ABCD Policy Synthesis: Improving Access to Treatment Services in EPSDT
(Early Periodic, Screening, Diagnosis and Treatment)

This policy synthesis is based upon a policy brief by the National Academy for State Health Policy entitled: Managing the “T” in EPSDT Services, by Kay Johnson, June 2010 and ABCD analysis of New Jersey’s EPSDT rates

Early Periodic Screening Diagnostic and Treatment (EPSDT)

EPSDT is a mandatory Medicaid benefit for most children under the age of 21 which provides comprehensive “well child” and medically necessary treatment services. EPSDT is an optional service for a state to offer for children who are in the medically needy group. EPSDT components are designed to target health conditions and problems for which growing children are at risk, including iron deficiency, obesity, lead poisoning, and dental disease. They are also intended to detect and correct conditions that can hinder a child’s learning and development, such as vision and hearing problems. All types of conditions—medical, mental, developmental, acute, and chronic—must be treated, including conditions not newly discovered or those detected outside of an EPSDT comprehensive well-child “screening” visit. For many children, especially those with chronic conditions, EPSDT is important in identifying the need for essential medical and supportive services, and in making these services available.

EPSDT enables health professionals to assess the child's health needs through initial and periodic examinations and evaluations. It also assures that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. Diagnostic and treatment services are provided when a screening examination indicates the need for further evaluation of an individual's health. Any diagnostic or treatment that is medically necessary to improve a condition detected in a screen must be provided.

Definition of “T” (Treatment) in EPSDT

Most EPSDT treatment services fall within the usual Medicaid benefits categories. Common EPSDT treatment and intervention services beyond most states’ Medicaid coverage for adults include: eyeglasses, hearing aids, orthodontia, wheelchairs and prosthetic devices, occupational and physical therapy, prescribed medical formula and nutritional supplements, assistive communication devices, personal care, therapeutic behavioral services, behavioral rehabilitation, and substance abuse treatment.

Federal Medicaid law requires coverage of “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions.” Thus, the EPSDT medical necessity standard assures a level of coverage sufficient not only to treat an already-existing illness or injury but also to prevent the development or worsening of conditions, illnesses, and disabilities.
Pediatric Medical Necessity

Medicaid, like commercial insurers, will not pay for treatment unless it is considered to be medically necessary.

As previously mentioned, Federal Medicaid law requires coverage of “necessary health care, diagnostic services, treatment and other measures… to correct or ameliorate defects and physical and mental illness and conditions”. Thus, the EPSDT medical necessity standard assures coverage sufficient to 1) treat already existing illness or injury and 2) to prevent the development or worsening of a condition.

Federal Medicaid law also requires that coverage must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may limit the amount, duration and scope of services based upon medical necessity, but these limits must be determined on a case-by-case basis.

Barriers to EPSDT

Despite EPSDT’s broad benefits, studies suggest that not all children are receiving the services to which they are entitled. While most studies discuss low rates for comprehensive, well-child “screening” visits, some researchers have looked specifically at utilization of treatment services. For example, one study used medical records to assess whether health problems were identified and whether treatment, follow-up, or referral care was provided within six months of an EPSDT screening visit. Health problems were identified for 43% of the children; 22% received treatment, and 18% were referred for specialty care. Almost one-third of the children referred for specialty care did not receive such care.

Barriers that inhibit use of screening, diagnosis, and treatment services include:

- Low provider participation in Medicaid, particularly among dentists, mental health providers, and pediatric specialists. Families may face challenges in finding a provider who accepts Medicaid. This may be due to providers’ perceptions of the adequacy of payment levels, the level of administrative burden associated with participation, or the type of patients who are covered by Medicaid.

- Parents face different barriers for treatment than for well-child care. Low-income families seeking care for their children are more likely than middle/high income families to have a “big problem” getting necessary care and have trouble getting a referral to a specialist.

- Unequal treatment by racial/ethnic status also appears to be a factor. National survey data suggest a need for improved access and quality for children who are racial and ethnic minorities.

New Jersey’s Use of EPSDT

Over the past five years New Jersey has made progress in increasing the participation rate of children in screening, but much more needs to be done. The annual EPSDT report (Form CMS-416) provides basic information on participation in the Medicaid child health program. This information is used to assess the effectiveness of State EPSDT programs in terms of the number of children who are provided child health screening services, referred for corrective treatment and receive dental services. Based on an initial review of New Jersey’s Form CMS-416 and other neighboring states, New Jersey is generally performing better in the area of screening than other states including Delaware, Pennsylvania, New York and Connecticut.
Child health screening services are defined for purposes of this report as initial or periodic screens required to be provided according to the State’s screening periodicity schedule. The children included in this count include all individuals regardless of whether the services are provided under fee-for-service or managed care.

### New Jersey EPSDT Participation Rate for Screenings by Age

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<tbody>
<tr>
<td>under age 1</td>
<td>1</td>
<td>1</td>
<td>.90</td>
<td>.92</td>
<td>.93</td>
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<tr>
<td>age 1-2</td>
<td>.74</td>
<td>.75</td>
<td>.77</td>
<td>.79</td>
<td>.81</td>
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<tr>
<td>age 3-5</td>
<td>.65</td>
<td>.66</td>
<td>.68</td>
<td>.71</td>
<td>.75</td>
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<tr>
<td>age 6-9</td>
<td>.44</td>
<td>.46</td>
<td>.49</td>
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<td>.55</td>
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<tr>
<td>age 10-14</td>
<td>.43</td>
<td>.44</td>
<td>.47</td>
<td>.52</td>
<td>.56</td>
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<tr>
<td>age 15-18</td>
<td>.43</td>
<td>.42</td>
<td>.44</td>
<td>.46</td>
<td>.48</td>
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<tr>
<td>age 19-20</td>
<td>.30</td>
<td>.29</td>
<td>.30</td>
<td>.31</td>
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Source: Form CMS-416

There has been progress in New Jersey’s participation rate for screening children under age 1 and between ages 1-2. In FY 2003 (data not on the table above), New Jersey’s participation rate for those age categories was .88 and .71 respectively. As can be seen in the table, in FY 2009, the participation rate was .93 and .81 respectively. While this is a significant jump in the percentage of children who were screened through EPSDT much improvement is still needed for children between the ages of 1-2.

Unfortunately, children age 3 and above have significantly low screening rates. In fact, children age 6 and above have screening rates at .55 or below.

Corrective treatment includes all individuals, including those in managed care, who, as the result of at least one health problem identified during an initial or periodic screening serving, were scheduled for another appointment with a screening provider or referred to another provider for further needed diagnostic or treatment services. These numbers and rates do not include correction of health problems during the course of a screening examination.

### Total Eligibles referred for Corrective Treatment
(Rate of referral to Treatment after initial or periodic screening)

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<tr>
<td>under age 1</td>
<td>143 (.003)</td>
<td>133 (.002)</td>
<td>116 (.003)</td>
<td>90 (.002)</td>
<td>157 (.004)</td>
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<tr>
<td>age 1-2</td>
<td>1,101 (.018)</td>
<td>1,939 (.03)</td>
<td>4,227 (.06)</td>
<td>5,077 (.07)</td>
<td>7,149 (.09)</td>
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<tr>
<td>age 3-5</td>
<td>1,075 (.019)</td>
<td>5,367 (.09)</td>
<td>18,884 (.3)</td>
<td>20,472 (.3)</td>
<td>25,365 (.32)</td>
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<tr>
<td>age 6-9</td>
<td>558 (.013)</td>
<td>4,552 (.09)</td>
<td>18,708 (.4)</td>
<td>20,633 (.36)</td>
<td>22,692 (.35)</td>
</tr>
<tr>
<td>age 10-14</td>
<td>253 (.005)</td>
<td>4,229 (.09)</td>
<td>16,797 (.32)</td>
<td>17,388 (.3)</td>
<td>19,382 (.29)</td>
</tr>
<tr>
<td>age 15-18</td>
<td>84 (.003)</td>
<td>2,359 (.07)</td>
<td>10,728 (.3)</td>
<td>10,708 (.27)</td>
<td>12,324 (.29)</td>
</tr>
<tr>
<td>age 19-20</td>
<td>8 (.0015)</td>
<td>389 (.07)</td>
<td>2,141 (.33)</td>
<td>2,356 (.34)</td>
<td>2,902 (.35)</td>
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</table>

Source: Form CMS-416
There has been an increase in the number and rates of children age 3 to age 20 in referrals for corrective treatment over the past five years. However, given that initial screening rates (earlier table) have been so low for this population group, more individuals may be in need of treatment but do not even receive screening to determine if they need additional treatment.

For children under age 1 and between ages 1-2, treatment rates are significantly below that of other age groups. New Jersey needs to improve its referral for corrective treatment of these children. New Jersey may have significantly more children in need of treatment provided under the Early Intervention (EI) program, but is unaware of the need because of low referral rates for corrective treatment. New Jersey would be able to receive additional matching federal funds for serving these children in the Early Intervention program under the Treatment component of EPSDT.

Other State’s Strategies for improving Delivery of Treatment services in EPSDT

According to the study by the National Academy of State Health Policy, there are strategies which some states have used to improve child health outcomes, manage costs, and maximize the time of available providers. New Jersey should review its current strategies and implement other strategies which it has not yet used.

- **Collect and report data:** Improved data on referrals and treatment can help states support families and assure completed referrals. Revised reporting forms, electronic reporting, and tools for providers are some options for improving data.

- **Focus on quality improvement:** Major new opportunities to measure child health quality are emerging through public and private sector projects. States also have opportunities to better use existing tools for quality improvement, such as HEDIS measures and improvement partnerships.

- **Identify Children with Special Health Care Needs:** By definition, children with special health care needs use an above average amount of health services. When enrolled in Medicaid, they account for a disproportionate share of EPSDT treatment services. States can better serve these children and their families, as well as better manage costs, through clear definitions, consistent identification of these children, and use of mechanisms to manage care.

- **Maximize the medical home and case management/care coordination:** Medical homes and care coordination are important approaches for assuring receipt of appropriate and needed treatment. The medical home is an essential tool for assuring appropriate utilization of child health services, and state Medicaid agencies can do more to support, administratively and financially, medical homes. States also have an opportunity to use case management/care coordination to improve linkages among providers and to support families in their efforts to use appropriate treatment services.

- **Communicate with Families and Providers:** Lack of knowledge among families and providers is one of the widely reported reasons children do not receive the EPSDT treatment services to which they are entitled. Pediatric providers need information that can help them understand how to make referrals, what case management may be available, and how to traverse the process for determining the medical necessity of a recommended treatment. Families need to be informed about the benefits available to their children.
• **Adapt improved policies:** When an area of improvement is identified, states have an opportunity to make both small and large changes to Medicaid policy. Studies have shown that even small changes, such as clarifying billing codes or provider guidance, can help improve service delivery for children.

**Conclusion**

The importance of fully capitalizing on the EPSDT for the developmental disabilities community as a whole cannot be understated. The EPSDT is a vital identification and funding mechanism for services critical to individuals with developmental disabilities. It is for this reason that New Jersey has been working to improve its EPSDT program and has seen some positive results. Periodic screening and diagnostic services under EPSDT have improved over the past few years.

There have also been improvements in Referral for Treatment for children age 6 and above, but the results have not been as positive for children under the age of 1 and between ages 1-2. Early detection is an important part of treatment and New Jersey must focus on significantly improving EPSDT usage in these age ranges.

One suggestion for achieving the desired increase in screenings, referrals, and services delivered for children below age 2 is for the New Jersey Early Intervention System (NJEIS) to work with Medicaid to ensure that EPSDT services are obtained for children evaluated for the Early Intervention program. EPSDT allows treatment for conditions found during outside screenings creating an optimal situation for coordination with the NJEIS. The two programs have similar goals. EPSDT’s programmatic standards require the treatment of existing conditions and preventing these conditions from worsening. Early Intervention is dedicated to remediating the long-term effects of developmental delays during the crucial timeframe of birth to three. NJEIS is one way in which qualifying children insured by Medicaid could receive many of the important services that would be identified and paid for by the EPSDT. Effective use of the EPSDT will help ensure the success of the NJEIS Child Find, will makes services more accessible, will increase positive outcomes among children with developmental delays and disabilities, and may increase the amount of federal revenue brought into the NJEIS system.

New Jersey should institute strategies from other states such as data collection, quality improvement, identification of children with special health care needs, maximizing the medical home and case/care coordination, increased communication with providers and families, and policy adjustment in order to improve its EPSDT program. Also, since a significant number of eligible children for EPSDT are in managed care in New Jersey (602,492 of the total 642,519) more work is needed with managed care organizations to ensure use of this important program.