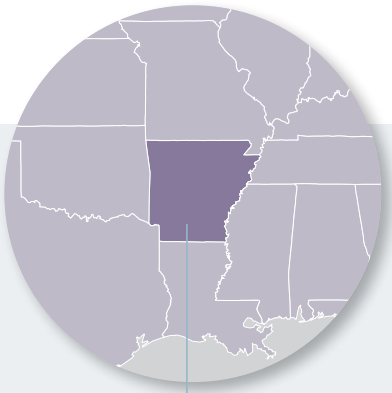
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



ARKANSAS (AR)

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

Arkansas'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 Arkansas'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. Arkansas'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] Information is current as of April 2018.

Summary of Findings

- Arkansas's 2018 EPSDT screening recommendations are based on the Bright Futures/AAP Recommendations, but no link or reference is made to the current version of Bright Futures. The state's EPSDT periodicity schedule, according to its provider manual, "has been changed in accordance with the most recent AAP recommendations." However, the schedule listed is 5 fewer visits than recommended by the AAP.
- The state's medical necessity definition, described below, incorporates a preventive purpose.
  - All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if its reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization. Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate or ineffective unless objective clinical evidence demonstrates circumstances making the service necessary.
- According to CMS, in 2016, Arkansas reported on 9 of the 10 pediatric preventive care measures in the Child Core Set. The measure not reported on was BMI documentation.
- Arkansas's performance rates were higher than the national average for PCP visits for children ages 7 to 11 and preventive dental services, as shown in the table below. The state's performance rates were lower than the national average for PCP visits for children ages 12 to 24 months, ages 25 months to 6 years, and adolescents ages 12-19; well care visits for all child/adolescent age groups; childhood and adolescent immunizations; HPV vaccinations; and chlamydia screening. The state EPSDT official noted that they are working with physicians on improved reporting of services offered during preventive visits (e.g., immunizations, BMI screening).
- The state has pediatric preventive care performance improvement projects underway related to BMI screening and well child and adolescent visits.

Promising Practices

Arkansas's Patient Centered Medical Homes (PCMH) established quality metrics and targets regarding children's well child visits as follows:

- Percentage of beneficiaries who turned 15 months old during the performance period who received at least four wellness visits in the first 15 months. Target = >70%
- Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year = >67%
- Percentage of beneficiaries 12-20 years of age who had one or more well care visits during the measurement year = >50%
  This information is tracked for the state's Shared Savings Incentive Payments.

Comparison of AR EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on Arkansas's EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 Arkansas 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 requirements

See Bright Futures/AAP Periodicity Schedule for more information.

Number of Well Child Visits by Age	AR EPSDT	Bright Futures
- Birth through 9 months	5	7
- 1 through 4 years	6	7
- 5 through 10 years	4	6
- 11 through 14 years	4	4
- 15 through 20 years	6	6

Universal (U) and Selected (S) Screening Requirements	AR 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 AR 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 requirements

See Bright Futures/AAP Periodicity Schedule for more information.

Universal (U) and Selected (S) Screening Requirements	AR 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 Arkansas'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	AR	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	90.5	95.2
• Ages 25 months-6 years (in past year)	84.7	87.7
• Ages 7-11 (in past 2 years)	91	90.9
• Ages 12-19 (in past 2 years)	87.9	89.6
- % of children by 15 months receiving 6 or more well-child visits	35.3	60.8
- % of children ages 3-6 with one or more well-child visits	59.6	68
- % of adolescents ages 12-21 receiving 1 well care visit	35.2	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	67.6	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	47.5	70.3
- % of sexually active women ages 16-20 screened for chlamydia	42.7	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	9.3	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	48.4	48.2

Pediatric Preventive Care Financial Incentives, 2016	AR	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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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.