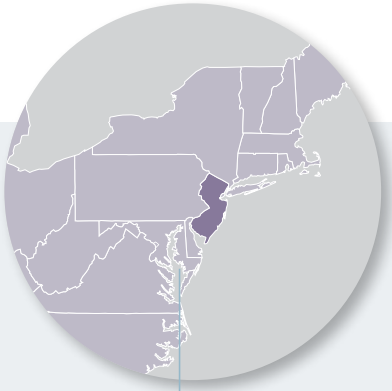
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



NEW JERSEY (NJ)

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

New Jersey'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 New Jersey'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. New Jersey'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

- New Jersey's 2018 EPSDT periodicity schedule calls for 2 fewer visits than recommended by the Bright Futures/AAP Periodicity Schedule. The state's EPSDT screening requirements are similar to Bright Futures' screening recommendations, although a few screening services are not specified, as shown in the table below.
- The state's EPSDT medical necessity definition, described below, incorporates a preventive purpose.
  - Medically Necessary Services—services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness of infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity of malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for the purpose of this contract. Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance.
  - In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.
- According to CMS, in 2016, New Jersey selected all 10 pediatric preventive care measures in the Child Core Set.
- New Jersey quality performance rates for 8 of these pediatric preventive care measures, as shown in the table below, were higher than the national average. Performance rates for childhood immunizations and HPV vaccinations were lower than the national average.
- New Jersey has pediatric preventive care performance improvement projects underway related to BMI screening, lead screening, oral health, and well child and adolescent visits.

Promising Practice

In response to low statewide lead screening rates, New Jersey Medicaid (NJ FamilyCare) incorporated several changes to its managed care contracts. These include: 1) the development of a lead case management program in each managed care organization, 2) a requirement to monitor individual provider screening rates semiannually and, if not at or above 80%, the provider is required to submit a corrective action plan, 3) semiannual outreach to caregivers of children who have not received their lead screen, and 4) annual reporting of lead outreach and activities planned for the coming year. New Jersey Medicaid has also created a Medicaid Lead Screening Database to identify and track children who are in need of blood lead screening or are lead-burdened. In calendar year 2015, New Jersey Medicaid's lead screening rates were at 73%.

Comparison of NJ EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on New Jersey's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 New Jersey Medicaid EPSDT requirements with the 2017 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care.[2]

Code

NS = Not specified
U = Universal (all screened)
S = Selective screening (only those of higher risk)
U/S = Universal and selective requirement
NA = Not available

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	NJ EPSDT	Bright Futures
- Birth through 9 months	6	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	NJ 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	U	S
- Hearing	U	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	NS	U
- Anemia	U	S
- Lead	U/S	S
- Tuberculosis	U	S
- Oral health	U	U/S
- Fluoride varnish	NS	U
- Fluoride supplementation	NS	S
- Nutritional assessment	U	U

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

Code

NS = Not specified
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NA = Not available

See Bright Futures/AAP Periodicity Schedule for complete information.

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

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

Included in the tables below are New Jersey'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	NJ	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	97.3	95.2
• Ages 25 months-6 years (in past year)	93.2	87.7
• Ages 7-11 (in past 2 years)	95.5	90.9
• Ages 12-19 (in past 2 years)	93.1	89.6
- % of children by 15 months receiving 6 or more well-child visits	65.7	60.8
- % of children ages 3-6 with one or more well-child visits	77.7	68
- % of adolescents ages 12-21 receiving 1 well care visit	59.4	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	61.4	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	82.8	70.3
- % of sexually active women ages 16-20 screened for chlamydia	50.2	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	20.4	20.8
- % of children ages 3-17 whose BMI was documented in medical records	68.6	61.2
- % of children ages 1-20 with at least 1 preventive dental service	49.2	48.2

Pediatric Preventive Care Financial Incentives, 2016	NJ	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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This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under UC4MC28034 Alliance for Innovation on Maternal and Child Health. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.