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Briefing

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Improving EPSDT Periodicity Schedules to Promote Healthy Development

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Federal regulations require each state Medicaid agency to develop an EPSDT schedule based on professional guidelines and standards. When developing these schedules, state agencies must consult with organizations that represent the full range of providers who deliver health care to children, including those who deliver mental and oral health care. State agencies must update EPSDT schedules at intervals that meet reasonable standards of medical practice. As a result many states have worked to facilitate primary care provider efforts to follow American Academy of Pediatrics recommendations for developmental surveillance and screening. These efforts include both recommending specific tools for use during structured screening at appropriate intervals and adding visits to their EPSDT periodicity schedules as well. This *State Health Policy Briefing* summarizes findings from a review of state websites and an informal survey of state EPSDT Coordinators designed to identify the extent to which states were changing Medicaid policies to incorporate the 2007 Bright Futures guidelines into their programs, with a specific focus on the 30-month well-child visit (EPSDT screen).

Increasingly, and particularly for young children, the role of the health system is viewed in much broader terms of disease prevention and health promotion.[1] Disease prevention and health promotion affect the trajectory of children's development, including reducing risk factors and strengthening protective ones.[2] Also, an emphasis must be placed on regular check-ups and anticipatory guidance and education for parents to promote healthy child development.[3]

Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit is comprehensively designed to promote children's healthy development.[4] EPSDT includes outreach, comprehensive well-child visits (referred to as EPSDT screens), treatment and case management. An EPSDT screen is the core service of this benefit. EPSDT screens are designed to identify any physical, developmental, oral or mental health condition a child may have, as well as provide parents (and adolescents) with information to help them promote the child's optimal development. Each state Medicaid agency must establish a [1]schedule that specifies at what age EPSDT screens should occur. Additional EPSDT screens must also be provided when needed—these are often referred to as interperiodic screens.

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EPSDT Periodicity Schedules

Federal regulations require each state Medicaid agency to develop an EPSDT schedule based on professional guidelines and standards. When developing these schedules, state agencies must consult with organizations that represent the full range of providers who deliver health care to children, including those who deliver mental and oral health care.[5] State agencies must update EPSDT schedules at intervals that meet reasonable standards of medical practice.

In addition to covering the EPSDT well-child visits listed in their periodicity schedule, states are required to finance additional visits to a health care provider when needed outside of the schedule to determine whether a child has a condition that needs further care. These types of visit are called "interperiodic screens." By law, persons outside the health care system —such as a teacher or parent—can also determine the need for an interperiodic screen. In general, interperiodic screens are intended to be used for checking a child's health status when conditions arise outside of the EPSDT periodic visit schedule.

Why states are updating EPSDT periodicity schedules now

In October 2007, the American Academy of Pediatrics (AAP) updated and published the 3rd edition of their Bright Futures Guidelines for Health Supervision.[6] The new guidelines were developed by a steering committee of pediatricians and other experts and based on recommendations made by Multidisciplinary Expert Panels informed by a thorough assessment of available scientific evidence.[7] These recommendations for preventive pediatric care represent the core content of care for well-child visits from birth through age 21.[8] In 2007, the AAP also revised their recommended periodicity schedule to be more consistent with the Bright Futures guidelines. In accordance with the Bright Future guidelines, these revisions included adding three new well-child visits to their periodicity schedule. These new visits are to occur at 30 months, 7 years, and 9 years of age.

The 30-month visit is particularly critical for identifying children at-risk for developmental delay because it is the last of three visits in which the AAP recommends that primary care providers augment developmental surveillance with a validated, age-appropriate developmental screening tool. It is also an opportune time to check children's language and social development.[9] (The AAP also recommends using a developmental screening tool at the 9 and 18 month visits.) There is evidence that (1) many children with developmental delays are not identified (and thus do not receive treatment) until they enter school and (2) providers who use a developmental screening tool in addition to their clinical judgment more effectively identify children with developmental delays than those who rely solely on clinical judgment.

In recent years states have recognized it is important to identify and treat developmental delays early in a child's life. As a result many states have worked to facilitate primary care provider efforts to follow AAP recommendations for developmental surveillance and screening. These efforts include both recommending specific tools for use during structured screening and adding the 30-month visit and developmental screening at appropriate intervals to their EPSDT periodicity schedules as well.

Adding the 30-month well child visit (EPSDT screen)

Most states base their periodicity schedules on AAP recommendations but often modify them to reflect Medicaid-specific policies (such as federal requirements for lead testing and referrals to a dental provider). As previously described, state Medicaid agencies must consult with professional organizations and experts when developing their periodicity schedules. A few states have found that primary providers in their state do not agree with all of the national Bright Futures recommendations and some of these states have developed schedules to accommodate the local variation in practice. For example, when Colorado recently added the 30-month visit; the state chose to remove other recommended sections and/or screenings based on feedback from the provider community, relying upon a multi-disciplinary EPSDT advisory committee to make such decisions. In Minnesota, providers and health plans have agreed upon an alternate visit schedule that is being used by Medicaid.

Also, most states do not automatically update their schedules as the AAP issues new recommendations. Rather, most Medicaid agencies must act to integrate new AAP recommendations into their programs. New York is an exception. This state requires Medicaid providers to follow the most current version of AAP Bright Futures Guidelines for Health Supervision.

Recently, NASHP conducted a review of state websites and an informal survey of state EPSDT Coordinators to identify the extent to which states were changing Medicaid policies to incorporate the 2007 Bright Futures guidelines into their programs, with a specific focus on the 30-month well-child visit (EPSDT screen). We emphasized the 30-month visit as a key change recommended by the Guidelines to (among other reasons) improve identification of young children at risk for developmental delay—a documented policy goal for many states. Through this effort NASHP identified 14 Medicaid agencies that had, as of June 2009, added the 30-month visit to their periodicity schedules. An additional seven were in the process of adding the visit. (See Table 1). Note that the states listed here are those that NASHP staff positively identified as taking action—others may also have made or be in the process of making changes.

In addition, a small number of states—including Arizona and Illinois—have not added the 30-month visit but are encouraging developmental screening at the 24-month EPSDT visit already on their schedule. In these states, a child could receive a third recommended developmental screen but perhaps not at the optimal age.

Finally, as previously discussed, an interperiodic screen can be provided at the discretion of the primary provider or upon request by someone outside the health care system such as a parent or provider. Therefore, those primary care providers that opt to provide the 30-month visit in states that have not added that visit to the formal periodicity schedule can most likely bill for that screen as an interperiodic visit. Indeed, four states (Louisiana, Massachusetts, Maryland and Virginia) specifically reported that although they did not add the 30-month visit to the periodicity schedule they would pay for 30-month visits as interperiodic screens. This approach does not establish an expectation that Medicaid-covered children will receive a 30-month visit but it does enable payment to providers who opt to conduct the recommended 30-month visit.

Table 1: State coverage of the 30-month well-child visit (EPSDT Screen)

California	Y
Connecticut	Y
Colorado	Y
Florida	P
Georgia	Y
Hawaii	P
Iowa	P
Kansas	Y
Maine	P
Michigan	Y
Nevada	P
New York	Y
Ohio	Y
Oregon	Y
Pennsylvania	Y
Puerto Rico	Y
Rhode Island	Y
South Dakota	Y
Texas	P
West Virginia	P
Wisconsin	Y

Y - added 30-month visit

P - in process of adding visit

How State Medicaid Agencies Can Facilitate Adoption of Improved Standards of Care

Each state's EPSDT periodicity schedule incorporates the Medicaid agency's expectations for well-child care by specifying the minimum intervals at which EPSDT screens should occur and what activities each should include. Therefore, incorporating new guidelines into the schedule is an important step in facilitating adoption of improved standards of care. However there is more, that states can do to facilitate adoption, including improving payment and coverage policies, supporting practice change through training and resources, and measurement to create the case for and reward improvement. The following examples are drawn from the Assuring Better Child Health and Development (ABCD) Screening Academy[10] which brought together states to facilitate implementation of objective developmental screening based on AAP recommendations, as well as information gleaned during a web conference with State Medicaid EPSDT Coordinators. (See http://abcd.nashpforums.org/ for complete information about ABCD Screening Academy results.)

- Illinois allows a 30-month visit but has not yet mandated it. However, a monthly data profile notifies providers when either a 24- or 30-month screening has been done/

not done. Providing this feedback to the providers has gone far to move the provider community to adoption of improved standards of care and in turn has improved screening rates significantly.

- Massachusetts has worked extensively on spreading structured behavioral health screening in EPSDT through a comprehensive in-person statewide training program. In response to a court mandate, the Medicaid program and Managed Care Organizations (MCOs) partnered to design an agenda facilitated by local developmental pediatricians. Participating providers reported appreciating the peer-to-peer learning opportunity and the perspective of a trainer who could speak directly to both clinical and office implementation issues.
- North Carolina pediatricians focused on improvements in developmental screening in clinical practice. In turn, these efforts resulted in a policy change with the state EPSDT (Health Check) requirements in 2004. One of the many components of a complete EPSDT visit is developmental screening including mental, emotional, and behavioral. The new policy requires practices to use a formal, standardized developmental screening tool and encourages the use of the Current Procedural Terminology (CPT) code 96110-EP on the claim form.[11]
- Kansas' Medicaid program developed a web-based training for health care providers. Topics include requirements for developmental screening, recommendations for specific tools, and detailed information about billing and coding procedures related to developmental screening in primary care. These requirements were included in revised EPSDT guidelines.[12]
- Colorado, Iowa, Maine and Minnesota use local EPSDT coordinators (typically public health nurses or social workers employed by the local health departments) to assist providers and families in coordinating and tailoring the delivery of EPSDT services for individual families and children.[13]

Finally, more than half the states in the ABCD collaborative found suggesting and recommending specific screening tools to be used during well child exams and testing them in pilot sites made a difference[14]. For example, both Minnesota and Oregon developed comprehensive websites dedicated to promoting healthy development which included recommendations for specific tools. Other states have produced several iterations of recommended tool lists, recognizing that different providers want varying levels of advice/instruction as they adopt improved standards of care.

Opportunities for Improvement

States can accelerate adoption of improved standards of care. State Medicaid agencies can develop their EPSDT periodicity schedules to support practice change and incorporate new standards of care which actively encourage effective practice. Adding age-appropriate visits to periodicity schedules, recommending the use of validated developmental screening tools during well child care and ensuring that required and recommended services are provided in a coordinated way to families and children are just a few of the strategies states are using to improve the quality of well child care provided under EPSDT.

Endnotes

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3 Ibid.

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8 Bright Futures/American Academy of Pediatrics. "Recommendations for preventive pediatric health care" (periodicity schedule). (Elk Grove Village, IL, AAP, 2007). Retrieved July 15, 2009. http://practice.aap.org/content.aspx?aid=1599&nodeID=4003, or http://brightfutures.aap.org/pdfs/Guidelines_PDF/20-Appendices_PeriodicitySchedule.pdf.

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10 Please visit http://abcd.nashpforums.org/ for more information.

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13 Jill Rosenthal and Kay Johnson. *Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States*. (Portland, ME: National Academy for State Health Policy, April 2009). Retrieved July 28, 2009. http://www.nashp.org/files/ABCD_III_background_paper.pdf.

14 Please visit the ABCD Resource Center for more details at http://nashpforums.org/abcd.

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