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Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet

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The problem is to discover, as early as possible, the ills that handicap our children. There must be continuing follow-up treatment so that handicaps do not go untreated. . . . We must enlarge our efforts to give proper eye care to a needy child. We must provide health to strengthen a poor youngster's limb before he becomes permanently disabled. We must stop tuberculosis in its first stages before it causes serious harm.

President Lyndon B. Johnson
Introducing the EPSDT Legislation
90th Cong., 1st Sess. (1967).

EPSDT does not trickle down; it requires hard work and mandatory language. . . .

Judge John T. Nixon, John B. v. Menke, 176 F. Supp. 2d 786, 801 (M.D. Tenn. 2001)

Introduction

The Early and Periodic Screening, Diagnostic and Treatment service, EPSDT, is a comprehensive set of benefits available to children and youth under age 21 who are enrolled in Medicaid.

This fact sheet answers some commonly asked questions about EPSDT:

- Why EPSDT?
- How does EPSDT address screening?
- How does EPSDT address treatment services?
- How does the Deficit Reduction Act of 2005 affect EPSDT?
- How should children and families find out about EPSDT?
- How can I measure EPSDT performance and hold programs accountable?
- How can I learn more about EPSDT?

Why EPSDT?

Low socioeconomic status carries with it numerous by-products: poor nutrition, fewer educational opportunities, greater exposure to environmental hazards, and inadequate housing, to name just a few. All of these disadvantages increase the likelihood that a poor child will be in poor health. Indeed, children living in poverty, particularly children of color, are more likely than other children to suffer from ill health, including vision, hearing and speech problems, dental problems, elevated lead blood levels, behavioral problems, anemia, asthma, and pneumonia.[1] There is a growing body of evidence establishing that lifelong patterns of health and well-being are established during childhood.[2]

Early detection of health conditions, comprehensive treatment and health education are needed. Added to the Medicaid Act in 1967, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) entitles children and youth to preventive care and treatment services.

Medicaid extends coverage to more than one in four children (27%) in the United States and more than half (51%) of children who live in families whose incomes are below the federal poverty level.[3] Because they are eligible for Medicaid, most of these children are entitled to EPSDT. Thus, EPSDT has the potential to improve dramatically the overall health of children living in the United States.

Since its inception, however, the program's success in screening and treating eligible children has not met expectations. For example, Congress has made dental screening a mandatory component of each state's EPSDT program. In fiscal year 2004, however, only 30 percent of children received any dental services, and only 22 percent had a preventive visit. Even fewer children, 16 percent, received any dental treatment services.[4]

The United States continues to lag behind many other countries in child health indicators.[5] Until child health truly becomes a national priority, this trend is certain to continue.

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[1] *See* Edward L. Schor et al., *Medicaid: Health Promotion and Disease Prevention for School Readiness*, 26 HEALTH AFFAIRS 420, 423 and n. 21 (Mar.-Apr. 2007) (noting that 39% of young children on Medicaid are at risk of developmental, behavioral, or social delay); Paul Newacheck et al., *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).
[2] *See* Edward L. Schor, *supra* n. 1 at 421.
[3] *See* Kaiser Family Foundation, *Quick Takes-Medicaid/SCHIP, available* at http://facts.kff.org/?CFID=34872150&CFTOKEN=20197859 (accessed Sept. 9, 2008).
[4] Testimony of Jane Perkins, NHeLP, to the U.S. House of Representatives Committee on Oversight and Government Reform, Subcommittee on Domestic Policy, *Hearing on Oversight of Dental Programs for Medicaid-Eligible Children* (May 2, 2007), at www.healthlaw.org.
[5] *See* UNITED NATIONS CHILDREN'S FUND, THE STATE OF THE WORLD'S CHILDREN 2007 at 112-13 (tbl. 3) (2006).

How does EPSDT address screening?

Screens, or well-child check ups, are a basic element of the EPSDT program. Four separate types of screens are required: medical, vision, hearing, and dental.

Medical Screens. The medical screen must include at least the following five components:

- A comprehensive health and developmental history;
- A comprehensive unclothed physical exam;
- Immunizations (as determined by the Advisory Committee on Immunization Practices);
- Laboratory testing when appropriate, including lead tests (required at 12 and 24 months of age and up to 72 months of age if there is no record of a previous test), and
- Health education and anticipatory guidance.[6]

Medical screens must be provided according to a "periodicity schedule." The periodicity schedule is set by the state after consultation with recognized medical organizations involved in child health care. Congress and CMS have suggested the periodicity schedule of the American Academy of Pediatrics (AAP).[7] An excellent periodicity schedule is reflected in the recently-updated *Bright Futures*, which emphasizes the prevention and health promotion needs of infants, children, and adolescents.[8] An EPSDT Forum, comprised of state and federal Medicaid and child health officials, educators, and policy analysts, recently urged states to make their EPSDT screening standards as compatible as possible with *Bright Futures.*[9]

Vision, Hearing, and Dental Services. States are also responsible for providing for periodic vision, hearing, and dental examinations, as well as diagnosis and treatment for vision, hearing, and dental problems.

- Vision services must include vision screens and diagnosis and treatment of vision defects, including eyeglasses.[10]

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[6] *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH & HUMAN SERVICES, STATE MEDICAID MANUAL § 2700.4 (hereafter CMS, STATE MEDICAID MANUAL). Note: All five elements of the screen must occur if the examination is to be reported by the state on the Form CMS-416 as an EPSDT medical screen.

[7] *See* H.R. REP. NO. 101-247, at 399 (Sept. 20, 1989), *reprinted at* 1989 U.S.C.C.A.N. 1906, 2125. *See also* CMS, STATE MEDICAID MANUAL § 5240.

[8] *See* Hagan, JF, Shaw JS, Duncan, PM, eds., *Bright Futures: Guidelines for Infants, Children, and Adolescents*, (3d ed. 2008), at http://brightfutures.aap.org.

[9] National Academy for State Health Policy, *New Opportunities and Continuing challenges: A Report from the NASHP EPSDT Forum* 10 (July 2008), *at www.nashp.org/Files/EPSDT_Forum.pdf.*

[10] *See* 42 U.S.C. § 1396d(r)(2).

- Hearing services must include hearing screens and diagnosis and treatment for defects in hearing, including hearing aids.[11]
- Dental services must include dental screens, relief of pain and infections, restoration of teeth, and maintenance of dental health.[12]

Vision, hearing, and dental services must be provided according to their own separate periodicity schedules. The periodicity schedule for each type of screen must be determined by the state after consultation with recognized medical and dental organizations involved in child health care. An oral screening as part of a physical examination does not substitute for examination by a dental professional.[13]

Interperiodic screens. In addition to covering scheduled, periodic check ups, EPSDT covers visits to a health care provider when needed outside of the periodicity schedule to determine whether a child has a condition that needs further care. These types of screens are called "interperiodic screens." Persons outside the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen, and "any encounter with a health care professional acting within the scope of practice is considered to be an interperiodic screen, whether or not the provider is participating in the Medicaid program at the time those screening services are furnished."[14] This is significant because an interperiodic visit thus qualifies the child for the EPSDT treatment benefits described below.

How does EPSDT address treatment services?

EPSDT requires state Medicaid agencies to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment."[15] This means that state Medicaid programs should not await claims to be submitted for EPSDT services but rather affirmatively arrange for treatment, either directly or through appropriate referrals.

The Medicaid Act defines a comprehensive package of EPSDT benefits, and it sets forth the medical necessity standard that must be applied on an individual basis to determine each child's needs:

> **Scope of benefit:** Covered services include all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults. A listing of the Medicaid/EPSDT services is included at the end of this Fact Sheet.

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[11] *See Id.* at § 1396d(r)(4).
[12] *See Id.* at § 1396d(r)(3).
[13] *See* CMS, STATE MEDICAID MANUAL § 5123.G.
[14] *See, e.g.,* Memorandum from Director, *Health Care Financing Administration Medicaid Bureau*, to Region III Administrator, *Health Care Financing Administration* (Apr. 12, 1991) (on file with author).
[15] 42 U.S.C. § 1396a(a)(43)(C).

Medical necessity: The Medicaid Act contains a federal definition of medical necessity that all states must apply. The Act requires coverage of "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions[.]"[16]

In sum, if a health care provider determines that a service is needed, it should be covered to the extent needed and allowed under the federal Medicaid Act. For example, if a child needs personal care services to ameliorate a behavioral health problem, then EPSDT should cover those services to the extent the child needs them — even if the state places a quantitative limit on personal care services or does not cover them at all for adults. Recent court decisions have consistently affirmed the broad EPSDT scope of benefits and the medical necessity definition outlined above.[17]

How does the Deficit Reduction Act (DRA) affect EPSDT?

The DRA of 2005 does not amend the EPSDT provisions. Rather, the law gives states new options to require state-selected population groups to obtain Medicaid through "benchmark" health insurance plans. In so doing, the state can ignore Medicaid's traditional rules requiring coverage of mandatory and optional services, free choice of provider, and comparability of services.[18] Some populations of children are excluded from mandatory enrollment in these health plans, including those who qualify for Medicaid because they are blind or disabled, children receiving foster care or adoption assistance, and children receiving care through a family-centered, community care system under title V.[19]

Moreover, regardless of the health plan option selected, the DRA clearly provides that a state will provide "wraparound benefits" for any child under 19

[16] *Id.* at § 1396d(r)(5).
[17] *See Rosie D. v. Romney,* 410 F. Supp. 2d 18, 25 ("[A]s broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are far more expansive"); *see also, e.g. Collins v. Hamilton,* 349 F.3d 371, 375-76 n.8 (7th Cir. 2003) (citing 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r) and holding "a state's discretion to exclude services deemed 'medically necessary' by an EPSDT provider has been circumscribed by the express mandate of the statute"); *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F. Supp. 2d 905, 912 (S.D. Ohio 2008) (state is bound by federal law to provide medically necessary services); *Moore v. Medows*, 563 F. Supp. 2d 1354 (N.D.Ga.,2008) (same) (on appeal); *Ekloff v. Rodgers*, 443 F. Supp. 2d 1173, 1179 (D. Ariz. 2006).
[18] *See* 42 U.S.C. § 1396u-7 (enacted as § 6044 of the Deficit Reduction Act). The DRA offers states four benchmark options, including enrollment in the standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan or any plan that the Secretary of the Department of Health and Human Services determines to be appropriate. *Id.*
[19] *Id.;* see also CMS, *Dear State Medicaid Director* (Mar. 31, 2006) (SMDL #06-008).

years of age "consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905r [42 U.S.C. § 1396d(r)]."[20]

Thus, while offering significant protection, there is cause for concern. Youth aged 19-21 can be enrolled in the benchmark coverage, and the DRA introduces confusion about their EPSDT coverage because it extends the wraparound benefit to children under 19 years of age. In addition, there is a great risk that services and administration between the benchmark and wraparound EPSDT benefits will be uncoordinated and confused. Advocates should work to assure clear guidelines and education regarding them. One place to look for a track record (good or bad) is how your state has coordinated the provision of services when contracting with managed care plans that do not provide the full scope of Medicaid benefits, for example carving out mental health, dental, or long term care services. Lessons learned from this past experience may inform the new debate. Moreover, the benchmark options contained in the DRA are the same as those provided to states for their State Children's Health Insurance Program (SCHIP). Thus, states' experiences with SCHIP contracting will be relevant.

To date, nine states are using this option: Idaho, Kansas, Kentucky, Missouri, South Carolina, Virginia, Washington, and West Virginia. Experts have noted that the DRA option has the "potential to undermine the evolving standard of pediatric preventive care,"[21] so activities by states to implement the DRA benchmark coverage option must be closely monitored.

How should children and families find out about EPSDT?

If EPSDT is to work, there is an absolute need for effective outreach and informing. As noted by the Seventh Circuit Court of Appeals:

> [States cannot] expect that children of needy parents will volunteer themselves or that their parents will voluntarily deliver them to the providers of health services for early medical screening and diagnosis. By the time [a child] is brought for treatment it may too often be on a stretcher. . . . EPSDT programs must be brought to the recipients; the

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[20] *See* 42 U.S.C. § 1396u-7(a)(1)(A)(ii); *see, e.g.,* CMS, *Dear State Medicaid Director* (Mar. 31, 2006) (SMDL #06-008); Letter from Charles Grassley, Chairman, Senate Committee on Finance, and Joe Barton, Chairman, House Committee on Energy and Commerce, to Hon. Michael O. Leavitt, Secretary, DHHS (Mar. 29, 2006) (on file with author) ("We insist that CMS reject any state plan amendment involving benchmark ... coverage that does not also provide for wraparound EPSDT services and benefits to individuals under age 19.... Congress intended to make no change to EPSDT coverage."); Dep't of Health & Human Services, *Statement by Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services* (undated) (on file with author) ("Children under age 19 will receive EPSDT benefits.").

[21] Sara Rosenbaum & Paul H. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 HEALTH AFFAIRS 382 (Mar.-Apr. 2007).

recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose.[22]

In the EPSDT legislation, Congress has required states to inform all Medicaid-eligible persons in the state who are under age 21 of the availability of EPSDT and immunizations.[23] States must use a combination of written and oral methods to effectively inform eligible individuals about: (1) the benefits of preventive health care; (2) the services available through EPSDT; (3) that services are without charge, except for premiums for certain families; and (4) that support services, specifically transportation and appointment scheduling assistance, are available on request. If the child/family has difficulty reading or understanding English, then the information needs to be conveyed in a format that can be understood. Notably, states must offer both transportation and appointment scheduling assistance "prior to each due date of a child's periodic examination."[24]

How can I measure EPSDT performance and hold programs accountable?

The Medicaid Act requires each state to report annually on EPSDT, by age group and basis of eligibility:

- the number of children provided screening services;
- the number of children referred for corrective treatment;
- the number of children receiving dental services; and
- the participation rates for the program.

The Medicaid Act provides that the Secretary of the Department of Health and Human Services shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each state for participation of children in EPSDT.[25] In 1990, the Secretary established that each state should be providing at least 80 percent of EPSDT recipients with timely medical screens by fiscal year 1995.[26] The Secretary has not subsequently revised these participation goals.

Form CMS-416. States are to report EPSDT compliance on the Form CMS-416 and to submit the completed form to CMS by April 1 of each year. The information on the form serves to:

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[22] *Stanton v. Bond*, 504 F.2d 1246, 1251 (7th Cir. 1974), *cert. denied*, 420 U.S. 894 (1975) (subsequent history omitted).
[23] *See* 42 U.S.C. § 1396a(a)(43)(A). Congress has said states need to take "aggressive action" to inform children and families about EPSDT. *See* 135 CONG. REC. S 13234 (Oct. 12, 1989).
[24] CMS, STATE MEDICAID MANUAL §§ 5121, 5150.
[25] *See* 42 U.S.C. § 1396a(a)(43)(D).
[26] The Secretary established 80 percent participant and screening rate goals. *See* CMS, STATE MEDICAID MANUAL § 5360.B.2 (Exhibit A, Expected Improvement in EPSDT Participation); *Id.* at § 5360.C (establishing screening goal).

- demonstrate the state's attainment of participant and screening goals; and
- show trend patterns and projections from which decisions can be made to ensure that eligible children are given the best possible health care.[27]

The Form CMS-416 is a public document that can be obtained and used to advocate for EPSDT improvements and enhanced program accountability.

In 1999, CMS revised the CMS-416 significantly, affecting:[28]

- *Age groupings*: The revised form requires states to use seven age groupings (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-21). Previously, the Form used four age groupings.

- *Dental reporting*: The revised form requires states to report on three aspects of oral health: the unduplicated number of children (i) receiving *any* dental services; (ii) receiving preventive dental services; and (iii) receiving dental *treatment* services. The previous form looked at only the number of eligible children receiving dental assessments.

- *Lead blood testing*. States must now report on the lead testing received by young children. CMS had not previously required this information.

On the other hand, the Form CMS-416 includes other changes that, while making the reporting easier for states and managed care plans, result in the loss of important information, such as:

- *Allowing states to use their own periodicity schedules*. For reporting purposes, the previous form used a national periodicity schedule based on the recommendations of the American Academy of Pediatrics. Because each state can use a different periodicity schedule, comparison among states is difficult. If a state decides to change its periodicity schedule, this could affect comparisons between years.

- *Allowing states to use certain Current Procedural Terminology (CPT) codes or state-specific EPSDT codes as a proxy for the EPSDT medical screen*. Nothing in the listed CPT codes reveals whether all five of the mandatory components of the EPSDT medical screening were provided. CMS has stated: "Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients."[29]

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[27] *Id.* at § 2700.4.
[28] *Id.*; Health Care Financing Administration (predecessor to CMS), *Dear State Medicaid Director* (July 19, 1999) (on file with author).
[29] CMS, STATE MEDICAID MANUAL § 2700.4.E.

• *Eliminating reporting of vision and hearing assessments*. The only mention of these mandatory screens is a reminder to states to include vision and hearing referrals when reporting on total eligibles referred for corrective treatment. For additional discussion of the revised Form CMS-416, please consult the CMS instructions for completing the form and the NHeLP publication, *Measuring Preventive Health Performance: A Primer for Child Advocates on the Medicaid EPSDT Reporting Form* (Oct. 2003).

Managed care reporting. Many states contract with managed care organizations (MCOs) to provide EPSDT services. States may require these MCOs to report information about EPSDT. For example, MCOs in some states report using Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS data should be publicized and, if not, obtainable through a public records request. Annual independent external quality reviews are required, and some states have used these reviews to assess aspects of EPSDT. Again, these reviews should be made available to the public.

Given that children are a significant proportion of the Medicaid beneficiaries enrolled in MCOs, it is surprising that states EQRs do not pay more attention to EPSDT. The American Academy of Pediatrics has made recommendations for enhancing states' quality monitoring and improvement activities for children and youth.[30]

How can I learn more about EPSDT?

National Health Law Program publications include:

EPSDT Case Docket (updated regularly)

Measuring Preventive Health Performance: A Primer for Child Advocates on the Medicaid EPSDT Reporting Form (Oct. 2003)

Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services for Poor Children and Youth (Apr. 2003)

Children's Health under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment, 1999-2003 (3d ed. May 2005), *1997-1998* (2d ed. Sept. 2001), *1994-1996* (1st ed. Aug. 1998)

For additional information and resources on EPSDT, please consult our website, www.heatlhlaw.org, and the links we offer there.

[30] American Academy of Pediatrics, Committee on Child Health Financings, *Medicaid Policy Statement*, 116 PEDIATRICS 274, 278 (July 2005), *available at* http://pediatrics.aappublications.org/cgi/content/full/116/1/274.

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

Optional services (for adults, mandatory under EPSDT when necessary to correct or ameliorate an illness or condition):

- 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
- Dental services
- Physical therapy and related services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- 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
- Case-management services
- 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 DHHS)