EPSDT’s Role in Improving Child Vision, Hearing, and Oral Health

Jane Perkins

Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is an expansive legal entitlement for Medicaid-eligible children under age 21. Among other things, EPSDT targets vision, hearing, and dental health. Today, more than 40 million children in the United States qualify for Medicaid and EPSDT. Congress added the EPSDT provisions to the Medicaid Act (the Act) in 1967 for a simple reason — to make children healthier. In doing so, it recognized that the law can play a significant role in advancing child health. Properly implemented, EPSDT’s clinical and community coordination requirements can improve child health while creating a bridge between medical and social services to emphasize prevention, health promotion, and community integration. After providing a brief explanation of the EPSDT benefit, this article discusses EPSDT’s role in improving child vision, hearing, and oral health.

Overview of EPSDT

Screens, or well-child check-ups, are a basic element of each state’s Medicaid EPSDT program. Four separate types of screens are required: medical, vision, hearing, and dental. The medical screen must include: (1) a comprehensive health and developmental history; (2) a comprehensive unclothed physical exam; (3) immunizations; (4) laboratory testing; and (5) health education and anticipatory guidance. Each type of screen must be provided according to its own “periodicity schedule,” which is to be set by the state in consultation with entities and organizations, such as the American Academy of Pediatrics, with expertise in child health care. EPSDT also includes “interperiodic screens,” which are 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. Persons outside of the health care system (for example, a teacher or parent) can determine the need for an interperiodic screen.

EPSDT is more than just a screening program. The Act requires state Medicaid agencies to “arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment.” Significantly, the Act defines a comprehensive package of EPSDT benefits that each state must cover and establishes the medical necessity standard that must be applied to decide each child’s service needs. Covered services include all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults. Medical necessity is defined as “necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions[.]” In sum, EPSDT coverage is broad and deep. For example, if a child needs dental care to ameliorate a problem, then EPSDT must cover it — even if the state does not cover dental services for adults.

Moreover, if EPSDT is to work, there is an absolute need for effective outreach to Medicaid-enrolled families and children. 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

Jane Perkins, J.D., M.P.H., is the Legal Director of the National Health Law Program and a Senior Attorney for the Network for Public Health Law.
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.7

Therefore, states must use a combination of written and oral methods to effectively inform EPSDT-eligible individuals and their families 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 information needs to be conveyed in a format that can be understood.8

EPSDT is more than just a screening program. The Act requires state Medicaid agencies to “arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment.” Significantly, the Act defines a comprehensive package of EPSDT benefits that each state must cover and establishes the medical necessity standard that must be applied to decide each child’s service needs. Covered services include all mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults.

Finally, the EPSDT requirements must be met regardless of the delivery system being used by the state Medicaid program, for example fee-for-service, managed care, or accountable care organizations. As recently noted by the Centers for Medicare & Medicaid Services (CMS), “The goal of EPSDT is to assure that individual children get the health care they need when they need it — the right care to the right child at the right time in the right setting.”9

EPSDT and Vision
An estimated 25 percent of children in the United States have a vision problem significant enough to affect school performance, and low-income children and children of color are disproportionately affected.10 Not surprisingly, vision services are a mandatory component of the EPSDT benefit. At a minimum, services must include ongoing screening, diagnosis and treatment for defects in vision, including eyeglasses. Replacements for lost, broken, or stolen glasses must also be covered.11

Some states have implemented policies designed to maximize vision services through the EPSDT program. For example, Wisconsin uses a comprehensive periodicity schedule that emphasizes regular screening of children aged 0-5. Wisconsin is also among a handful of states that has specially mentioned the need to screen young children for amblyopia (a common, but preventable, cause of adult blindness).12 The Michigan Medicaid program has included provisions in its contracts with managed care organizations that require vision screening to follow the American Academy of Pediatric protocols, with additional screening as required by court order, foster care placement, or medical necessity.13 Illinois has developed strong provisions for vision services by, among other things, specifying the various vision assessment tools that can be used during an EPSDT screen for children at various ages. Finally, a handful of states (e.g., Maine, Minnesota, Hawaii) have developed reporting and monitoring methods designed to help the state evaluate the extent to which vision services are being provided through EPSDT.14

EPSDT and Hearing
Despite the proliferation of hospital-based newborn hearing screening programs, a significant number of children with possible hearing loss are not receiving prompt diagnosis and treatment. Children from low-income households experience hearing loss at a greater rate than more affluent children.15

As with vision services, hearing services are a mandatory EPSDT component. At a minimum, services must include assessment, diagnosis, and treatment for defects in hearing, including hearing aids, augmentative communication devices, and cochlear implants.
The vast majority (but not all) of states have established separate EPSDT periodicity schedules for hearing screening. Some states, including Louisiana, have outlined the testing frequencies that EPSDT-participating providers should use, as well as acceptable hearing threshold levels. Other states (including Alabama, Massachusetts, and Virginia) have included provisions that instruct providers to take specific steps to address missed hearing appointments or failed hearing tests.\(^7\) As with vision services, some states are monitoring performance. In the District of Columbia, for example, Medicaid-participating managed care organizations must report each month on the number and percentage of eligible children who received hearing and vision screening.\(^8\)

**EPSDT and Dental**

Dental disease is a chronic condition experienced by all too many children, particularly low-income children. Dental disease affects not only oral health but also physical health, school attendance, and job and school performance.\(^9\)

EPSDT covers the full range of oral health services that children need. In addition to periodic and inter-periodic assessment of the child’s teeth, EPSDT coverage must, at a minimum, include “relief of pain and infections, restoration of teeth, and maintenance of dental health.”\(^10\) EPSDT anticipates direct referral to a dentist, generally beginning at age one, and states must cover orthodontia when needed to restore oral structures to health and function (but not for cosmetic reasons).\(^11\)

State Medicaid agencies are using many approaches to increase the oral health of low-income children. Iowa’s Medicaid agency has entered into interagency agreements to provide for more effective care coordination services and to secure Medicaid reimbursement for oral health services provided by dental hygienists who are employed or contracted by agencies that receive Title V maternal and child health block grant funding from the federal government to improve the health and well-being of women and children.\(^12\) Most state EPSDT programs cover dental sealants and fluoride varnish that enable children to avoid cavities. Wisconsin’s Seal-A-Smile program has focused on delivering sealants in school sites, which has reduced both Medicaid spending and cavities.\(^13\) As of January 1, 2016, a billing code (CDT D1354) is available to state Medicaid programs for reimbursing the application of anti-microbials. Finally, states such as California and Oregon are experimenting with providing integrated care that, among other things, targets children at high risk of dental caries for early intervention, disease management, and more intensive care.\(^14\)

**Conclusion**

In recent years, the federal Medicaid agency, CMS, has encouraged states to improve EPSDT coverage of vision, hearing, and dental screening and services. Among other things, it has created extensive web pages that offer concrete, best practice examples that states can model as they work to increase the number of children served through EPSDT.\(^15\) In addition, CMS has made it easier for schools to bill for vision, hearing, and dental services in school settings.\(^16\) Moreover, organizations such as the Network for Public Health Law and the National Health Law Program have surveyed state EPSDT laws, policies, and managed care contracts to report on states’ model activities and where states are falling short. Yet, there is room for improvement. Stakeholders can increase awareness of the problems children are experiencing and work with state Medicaid agencies and their contractors to ensure that low-income children are benefited by EPSDT’s promise of comprehensive vision, hearing, and oral health.

**References**

2. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4) (B), 1396d(r).
5. Id. § 1396d(r)(5) (referring to 42 U.S.C. § 1396d(a)).
6. Id.
7. Stanton v. Bond, 504 F.2d 1246, 1251 (7th Cir. 1974).
11. 42 U.S.C. § 1396d(r)(2); see also, e.g., CMS, EPSDT-A Guide for States, supra note 9, at 15-16.