Part One

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit for Children
Part One / Key Takeaway Messages

- EPSDT is the child health benefit in Medicaid and sets federal requirements and expectations for using Medicaid to promote and improve child health. Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. The EPSDT benefit provides a legal entitlement to children covered under Medicaid and is intended to guarantee children coverage for all services allowed under Medicaid in federal law, even if the state does not cover them for other populations.

- EPSDT requires states to finance a wide array of prevention and treatment services. This includes comprehensive well-child visits to screen for, identify, and respond early to conditions that affect the child’s health. EPSDT required benefits also include informing families about their benefits, providing assistance in scheduling appointments, arranging for treatment, and financing for transportation to keep appointments.

- Despite federal requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive and primary care and in terms of services for children with special health care needs (CSHCN), disabilities, and other conditions necessitating treatment.

- Medicaid and its EPSDT benefit not only enable states but set expectations for states to provide high quality primary and preventive health care. The opportunities to cover appropriate, effective, and cost-effective services for young children under Medicaid are discussed further throughout this report and in the context of a high performing medical home. Federal law sets a strong framework and expectation for states to provide comprehensive preventive services for young children, starting with the office visit. EPSDT forms a legal basis for financing of “high performing medical homes” for young children and other prevention and early intervention services, as they are discussed in parts two through five of this report.

Basic EPSDT Framework

EPSDT is the child health benefit in Medicaid. It sets broad federal requirements and expectations for using Medicaid to promote and improve child health. EPSDT was enacted in 1967 to build on the vision of President Lyndon B. Johnson and Congress to “discover, as early as possible, the ills that handicap our children” and to provide “continuing follow up and treatment so that handicaps do not go neglected.”

For more than 60 years, federal EPSDT law and state efforts have evolved to include changes in standards of pediatric care, structures in the health care system, and knowledge regarding the physical, developmental, social and emotional needs of low-income children.

Required in every state Medicaid program, EPSDT finances a wide array of appropriate and necessary pediatric services. As discussed above, this benefit requirement includes children enrolled by states through Medicaid expansion CHIP, but not those in private, separate CHIP plans, unless a state sets those as a CHIP requirement. Individuals under age 21 enrolled in Medicaid receive coverage for services — at regular intervals and whenever a problem appears — to identify and address physical, developmental, dental, and mental health conditions. The EPSDT benefit is intended to guarantee children coverage for all services allowed under Medicaid in federal law. In addition to health services, EPSDT required benefits include informing families about their benefits and providing assistance in scheduling appoint-
ments, arranging for treatment, and financing for transportation to keep appointments. (42 U.S.C. Sections 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)) As described in federal rules, states are required to: “[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly,. . . that informing methods are effective, . . . [and] that services covered under Medicaid are available.” (CMS, State Medicaid Manual Sections 5010, 5121, 5310)

**EPSDT Well-Child Visits**

Known as EPSDT screening visits, Medicaid finances preventive well-child visits that include a comprehensive health and developmental history, an unclothed physical exam, immunizations, laboratory tests, and health education and guidance for parents and children. Such EPSDT “check-up” visits are covered at age-appropriate periodic intervals recommended by professionals on a schedule set by states, and at other times, as needed. The periodic visit schedule defined in *Bright Futures* is widely used by both state Medicaid agencies and private plans for this purpose. The *Bright Futures* schedule recommends: a visit at birth; six visits for infants (at ages 3-5 days, and at 1, 2, 4, 6 and 9 months); five visits for toddlers ages 1 and 2 (at ages 12, 15, 18, 24, and 30 months); and three visits for preschoolers ages 3, 4, and 5.

Not all states operate in accordance with the *Bright Futures* periodicity schedule. (See Appendix B.) In FFY 2016, among 49 states and the District of Columbia, eight did not meet the standard for infants, and 30 did not meet the standard for toddlers. All states met the standard for at least three visits among preschoolers. In total, the American Academy of Pediatrics (AAP) recommends 14 visits for young children prior to the sixth birthday (with the newborn visit often done in the hospital making the total 15). In FFY 2016, 22 states — nearly half — did not have 14 or 15 pediatric well-child visits for young children birth through 5 on their EPSDT periodicity schedules. Such gaps in periodicity schedules can lead providers to reduce the number of visits they schedule for families, believing additional visits might not be covered.

In addition, required vision, hearing, and dental services are typically provided separately under a distinct schedule based on professional standards, but must include screening, diagnosis, and treatment. Similar to *Bright Futures* concordance, many states do not have up-to-date periodicity schedules for the additional services. For example, a 2013 review of states’ adherence to the American Academy of Pediatric Dentistry’s recommended schedule found that only 32 states had dental periodicity schedules and only 11 states adhered to the professional standard of practice for requiring referral to a dentist for a first dental visit by age 1. Since dental decay is found among approximately 30 percent of low-income young children ages 2-5 years, this is another important early childhood periodicity gap.
Medically Necessary Treatment Services

Under EPSDT, Medicaid not only covers preventive, well-child visits, it also covers medically necessary services to intervene for or treat identified physical, dental, developmental, and mental health conditions. This includes all “medically necessary” services that are included within the categories of mandatory and optional services (as defined in Medicaid law section 1905(a)), regardless of whether such services are covered for adults. Determinations of medical necessity are made by the state but must be made on a case-by-case basis, taking into account the needs of the individual child and guided by information from the child's health providers. Moreover, when a problem is identified through screening and diagnostic services, EPSDT requires states to “arrang[e] for ... corrective treatment,” either directly or through referral to appropriate providers or licensed practitioners, for any illness or condition detected ...” (CMS, State Medicaid Manual Section 5124)

Examples of services covered for children that may not be covered for adults in a given state are shown in Table 2. Note that CMS has made it clear for decades that not all covered services are named on the list. For example, mental health services do not appear as a discrete category but might be covered under physician, clinic, inpatient or other service categories. A longer list of possible services and approaches to coverage for young children and their families can be found in Appendix C.

Children with special health care needs (CSHCN) “have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and also require health and related services of a type or amount beyond that required by children generally.” While an estimated 15 percent of children under age 18 have special health needs, Medicaid and CHIP provide coverage for nearly half (48 percent) of all CSHCN. For many, such special needs begin at birth with a preterm birth, a hereditary disorder, or other conditions. Others can develop conditions such as autism, developmental disabilities, and speech-language-hearing problems in early childhood. For many young CSHCN with medical conditions, a diagnosis may confirm their condition and point to medically necessary treatment.

For young children experiencing emotional and mental health conditions, developmental delays, attachment disorders, and trauma, the related child and family risks may be identified before a diagnosis would apply. A specific diagnosis is not a requirement for intervention services financed under EPSDT. A
Regulations related to EPSDT Medical Necessity and Treatment

§5122 F. “Limitation of Services.—The services available...are not limited to those included in your State [Medicaid] plan.... the services must be necessary... to correct or ameliorate defects and physical or mental illnesses or conditions... [the states] make the determination as to whether the service is necessary.”

“42 CFR 440.230 allows you [the states] to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.”

A growing number of states have adopted Medicaid approaches for financing early childhood mental health services, including parent-child dyadic therapies and in-home mental health treatment. In response to the opioid epidemic, some states are adopting family-focused approaches to substance abuse in the household, particularly when young children are present.

Services to address social determinants of health for young children and their families, as long as their objective is in improving child health, also can be financed using Medicaid. Home visiting and other preventive, developmental, and two-generation approaches are discussed further in parts four, and five.

States vary in how they administer and implement Medicaid for all covered populations (e.g., low income children, adults, seniors, and persons with disabilities). Despite EPSDT requirements, states vary in how they implement the EPSDT benefit, both in terms of preventive health care and in terms of services to CSHCN and other conditions requiring treatment. Some states have good policies in place, but health providers and families are not well informed about the coverage. Families, child advocates, and child health providers have worked with state agencies for decades to help ensure that Medicaid finances quality services under recognized standards of care and that each child’s needs are identified early and addressed promptly and effectively. This remains an ongoing challenge, but also represents an opportunity.

States have the authority and flexibility, particularly through EPSDT, to structure coverage of services for children to achieve goals for prevention, healthy development, and minimization of disability. The opportunities to cover appropriate, effective, and cost-effective services for young children are discussed further throughout this report.
The Rationale for a Broad Perspective on Medicaid Coverage of Services for Young Children

When children are very young (0-3), they are setting the foundation and trajectory for all future development — largely through interactions with their parents and other caring adults. The safety, stability, and nurturing in the home environment is critical to young children's health and development. Child health providers play a leading role in ensuring health through identifying and responding to conditions of a newborn, treating disease and injury, providing immunizations, and diagnosing and responding early to other clinical medical and health concerns. However, that is only a part of what contributes to a child's health trajectory and long-term healthy growth and development.

In the case of young children with recognized and diagnosed medical conditions, successful treatments and related services are generally covered under Medicaid. This is particularly true when the treatment is found to be medically necessary for an individual child. Young children often have identified risks or live in conditions that have not resulted in a specific diagnosis at their age or stage of development. Medicaid, under the broad mandate of the EPSDT child health benefit, finances services for young children without a specific medical diagnosis in order to prevent, ameliorate, or correct risks and conditions. This might include: developmental services for a child at risk of developing a developmental disability or parent-child dyadic mental health therapy when a mother is depressed, even if the parent is not covered by Medicaid.

State Medicaid agencies also finance an array of prevention and early intervention services that do not require individual determinations of medical necessity. Within a primary care practice, this might mean reimbursement for time spent delivering Reach Out and Read, work of a Healthy Steps program specialist, outreach visits by a community health worker to assess home safety, or anticipatory guidance when the parent has a concern about the child's behavior or mental health. Other prevention programs financed by Medicaid include: home visiting programs for families with young children, early childhood mental health consultation in community settings when provided to individual children, and health-related services under the Individuals with Disabilities Act Part C Early Intervention Program for Infants and Toddlers. (See discussion of other services and programs in part six of this sourcebook.)
References


