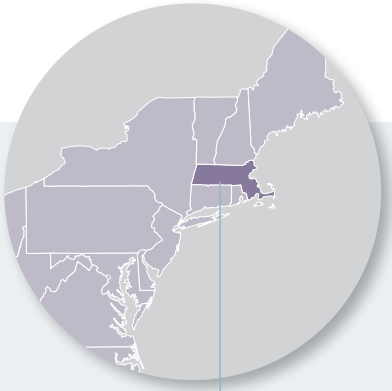
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



MASSACHUSETTS (MA)

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

Massachusetts'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 Massachusetts'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. Massachusetts'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 February 2018.

Summary of Findings

- MassHealth's 2018 EPSDT requirements are similar to the Bright Future/AAP Periodicity Schedule and screening requirements. The state's periodicity schedule represents a minimum and calls for one fewer preventive visit between ages 1 and 4. Although the state's screening recommendations are similar to Bright Futures in most instances, there are certain screening services not specified, as noted in the table below. There are also additional screens that MassHealth calls for that Bright Futures does not mention, including screening for eating disorders starting in middle childhood and Hepatitis C for children at high risk. The MassHealth website includes AAP's Bright Futures and AMA's Guidelines for Adolescent Preventive Services as references.
- The state's medical necessity definition for EPSDT incorporates a preventive purpose.
  - A service is "medically necessary" if 1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and 2) there is no other medical source or site of service, comparable in effect, available, and suitable for the member requesting the service that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorized request, to be available to the member through sources described in 130 CMR 450.317©, 503.007, or 517.007. Medically necessary services must be a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records available to the MassHealth agency upon request.
- According to CMS, in 2016, Massachusetts reported all 10 pediatric preventive care measures in the Child Core Set.
- Massachusetts quality performance rates for all 10 pediatric preventive care measures, as shown on the table below, were higher than the national average.
- MassHealth has performance improvement projects underway related to weight assessment and adolescent immunizations.

Promising Practices

The Children's Behavioral Health Initiative (CBHI) is an interagency effort to develop an integrated system of behavioral health services for children, youth and their families. MassHealth's EPSDT program has been actively involved in ensuring that its EPSDT providers are trained in using MassHealth-approved standardized behavioral screening tools. The state has also prepared a set of billing guidelines, including billing for developmental and behavioral screens as part of well child/adolescent visits.

Comparison of MA EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on Massachusetts's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 Massachusetts 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.
- NA = not applicable
- NS = not specified
- 1 = Instructions for plotting growth parameters for all ages requires the use of an appropriate growth chart. For those under 3, that includes the use of a height for weight chart.
- O = Objective screening (meaning that the item is tested by actual measurement). Hearing and vision screens can be considered to be objective in that they are quantified through both subjective (a child response to ability to hear an auditory cue) and objective means (direct measurement e.g., optoacoustic emissions testing).
- Sb = Subjective screening (meaning that the item is tested by history or the patient's sensory experience).
- 2 Cholesterol screening is required once between ages 2 to 17 years for children with familial risks and once between 18-21 years, if not done previously.

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	MA EPSDT	Bright Futures
- Birth through 9 months	7	7
- 1 through 4 years	6	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	MA EPSDT	Bright Futures
Infancy (Birth-9 months)		
- Length/height & weight	U	U
- Head circumference	U	U
- Weight for length	1	U
- Blood pressure	U/S	S
- Vision	U	S
- Hearing	U/S	U/S
- Developmental screening	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Maternal depression screening	S	U
- Newborn blood screening	U	U
- Critical congenital heart screening	NS	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	S	S
- Oral health	S	U/S
- Fluoride varnish	U	U
- Fluoride supplementation	U	S
- Nutritional assessment	U	—
Early Childhood (Ages 1-4)		
- Length/height & weight	U	U
- Head circumference	U/S	U
- Weight for length	1	U
- Body mass index	U/S	U
- Blood pressure	U/S	U/S
- Vision	U/S	U/S
- Hearing	U	U/S
- Developmental screening	U(0&Sb)	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	2	S

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

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Sb = Subjective screening (meaning that the item is tested by history or the patient's sensory experience).

2 Cholesterol screening is required once between ages 2 to 17 years for children with familial risks and once between 18-21 years, if not done previously.

See Bright Futures/AAP Periodicity Schedule for complete information.

Universal (U) and Selected (S) Screening Requirements	MA EPSDT	Bright Futures
Early Childhood (Ages 1-4) *continued*		
- Oral health	U	S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S
- Cholesterol Screening	S	—
- Hepatitis C	U	—
- Nutritional assessment	U	—
Middle Childhood (Ages 5-10)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U/S (0)	U/S
- Hearing	U/S (0)	U/S
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	S	S
- Dyslipidemia	2	U/S
- Oral health	U	S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S
- Eating disorder screening	U	—
- Cholesterol screening	S	—
- Hepatitis C	S	—
- Nutritional assessment	U	—
Adolescence (Ages 11-20)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U/S (0)	U/S
- Hearing	U/S (0)	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Tobacco, alcohol or drug use assessment	U	S
- Depression screening	U	U
- Anemia	S	S
- Tuberculosis	S	S
- Dyslipidemia	2	U/S
- Sexually transmitted infections	S	S
- HIV	U/S	U/S
- Fluoride supplementation	S	S
- Eating disorder screening	U	—
- Cholesterol screening	S	—
- Hepatitis C	S	—
- Nutritional assessment	U	—

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

Included in the tables below are Massachusetts'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	MA	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	96.0	95.2
• Ages 25 months-6 years (in past year)	94.7	87.7
• Ages 7-11 (in past 2 years)	97.6	90.9
• Ages 12-19 (in past 2 years)	96.1	89.6
- % of children by 15 months receiving 6 or more well-child visits	82.7	60.8
- % of children ages 3-6 with one or more well-child visits	85.8	68
- % of adolescents ages 12-21 receiving 1 well care visit	68.4	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	81.1	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	82.4	70.3
- % of sexually active women ages 16-20 screened for chlamydia	68.7	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	20.9	20.8
- % of children ages 3-17 whose BMI was documented in medical records	83.4	61.2
- % of children ages 1-20 with at least 1 preventive dental service	54.6	48.2

Pediatric Preventive Care Financial Incentives, 2016	MA	US
- Use of preventive incentives for consumers	No	NA
- Use of performance incentives for providers	No	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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