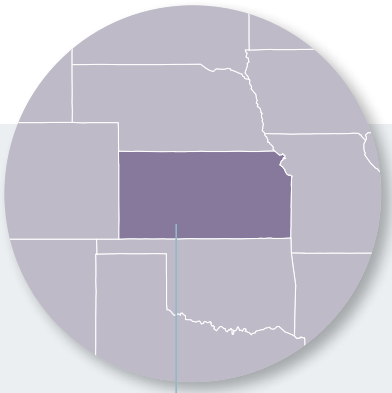
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



KANSAS (KS)

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 Kansas's EPSDT benefit was conducted by the AAP to promote the use of Bright Futures as the professional standard for pediatric preventive care.

Kansas's 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 Kansas'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 is also found here. Kansas'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 April 2018.

Summary of Findings

- Kansas's 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations.
- The state's medical necessity definition for EPSDT, described below, incorporates a preventive care purpose in regulations that define treating as preventing, diagnosing, detecting, or palliating a medical condition.
  - Medical necessity means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
    - Authority: The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
    - Purpose: The health intervention has the purpose of treating a medical condition.
    - Scope: The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
    - Evidence: The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3). For existing interventions, effectiveness shall be determined as provided in paragraph (ooo)(4).
    - Value: The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet the definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.
- According to CMS, in 2016, Kansas selected all 10 pediatric preventive care measures in the Child Core Set.
- Kansas's quality performance rates, as shown in the table below, were higher than the national average for adolescent well care visits and childhood immunizations. The state's performance rates were lower than the national average for PCP visits, well care visits for children in the 1st 15 months of age and ages 3 to 6, adolescent immunizations, HPV vaccinations, chlamydia screening, BMI documentation, and preventive dental services.
- Kansas has performance improvement projects underway related to immunizations.

Comparison of KS EPSDT and AAP/Bright Futures Periodicity Schedules

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

Code

U= Universal (all screened)
S = Selective (only those of higher risk)
U/S = Universal and selective requirements

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	KS 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	KS 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 KS EPSDT and AAP/Bright Futures Periodicity Schedules *continued*

Code

U= Universal (all screened)
S = Selective (only those of higher risk)
U/S = Universal and selective requirements

See Bright Futures/AAP Periodicity Schedule for complete information.

Universal (U) and Selected (S) Screening Requirements	KS 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 Kansas'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	KS	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	94.2	95.2
• Ages 25 months-6 years (in past year)	86.1	87.7
• Ages 7-11 (in past 2 years)	89.5	90.9
• Ages 12-19 (in past 2 years)	88.9	89.6
- % of children by 15 months receiving 6 or more well-child visits	58.7	60.8
- % of children ages 3-6 with one or more well-child visits	64.8	68
- % of adolescents ages 12-21 receiving 1 well care visit	46.8	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	70.6	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	62.3	70.3
- % of sexually active women ages 16-20 screened for chlamydia	41.3	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	18.4	20.8
- % of children ages 3-17 whose BMI was documented in medical records	48.6	61.2
- % of children ages 1-20 with at least 1 preventive dental service	45.8	48.2

Pediatric Preventive Care Financial Incentives, 2016	KS	US
- Use of preventive incentives for consumers	No	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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