Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): National Environmental Scan Results

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ABSTRACT

Enacted in 1967, and significantly expanded in 1981 and 1989, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitles Medicaid beneficiaries from birth to age 21 to both comprehensive coverage and access to covered services. States administer EPSDT in accordance with broad Federal statutory and administrative standards, which are overseen by the Center for Medicare & Medicaid Services (CMS).

Section 11004 of the Bipartisan Safer Communities Act, signed into law by President Biden in June 2022, required the "review of state implementation of the EPSDT benefit" and "to identify gaps and deficiencies in state compliance." CMS contracted with NORC at the University of Chicago (NORC), the National Health Law Program, RTI International, Center for Health Care Strategies, Sara Rosenbaum, and Kay Johnson ("The NORC team") to complete this work. As a first step, the NORC team conducted an environmental scan of states' informing materials. This poster summarizes the findings of that environmental scan.

LESSONS LEARNED

- No state or resource is uniformly strong when it comes to EPSDT implementation or communication with EPSDT beneficiaries.
- Almost every state has examples of best practices that can be used as a model by other states.
- Every state has opportunities for improvement that should be addressed.

BACKGROUND

EPSDT requires states to:

- Cover a broad range of preventive, diagnostic, and treatment services and to ensure that children receive care;
- Provide any medically necessary treatment defined as medical assistance, **apart from whether adult Medicaid beneficiaries receive such services**. EPSDT sets out a special definition of medical necessity that relates to **early identification and amelioration** of physical, mental, and developmental conditions; and
- Arrange (directly or through contracts or other arrangements) for children to receive medically necessary treatment and must see that 1905(a) of the SSA services are provided.

Since 1967, EPSDT implementation efforts have responded to changes in standards of pediatric care, changes in health care financing and delivery such as managed care, and new knowledge regarding the developmental, health, and social needs of children in low-income households.

For more information, please see https://www.hhs.gov/guidance/document/epsdt-guide-states-coverage-medicaid-benefit-children-and-adolescents

CONTACT

States that are interested in technical assistance related to EPSDT informing and improvement should email EPSDT@cms.hhs.gov.

METHODS

The NORC team reviewed EPSDT-related materials across the 50 states, the District of Columbia, and three territories (Guam, Puerto Rico, and often the Virgin Islands). The team utilized multiple methods for the environmental scan, bringing together a variety of qualitative and quantitative data for a holistic review of EPSDT services.

Document Review Materials. As seen in Table 1.

Table 1: Total Number of Sources Reviewed by Type

State Plans	52
Comprehensive managed care plans (MCP) provider handbooks	49
Comprehensive MCP beneficiary handbooks	49
State provider handbooks	48
State beneficiary informing materials	47
Comprehensive MCP contracts	44
Specialty MCP beneficiary handbooks (foster care, children and youth with special health care needs, behavioral health)	27

Quantitative Resources. Data from the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (2018-2020) and the Form CMS-416 Annual Reporting Data Files (2021).

Listening Sessions. The NORC team facilitated listening sessions focused on screening, diagnostic, and treatment (SDT) service components of EPSDT and mental/behavioral health. Each topic area was discussed in a series of three constituency-specific listening sessions with representatives of state Medicaid agencies, caregivers (including several family-run organization leaders who have lived experience), and legal advocates, for a total of six listening sessions.

Analytic Methods. To prepare the data for analysis, questions were divided by topic and then organized by state and document type. The NORC team analyzed data using qualitative coding methods to identify key themes and convert answers to fit a yes/no/sometimes structure (or as appropriate to the question). We used the source, rather than the state, as the basis for analysis to account for states with different Medicaid delivery systems and to explore differences in the source types themselves.

FINDINGS: EPSDT Description

States should ensure that EPSDT is described clearly, with definitions of "early," "periodic," "screening," "diagnostic," "treatment," and "ameliorate."

- Most states clearly communicate that EPSDT is more than well-child visits.
  - However, several states have unclear/missing definitions of EPSDT.
  - Fewer than half of documents used "correct and ameliorate" or synonymous language.
- Half of the sources included EPSDT-specific information around medical necessity or prior authorization.
- Most states follow the screening schedule recommended by AAP Bright Futures™ (Table 2).

Table 2: Screening Periodicity Schedules Reported on the 2021 Form CMS-416

	# of States	<1 Years	1–2 Years	3–5 Years	6–9 Years	10–14 Years	15–18 Years	19–20 Years
Follows AAP Bright Futures Periodicity Schedule	40/53	46/53	46/53	51/53	50/53	50/53	50/53	50/53

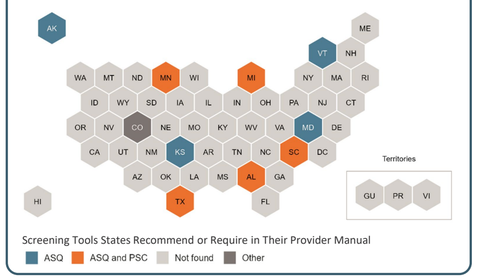
- Most of the sources that give diagnosis guidance specific to EPSDT provide general guidance, with the most frequent language being that diagnosis must be made "without delay".
- Fewer than half of sources are clear that treatment determinations should be tailored to the individual.
- Limits ("Soft" limits can be exceeded and "hard" limits cannot.)
  - It appears that some states may have imposed hard limits on services.
  - Hard limits are usually seen when limits approved for adults did not have a clearly communicated way to exceed limits for children.
  - Service descriptions do not always clearly communicate that stated plan limits may be exceeded based on an individual child's medical necessity.
- Listening sessions revealed that beneficiaries may have difficulty accessing covered services, particularly in rural areas.

FINDINGS: Mental Health

Behavioral health services may be covered under several 1905(a) categories, leading to variation in state benefits and providers.

- MCP contracts in most states include a requirement for children to receive all medically necessary mental health care.
- State beneficiary informing materials do not universally include information about comprehensive mental health treatment availability for children.
- Only ten state and MCP provider handbooks reviewed recommend or require specific behavioral and mental health screening tools (Figure 1).
  - Some provider handbooks request use of more specific behavioral health (e.g., autism, SUD, etc.) screening tools not noted here.
- Most state beneficiary informing materials provide a phone number to call for information about accessing mental health services.
  - Additional details that would help beneficiaries and providers connect with appropriate mental health providers are often included as well, but they are not consistent.
- Provider handbooks often lack information that would help support providers looking to refer a patient to a mental health provider.
- Limits:
  - Ten states seemed to be placing hard limits on mental health services.
  - During listening sessions, service limitation issues were mainly due to workforce capacity, utilization management, and inadequate care coordination.

Figure 1: States or MCPs That Recommend or Require Behavioral and Mental Health Screening Tools



FINDINGS: Dental and Oral Health

EPSDT entitles children to receive dental and oral health care needed for pain, infection, restoration of teeth, and maintenance of health, as well as emergency, preventive, and therapeutic services. These services may be provided by dentists or those working under the supervision of dentists.

- Most states do not include information about dental benefits in their descriptions of EPSDT. Those that do vary significantly in the information provided.
- Most state beneficiary informing materials and MCP beneficiary handbooks contain information on how to access dental care.
  - Fewer than half of state provider handbooks reviewed contain instructions for families needing to access dental care services.
- Fewer than half of eligible children receive preventive dental or oral health care in 51 out of 53 states (Figure 2).
  - When stratified by age, more than half of children ages six to nine years old receive preventive dental or oral health services. In other age groups, less than half of children receive services.
- Most state beneficiary informing materials and MCP beneficiary handbooks do not specify hard oral health service limits.

Figure 2: Preventive Dental and Oral Health Services by State