

State EPSDT Policies for Adolescent Preventive Care

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Adolescents are generally healthy. Yet, adolescence is the time that many chronic conditions, particularly mental health conditions such as mood disorders and physical health conditions such as diabetes manifest. It is also the time when significant health risk behaviors -- drug use, unprotected sex, unhealthy eating patterns, and physically dangerous behavior -- become more common, especially among low-income adolescents. Left unidentified and without appropriate management and intervention, health conditions are likely to become serious, and risk-taking behaviors are likely to persist into adulthood.

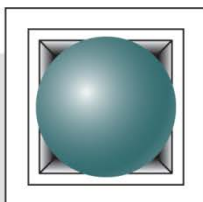
Fortunately for all children up to age 21 enrolled in the Medicaid program, the mandatory EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) benefit requires the early identification of health problems and the assurance that all necessary diagnostic and treatment services to address these problems will be furnished, provided that they are federally allowable Medicaid services. The federal statute is clear in its expectation that the preventive visit includes a comprehensive health and developmental history that encompasses both physical and mental development, an unclothed physical exam, appropriate immunizations, laboratory tests appropriate for age and risk factors, and health education including anticipatory guidance. Also required are vision, dental, and hearing services.¹ Federal regulations reiterate these

requirements but do not give states much additional guidance about the content of the preventive component of EPSDT.²

In the absence of further federal directives, states have evolved their own policies to implement the statutory mandate, and therefore the content and amount of guidance states give their EPSDT providers varies considerably. The purpose of this analysis was to determine what policies states have established with respect to the EPSDT preventive office visit for adolescent patients ages 12 to 21. Our findings address states' policies with respect to the periodicity schedule; the content of the comprehensive health history and assessment, physical examination and lab tests, and anticipatory guidance and health education; and also the referral requirements and supports. Policies pertaining to coverage for diagnostic and treatment services were not examined.

Methodology

Information for this analysis was collected in the winter and spring of 2011 and was drawn from several sources. For the 29 states in which a majority of Medicaid-enrolled children receive their care from providers paid on a free-for-service (FFS) basis, we examined the relevant guidance in the states' provider manuals. For the 21 states in which the majority of children are



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served through managed care organizations (MCOs), we examined MCO contracts and as well as provider manuals, which are almost always incorporated into the contracts by reference. To ensure that we were using all relevant documents, we contacted each state's EPSDT coordinator and in some cases were directed to administrative codes, documentation forms, and state periodicity schedules, which we then also examined. In addition, other issues were clarified via email with state EPSDT coordinators. Also, interviews with coordinators in selected states were conducted by telephone.

Information on adolescent-relevant guidance to providers was collected for 49 states and the District of Columbia. (Oregon was excluded because its Medicaid program has a federal waiver of the EPSDT mandate.) We considered guidance from the state to constitute a requirement if providers were required, expected, or mandated to perform a particular component of a preventive visit, or if verbs such as "must" or "should" were used. Where the language used in the guidance indicated that the component was optional, as when the verbs such as "may" or "recommend" were used, or the component was only found on a recommended documentation form, we considered the guidance to be suggested.

Results

All states make clear in their policy statements for providers that children are to receive EPSDT services, as defined in the Medicaid statute. As such, they all stipulate that with respect to preventive care, EPSDT services include a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, vision and hearing screenings, dental screening or referral, health education including anticipatory guidance, and referral for diagnosis and treatment. While most states provide extensive detail about the physical examination, laboratory tests, and immunizations, there is significant variation in the extent to which they establish requirements for the other components of the visit.

As for how EPSDT services for the adolescent population are handled in these state documents, there is also a considerable variation. Almost three-quarters of states address adolescent needs as part of their guidance for children's preventive care and include adolescent-relevant issues -- such as STD screening or tobacco cessation counseling -- under general headings for history taking, assessment, or health education. Many of these states, however, also have detailed documentation forms specifically for adolescent visits. Of the remaining states, the majority describe the content of adolescent preventive care in a separate section in their manuals, but a handful address adolescent needs only in their periodicity charts and billing codes.

Most states indicate that the Bright Futures periodicity schedule, *Bright Futures Recommendations for Preventive Pediatric Health Care*,³ was used in developing their periodicity schedules for well-child visits. In fact, 10 states require that providers follow these recommendations. States far less often incorporate the comprehensive Bright Futures guidelines, *Bright Futures Guidelines for Child Health Supervision of Infants, Children, and Adolescents*,⁴ into their provider guidance. There is one state that requires its providers to adhere to these comprehensive guidelines, and there are three that identify the Bright Futures guidelines as a resource for providers in their guidance materials. Beyond that, the section of the guidelines that relates to anticipatory guidance is required in several states and either suggested or identified as a reference in more than a dozen others. Also, a handful mention the guidance as a reference specifically for nutritional assessments or for mental health assessments and screening tools.

The Periodicity Schedule

Importantly, not all states require an annual preventive visit for adolescents ages 12 to 21, contrary to the recommendation of the American Academy of Pediatrics. Currently, there are only 36 states that require an annual preventive visit during adolescence, up from 33 in 2007. Among

those that do not require annual visits during adolescence, 12 states require a visit every two years, one requires a visit every three, and one requires a visit every four years. One state now requiring biannual preventive visits reported that it is planning to require annual visits in the near future.

Comprehensive Health History and Developmental Assessment

A comprehensive health and developmental history is required as part of the preventive visit by all states. Federal regulations specify that history taking includes an assessment of physical and mental health, growth, development, and nutritional status. Yet, four states make no mention of the nutrition assessment, and seven make no mention of the mental health assessment. In addition, there are seven states that provide no guidance on sexual behavior, no guidance on violence and injury potential, and no guidance on substance use as part of the comprehensive developmental assessment.

Still, the majority of states have in various ways established requirements for providers that we consider comprehensive with respect to history taking and assessments for adolescent patients. These 31 states either explicitly or implicitly require a history taking or assessment that, at a minimum, addresses five critically important components of adolescent health: **mental health, substance use, violence injury potential, sexual behavior, and nutritional health.**

Of these 31 states, nine are explicitly comprehensive. One requires providers to conduct a history and assessment using *Bright Futures Guidelines for Health Supervision*. The other eight states take a comprehensive approach to adolescents by including in their provider guidance specific requirements for addressing each of the five components in their history taking or assessments. Often they provide further detail, elaborating on the scope of the assessment and the underlying factors that should be examined as well as specific screening tools. Two of the eight states establish

their comprehensive requirements for adolescent history taking and assessment by requiring providers to complete detailed documentation forms.

The remaining 22 states considered comprehensive in their requirements for history taking or assessment are ones that use language that is very general but appears to encompass each of the five components important to adolescent health status. Leaving broad discretion to the provider, they typically require providers to conduct a “psychosocial/behavioral assessment,” as required by the Bright Futures periodicity schedule, which should include an assessment of mental health, substance use, violence and potential for injury, and sexual behavior. These states also require a nutritional assessment, as mandated by federal regulation, or sometimes simply a BMI and cholesterol screening. The majority of these implicitly comprehensive states, in addition to establishing these very general requirements, also have specific requirements for at least one of the five components, sometimes in the form of screening tools.

Among the 19 states that we did not consider comprehensive in their requirements for the history taking and assessment of adolescent patients, there is wide variation in the number and type of health issues they elect to address. Looking at these same five components of history taking and assessment that are essential to adolescent preventive care -- mental health, substance use, violence/injury prevention, sexual behavior, and nutritional health -- we found only two states that require providers to address four of the five components. In fact, five states require only three of the components, six states require only two, and four states require only one. However, while some states do not require all five of the components as part of history taking and assessment, they do suggest or recommend other components as health issues that providers may want to address.

Nutritional Health: Nutritional assessments, as required by federal regulation, are a mandatory component of history taking and assessment in almost all states. Forty-eight states require nutritional assessments in some way. Forty-five

do so explicitly, with about half stating simply that a nutritional assessment is required and the remainder furnishing more specific guidance, usually directing providers to assess the patient's dietary history or eating patterns. In several cases these states also have requirements for providers to assess familial, cultural, and environmental factors influencing a patient's nutritional status, and in a few they also have requirements for them to screen for adolescent-specific problems pertaining to eating disorders and body image. The other three states that require a nutritional assessment do so implicitly by requiring tests such as BMIs and cholesterol and also requiring health education for nutrition. The two remaining states suggest but do not require a nutritional assessment, in one case by recommending relevant tests and education.

Mental Health: Almost all states also mandate providers to conduct mental health assessments, which the Medicaid statute identifies as a required part of history taking and assessment. Forty-seven states have some type of directive for mental health assessments. Among these 47 states, 39 establish the requirement explicitly, with a few stating also that providers must screen adolescents for depression. About a third of the 39 states require or recommend one or more particular screening tools -- a mental health screening tool, such as the PSC,⁵ SDQ,⁶ or the Bright Futures in Practice Mental Health Tool Kit⁷ or a general tool that includes mental health such as GAPS.⁸ Also one state suggests a screening tool specifically for depression, the PHQ.⁹ The other eight states can be considered to require a mental health assessment implicitly by virtue of requiring a psychosocial assessment. Mental health assessment are suggested but not required in the remaining three states, two of which suggest a screening tool.

Sexual Behavior: About three-quarters of states in some way also require providers to address sexual behavior as part of the history taking and assessment. Among these 38 states, 17 expressly require providers to conduct a sexual history that includes sexual activity or sexual development, in some cases requiring or suggesting the use of a general risk assessment tool such as HEADSS¹⁰ or GAPS, also. Only in a

handful of states are providers directed to screen for risky sexual behavior or condom use, and only in a couple are they directed to ask about sexual orientation. The other 21 states are counted as implicitly requiring an assessment of sexual behavior because they either require lab work or exams applicable only for sexually active teens or because they require a psychosocial assessment. And an additional seven states suggest but do not require that sexual activity be included in this part of the exam, five of which do so by suggesting the use of a screening tool.

Substance Use: Two-thirds of states require providers to include substance use as part of history taking and assessment. Among these 33 states, 28 expressly mandate that substance use be addressed. States' guidance to providers typically encompasses alcohol, drugs, and tobacco use; however, in one state only alcohol use is mentioned and in two only drugs are mentioned. A quarter of the 28 states also direct providers to use the CRAFFT screening tool.¹¹ The other five states implicitly require an assessment of substance use by requiring a psychosocial assessment and sometimes also an assessment of risky behavior. There are an additional seven states that do not require an assessment of substance use but either suggest that substance use be addressed in history taking and assessment or recommend the use of CRAFFT.

Violence and Injury Potential: Least likely to be mandated are adolescent-relevant issues pertaining to violent behavior and the potential for injury. Of the 28 states that require a history taking or assessment of these issues, 11 specifically require providers to screen for violence or injury potential generally or else narrowly address issues such as weapons use or domestic or community violence. Some of the states also require or suggest a specific screening tool such as the SDQ, HEADSS, or GAPS, which include these issues. The other 17 states implicitly require an assessment of these issues through their general requirement for a psychosocial assessment. An additional six states either suggest a screening of the potential for violence and injury or suggest tools that include them.

Physical Examination, Laboratory Tests, and Immunizations

All states require a comprehensive unclothed physical exam as part of the assessment of physical health and development, typically specifying specific areas of the body to be examined. However, only 33 states explicitly require a pelvic exam for sexually active females, usually directing that the exam be performed three years after sexual debut or at age 18. An additional four states implicitly require pelvic exams by requiring Pap smears as part of lab tests.

Every state's EPSDT guidance requires that appropriate laboratory tests are administered during the preventive visit, but not all of the states require lab tests relevant to adolescents. Blood iron tests for patients at high risk of anemia, usually menstruating females, are required in 42 states. Tests for sexually transmitted infections are required for high-risk patients, usually patients who are sexually active, in 36 states. A cholesterol test for high-risk patients is required in 32 states. And a Pap smear is required, as necessary, for female patients in 29 states. Twenty-five states require providers to perform all of these lab tests: cholesterol, anemia, Pap smear, and sexually transmitted infections.

All states require that appropriate immunizations are delivered during the preventive visit, but a few do not provide any guidance on which immunizations should be delivered during adolescence. The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) has recommended three vaccines -- tetanus-diphtheria-acellular pertussis, meningococcal, and human papillomavirus (HPV) -- to be administered during adolescence. Others, such as tuberculosis or varicella (chickenpox), are administered in adolescence only in the event that they were not administered on schedule. In total, 47 states require that the three recommended vaccines are administered during adolescence, and the great majority of these states establish their requirements by referencing standards such as the ACIP.

Health Education

All states stipulate that health education or anticipatory guidance is a required part of the preventive visit, and almost all provide detail about one or more specific topics that must or could be addressed. States are more likely to recommend topics to providers than to require them, although in practice there may be little difference, given that providers generally use their discretion in selecting the topics most appropriate to focus on with individual adolescents. State guidance on health education topics, however, is not always comprehensive.

Still, about two-thirds of states address at least some topics in each of the five broad adolescent-relevant categories for health education described in *Bright Futures Guidelines for Child Health Supervision*: **physical growth and development, social and academic competence, emotional well-being, risk reduction, and violence and injury**. Some of these states are ones that reference the entire anticipatory guidance section of the guidelines in their manuals, but usually as a recommendation, not as a requirement.

Violence and Injury: Violence and injury prevention is most likely to be addressed in states' guidance to providers on health education. It appears in the guidance of 45 states. Typically these states specify injury prevention, violence prevention, or car safety. Twelve states have guidance for providers on all of the Bright Futures topics under this category, which include guns, conflict resolution, and sports safety.

Physical Growth and Development: More than three-quarters of states address at least one of the Bright Futures health education topics under the category of physical growth and development. Among these 40 states, the topic they typically specify is nutrition. All of the other topics under this category -- balanced diet, physical activity, limiting TV and computer use, body image, and dental care -- also are addressed in 11 states.

Risk Reduction: About the same number of states have guidance pertaining to risk reduction. Thirty-nine states address at least one of the topics under this category, most often tobacco use, STI prevention, or pregnancy prevention. Many states, 15, specify these as well as each of the other topics under this category -- alcohol, drugs, and contraception.

Emotional Well-Being: Almost three-quarters address emotional well-being in their guidance on health education. In these 36 states, guidance to providers specifies at least one of the topics in this category, most often sexual development and puberty. Eleven states, however, also mention the other Bright Futures topics that are part of emotional well-being -- stress, decision making, and mental health concerns.

Social and Academic Competence: Over two-thirds of states include guidance pertaining to social and academic competence. The 34 states address at least one health education topic under this category, usually peer and family relationships. Eleven states also include the related Bright Futures topics of school, community involvement, age-appropriate limits, friends, and rules.

Referral for Follow-Up Services

Most states in some way stipulate in their guidance that providers are required to make appropriate referrals for diagnostic and treatment services. Forty-four states have such a requirement, and about three-quarters of them also have language making clear that referrals are required whenever the result of a screen is positive. Six states have no general directive about the requirement to make referrals. Yet, among all 50 states, there is only one state that has not established a referral requirement for at least one specific type of health care service. In fact, a third of states have two or more such requirements. States least likely to have these referral requirements for specific services are those that simply direct providers to refer whenever a screen is positive.

Referral requirements relevant to adolescent

care are most often for mental health, substance use, nutrition, or sexual health services. Seventeen states have referral requirements for mental health services, and the same number have referral requirements for substance abuse services. Referrals are required for nutrition services in 14 states and for sexual health services in six states. Language varies depending on the type of health problem, but states typically clarify in their guidance that if there is evidence of a health concern or a need for further assessment, evaluation, counseling or treatment service, providers should furnish the necessary services to the extent they are trained and able or otherwise should make a referral to a provider who can deliver appropriate care. In some cases, specific reference is made to the particular type of provider to whom the referral should be made.

Guidance regarding the timeliness of referrals is not always included. Some states, though, emphasize the importance of timely referrals, some direct providers to make referrals without delay, and others stipulate that appointment be scheduled within 60 days.

Additionally, 13 states specify that special assistance to help providers make referrals and coordinate specialty care for patients is available. Most of these states furnish a list of specialty providers, provide information about care coordinators who can work directly with families, or describe referral procedures for particular services. Some states offer a phone service that connects providers with referral support. In some cases the assistance is limited to mental health or substance abuse treatment, as when SBIRT¹² is required.

Private Time with Providers

Although not federally required, private meetings with their primary care providers is considered appropriate practice once an adolescent reaches age 13 and is a recommended component of *Bright Futures Guidelines for Health Supervision*. For that reason we examined whether states established a requirement for private meetings in their provider manuals and found that it happened only rarely. There are

only two states that require providers to meet with adolescents alone and four others that indicate providers have the option to do so. Twelve states, though, make clear that adolescents are able to consent for the receipt of certain services. Eight of these states explicitly refer providers to state statutes regarding minor consent for general or specific health services, including sexual and mental health services, and an additional five states stipulate that adolescents are able to consent for sexual health services but do not reference a state law. Also significant, 20 states appear to acknowledge the potential for adolescents to play a larger role in their own care by providing age-specific health education materials or directing providers to furnish health education directly to the adolescent.

Conclusion

Most, though certainly not all, states call for an annual preventive visit for adolescents, consistent with Bright Futures recommendations. Most states also require providers to conduct comprehensive assessments for adolescents and perform age-appropriate unclothed physical exams and laboratory tests, although the extent to which they give explicit guidance about provider expectations varies substantially. With respect to health education topics and referrals for diagnosis and treatment, state requirements, as might be expected, are far less common and much greater discretion is left to providers.

Nine states, though, have detailed EPSDT provider requirements that address adolescent needs comprehensively. Each of these states, we learned through our interviews, evolved their requirements as a result of considerable collaborative effort with other state agencies and providers, most importantly state AAP chapters, and in some cases with health plans, academic

health centers, and adolescents as well. The focus of a few of the states was on making EPSDT preventive care more comprehensive for all children and adolescents. The clear intent of the others, however, was to use EPSDT as a vehicle for improving the physical and mental health status of adolescents through the use of adolescent-specific tools such as GAPS or HEADSS, or through the development of their own set of comprehensive provider requirements. In two instances, changes in EPSDT were made in tandem with changes in adolescent preventive care requirements and quality measures established for all payers.

Certainly more states need to strengthen their EPSDT provider guidance -- and perhaps also implement payment incentives -- to ensure that adolescents receive the comprehensive preventive care they require. Periodicity schedules need to come into compliance with professional guidelines, and directives regarding the content of care need to be better articulated, especially with respect to screening services for sexual health, substance use, and violence and injury potential. Supporting providers through referral assistance is also important, as is training in collaboration with professional organizations on interviewing skills and strategies for engaging adolescents.

Yet, nationwide only about 40% of Medicaid-enrolled adolescents receive preventive care,¹³ and low utilization rates are reportedly even a problem for states with comprehensive provider requirements. It would seem that all states need to implement more effective outreach strategies to encourage adolescents to seek preventive care, promote greater use of cell phone and email technology to remind adolescents about appointments, place more attention on the assurance of confidentiality protections, and consider how to make practices more teen-friendly.

Acknowledgements

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Endnotes

¹ *Compilation of the Social Security Laws*. Available at www.ssa.gov/OP_Home/ssact/title19/1905.htm. Accessed on January 10, 2011.

² *Code of Federal Regulations*. Available at <http://cfr.vlex.com/vid/440-345-epsdt-services-requirement-287466407>. Accessed on January 10, 2011.

³ *Bright Futures/American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care*. Elk Grove Village, IL: AAP, 2008.

⁴ Hagan JF, Shaw IS, Duncan P (eds). *Bright Futures Guidelines for Health Supervision on Infants, Children, and Adolescents* (3rd ed.). Elk Grove Village, IL: AAP, 2008.

⁵ The Pediatric Symptom Checklist (PSC)

⁶ The Strengths and Difficulties Questionnaire (SDQ)

⁷ Jellinek M, Patel B, Froehle M (eds). *Bright Futures in Practice: Mental Health—Volume II, Tool Kit*. Arlington, VA: National Center for Education in Maternal and Child Health, 2002.

⁸ Guidelines for Adolescent Preventive Services (GAPS)

⁹ Patient Health Questionnaire (PHQ)

¹⁰ Home, Education, Activities, Drugs, Sexuality, and Suicide (HEADSS)

¹¹ Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)

¹² Screening, Brief Intervention, Referral and Treatment (SBIRT)

¹³ Center for Medicare and Medicaid Services. *Annual EPSDT Participation Report, Form CMS 416, Fiscal Year 2009*. Available at www.cms.gov/MedicaidEarlyPeriodicScrnl/Downloads/2009National.pdg. Accessed on August 10, 2011.

The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

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