APPENDIX Q

MEDICAID & HEALTH TRACKS FOR CHILDREN IN NORTH DAKOTA, UNDERSTANDING EPSDT

Jodi Hulm, Administrator EPSDT

North Dakota MEDICAID

north dakota department of human services

What is EPSDT?

Early and Periodic Screening, Diagnosis & Treatment

The federally mandated health care benefit package, administered in partnership with each state, for essentially *ALL* Medicaid enrolled children, ages birth through 20 years.

The goal of EPSDT is early detection, prevention, and treatment of problems for ALL children and youth enrolled in Medicaid.

Who is Eligible for EPSDT?

Any child who is Medicaid-enrolled is eligible for EPSDT benefits up until their 21st birthday.

Is EPSDT Different From Medicaid?

Through EPSDT, each state's Medicaid plan must **provide to any EPSDT recipient** *any medically necessary health care service*, **even if the service is not available under the State's plan to the rest of the Medicaid population.**

EPSDT

Coverage does not include:

- Experimental treatments
- Services or items not generally accepted as effective
- Services for the caregiver's convenience

The EPSDT Benefit consists of:

Assuring availability and accessibility of required health care services and items (within limitations).

Why is EPSDT so Important?

- More than HALF of all Medicaid enrollees across the country are children.
- EPSDT is designed to enhance primary care of children with emphasis on prevention, early diagnosis and timely treatment.

ND Enrollment as of September 2015 - 39,742

Medicaid Mandatory & Optional Services

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services for those 65 and older in Institutions for Mental Disease (IMD)
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services for those Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services and Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy-Related Services and services for other conditions that might complicate pregnancy	Dental and Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy and Occupational Therapy	Nursing Facility Services for those Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating Hospital
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

"Medically necessary"

is defined as a covered service or item if it will do, or is reasonably expected to do, one or more of the following:

- Arrive at a correct medical diagnosis;
- Prevent the onset of an illness, condition or injury or disability in the individual or in covered relatives, as appropriate;

Medically necessary continued

- Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability;
- Assist the individual to achieve or maintain sufficient functional capacity to perform age appropriate or developmentally appropriate daily activities.

Medicaid Co- pays

- • $1 for spinal manipulation received during a chiropractic appointment
- • $1 for each outpatient speech therapy visit
- • $2 for each office visit – this includes all medical doctors, nurse practitioners (NP), and physician assistant-certified (PA-C)
- • $2 for each dental clinic appointment
- • $2 for each outpatient physical therapy visit
- • $2 for each outpatient occupational therapy visit
- • $2 for each optometry appointment
- • $2 for each outpatient psychological appointment
- • $2 for each outpatient hearing test visit
- • $3 for each hearing aid supplied
- • $3 for each clinic appointment to a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)
- • $3 for each podiatry office appointment
- • $3 for brand name prescription drugs
- • $3 for each emergency room visit that is not an emergency
- • $75 for each inpatient hospital stay

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EPSDT implies the importance of ***Early and Periodic Screening, Diagnosis and Treatment*** *in children.*

There are benefits in EPSDT that are not provided for in regular Medicaid. ***The most obvious is the Health Tracks (periodic) screen.***

What is a Health Tracks screen?

Health Tracks Screenings: The Foundation

Health Tracks requires Medicaid providers to assess a child's health needs through initial and periodic examinations, and to assure that any health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

Health Tracks Screenings

Medicaid enrolled children receive both comprehensive well-child exams (periodic screenings) **AND** any necessary visits in between (inter-periodic visits).

Periodic Screen

The Health Tracks (periodic) screen is a comprehensive check-up. It is not necessarily a well-child checkup, because the doctor can do a comprehensive checkup sometimes when a child is ill. However, a comprehensive checkup is usually done at the time a well-child checkup is scheduled.

Periodic Screen

In order for a comprehensive checkup to be counted as a Health Tracks (periodic) screening, the checkup must include all of the components outlined for in Health Tracks screening (i.e. mental health, hearing, dental, developmental, laboratory screenings). If only some components are included, it should be considered an inter-periodic screen.

Health Tracks Screenings – The First Step

Screenings are completed by the PCP (Primary Care Provider) or Local Public Health Unit.

Health Tracks Screenings – The First Step

Screenings should be provided at intervals established by state medical consultants.

* ND uses Bright Futures

North Dakota's Periodic Screening Schedule:

- 3 to 5 days after birth
- By 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Annually up thru age 20

***Child to be seen by a dentist starting at first tooth eruption or by 1 year, or earlier if a problem exists.**

Components of a Health Tracks screening include:

- Health history
- Unclothed “head to toe” physical examination
- Identification of all medical conditions and needs
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) schedule
- Age appropriate laboratory tests
- Health education including anticipatory guidance

Continued…

Components of a Health Tracks screening include:

- Developmental Assessment
- Nutritional Assessment
- Mental Health Screening
- Vision Screening
- Hearing Screening
- Oral inspection; send child to a dentist twice per year, starting no later than 1 year of age
- Treatment and referrals for any necessary services

With Particular Emphasis On:

Appropriate **immunizations** in accordance with the ACIP schedule;

Laboratory test for lead toxicity at one AND two years old, OR any time up to age 6, if not previously tested;

Mental health screening and coordination;

Vision Services – including corrective lens;

Hearing Services – including hearing aids;

Dental Services – bi-annual exam by a dentist, including restoration of teeth and maintenance of dental health;

Health Education – including anticipatory guidance.

Inter-periodic Visits

Any care that occurs outside the periodic screening schedule.

(Includes partial screenings.)

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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name
DRUG ALLERGIES	CURRENT MEDICATIONS		ID NUMBER
WEIGHT (%) See growth chart.	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	BIRTH D

History

☐ Previsit Questionnaire reviewed
☐ Child has special health care needs

Newborn screening ☐ NL
Hearing screening ☐ NL

Concerns and questions ☐ None ☐ Addressed (see other side)

Follow-up on previous concerns ☐ None ☐ Addressed (see other side)

Interval history ☐ None ☐ Addressed (see other side)

☐ Medication Record reviewed and updated

Social/Family History

Physical Examination

☑=NL

Bright Futures Priority

- ☐ **HEAD/FONTANELLE** (positional skull deformities)
- ☐ **EYES** (red reflex/strabismus/ appears to see)
- ☐ **HEART**
  - ☐ **FEMORAL PULSES**
- ☐ **ABDOMEN**
- ☐ **MUSCULOSKELETAL** (torticollis)
  - ☐ **HIPS**
- ☐ **NEUROLOGIC** (tone, strength, symmetry)

Abnormal findings and comments

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Relationship with parents/siblings _____

Risk Assessment

If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)

HOME
- Eats meals with family ☐ Yes ☐ No
- Has family member/adult to turn to for help ☐ Yes ☐ No
- Is permitted and is able to make independent decisions ☐ Yes ☐ No

EDUCATION
- Grade _____
- Performance ☐ NL _____
- Behavior/Attention ☐ NL _____
- Homework ☐ NL _____

EATING
- Eats regular meals including adequate fruits and vegetables ☐ Yes ☐ No
- Drinks non-sweetened liquids ☐ Yes ☐ No
- Calcium source ☐ Yes ☐ No
- Has concerns about body or appearance ☐ Yes ☐ No

ACTIVITIES
- Has friends ☐ Yes ☐ No
- At least 1 hour of physical activity/day ☐ Yes ☐ No
- Screen time (except for homework) less than 2 hours/day ☐ Yes ☐ No
- Has interests/participates in community activities/volunteers ☐ Yes ☐ No

DRUGS (Substance use/abuse)
- Uses tobacco/alcohol/drugs ☐ Yes ☐ No

SAFETY
- Home is free of violence ☐ Yes ☐ No
- Uses safety belts/safety equipment ☐ Yes ☐ No
- Impaired/Distracted driving ☐ Yes ☐ No
- Has relationships free of violence ☐ Yes ☐ No

SEX
- Has had oral sex ☐ Yes ☐ No
- Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

SUICIDALITY/MENTAL HEALTH

Anticipatory Guidanc

☐ Discussed and/or handout given

☐ PHYSICAL GROWTH AND DEVELOPMENT
- Balanced diet
- Physical activity
- Limit TV
- Protect hearing
- Brush/Floss teeth
- Regular dentist visits

☐ SOCIAL AND ACADEMIC COMPETENCE
- Age-appropriate limits

- Fr
- Fa
- C
- E
- R
- P

☐ EM
- D
- D
- M
- Se

Plan

Immunizations (See Vaccine Admi

Laboratory/Screening results: ☐

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name

PROVIDER 1

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Bright Futures

Bright Futures Adolescent Suppl Questionnaire 15 to 17 Year V

For us to provide you with the best possible health care, we would like to get to know you better and k Our discussions with you are private. We hope you will feel free to talk openly with us about yourself a shared with other people without your permission unless we are concerned that someone is in dange

Your Name _____ Toda

Your Age _____ Your Sex (circle one): M F Your

Your Growing and Changing Body: Physical Growth and De

1.	Do you live in your parents' home?	
2.	Do you go to school?	
3.	Are you having any problems in school or at work? Circle all that apply: grades worse than last year fighting homework suspension in the last year missing school or work other _____	

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Bright Futures™

Bright Futures Parent Hand
1 Month Visit

Here are some suggestions from Bright Futures experts that may be of valu

PARENTAL WELL-BEING

How You Are Feeling

- Taking care of yourself gives you the energy to care for your baby. Remember to go for your postpartum checkup.
- Call for help if you feel sad or blue, or very tired for more than a few days.
- Know that returning to work or school is hard for many parents.
- Find safe, loving child care for your baby. You can ask us for help.
- If you plan to go back to work or school, start thinking about how you can keep breastfeeding.

Getting to Know Your Baby

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Put your baby to sleep on his back

SAFETY

Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your seat belt and never drive after using alcohol or drugs.
- Keep your car and home smoke free.
- Keep hanging cords or strings away from and necklaces and bracelets off of your baby.
- Keep a hand on your baby when changing clothes or the diaper.

Your Baby and Family

- Plan with your partner, friends, and family to have time for yourself.
- Take time with your partner too.

FEEDING ROUTINES

- Pat, rock, wake you
- Feed you hunger.
  - Putting
  - Suckin
- End feedi is full.
  - Turning
  - Closing
  - Relaxe
- Breastfee
- Burp your
- Having 5- day show

If Breast

- Continue

Mental Health Screening Tools

- Ages 0 through 60 months
  - Ages and Stages Questionnaires: Social – Emotional
  - Brigance Screen II
  - Brief Infant and Toddler Social Emotional Assessment (BITSEA)

Please read each question carefully and

1. Check the box ❑ that best describes your child's behavior *and*
2. Check the circle ❍ if this behavior is a concern

	MOST OF THE TIME	SOMETIMES
1. Does your child look at you when you talk to him?	☒ z	❑ v
2. Does your child cling to you more than you expect?	❑ x	❑ v
3. Does your child talk and/or play with adults she knows well?	❑ z	☒ v
4. When upset, can your child calm down within 15 minutes?	☒ z	❑ v
5. Does your child like to be hugged or cuddled?	❑ z	☒ v

- Ages 5 through 21
  - Pediatric Symptom Checklist (PSC)
  - Pediatric Symptom Checklist – Youth Report (Y-PSC)
  - Strength and Difficulties Questionnaire (SDQ)

Pediatric Symptom Checklist (PSC-17)

Please mark under the heading that best describes your child:

		(0) NEVER	(1) SOMETIMES	(2) OFTEN
1.	Feels sad, unhappy	☐	☐	☐
2.	Feels hopeless	☐	☐	☐
3.	Is down on self	☐	☐	☐
4.	Worries a lot	☐	☐	☐
5.	Seems to be having less fun	☐	☐	☐
6.	Fidgety, unable to sit still	☐	☐	☐
7.	Daydreams too much	☐	☐	☐
8.	Distracted easily	☐	☐	☐
9.	Has trouble concentrating	☐	☐	☐
10.	Acts as if driven by a motor	☐	☐	☐
11.	Fights with other children	☐	☐	☐
12.	Does not listen to rules	☐	☐	☐
13.	Does not understand other people's feelings	☐	☐	☐
14.	Teases others	☐	☐	☐
15.	Blames others for his/her troubles	☐	☐	☐
16.	Refuses to share	☐	☐	☐
17.	Takes things that do not belong to him/her	☐	☐	☐

Does your child have any emotional or behavioral problems for which she/he needs help? __No __Yes

BRIGHT FUTURES TOOL FOR PROFESSIONA

Pediatric Symptom Checklist (PS

Emotional and physical health go together in children. Because parents are often the first to notic child's behavior, emotions, or learning, you may help your child get the best care possible by answ Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

			Never	Sometin
1.	Complains of aches and pains	1		
2.	Spends more time alone	2		
3.	Tires easily, has little energy	3		
4.	Fidgety, unable to sit still	4		
5.	Has trouble with teacher	5		
6.	Less interested in school	6		
7.	Acts as if driven by a motor	7		
8.	Daydreams too much	8		
9.	Distracted easily	9		
10.	Is afraid of new situations	10		
11.	Feels sad, unhappy	11		

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answer best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior ov months or this school year.

Child's name .....

Date of birth.....

	Not True	Somewha True
Considerate of other people's feelings	☐	☐
Restless, overactive, cannot stay still for long	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐
Often loses temper	☐	☐
Rather solitary, prefers to play alone	☐	☐
Generally well behaved, usually does what adults request	☐	☐
Many worries or often seems worried	☐	☐

Other Screening Tools

- M-CHAT – Autism
- CRAFFT – Substance Abuse and Alcohol Abuse Screening
- Patient Health Questionnaire Modified for Teens (PHQ-9)
- Kutcher Adolescent Depression Scale

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the
is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Ye
2.	Does your child take an interest in other children?	Ye
3.	Does your child like climbing on things, such as up stairs?	Ye
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Ye
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Ye
6.	Does your child ever use his/her index finger to point, to ask for something?	Ye
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Ye
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Ye
9.	Does your child ever bring objects over to you (parent) to show you something?	Ye

The CRAFFT Screening Questions

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	☐	☐

If the patient answered NO to ALL of the questions in Part A, ask the CAR question only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

Part B	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐

PHQ9P

PATIENT HEALTH QUESTIONNAIRE-9

72883

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3

Kutcher Adolescent Depression Scale (11-Item)

Over the last week, how have you been "on average" or "usually" regarding the following items:

1. low mood, sadness, feeling blah or down, depressed, just can't be bothered.
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

2. irritable, loosing your temper easily, feeling pissed off, loosing it.
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

3. sleep difficulties - different from your usual (over the years before you got sick): trouble falling asleep, lying awake in bed.
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

4. feeling decreased interest in: hanging out with friends; being with your best friend; being with your boyfriend/girlfriend; going out of the

7. trouble concentrating, can't keep your mind on
   work, daydreaming when you should be working
   when reading, getting "bored" with work or scho
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

8. feeling that life is not very much fun, not feeling
   usually (before getting sick) would feel good, no
   pleasure from fun things as usual (before getting
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

9. feeling worried, nervous, panicky, tense, keyed u
   a) hardly ever
   b) much of the time
   c) most of the time
   d) all of the time

Children's Mental Health Training

- http://www.nd.gov/dhs/services/mentalhealth/children-training.html
- Joint training held with the Medical Services Division and the Behavioral Health Division

Other Screening Tools:

- Maternal Depression Screenings
  - Edinburgh Postnatal Depression Scale (EPDS)
  - Patient Health Questionnaire – 9 (PHQ-9)
  - Beck Depression Inventory (BDI)

Screening Results

If the screening is normal, the PCP or Public Health Unit should:

- Assist the family in scheduling the next Health Tracks screening
- Ensure that bi-annual dental exams occur (by 1 year of age)

If the screening is abnormal:

- Develop a treatment plan
- Provide treatment, if appropriate
- Refer to a provider for further evaluation or treatment, if necessary
- Assist the family in scheduling the next Health Tracks screening
- Ensure that bi-annual dental exams occur (at age 1 year of age)

Meeting Medical Necessity

To justify extraordinary and expensive services, particularly those that require a service authorization.

Services may not be for the convenience of the caregiver.

An Example of Medical Necessity

When it is a service not covered by regular Medicaid or it is a service that is going beyond service limits.

Service Limits

- Chiropractic manipulation visits – 12 per year
- Chiropractic x-rays – 2 per year
- Occupational therapy evaluation – 1 per year
- Occupational therapy – 20 visits per year. Applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.
- Psychological evaluation – 1 per year
- Psychological therapy visits – 40 per year
- Psychological testing – 4 units (hours) per year
- Speech therapy visits – 30 per year. Applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.
- Speech evaluation – 1 per year
- Physical therapy evaluation – 1 per year
- Physical therapy visits – 15 per year. Applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.
- Vision testing and prescriptions for glasses. Under 21 years of age – 1 exam and 1 set of glasses per year; 21 and older – 1 exam and 1 set of glasses every two years.

Service Authorization:

Any service authorization form shall include the following information:

- *A description of the child's condition;*
- *A description of the proposed treatment plan;*
- *The effective date and estimated length of time treatment will be needed;*
- *The name and identification numbers of the child, ordering physician, PCP and the rendering provider; And*
- *The evaluation, diagnosis, prognosis, or any other clinical information necessary to establish medical necessity for the child*

Out of State Authorizations

- All out-of-state services require a service authorization
- Unless it is provided in a boarder community (within 50 miles)
- The request for prior authorization must be made by the primary care provider or in-state specialist

Out of State Authorizations

- Current medical reports to support the out-of-state request must be submitted with the State form
- In order for an out-of-state service to be approved it has to be medically necessary and not available in North Dakota

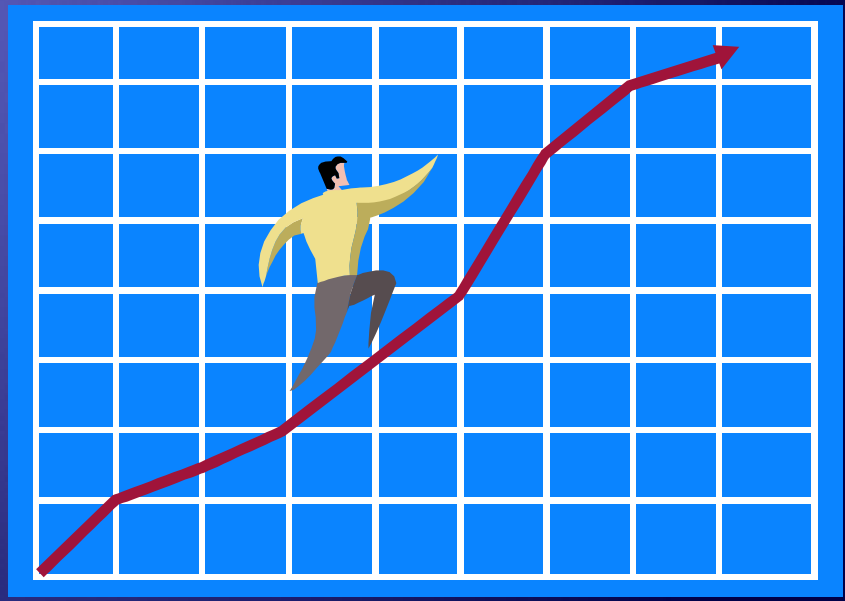
EPSDT Benefit Plan

- Periodic and Interperiodic Screenings
- Blood Lead Screens
- Orthodontia
- PATH Family Support

Percentage of Enrolled Medicaid Children Screened

- 2007 – 62%
- 2008 – 64%
- 2009 – 71%
- 2010 – 64%
- 2011 – 60%
- 2012 – 64%
- 2013 – 70%
- 2014 – 69%

*Federal Goal is 80%



Lead Screenings

- 2007 – 957
- 2008 – 1,735
- 2009 – 1,285
- 2010 – 1,838
- 2011 – 1,743
- 2012 – 1,838
- 2013 – 1,890
- 2014 – 2,318

Dental Screenings

- 2007 – 25%
- 2008 – 29%
- 2009 – 32%
- 2010 – 32%
- 2011 – 27%
- 2012 – 32%
- 2013 – 30%
- 2014 – 30%

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