1/2006)

- ❖ Definition clarified
 - Assessment
 - Development of care plan
 - Referrals
 - Monitoring and follow-up
- ❖ Excludes from the definition
 - Direct delivery of referred medical, educational, social, or other services such as foster care administration
 - Potentially related to Part C, home visiting, mental health, child development, etc.
- ❖ FFP available only if no other third parties are liable to pay for services



Medicaid Managed Care and Child Health

Pediatric Issues in Managed Care

- Pediatricians as primary care provider
- Pediatric specialists in network
- Child-focused benefits (EPSDT)
- Child-focused medical necessity standard
- Children with special health needs defined
- Appropriate quality measures
- Coordination with other children's programs

Contracts in Regulatory System

Source: *Negotiating the New Health System*, Rosenbaum et al. 1997



In or out of contract?

- ❖ Contract should specify what will be covered by MCO and what is “wraparound.”
 - MCOs need to know exactly what services they are responsible for covering.
 - Families of enrolled children need to know what services they are entitled to receive from the MCO and what services they are entitled to that will be otherwise financed by the state Medicaid program.
- ❖ Similar situation may apply with benchmark benefit packages under Deficit Reduction Act (DRA).



First day at school!

Together you can assure services, support families, and improve child health outcomes by using the power inherent in EPSDT.

More Resources

- ❖ For general use
 - www.cms.gov
 - <https://www.cms.hhs.gov/medicaid/epsdt/default.asp>
 - www.cms.hhs.gov/EPSTDDentalCoverage
 - http://www.hrsa.gov/medicaidprimer/maternal_child_part3only.htm
 - www.kff.org
 - www.gwumc.edu/sphhs/healthpolicy/c_hsrp/newsps
 - www.cmwf.org
 - www.nashp.org
 - www.mchlibrary.info/KnowledgePaths
 - www.chcs.org
 - www.mchpolicy.org
- ❖ For families
 - www.family-networks.org
 - www.partoparvt.org
 - www.healthconsumer.org/cs009epsdt.pdf
 - www.familyvoices.org
 - www.wpas-rights.org
- ❖ For providers
 - www.aap.org
 - www.brightfutures.org/mch/epsdt.html
 - www.medicalhomeinfo.org/tools/screening.html