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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive package of benefits available to children enrolled in Medicaid. All children and youth under age 21 are entitled to receive EPSDT. [\(1\)](#)

This fact sheet answers some commonly asked questions about EPSDT and addresses coverage of mental health services. In particular, the following questions are answered:

How does EPSDT address screening of poor children?

How does EPSDT address treatment services?

- How should children and their families find out about EPSDT?
- What is the current status of EPSDT screening?
- What role does litigation play in improving EPSDT?

How Does EPSDT Address Screening of Poor Children?

Screens, or well-child check ups, are a basic element of the EPSDT program. Four separate types of screens are required: medical, vision, hearing, and dental. The medical screen must include at least the following five components:

- a comprehensive health and developmental history **including assessment of both physical and mental health**; [\(2\)](#)
- a comprehensive, unclothed physical examination;
- appropriate immunizations;
- laboratory tests (including lead blood testing at 12 and 24 months and otherwise according to age and risk factors); [\(3\)](#) and
- health education, including anticipatory guidance. [\(4\)](#)

Each of the four types of screens -- medical, vision, hearing, and dental -- must be performed at distinct intervals, as determined by "periodicity schedules" that meet the standards of pediatric and adolescent medical and dental practice. For example, current practice guidelines call for annual screening of adolescents with a focus on psycho-social needs. [\(5\)](#)

In addition to covering scheduled, periodic check ups, EPSDT covers visits to a health care provider when needed outside of the periodicity schedule to determine whether a child has a condition that needs further care. These types of screens are called "interperiodic screens." Persons outside the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen, and "any encounter with a health care professional acting within the scope of practice is considered to be an interperiodic screen, whether or not the provider is participating in the Medicaid program at the time those screening services are furnished." [\(6\)](#)

How Does EPSDT Address Treatment Services?

EPSDT requires state Medicaid agencies to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment." [\(7\)](#) Significantly, the Medicaid Act defines a comprehensive package of EPSDT benefits, and it sets forth the medical necessity standard that must be applied on an individual basis to each eligible child.

Covered services include all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults. A listing of the Medicaid/EPSDT services is included as "Attachment A" to this fact sheet.

Medical necessity is defined to cover "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions[.]" [\(8\)](#)

In sum, if a health care provider determines that a service is needed, it should be covered to the extent needed and allowed under the federal Medicaid Act. For example, if a child needs personal care services to ameliorate a behavioral health problem, then EPSDT should cover those services to the extent the child needs them -- even if the state places a quantitative limit on personal care services or does not cover them at all for adults.

How Should Children and Their Families Find Out about EPSDT?

If EPSDT is to work, there is an absolute need for effective outreach and informing. As noted by the Seventh Circuit Court of Appeals:

[States cannot] expect that children of needy parents will volunteer themselves or that their parents will voluntarily deliver them to the providers of health services for early medical screening and diagnosis. By the time [a child] is brought for treatment it may too often be on a stretcher. . . . EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose. [\(9\)](#)

In the EPSDT legislation, Congress has required states to inform all Medicaid-eligible persons in the state who are under age 21 of the availability of EPSDT and immunizations. [\(10\)](#) States must use a combination of written and oral methods to effectively inform eligible individuals about: (1) the benefits of preventive health care; (2) the services available through EPSDT; (3) that services are without charge, except for premiums for certain families; and (4) that support services, specifically transportation and appointment scheduling assistance, are available on request. If the child/family has difficulty reading or understanding English, then the information needs to be conveyed in a format that can be understood. Notably, states must offer both transportation and appointment scheduling assistance "prior to each due date of a child's periodic examination."

[\(11\)](#)

What is the Current Status of EPSDT Screening?

Too few children are receiving EPSDT. The National Health Law Program recently reviewed state-reported data for fiscal years 1994, 1995, and 1996 and found that, while screening rates have improved, EPSDT does not meet expectations. ⁽¹²⁾ In 1996, 22.9 million children were eligible for EPSDT. ⁽¹³⁾ Only 37 percent of these children received a medical check-up through EPSDT; 21 percent, a dental screen; 15 percent, a vision screen; and 13 percent, a hearing screen.

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The report found that screening is not evenly distributed among age groupings. With the exception of dental services, infants and young children are significantly more likely to receive health screens.

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Not surprisingly, state profiles of EPSDT participation vary considerably.

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A number of barriers to EPSDT have been identified, in particular: There is a shortage of providers participating in the Medicaid program. Beneficiaries are not effectively informed of the program and its benefits. Service delivery in managed care settings and the provision of mental health services present particular challenges. Finally, the program has political opposition from those who view it as prescriptive and potentially expensive.

What Role Does Litigation Play in Improving EPSDT?

Cases from Tennessee and Maine illustrate the role that litigation is playing in improving access to EPSDT services. The Tennessee case, *John B. v. Menke*, represents a comprehensive challenge to a statewide managed care program's failure to assure that children get EPSDT services. ⁽¹⁷⁾

In their complaint, children and their families noted numerous problems, including the lack of outreach and informing; failure to provide screening and diagnostic services; and failure to provide needed treatment, from wheelchairs to home-based mental health services. The case was settled when the state agreed to implement a plan that includes requirements for:

- improving outreach and informing to beneficiaries. Among other things, managed care organizations (MCOs) are required to target informing to "at risk" groups, including mothers with babies, adolescents, first time eligibles, and those not recently using the program.

- updating and implementing statewide periodic screening requirements to identify both medical and mental health problems. Developmental screening will include the use of culturally sensitive developmental assessments and avoidance of premature diagnosis labeling.
- improving access to needed treatments, with particular attention to children who are medically fragile. MCOs must provide services needed to correct, compensate for, improve, or prevent a condition from worsening -- even if the condition cannot be prevented or cured.
- enhanced measurement of performance by collecting information called for by the Health Care Financing Administration on its EPSDT reporting form and the National Committee for Quality Assurance (an accreditation entity that measures managed care performance).
- better integration of health care and custodial services for children in foster care. [\(18\)](#)

The Maine case, *French v. Concannon*, was filed on behalf of Medicaid-eligible children in Maine who have severe mental impairments, including mental retardation, autism, or mental illness, and who need home or community-based services to treat their impairments. [\(19\)](#)

Needed EPSDT-covered services included case management, in-home aides, medication monitoring, and mental health counseling. According to the complaint, the state Medicaid agency was failing to provide these services to children and their families in a timely manner. As a result, children were waiting months -- and in some cases years -- for services, or confined to institutions, many of them out-of-state. This case was also settled, and it offers children the promise of improved services through, for example:

- An employee position was created within the Department of Mental Health to identify children who need services and to make sure that treatment plans are developed and implemented. As a result, hundreds of children have been identified and provided services.
- The EPSDT brochure was revised to include easy-to-understand information about the range of behavioral services that are available to children.
- The state agreed to monitor and address provider capacity issues. It developed a "regional resource directory" that includes information about available providers and resources. The Departments obtained legislative appropriations to add case manager positions throughout the state. A new provider category -- behavioral health specialist -- is targeted to home and community-based settings. The state also is sponsoring a series of regional EPSDT training sessions for providers and case managers.

- The prior authorization process was streamlined and the need to use prior authorization reduced, as more home-based services are available through the regular Medicaid billing process. In addition, there is now a presumption that mental and behavioral health services described in treatment plans developed by authorized providers are medically necessary.
- The Medicaid agency has revised the EPSDT provider screening form to reflect age-specific information about mental health needs and anticipatory guidance.
- The Medicaid agency is implementing regulations that require prompt delivery of treatment services, equality of services between children with physical and mental health needs and between children with mental illness and mental retardation, and collaborative efforts that will focus on child-and family-oriented care. For example, the rules create a new category of Medicaid provider, behavioral health specialists who are authorized to bill Medicaid for the provision of mostly home-based services.

In many states, there are increasing numbers of children who have health care needs that cut across physical health to include mental, developmental, and psycho-social domains. ⁽²⁰⁾ Many of these children can be treated in the community but are languishing in acute settings for extended periods of time or placed on waiting lists for community-based services. Case management is often needed to assure that services are received in a timely manner, without unnecessary duplication or labeling. There is also a need to develop an adequate supply of behavioral health providers for home and community settings. Not surprisingly, child advocates in other states are working on an individual and class wide basis to obtain EPSDT coverage of behavioral and mental health services.

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Additional National Health Law Program EPSDT Resources

For breaking news, recent articles, and case updates about EPSDT, check our website regularly at: www.healthlaw.org, and click on "[children's health](#)"

Jane Perkins, "Maintaining Health Services for Children Amid Welfare Confusion: The

Importance of Early and Periodic Screening, Diagnosis and Treatment," 32 *Clearinghouse Rev.* 450 (Jan./Feb. 1999)

[National Health Law Program, EPSDT Case Docket \(Jan. 1999\) \(available at: www.healthlaw.org\)](http://www.healthlaw.org)

National Health Law Program, *Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment* (Aug. 1998)
(available from NHeLP, Los Angeles, CA)

National Health Law Program & National Center for Youth Law, "EPSDT Update: For Child Health Insurance and Medicaid Advocates," 191 *Health Advocate* 13 (Winter 1998)

National Association of Child Advocates & National Health Law Program, *Medicaid Managed Care: An Advocate's Guide for Protecting Children* (1996) (available from NACA, Washington, DC)

National Health Law Program & Texas Rural Legal Aid, *Toward a Healthy Future - Early and Periodic Screening, Diagnosis and Treatment for Poor Children* (Apr. 1995)

National Health Law Program, *An Advocate's Guide to the Medicaid Program* (1993) (updated edition forthcoming, Summer 1999)

Attachment A

Scope of Medicaid/EPSDT Services Described in 42 U.S.C. § 1396d(a) [\(22\)](#)

- Inpatient hospital services (other than services in an institution for mental disease)

- Outpatient hospital services

- Rural health clinic services (including home visits for homebound individuals)

- Federally-qualified health center services

- Other laboratory and X-ray services (in an office or similar facility)

- EPSDT services

- Family planning services and supplies

- Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)

- Medical and surgical services furnished by a dentist

- Medical care or any other type of remedial care

- Home health care services (in place of residence)

- Private duty nursing services (in the home, hospital, and/or skilled nursing facility)

- Clinic services (including services outside of clinic for eligible homeless individuals)

- Dental services

- Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)

- Prescribed drugs

- Dentures

- Prosthetic devices

- Eyeglasses

- Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)

- Services in an intermediate care facility for the mentally retarded

- Inpatient psychiatric hospital services for individuals under age 21

-- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle

-- Hospice care

-- Case-management services

-- TB-related services

-- Respiratory care services

-- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law

-- Community supported living arrangements services (e.g., personal assistance, habilitation services, assistive technology), to the extent allowed and defined in 42 U.S.C. § 1396u

-- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease

-- Primary care case management services

-- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation and personal care services in a recipient's home)

Notes

1. See 42 U.S.C.A. §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (West Supp. 1998). The Medicaid Act was amended in 1989 to strengthen the EPSDT provisions. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2263 (1989). It was amended in 1993 to add the Vaccines for Children program.

See

Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13631, 107 Stat. 312 (1993) (adding 42 U.S.C. §§ 1396a(a)(62), 1396s).

See also

42 C.F.R. § 441.50

et seq.

(1997). In 1993, the Health Care Financing Administration proposed rules to implement the 1989 amendments.

See

56 Fed. Reg. 51,299 (Oct. 1, 1993). The rules are on the agency's "long-term" agenda, meaning that action is not expected on them within the next 12 months.

See

63 Fed. Reg. 21676 (Apr. 27, 1998). The Health Care Financing Administration has published guidelines on EPSDT.

See

Health Care Financing Administration, U.S. Dep't of Health & Human Services, State Medicaid Manual Part 5 (available at <<http://www.hcfa.gov>>). "Instructions [in this Manual] are official interpretations of the law and regulations, and, as such, are binding on Medicaid state agencies."

Id.

at Foreword. Federal courts have cited the

Manual

with favor.

See, *e.g.*

, *Stowell v. Ives*, 3 F.3d 539 (1

st

Cir. 1993).

2. The developmental assessment is to be used to determine whether physical and mental development are appropriate in relation to age group and cultural background. See *Id.* at § 5123.2.A(1).

3. 42 U.S.C. § 1396d(r)(1)(B). See also, *e.g.*, Letter from Sally K. Richardson, Director, *Health*

Care Financing Administration

, to State Medicaid Directors (Apr. 13, 1998) (stating lead screening requirements) (available from National Health Law Program, Los Angeles, CA); Health Care Financing Administration, U.S. Dep't of Health and Human Services, State Medicaid Manual § 5123.2.

4. Legislative history to the 1989 EPSDT amendments stresses that "... anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment." H.R. Rep. No. 101-247, at 399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2125. *See also* Health Care

Financing Administration, U.S. Dep't of Health and Human Services, State Medicaid Manual § 5123.2.E.

5. *See* American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care (modified May 21, 1998) <<http://www.aap.org/prof/9535t11.htm>>; American Medical Ass'n, Guidelines for Adolescent Preventive Services (Dec. 1992).

6. *See, e.g.*, Memorandum from Director, *Health Care Financing Administration Medicaid Bureau*, to Region III Administrator, *Health Care Financing Administration*

(Apr. 12, 1991) (available from National Health Law Program, Los Angeles, CA). This is significant because the interperiodic visit qualifies the child for EPSDT's treatment benefits, described *infra*.

7. 42 U.S.C.A. § 1396a(a)(43)(C) (West Supp. 1998).

8. *Id.* at § 1396d(r)(5).

9. *Stanton v. Bond*, 504 F.2d 1246, 1251 (7th Cir. 1974), *cert. denied*, 420 U.S. 894 (1975) (subsequent history omitted).

10. *See* 42 U.S.C. § 1396a(a)(43)(A) (West Supp. 1998). Congress has said states need to take

"aggressive action" to inform children and families about EPSDT. See 135 Cong. Rec. S 13234 (Oct. 12, 1989). For a case requiring outreach to children in out-of-home placement, see, Sanders v. Lewis, No. 2:92-0353, 1995 WL 228308, reprinted in Medicare & Medicaid Guide (CCH) ¶ 43,120 (S.D.W.Va. Mar. 1, 1995 and Aug. 16, 1993) (consent order, compliance plan).

11. Health Care Financing Administration, U.S. Dep't of Health & Human Services, State Medicaid Manual §§ 5121, 5150.

12. Kristi Olson, Jane Perkins, and Tonya Pate, Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment (Aug. 1998) (available from National Health Law Program, Los Angeles, CA). The report used the data reported by states on the Health Care Financing Administration's EPSDT reporting form, Form 416.

13. *Id.* at 20 (Figure 1).

14. *Id.* at 9.

15. *Id.* at 23 (Figure 4).

16. *Id.* at 50-100.

17. No. 3-98-0168 (M.D. Tenn. Aug. 28, 1998) (Order).

18. With respect to foster children, the agreement called for an expert report and a subsequent joint filing with the court to verify acceptance of any recommendations from the report. Following release of the report, which found that children were not getting needed health care, the state refused to submit a joint filing. Telephone Interview with Michelle Johnson, Staff Attorney,

Tennessee Justice Center (Nov. 17, 1998).

19. No. 97-CV-24-B-C (D. Me. July 16, 1998) (Order of dismissal and agreement) (Clearinghouse Rev. No. 51,989).

20. Clinical studies documenting these problems are cited in Paul W. Newacheck et al., *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).

21. See, e.g., Emily Q. v. Belshe, No. 98-4181 WDK (AUX) (C.D. Cal , filed May 27, 1998) (available from Protection & Advocacy, Los Angeles, CA).

22. EPSDT covers all measures described in 42 U.S.C. § 1396d(a) necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5).