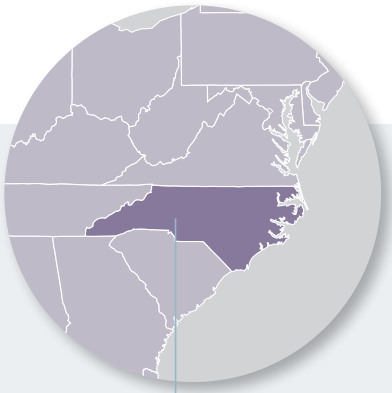
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



NORTH CAROLINA (NC)

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

North Carolina'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 North Carolina'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. North Carolina'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

- North Carolina's 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations. North Carolina has additional requirements for anemia and lead screening in the infancy period and developmental screening for the early childhood period.
- The state's medical necessity definition, described below, includes a preventive purpose.

  1. EPSDT services must be covered services within the scope of those listed in the federal law at 42 U.S.C. 1396d(a)(1905(a) of the Social Security Act). For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service request is not listed in DMA clinical policies or service definitions.
  2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition (health problem) diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or condition (health problem), ESPDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition (health problem).
  3. The request service must be determined to be medical in nature.
  4. The service must be safe.
  5. The service must be effective.
  6. The service must be generally recognized as an accepted method of medical practice or treatment.
  7. The service must not be experimental/investigational.

  Additionally, services can only be covered if they are provided by a NC Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll in an in-state provider is not available.
- According to CMS, in 2016, North Carolina selected all 10 pediatric preventive care measures in the Child Core Set.
- North Carolina's quality performance rates, as shown in the table below, were higher than the national average for PCP visits for children ages 12 to 24 months and ages 25 months to 6 years; well care visits for children under 15 months and children ages 3 to 6; chlamydia screening; and preventive dental services. For the following preventive care measures, the state was lower than the national average: PCP visits by children ages 7 to 11 and adolescents ages 12 to 19, adolescent well care visits, childhood and adolescent immunizations, HPV vaccinations, and BMI documentation.
- The state has pediatric preventive care performance improvement projects underway related to behavioral health screening and maternal depression screening.

Promising Practices

- In North Carolina's Health Check Program Guide, they have prepared a 3-page, age-specific EPSDT periodicity schedule and coding guide for clinicians. It also includes an EPSDT screening cross walk from ICD-9-CM to ICD-10-CM. In addition, this program guide provides concise information and links to screening tools for developmental, emotional/behavioral and other health risks.
- The state's Division of Medical Assistance has successfully partnered with its networks of pediatric providers through Community Care of North Carolina to implement and evaluate a broad set of quality improvement and care management efforts for children, including improving developmental screening and, most recently, incorporating the recognition and management of perinatal and postpartum depression into pediatric preventive care.

Comparison of NC EPSDT and AAP/Bright Futures Periodicity Schedules

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

Code

U = Universal (all screened)
S = Selective screening (only those of higher risk)
U/S = Universal and selective requirement

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	NC 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	NC 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	U	S
- Lead	U	S
- Tuberculosis	S	S
- Oral health	U/S	U/S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S

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

Code

U = Universal (all screened)
S = Selective screening (only those of higher risk)
U/S = Universal and selective requirement

See Bright Futures/AAP Periodicity Schedule for complete information.

Universal (U) and Selected (S) Screening Requirements	NC 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 North Carolina'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	NC	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	95.8	95.2
• Ages 25 months-6 years (in past year)	88.4	87.7
• Ages 7-11 (in past 2 years)	89.5	90.9
• Ages 12-19 (in past 2 years)	85.1	89.6
- % of children by 15 months receiving 6 or more well-child visits	61.4	60.8
- % of children ages 3-6 with one or more well-child visits	68.8	68
- % of adolescents ages 12-21 receiving 1 well care visit	38.6	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	66.5	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	65.5	70.3
- % of sexually active women ages 16-20 screened for chlamydia	53.5	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	17	20.8
- % of children ages 3-17 whose BMI was documented in medical records	23.2	61.2
- % of children ages 1-20 with at least 1 preventive dental service	50.6	48.2

Pediatric Preventive Care Financial Incentives, 2016	NC	US
- Use of preventive incentives for consumers	No	NA
- Use of performance incentives for providers	No	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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