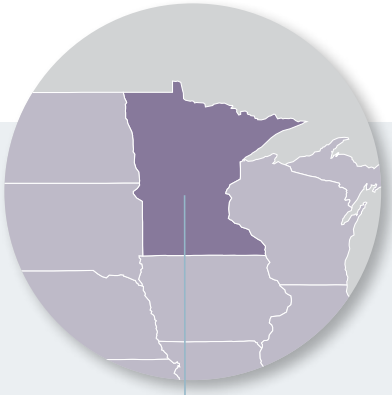
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



MINNESOTA (MN)

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

Minnesota'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 Minnesota'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. Minnesota'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

- Minnesota's 2018 EPSDT requirements for preventive care screenings are similar to Bright Futures. The state's periodicity schedule calls for one fewer visit than recommended by Bright Futures.
- Minnesota's EPSDT medical necessity definition, described below, incorporates a preventive purpose.
  - Medical necessity definition: Medically necessary or medical necessity means a health service that is consistent with the recipient's diagnosis or condition and A) is recognized as the prevailing standard or current practice by the provider's peer group' and B) is rendered in response to a life-threatening condition or pain; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or C) is a preventive health service under part 9505.0355.
- According to CMS, in 2016, Minnesota selected all 10 pediatric preventive care measures in the Child Core Set.
- Minnesota's quality performance rates, as shown in the table below, were higher than the national average for PCP visits for children ages 7 to 11 years and adolescents ages 12 to 19 years, adolescent immunizations, HPV vaccinations, and chlamydia screening. Performance rates were lower than the national average for PCP visits for children ages 12 to 24 months and 25 months to 6 years, well care visits for the 3 child/adolescent age groups, childhood immunizations, BMI documentation and preventive dental services. Minnesota officials note that they use a different pediatric overweight counseling measure, and their statewide rate is 90% for all reporting clinics.
- Minnesota's managed care plans are implementing a broad set of maternal and child health performance improvement projects and combining financial incentives for consumers to complete recommended services and pay-for-performance incentives to encourage specific pediatric preventive care improvements.

Promising Practices

The Integrated Health Partnership (IHP) program was designed as an accountable care model for Medicaid recipients in managed care and fee-for-service arrangements. The care delivery model is intended, in part, to integrate physical health care with mental health and chemical dependency services, safety net providers, social service agencies, counties, and public health resources. The program works to meaningfully engage patients and families as partners in the care they receive as well as in quality improvement activities and leadership roles. It also intends to support providers who serve the most vulnerable members by considering family risk factors in their payment methodologies. Helping to guide the current and future design of this program are the results from a multi-year study of family risk factors among Minnesota publicly insured children.[5]

The family risk factors that were examined within this multi-year study include 1) income and other tangible resources (<100% income, resident in high poverty census tract, parent/family homeless in last 5 years, family lacks vehicle worth at least $2,500); 2) family structure risk factors (parent unmarried, 4 or more children in household, child is medically complex, parent is disabled or has high health care utilization); 3) language and immigration (parent non-English speaking most of time, child immigrated to US, parent immigrated to US); 4) child maltreatment or diminished parental functioning (parent with chemical dependency diagnosis in last 18 months, parent with serious mental illness in last 18 months, child received child protection services in last 5 years).

Beginning in 2018, the Integrated Health Partnership program added a quarterly population-based payment that can be utilized for care coordination and other related investments for individuals served by the IHP. This payment is directly tied to an IHP population's overall clinical and social risk, with IHP's serving higher risk populations receiving a higher population-based payment. The family risk factor study was a critical input to identifying the social risk of an IHP population. Additionally, IHPs are provided quarterly aggregate reports showing the level of each of these factors within their Medicaid patient population to help guide the IHP's interventions and activities. Through the Integrated Health Partnership program, the state Medicaid agency and its EPSDT program seeks, in part, to strengthen the healthy development of its youngest generation by more effectively integrating services and working with Minnesota's most vulnerable children and families.

Comparison of MN EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on Minnesota's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 Minnesota 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 screened)
- U/S = Universal and selective requirements
- NS = Not specified
- R = Recommended for visit
- X = Risk assessment followed by appropriate action
- + = if no results on file for newborn screening, or did not pass, follow-up appropriate

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	MN EPSDT	Bright Futures
- Birth through 9 months	6	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	MN EPSDT	Bright Futures
Infancy (Birth-9 months)		
- Length/height & weight	U	U
- Head circumference	U	U
- Weight for length	U	U
- Blood pressure	NS	S
- Vision	X	S
- Hearing	X +	U/S
- Developmental screening	U	U
- Developmental surveillance/screening	U	U
- Psychological/behavioral assessment	U	U
- Maternal depression screening	R	U
- Newborn blood screening	+	U
- Critical congenital heart screening	+	U
- Anemia	+	S
- Lead	U	S
- Tuberculosis	X	S
- Oral health	U	U/S
- Fluoride varnish	U	U
- Fluoride supplementation	NS	S

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

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See Bright Futures/AAP Periodicity Schedule for complete information.

Universal (U) and Selected (S) Screening Requirements	MN 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	U/S
- Vision	X/U	U/S
- Hearing	X/R/U	U/S
- Developmental screening	R	U
- Autism spectrum disorder screening	R	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Anemia	U	U/S
- Lead	U	U/S
- Tuberculosis	X	S
- Dyslipidemia	X	S
- Oral health	U	S
- Fluoride varnish	U	U
- Fluoride supplementation	NS	S
Middle Childhood (Ages 5-10)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U	U/S
- Hearing	U	U/S
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	X	S
- Dyslipidemia	X	U/S
- Oral health	U	S
- Fluoride varnish	U	U
- Fluoride supplementation	NS	S
Adolescence (Ages 11-20)		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U	U/S
- Hearing	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Tobacco, alcohol or drug use assessment	X	S
- Depression screening	R/U	U
- Anemia	S	S
- Tuberculosis	X	S
- Dyslipidemia	X	U/S
- Sexually transmitted infections	X	S
- HIV	U/S	U/S
- Fluoride supplementation	NS	S

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

Included in the tables below are Minnesota'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	MN	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	94.9	95.2
• Ages 25 months-6 years (in past year)	87.4	87.7
• Ages 7-11 (in past 2 years)	91.1	90.9
• Ages 12-19 (in past 2 years)	91.4	89.6
- % of children by 15 months receiving 6 or more well-child visits	57.5	60.8
- % of children ages 3-6 with one or more well-child visits	57.4	68
- % of adolescents ages 12-21 receiving 1 well care visit	33.5	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	64.7	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	79.1	70.3
- % of sexually active women ages 16-20 screened for chlamydia	51.5	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	21.6	20.8
- % of children ages 3-17 whose BMI was documented in medical records	3.8	61.2
- % of children ages 1-20 with at least 1 preventive dental service	36.7	48.2

Pediatric Preventive Care Financial Incentives, 2016	MN	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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