EPSDT

EARLY, PERIODIC, SCREENING, DIAGNOSTIC AND TREATMENT PROGRAM

ALABAMA MEDICAID AGENCY

Early and Periodic Screening, Diagnostic and Treatment program

- Central component of state Medicaid program
- Package of Medicaid benefits for infants, children and adolescents enrolled in Medicaid
- Supported by a series of administrative services
- Critical to improving health of nation’s low-income children, especially for children with disabilities and other special needs

Access and Impact

- Nationally, more than 25 million children benefit – half of all Medicaid enrollees (Kaiser)
- More than 60% of all poor children (Kaiser)
- Estimated 20% of all funding for mental health care (NGA)
- Especially important to 1.3 million Medicaid-eligible children with disabilities (Kaiser)
- Even more benefit in poor states - 38% of all Alabama children or about half of all children under age 6 in the state are Medicaid eligible.

Program History

- Federal amendment to Medicaid enacted in 1967
- Prompted by 50% rejection rate for 1962 Vietnam draftees due to untreated childhood illnesses
- Part of a broader effort to improve quality, system capacity to identify and treat children with early signs of physical and mental health conditions that could affect growth and development.

Program Milestones – 1967-1989

- Important modifications in 1972 and again in 1981 to add specific outreach and family support requirements to promote health care access.
- EPSDT broadened by the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) to ensure full coverage for all medically necessary physical, mental and developmental conditions even if the service is not available under the State's Medicaid plan to the rest of the Medicaid

Program Milestones – 2005

Deficit Reduction Act of 2005 (DRA) signed in February 2006

- Gave States ability to modify Medicaid programs in certain ways
  - States may choose to offer a more limited benchmark package that may not offer all the same benefits to optional groups
  - States must provide all children under the age of 19 the wrap-around health services, including EPSDT
- EPSDT requirements unaffected by the DRA.
- Most importantly, however, the DRA does not affect the requirement that states cover all EPSDT services for children under the age of 19 as defined in OBRA ’89.

EPSDT Goals

- OBRA ’89 re-defined the Medicaid EPSDT program with two goals:
- Assure the availability and accessibility of required health care resources; and,
- Help Medicaid recipients and their parents or guardians effectively use available resources.

EPSDT goals enable Medicaid agencies to:

- Manage a comprehensive program prevention and treatment
- Seek out and inform eligibles of benefits of prevention and the health services and assistance available to them
- Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently.
- Assess the child's health needs through initial and periodic examinations and evaluations, and also
- Assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

Required Screening Services

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam;
- Appropriate immunizations
- Laboratory tests, including mandatory lead screening
- Vision, hearing, and dental screening
- Health education and anticipatory guidance

Required Diagnosis and Treatment Services

- Diagnosis and Treatment Services
- Vision, hearing and dental services
- Medically necessary health care that falls within federal definition of “medical assistance” and is necessary to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

Other Requirements

- Effective informing of eligible children / outreach
- Transportation or other assistance in securing services
- Federal reporting

EPSDT is a unique program

- Range and depth of the periodic health exams
- Explicit requirements to assess growth and development
- Unparalleled coverage of diagnostic and treatment services.
- Unlike private insurance, EPSDT does not distinguish between acute, curable conditions and lifelong or chronic conditions that can be “ameliorated” through health care.
- EPSDT governed by special necessity standard whose scope derives directly from statutory terms “early” and “ameliorate.”
- Federal agencies and courts have interpreted this to require interventions at the earliest possible time.

CHCS Modernization Study - 2005

- Funded by RWJ, Casey and Packard foundations, Commonwealth Fund
- Three areas of focus:
- Making coverage work effectively
- Measuring performance
- Integrating Medicaid-covered health services with social, educational programs financed through non-medical programs
- Designed to reflect changing health care system

Recommended Best Practices / Making Coverage Work

- Strong, first tier benefits
- Certain benefits on a supplemental basis for second tier
- Upper tier benefits limited to children with special needs (13% nationally)
- Focus on developmental risk, rather than specific underlying diagnoses
- Extreme care needed in approach to managing higher-cost services, such as enhanced home care, private duty nursing, family support services, DME, nutritional products and services.

Recommended Best Practices / Measuring Performance

- Based on currently accepted clinical/scientific evidence/guidance
- Accountability through benchmarks for targeted measures;
- Use of comprehensive measures
- Based on widely accepted measures for children with typical and special health care needs – sentinel events
- Monitoring of health disparities
- Maximization of value to providers – reduction of administrative burden

Recommended Best Practices for EPSDT / Program Coordination

- Clear roles and responsibilities for each program
- Shared information within privacy rules
- Medical home should be home for health care information

Strategies for Better Coordination

- Strengthen linkages among service providers
- Comprehensive approaches to coordinate care
- Establish medical home to oversee service requirements
- Adopt effective measures to share information across providers

EPSDT Issues and Concerns - Nationally

- Underutilization of program
- GAO Study: Lack of lead testing, dental visits cited
- Low provider participation, especially dental and mental health
- Parental unawareness of need for well-child, preventive care
- Cost to States: Open-ended nature of EPSDT benefit
- Most children less expensive than other Medicaid-covered populations
- $1,786 children (age 6-20) vs. $7,185 (age 65+) cost per eligible in Alabama in FY 07
- State lack of flexibility over benefits and cost sharing

EPSDT in Alabama – Early-mid 1990s

- SOBRA Expansion brings thousands of children into system
- Fragmented system; Medicaid providers can opt-in and out at will
- High ER utilization
- Low EPSDT rates; low rates of preventive care
- Parents who can advocate for their children more likely to get needed care

Three Alabama strategies for improved child health

1. Building medical homes
2. Shared information
3. Performance measurement

Strategy 1: Building Medical Homes

- Patient 1st program began in 1997; continues today
- “Health care close to home” for about 400,000+ recipients
- Statewide primary care case management program (PCCM)
- Ensures access to primary care services
- Establishes medical home for most Medicaid recipients
- Cornerstone of current Medicaid transformation effort
- Performance Measures / Incentives
- Profiler – Reports to PMPs; peer comparisons
- Money Saved: $11 million total
- Shared Savings - $5.5 in FY 07 shared by Patient 1st PMPs

Benefits of building Medical Homes

- Patient 1st doctor required to perform or ensure EPSDT screenings are performed
- 24/7 coverage to increase access to physician; discourage unnecessary ER use
- Required VFC participation – Vaccines for Children – Children more likely to get shots on schedule
- Central location for patient records; coordination of referrals
- Opportunity for improved patient-provider relationship; continuity of care
- Incentives for physicians to meet goals

Strategy 2: Share information electronically

- Electronic information – made available through Medicaid transformation grant
- Electronic Clinical Support Tool and Health Record
- Free to providers
- Able to exchange data with EMR systems
- Designed by Alabama physicians
- Claims based; has BCBS and Medicaid information
- ER visit, RX history DX information

Strategy 2: continued

- Printable patient summary
- Rules-based alerts for PMPs
- Foundation for data-driven quality improvement
- Strengthens medical home by providing complete information to PMP.
- Health reform expected to support expanded use of health information technology
- Federal Stimulus funds provide financial support for HIT

Strategy 3: Performance/Quality Improvement

- *Together for Quality* – AL's Medicaid Transformation Effort
- Measures and monitors "missed opportunities" based on currently accepted clinical/scientific evidence/guidance
- Certain patients with asthma and diabetes now monitored via **Q4U** pilot project
- Patients with higher risk targeted for intervention by care coordinators
- Many patients have significant improvements after small or inexpensive interventions (e.g. measuring cup example, asthma action plan)

Quality Improvement

- AL Medicaid leading Alabama HealthCare Improvement and Quality Alliance
- Encouraging collaboration on guidelines and measurement
- Encouraging collaborative development of projects to improve quality of care, patient safety across the continuum of care
- Identify critical elements of clinical and population-based health care that increase the likelihood of desired health outcomes
- Identify feasible, evidence-based interventions to enhance provision of and access to these elements of care.

Medicaid Transformation

- Alabama committed to Medicaid transformation as a means to improve health outcomes and quality of care.
- Meaningful transformation includes substantive improvements to
  - Quality of care provided recipients
  - Value to taxpayers who fund the program, and
  - Efficiency in which we do business with our providers and recipients
- Ultimate outcome is better health care at a lower cost