Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

GEORGIA (GA)

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

Georgia'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 Georgia'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. Georgia'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

- Georgia's 2018 EPSDT requirements follow Bright Futures/AAP Periodicity Schedule and screening recommendations.
- The state's medical necessity definition, described below, includes a preventive purpose.

  "Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

  – Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;

  – Compatible with the standards of acceptable medical practice in the community;

  – Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

  – Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and

  – Not primarily custodial unless custodial care is a covered service or benefit under the Members evidence of coverage.

  There must be no other effective and more conservative or substantially less costly treatment, service and setting available. For children under 21, the Contractor is required to provide medically necessary services to correct or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening or preventive health visit, regardless whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act."
- According to CMS, in 2016, Georgia selected all 10 pediatric preventive care measures in the Child Core Set.
- Georgia's performance rates, as shown in the table below, were higher than the national average for 9 of the 10 pediatric preventive care measures. PCP access rates were lower than the national average.
- The state has several pediatric preventive care performance improvement projects underway related to BMI screening, lead screening, immunizations, and well child and adolescent visits.

Promising Practices

Georgia's performance improvement project (PIP) for pediatric preventive care well-visits is called the "Bright Futures PIP." MCOs follow a defined framework based on the model of rapid cycle improvement (plan-do-study-act) to guide their efforts. Incorporated into the PIP process is a SMART data collection methodology to distinguish successful and unsuccessful efforts and to expand successful interventions. Each MCO, in collaboration with the state, defines its Bright Futures annual well-visit goal and measurement process. For example, one of Georgia's MCOs established a goal of improving the annual adolescent well-visit rate by 5% using a specific member outreach, education, and incentive strategy.

Comparison of GA EPSDT and AAP/Bright Futures Periodicity Schedules

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

See Bright Futures/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	GA 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	GA 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 GA EPSDT and AAP/Bright Futures Periodicity Schedules *continued*

Code

NS = Not specified
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	GA 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 Georgia'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	GA	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	94.4	95.2
• Ages 25 months-6 years (in past year)	84.4	87.7
• Ages 7-11 (in past 2 years)	88.5	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	66.7	60.8
- % of children ages 3-6 with one or more well-child visits	70	68
- % of adolescents ages 12-21 receiving 1 well care visit	52.3	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	79.6	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	85.6	70.3
- % of sexually active women ages 16-20 screened for chlamydia	51.1	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	22.5	20.8
- % of children ages 3-17 whose BMI was documented in medical records	62.8	61.2
- % of children ages 1-20 with at least 1 preventive dental service	51.8	48.2

Pediatric Preventive Care Financial Incentives, 2016	GA	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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