Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

OHIO (OH)

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

Ohio'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 Ohio'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. Ohio'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

- Ohio's 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations.
- The state's medical necessity definition, below, explicitly incorporates a preventive purpose.
  - OAC 5160-1-01 states

    (A) Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability….

    (C) Conditions of medical necessity are met if all the following apply:

    (1) Meets generally accepted standards of medical practice;

    (2) Clinically appropriate in its type, frequency, extent, duration, and delivery setting;

    (3) Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;

    (4) Is the lowest cost alternative that effectively addresses and treats the medical problem;

    (5) Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and

    (6) Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

    (D) The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment for it.

    (E) The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program.
- According to CMS, Ohio reported on 6 of the 10 pediatric preventive care measures that are part of the Child Core Set. The measures not selected were childhood and adolescent immunizations, HPV vaccinations, and BMI documentation.
- Ohio's quality performance rate, as shown in the table below, was higher than the national average for chlamydia screening. The state's quality performance rates were lower than the national average for PCP visits, well care visits for the 3 child/adolescent age groups, and preventive dental services.
- Currently, as described below, Ohio has a pediatric preventive care performance improvement project underway related to progesterone.

Promising Practice

Ohio's Progesterone Improvement Project is a partnership between the Ohio Perinatal Quality Collaborative, Ohio's 5 Medicaid managed care plans (MCPs) and their contracted home health providers and specialty pharmacies, the 88 county Pregnancy-Related Services (PRS) coordinators, and the Ohio Board of Pharmacy. To decrease the number of premature births born before 32 weeks of gestation, a proactive strategy was adopted to ensure continued Medicaid eligibility for pregnant women to avoid service gaps. County PRS coordinators contributed to helping women keep their Medicaid coverage during pregnancy by accepting MCP and physician notification of pregnancy rather than requiring this notification from the patient herself. This change in process was a primary component of the Progesterone Improvement Project. The state estimates there have been 94 fewer premature births as a result. Ohio plans to spread this practice to all Ohio Medicaid providers using a web-based pregnancy risk assessment form, which will provide simultaneous notification of pregnancy to the woman's county of residence and her MCP. In the case of women needing progesterone, it will also send a prescription to her MCP's specialty pharmacy and home health agency if she elects to receive injections in her home.

Comparison of OH EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on Ohio's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 Ohio 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 for complete information.

Number of Well Child Visits by Age	OH 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	OH 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 OH 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 for complete information.

Universal (U) and Selected (S) Screening Requirements	OH 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 Ohio'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	OH	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	91.1	95.2
• Ages 25 months-6 years (in past year)	86.2	87.7
• Ages 7-11 (in past 2 years)	88.8	90.9
• Ages 12-19 (in past 2 years)	88	89.6
- % of children by 15 months receiving 6 or more well-child visits	49.8	60.8
- % of children ages 3-6 with one or more well-child visits	64.6	68
- % of adolescents ages 12-21 receiving 1 well care visit	41.6	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	—	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	—	70.3
- % of sexually active women ages 16-20 screened for chlamydia	50.8	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	—	20.8
- % of children ages 3-17 whose BMI was documented in medical records	—	61.2
- % of children ages 1-20 with at least 1 preventive dental service	34.6	48.2

Pediatric Preventive Care Financial Incentives, 2016	OH	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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