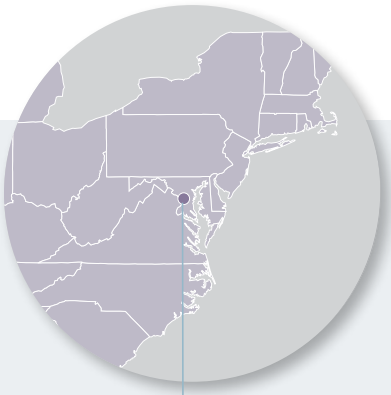
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



DISTRICT OF COLUMBIA (DC)

Medicaid's EPSDT benefit provides comprehensive health care services to children under age 21, with an emphasis on prevention, early detection, and medically necessary treatment. Each state Medicaid program establishes a periodicity schedule for physical, mental, developmental, vision, hearing, dental, and other screenings for infants, children, and adolescents to correct and ameliorate health conditions.

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA). The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th Edition)[1] and the corresponding Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)[2] provide theory-based and evidence-driven guidance for all preventive care screenings and health supervision visits through age 21. Bright Futures is recognized in federal law as the standard for pediatric preventive health insurance coverage.[3] The Centers for Medicare and Medicaid Services (CMS) encourages state Medicaid agencies to use this nationally recognized Bright Futures/AAP Periodicity Schedule or consult with recognized medical organizations involved in child health care in developing their EPSDT periodicity schedule of pediatric preventive care.[4,5] The following analysis of the District of Columbia's EPSDT benefit was conducted by the AAP to promote the use of Bright Futures as the professional standard for pediatric preventive care.

The District of Columbia's (DC) profile compares the state's 2018 Medicaid EPSDT benefit with the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition, and the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) published in *Pediatrics* in April 2017.[2] This state profile also contains information about the District of Columbia's 2016 Medicaid pediatric preventive care quality measures and performance based on the state's voluntary reporting on selected Child Core Set measures. Information about the state Medicaid medical necessity definition used for EPSDT and a promising practice related to pediatric preventive care is also found here. The District of Columbia's profile is based on a review of the state's Medicaid website, provider manual, and other referenced state documents; and an analysis of 2016 state Medicaid data reported to CMS on child health quality.[6] This profile was also reviewed by state Medicaid EPSDT officials. Information is current as of March 2018.

Summary of Findings

- The District of Columbia's 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations.
- DC's medical necessity definition for EPSDT, described below, incorporates a preventive purpose.
  - Medically Necessary: A covered service or item can be defined as medically necessary if it will do, or is reasonably expected to do, one or more of the following: a) arrive at a correct medical diagnosis; b) prevent the onset of an illness, condition or injury or disability in the individual or in covered relatives, as appropriate; c) reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability; d) assist the individual to achieve or maintain sufficient functional capacity to perform age appropriate or developmentally appropriate daily activities.
- According to CMS, in 2016, DC selected all 10 pediatric preventive care measures in the Child Core Set.
- DC quality performance rates, as shown in the table below, were the same or higher than the national average for all but PCP visits for children ages 12 to 24 months and well child visits for children by 15 months of age.
- DC's Medicaid managed care organizations have pediatric preventive care performance improvement projects underway related to improving perinatal care.

Promising Practices

The District of Columbia's EPSDT staff have played in a major role in the citywide integration of mental health in primary care for children. The DC Collaborative for Mental Health in Pediatric Primary Care, a public-private partnership, conducted between 2013-2015, was designed to support pediatric providers in screening for perinatal mood and anxiety disorders, such as postpartum depression, during well child visits. A Perinatal Mental Health Toolkit was created to aid pediatric providers, which includes a screening and referral algorithm and crisis action plan, perinatal mental health community resources, and more. DC Medicaid updated its billing requirements to allow for mental health screening and the DC Medicaid Director prepared a special transmittal to all EPSDT providers that highlighted the importance of mental health screening in pediatric primary care during National Children's Mental Health Awareness Week in 2017. In that transmittal, the Medicaid Director noted that over the course of the DC Collaborative for Mental Health in Pediatric Primary Care, the number of developmental/behavioral health screens billed to DC increased from 4,632 in FY 2013 to 20,728 in FY 2015. One major activity of this collaborative was the adoption and implementation of the DC MAP (Mental Health Access in Pediatrics), a Department of Behavioral Health-funded initiative that extends free mental health consultation services to all pediatric practices, similar to consultation services offered by Child Psychiatry Access Programs in over 30 states. These services include real-time telephone consultation with child mental health experts (within 30 minutes), community resource referrals, and mental health training and support.

Comparison of DC EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on the District of Columbia's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 District of Columbia Medicaid EPSDT requirements with the 2017 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care.[2]

Code

U = universal screening (all screened)

S = selective screening (only those of higher risk screened)

U/S = visits in that age group have universal and selective requirements.

See Bright Futures/AAP Periodicity Schedule information for complete information.

Number of Well Child Visits by Age	DC EPSDT	Bright Futures
- Birth through 9 months	7	7
- 1 through 4 years	7	7
- 5 through 10 years	6	6
- 11 through 14 years	4	4
- 15 through 20 years	6	6

Universal (U) and Selected (S) Screening Requirements	DC EPSDT	Bright Futures
Infancy (Birth-9 months)		
- Length/height & weight	U	U
- Head circumference	U	U
- Weight for length	U	U
- Blood pressure	S	S
- Vision	S	S
- Hearing	U/S	U/S
- Developmental screening	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Maternal depression screening	U	U
- Newborn blood screening	U	U
- Critical congenital heart screening	U	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	S	S
- Oral health	U/S	U/S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S

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Comparison of DC EPSDT and AAP/Bright Futures Periodicity Schedules *continued*

Code

U = universal screening (all screened)

S = selective screening (only those of higher risk screened)

U/S = visits in that age group have universal and selective requirements.

See Bright Futures/AAP Periodicity Schedule information for complete information.

Universal (U) and Selected (S) Screening Requirements	DC EPSDT	Bright Futures
Early Childhood (Ages 1-4)		
- Length/height & weight	U	U
- Head circumference	U	U
- Weight for length	U	U
- Body mass index	U	U
- Blood pressure	U/S	U/S
- Vision	U/S	U/S
- Hearing	U/S	U/S
- Developmental screening	U	U
- Autism spectrum disorder screening	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Anemia	U/S	U/S
- Lead	U/S	U/S
- Tuberculosis	S	S
- Dyslipidemia	S	S
- Oral health	S	S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S
Middle Childhood (Ages 5-10)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U/S	U/S
- Hearing	U/S	U/S
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	S	S
- Dyslipidemia	U/S	U/S
- Oral health	S	S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S
Adolescence (Ages 11-20)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U/S	U/S
- Hearing	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Tobacco, alcohol or drug use assessment	S	S
- Depression screening	U	U
- Anemia	S	S
- Tuberculosis	S	S
- Dyslipidemia	U/S	U/S
- Sexually transmitted infections	S	S
- HIV	U/S	U/S
- Fluoride supplementation	S	S

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

Included in the tables below are the District of Columbia's 2016 quality performance information on pediatric preventive care measures reported to CMS[6], as well as their use of financial incentives for pediatric preventive care.

Pediatric Preventive Care Quality Measures and Performance, 2016 Child Core Set	DC	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	93.5	95.2
• Ages 25 months-6 years (in past year)	87.9	87.7
• Ages 7-11 (in past 2 years)	92.7	90.9
• Ages 12-19 (in past 2 years)	90.5	89.6
- % of children by 15 months receiving 6 or more well-child visits	56	60.8
- % of children ages 3-6 with one or more well-child visits	78	68
- % of adolescents ages 12-21 receiving 1 well care visit	59.6	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	68.5	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	75.6	70.3
- % of sexually active women ages 16-20 screened for chlamydia	77.8	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	42.8	20.8
- % of children ages 3-17 whose BMI was documented in medical records	75	61.2
- % of children ages 1-20 with at least 1 preventive dental service	52.5	48.2

Pediatric Preventive Care Financial Incentives, 2016	DC	US
- Use of preventive incentives for consumers	Yes	NA
- Use of performance incentives for providers	Yes	NA

References

[1] Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2017.

[2] Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Work Group. 2017 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2017;139(4):e20170254.

[3] *FAQs about Affordable Care Act Implementation*. Washington, DC: US Department of Labor, Employee Benefits Security Administration, May 11, 2015.

[4] *EPSDT – A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents*. Baltimore, MD: Centers for Medicare and Medicaid Services, June 2014.

[5] *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits*. Baltimore, MD: Centers for Medicare and Medicaid Services, February 2014.

[6] Quality information from the CMS Medicaid/CHIP child core set for federal fiscal year 2016 was obtained from: https://data.medicaid.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy.

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