



# IMPROVING CHILDREN'S HEALTH IN NORTH CAROLINA

Using Medicaid's  
**Early and Periodic Screening,  
and Diagnostic and Treatment**  
to Address Social Determinants  
of Health

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 north carolina  
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**H**ealthy children are critical to North Carolina's future. When health needs go unaddressed, they not only can result in high-cost emergency medical care, but generate broader costs.<sup>1</sup> When families experience health needs and can't work or attend school, entire communities suffer. This is why it is important for North Carolina to improve its health outcomes for our children. Currently the state ranks 33rd for overall child well-being in the nation according to data collected in the 2017 Kids Count Data Book.

Preventative screenings ensure health conditions are identified early and health behaviors are supported, increasing the likelihood of better health outcomes.<sup>2</sup> Using an "upstream" approach that places emphasis on preventative health services can ensure child health priorities are maintained in a cost-effective way and minimize greater harm to health with chronic or severe health conditions. Going



upstream extends beyond health care to considerations of factors such as the quality of housing, adverse childhood experiences, school attendance, and access to healthy foods, all of which are connected to health outcomes. These social determinants of health are considered fundamental to achieving our priorities for healthy children and family well-being, especially when considered alongside how systems have created barriers over time for people of color in economic opportunity and access to systems that provide healthier outcomes.

Medicaid—the country's system delivering primary care to those who otherwise would not have health insurance—was founded to achieve greater population health, recognizing the role of access and care in driving better health outcomes. Medicaid has proven effective at reducing health care costs to the private system, improving health outcomes for children and families with low-incomes, and developing new models that inform a community-health approach. Yet, data suggests that in the last year only one-third of children with Medicaid received a well-child screening.<sup>3</sup>

One of the mandated guidelines that works to ensure North Carolina's children get the care they need, when they need it, is the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit of North Carolina Health Check (Child Medicaid). Under EPSDT, states are required to cover a broad array of medically necessary and rehabilitative services for children under the age of 21.<sup>4</sup> Successful EPSDT implementation is a component of a robust preventative care model that recognizes social determinants of health and seeks to address them.

According to data collected in the 2017 Kids Count Data Book, North Carolina ranks 33<sup>rd</sup> for overall child wellbeing among all states.

This report provides an overview of North Carolina's EPSDT program and examines the effectiveness of the program as it relates to identified child health priorities and social determinants of health. By highlighting best practices at both the state and national level, this report offers practice and policy models for how EPSDT delivery can be improved or modified to address social determinants of health and ultimately improve child health outcomes.

## North Carolina Health Check provides comprehensive health care to more than 1.25 million children

NC Health Check is a publicly funded children's health insurance program available to North Carolina residents under the age of 21, at or below 138-208 percent of the Federal Poverty Level (depending on the age of the child), and who meet immigration requirements.<sup>5</sup> During fiscal year 2016, more than 1.25 million children under the age of 21 in North Carolina were eligible for NC Health Check.<sup>6</sup> (See Figure 1)

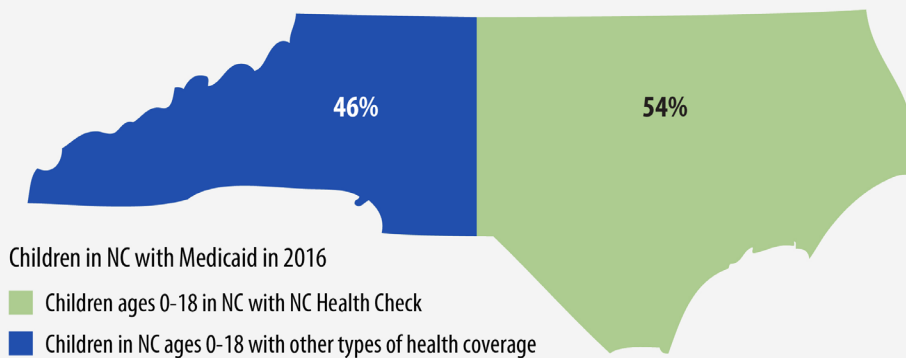
Children of color in North Carolina are more likely to have NC Health Check than their white peers, a result of the disproportionate engagement in low-wage work for people of color and higher joblessness. In turn, these parental outcomes are connected to deeper systemic issues, including but not limited to unaffordable higher education, barriers to educational attainment in communities of color, and geographic distance to good jobs. According to

Kids Count data from 2015, over 50 percent of Black and Latinx children in North Carolina are enrolled in NC Health Check, compared to just over one-quarter of white children.<sup>7</sup>

NC Health Check covers a wide array of medical services that ensure children receive the health care they need at the

time they need it. The covered services are technically referred to as the EPSDT benefit, which requires that NC Health Check provide all mandatory and optional services to children who have Medicaid, if those services are medically necessary.

**FIGURE 1: More than half of all children 0-18 in NC have NC Health Check**



SOURCE: US Census, NC Division of Medical Assistance

EPSDT also encompasses screenings and diagnostic services for children, such as a child's regular wellness check-up with a medical provider. EPSDT wellness visits and screenings follow age-specific schedules recommended by the American Association of Pediatrics and the Bright Futures Foundation Periodicity Schedule. Overall, EPSDT is a valuable tool to improve child health outcomes through preventative and comprehensive care.

### EPSDT is significantly underutilized in North Carolina, with rates decreasing as children age

Even though EPSDT is mandated by federal Medicaid law, national and state utilization rates show that not every child who is enrolled in Medicaid has received services related to EPSDT. In North Carolina, only 57percent (665,637) of children eligible for EPSDT received at least one initial or periodic screening in 2016 (see Figure 2). Compared to utilization rates of neighboring states in the most recent year available, North Carolina fares slightly better than Virginia and slightly worse than South Carolina.<sup>9</sup> However, nationwide EPSDT utilization rates in 2015 were only at 58 percent, indicating that all states need to do more to promote EPSDT.<sup>10</sup>

In North Carolina, 2016 reporting documents indicate that EPSDT utilization rates decrease as the child ages.<sup>11</sup>

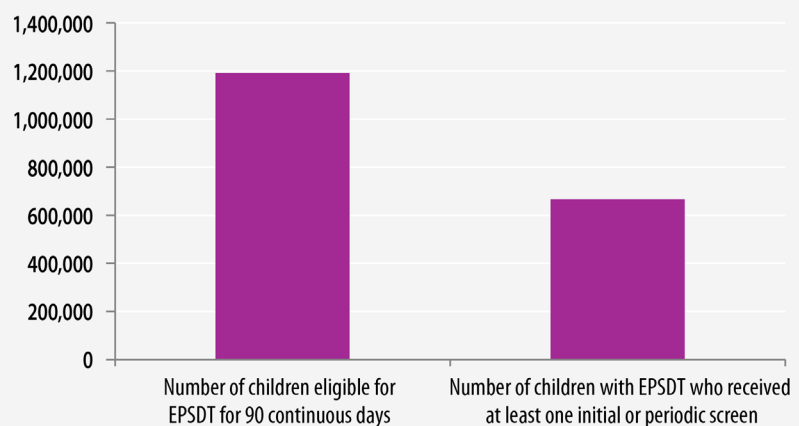
### EPSDT Covers a Wide Array of Medically Necessary Services

In order to be a covered EPSDT service, the service must fall within the scope of services listed under the Medicaid Act (42 U.S.C. §1396a(a) (43) and 1396d(r)).

*A medically necessary service can be defined as a service that corrects or ameliorates a condition. There is no set list that specifies what services are covered by EPSDT, but some examples include:<sup>8</sup>*

- Physician services
- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Prescribed drugs
- Dental services
- Case management

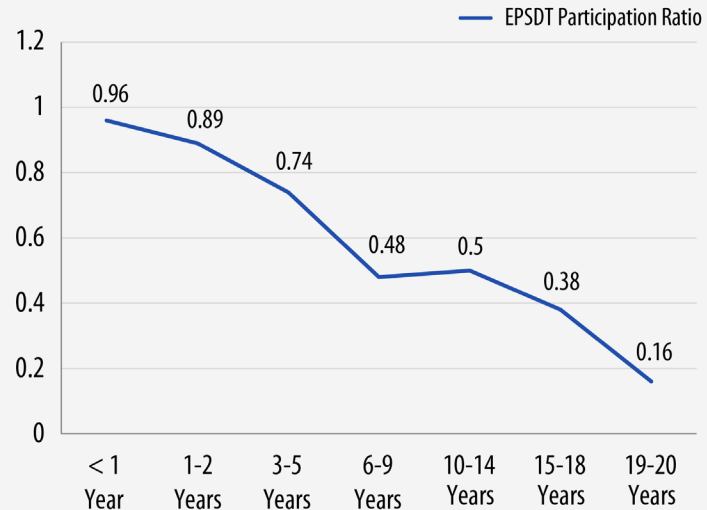
**FIGURE 2: More than half of children under age 21 who are eligible for EPSDT do not receive an initial or periodic screening in NC**



SOURCE: NC Division of Medical Assistance CMS 416 Participation Reporting FY 2016

Slightly more than 90 percent of very young children (ages 0-2 years) receive at least one initial or periodic screening. Once children turn six, utilization rates drop by nearly 50 percent. By the time children reach adolescence (ages 15-20 years) less than one-third of eligible children are receiving some kind of EPSDT-related screening (see Figure 3).

**FIGURE 3: As children age, EPSDT participation decreases**



SOURCE: NC DMA CMS 416 Participation Reporting FY 2016

This trend may be attributed to the high number of screenings recommended by the American Association of Pediatrics and the Bright Future’s Foundation for infants and toddlers. However, screening guidelines cannot explain why EPSDT is not received by 100 percent of eligible children.

**Health and social service systems are disconnected, making it difficult to maintain positive child health outcomes.**

There are several explanations as to why there are discrepancies between between legally mandated EPSDT and underutilization of the benefit. First, there is limited information shared with parents and caregivers of children who are enrolled in NC Health Check about the EPSDT benefit and how it can address children’s health priorities. When speaking to parents and caregivers of children enrolled in NC Health Check across the state, only one was familiar with EPSDT. Parents and caregivers voiced that they wanted more information about what EPSDT covers in a way that is detailed, clear, and consistent. Without sufficient knowledge about the benefits of these screenings and the potential to received covered services to address their findings, parents and caregivers did not feel they had the information to advocate for their children.

In addition to increased information to parents and caregivers, providers need further guidance and education about what is expected under EPSDT at a medical examination

and how to appropriately document the encounter.<sup>12</sup> EPSDT billing codes need to be clarified so providers are aware of which services are required and how to receive Medicaid reimbursement for the screenings and diagnostic tests. Moreover, providers need to be able to effectively connect families to the services in the community that address needs identified through health screenings and diagnostic tools. There is a significantly larger systemic issue of disintegration of the health care systems to the larger institutional network of public, private, and non-profit organizations addressing a range of social determinants of health.

Thus even if EPSDT is delivered, there is a great need for coordination between health care and social systems to achieve positive health outcomes. For example, families are unsure of the correct steps to take when seeking services to address a documented health need at its roots, or such services are prohibitive in their cost or not readily available in the local community. Even in cases where medical and social services are coordinated, community agencies may not have the capacity to manage an influx of referrals. Navigation across these systems can be considerably time-consuming and costly. Scheduling an appointment often requires moving through a complex phone tree, leaving the consumer with several options that may or may not match the reason they are calling. Contacting a medical office or social service agency can result in long wait times, which can be problematic if the consumer has limited minutes on a cellular phone. Additionally, families may not have money to purchase prescriptions or be required to forego a day's wages to take their child to an appointment.

In these ways, the EPSDT benefit can also serve to forge greater connections across community



### **Parents and Caregivers Do Not Feel They Have Adequate Information to Advocate for Their Children's Health**

**One participant voiced, "My child has ADHD and the teacher brought that to my attention. I wish I would have known about it sooner. The doctor should be able to see certain things based off screenings given."**

**I would like to see information about timing and ages to start looking for different things."**

institutions to support the health of the whole child and their family. By clarifying health needs for families, providing referrals to relevant services and even, in some cases, covering the costs of those services, Medicaid can drive a continuity of care and community health orientation that is fundamental to our state's well-being.

## Social determinants of health address factors beyond health care

Social determinants of health can be defined as a collection or lack of various social resources and privilege that influence one's health status and ultimately quality of life.<sup>13</sup> These determinants include factors related to housing, transportation, educational attainment, employment, and community economic development, among others. The extent to which one has access to these social resources, and more broadly the extent to which families have had access throughout generations, contributes to differences in health outcomes across

racial and ethnic groups as well as immigration status.

Access to safe housing, good jobs that pay a living wage, and access to outdoor spaces can explain, in part, why communities of color experience worse health outcomes than their white counterparts.<sup>14</sup> Research suggests that health outcomes can be improved as factors related to social determinants of health are also improved. Thus, it is crucial to drive improved children's health outcomes across key indicators like asthma, physical activity, nutrition, depression, anxiety, and toxic stress,

as well as screening for these broader health care factors and orienting alignment of the health care system to services that address exacerbating factors.

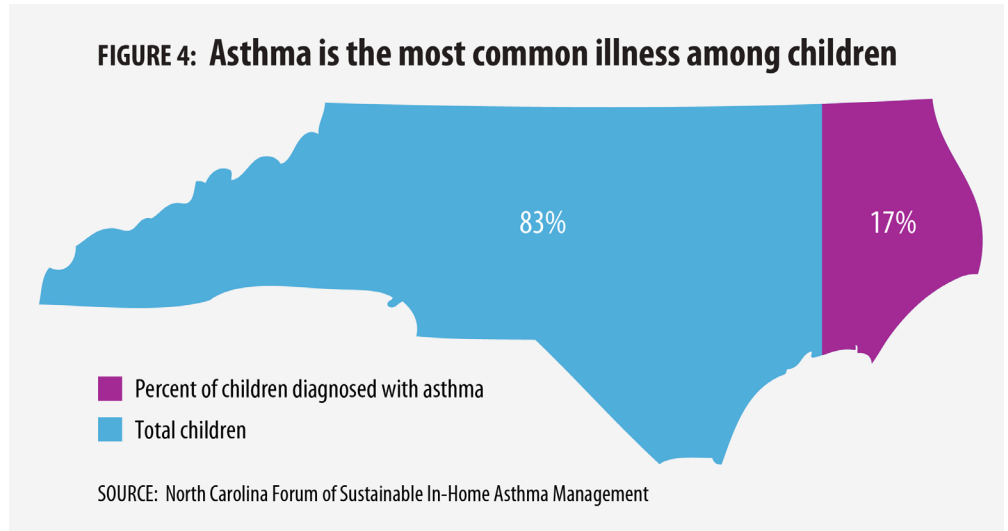
Below is an overview of the key health indicators identified from data, provider and stakeholder input, and parent interviews. In each section, we review outcomes for children in North Carolina and provide examples of how addressing social determinants of health can improve health outcomes.





## Children of color experience higher rates of asthma than white children

Asthma is the most common illness among children in the United States. In North Carolina, 17.5 percent of children have been diagnosed with asthma.<sup>15</sup> (See Figure 4) African American children experience asthma at a rate of nearly double that of white children (28.1 percent and 14.4 percent, respectively).<sup>16</sup> The Centers for Disease Control and Prevention identified asthma as a leading cause of missed school days for health-related reasons. Due to existing racial and ethnic disparities among asthma diagnoses, children of color are more likely to miss a greater number of school days due to their illness.<sup>17</sup> In addition, when compared to white children, African American children have four times the rate of emergency room visits for asthma care and seven times the death rate.<sup>18</sup> In 2014, 2,754 children in North Carolina ages 0-14 went to the emergency room for asthma-related emergencies,<sup>19</sup> and 13 died due to asthma-related complications, a preventable disease, in 2017. All were African American.<sup>20</sup>



## Substandard housing is associated with poor child health outcomes

The North Carolina Department for Health and Human Services identifies housing hazards, pests, dampness, mold, and tobacco smoke as key indicators to developing asthma.<sup>21</sup> Many of these factors are a result of substandard housing. Due

to rapidly increasing rent and home prices, stagnant wages, and the underinvestment in quality affordable housing, families with lower incomes are more likely to live in housing that lacks proper insulation and ventilation systems and is in need of

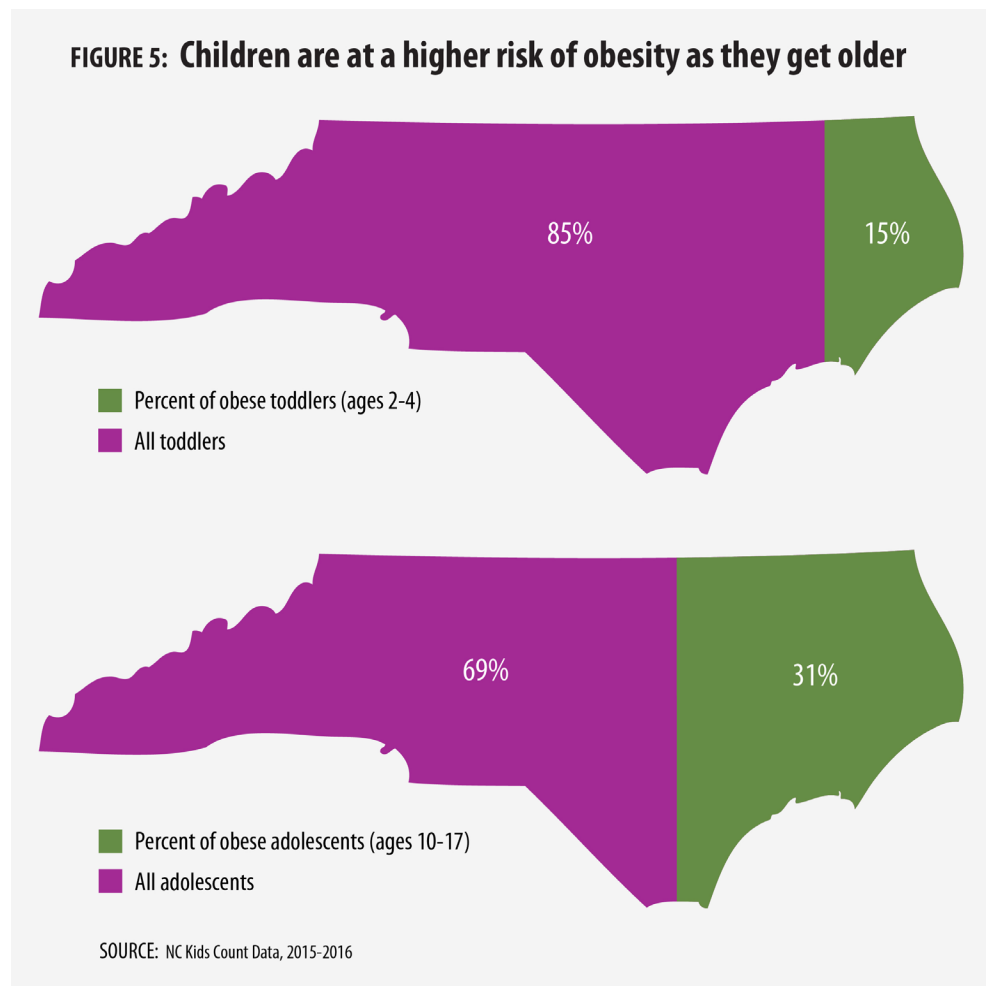
repair and deep cleaning. Substandard housing is also more prone to pests and rodents.<sup>22</sup> Access to stable and safe housing has been shown to significantly improve health outcomes, especially among children.<sup>23</sup>

## Children living in households with low incomes are at greater risk of obesity

Physical activity and sufficient nutrition are important for kids' physical and behavioral health and school performance, however, only 32.5 percent of North Carolina children meet recommended guidelines for physical activity.<sup>24</sup> Children who live in households with low incomes are especially susceptible to health problems related to low levels of physical activity. According to the Build the Foundation 2017 Health Report, 15 percent of North Carolina toddlers (ages 2-4) who live in households below 100 percent of the Federal Poverty Level are obese.<sup>25</sup> The obesity rate more than doubles as children age into pre-teenage and teenage years (ages 10-17).<sup>26</sup> (See Figure 5)

In addition, households with low incomes are likely less able to buy nutrient-rich foods and fresh fruit and vegetables because those foods are more expensive than high-calorie, high-sugar foods, further augmenting the likelihood of obesity. Nutrition in households with low incomes is

often limited by financial constraints to healthy foods, proximity to grocery stores selling fresh produce, and availability of safe recreational opportunities. Furthermore, neighborhoods where many households with low incomes reside have fewer opportunities for physical activities or residents may feel that their neighborhoods are unsafe for such activities.<sup>27</sup>



## **Under-Resourced Neighborhoods Can Significantly Decrease A Child's Physical Health And Wellbeing**

Similar to safe and stable housing proving to be a strong indicator of health, neighborhood characteristics also play a key role in maintaining positive health outcomes among children. Physical characteristics such as parks, sidewalks, streetlights, and greenspaces provide safe places for children to play and for adults to exercise.<sup>28</sup> These factors are correlated with increased physical activity and social capital.<sup>29</sup> If the neighborhood has safe and clean places to play and recreate, community members are more likely to spend time outside, enhancing neighborhood connections and increasing community accountability.



Many families with low incomes live in areas that are under-resourced, forcing families to travel long distances to adequate grocery stores. Living walking distance or very close to a grocery store makes it easier for families to prepare and eat healthy meals.

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## **Chronic socioeconomic stressors can be related to increased anxiety and depression**

Access to a broad array of behavioral health services, including periodic screenings, is explicitly stated by the Centers for Medicare and Medicaid Services as a covered benefit under EPSDT. Nationwide, children enrolled in Medicaid are disproportionately affected by behavioral health disorders such as anxiety, depression, and toxic stress.<sup>30</sup> In North Carolina, over 20 percent of children have one or more emotional, behavioral or developmental conditions.<sup>31</sup>

Medicaid's eligibility guidelines require households to make below 138 percent of the Federal Poverty Level, or \$33,024 per year for a household of four. As a result, many children who are enrolled in Medicaid live in poverty. Living in poverty has a documented history of being associated with poor behavioral health outcomes, especially in children. It can cause households to experience immense stressors related to housing instability, inadequate food,

## Adverse Childhood Experiences Can Be Used to Define Childhood Trauma and Behavioral Health Needs

Too many children in North Carolina have experienced adverse childhood experiences (ACEs), which often result in various behavioral health conditions, particularly anxiety and depression.<sup>35</sup> ACEs are stressful or traumatic experiences that impact individuals throughout the lifespan.<sup>36</sup> ACEs encompass a child's exposure to abuse, neglect, and household dysfunction. For example, experiencing physical abuse and/or sexual abuse, living with a family member with substance misuse disorder, and whether or

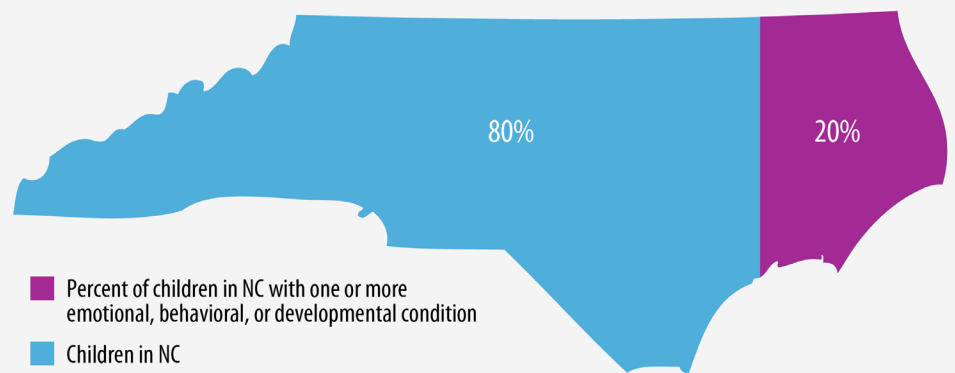
not a parent went to prison are considered ACEs. They have increasingly been used in medical practices as indicators for understanding mental health diagnoses and in implementing trauma-informed services.

Children who receive Medicaid are found to be particularly susceptible to ACEs. While not specific to North Carolina, some data show that 64 percent of children with Medicaid report one or more ACEs.<sup>37</sup> According to data in other states, nearly 30 percent of children with Medicaid between 12 and 17 years

reported having three or more ACEs.<sup>38</sup> In North Carolina, nearly a quarter of children have experienced two or more ACEs.<sup>39</sup> Kids COUNT Data from 2015-2016 indicates that 36 percent of Black children in North Carolina experienced two or more ACEs, followed by Latinx children (23 percent) and white children (20 percent).<sup>40</sup> (See Figure 7) Considering these data, increasing the utilization and awareness of EPSDT is one pathway to prevent, monitor, assess, and treat ACEs and other complex traumas.

and inability to pay for medical care. These stressors can result in higher rates of violence in the household and can significantly alter a child's brain function.<sup>32</sup> Depression and anxiety have been cited to be correlated with ongoing stress and exposure to violence and other traumatic events,

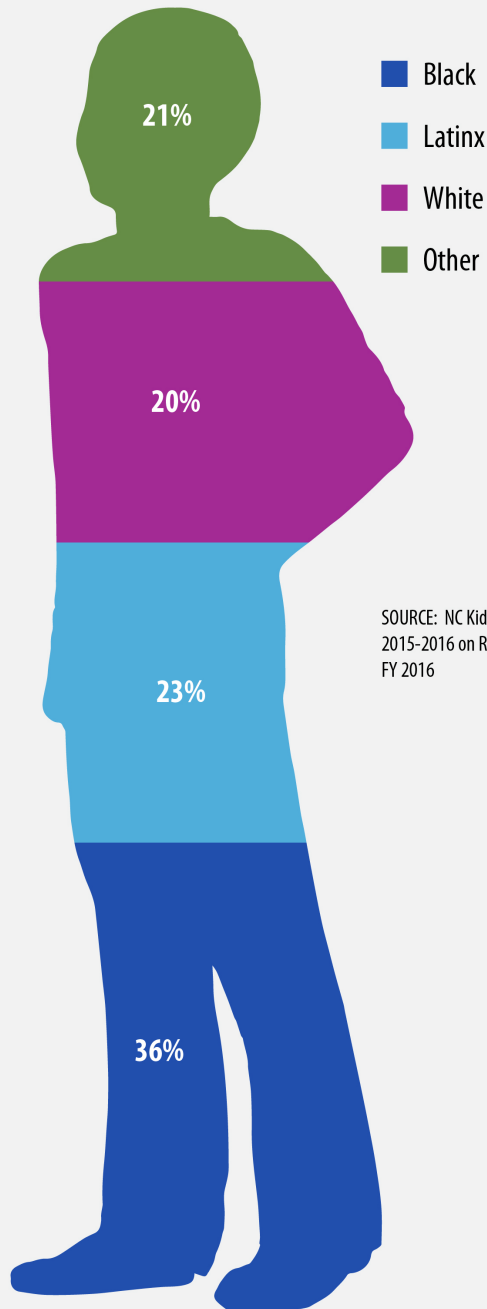
**FIGURE 6: One-fifth of children in NC have a behavioral health condition**



SOURCE: North Carolina Forum of Sustainable In-Home Asthma Management

**FIGURE 7: ACEs affect children of all races and ethnicities**

*Percent of children in NC reporting 2 or more ACEs*



SOURCE: NC Kids Count 2015-2016 on Reporting FY 2016

especially as children age into adolescence and adulthood.<sup>33,34</sup>

Nationwide trends show that among children enrolled in Medicaid, the frequency of seeing a behavioral health professional increases as children age. When compared with children who are privately insured, children enrolled in Medicaid who have special health needs accessed behavioral health care at higher rates. This may reflect a success in comprehensive coverage offered through EPSDT. However, North Carolina can improve assurance that children not only receive broad behavioral health services, but also enrich continuity of care when seeking behavioral health services.

### **Coordinating Care and Aligning Systems Can be Supported by Increased EPSDT Utilization**

Care coordinators are well-equipped to improve child health priorities by addressing gaps in health care and social services systems and participation rates among families receiving EPSDT. Care coordinators use targeted case management to work with families to help them

understand their options and maintain quality health care services, and do not need to be medical professionals. Often, they are social workers or licensed professionals that have a connection to the community.

Care coordination is a cost effective method because it reduces fragmentation of care and inefficiency within the health care and social service systems. Coordinators are given a broad capacity under which to work, representing an ideal model to address health-related needs as well as social determinants of health. For example, care coordinators assist families with scheduling follow up appointments, arranging transportation, securing housing, and understanding prescribed medication, which can greatly improve health literacy and



continuity of care. Care coordinators function as educators, navigators, and advocates, often becoming trusted members of a consumer's medical team. This places care coordinators in an ideal position to inform consumers about EPSDT and increase EPSDT utilization. By presenting resources available to consumers, care coordinators help consumers make informed health care decisions and enhance self-management skills.<sup>41</sup> Several agencies, including the American Association of Pediatrics and the US Department of Health and

Human Services, recommend care coordination as a means of ensuring patient and family centered care. Care coordination considers all aspects of health and has been shown to be an essential tool to help patients navigate health care and social service systems.

While care coordinators improve overall health outcomes of consumers, they also positively impact providers. They partner with providers to better understand the consumer's care plan. Care coordinators can play a critical role in linking medical professionals to the community, and vice versa. Care coordinators are often acutely aware of community characteristics and can identify needs related to social determinants of health. Additionally, care coordination alleviates several administrative tasks from medical providers, such as follow-up calls for appointments and referrals, medication assistance, and overall health care navigation.<sup>42</sup> This overall model allows for flexibility to cater specific services to the needs of individual consumers. This flexibility provides an opportunity to engage care coordinators in addressing social determinants of health. The care coordination model is positioned to complement outcomes for health system transformation: better care, better health, and lower costs.

## Properly funded care coordination efforts have the capacity to carry out many of the recommended improvements

Care coordinators are a versatile and valuable tool in maintaining comprehensive quality care over time. Care coordination services can receive reimbursement through EPSDT. In 2013, Current Procedural Terminology (CPT®) codes were added by the American Medicaid Society to allow providers to bill for coordinating care, linking patients to resources,

and supporting transitions from inpatient care to other settings.<sup>44</sup> As of November 2017, year to date expenditures of Medicaid payments to Community Care of North Carolina for care coordination exceeded the budgeted amount by over \$20 million.<sup>45</sup> This spending represents a growing utilization of and need for care coordination services.<sup>46</sup>

Care coordinators encompass these priorities and have been used to improve child health outcomes in North Carolina. Under the Medicaid Health Home Model, Community Care of North Carolina employs care coordinators to assist consumers enrolled in Medicaid who live with one or more chronic conditions.<sup>43</sup> This model can be expanded upon to better integrate the needs of children and more effectively address social determinants of health. Ultimately, care coordinators help involve families to make decisions about their child's care. Parent and caregiver involvement improves sustainability and continuity of their children's health because they better understand the process and the rationale behind care decisions.

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## National and state-based models inform improvements to EPSDT delivery in North Carolina

Several states, including North Carolina, have developed innovative approaches to improve child health outcomes using a holistic approach.

### **Asthma action plans and community-prevention programs can decrease asthma symptoms.**

The Centers for Disease Control and Prevention developed a six-part initiative that integrates evidence-informed practice and policy recommendations to improve health outcomes. Named **The 6|18 Initiative**, the project partners with health care purchasers, payers, and providers with a goal of improving health outcomes while controlling costs. Asthma is identified as one of the six health priorities within the initiative. The initiative proposes the following:<sup>47</sup>

- Use of the National Asthma Education and Prevention Programs' guidelines for medical management in both clinic and home settings;
- Increased access to affordable asthma medication to improve medication adherence;
- Expanded utilization and reimbursement of licensed professionals or qualified lay health workers that can provide education and support about self-management and home triggers.

The Centers for Disease Control and Prevention also recommends the use of community education and written asthma action plans that follow the National Asthma Education and Prevention Program guidelines. Asthma action plans indicate specific steps on how

to control home-based triggers and can provide ideas for funding to implement changes within the home.<sup>48</sup> Providing education and support to parents about household triggers and assisting parents in developing a specific asthma action plan has been an effective and inexpensive model to reduce asthma symptoms and emergency room visits, reductions of which indicate improved overall child health outcomes. Care coordinators can be responsible for assisting consumers with asthma action plans. Their role as educators and advocates fits nicely in this model.

In 2010, Massachusetts approved a Section 1115 Medicaid Demonstration waiver to pilot a program allowing Medicaid to cover community-prevention services not traditionally reimbursed by Medicaid. The newly covered services include home visits, care coordination, and supplies to reduce environmental triggers. Through the pilot, Medicaid will support select providers to offer the additional services. The program targets children ages 2-18 who are enrolled in Medicaid and have "high-risk" asthma as defined by an asthma-related hospital visit.<sup>49</sup> North Carolina recently submitted a Section 1115 Medicaid Demonstration waiver, and

### Data collection methodology included parent interviews, stakeholder convenings, and state and national sources

The research for this report used both epidemiological and quantitative data as well as qualitative data to inform the development of this report. Data from state and national sources helped identify child health priorities. Researchers conducted interviews with parents and caregivers to confirm child health priorities in addition to providing context to the health priorities. Qualitative data was collected from 12 participants and four counties in Western and Eastern North Carolina. Questions from the interview guides included:

- What is the biggest health priority for your child(ren)?
- How have health concerns been addressed at the doctor's office?
- When your child(ren) was granted eligibility for Medicaid, what information were you given about covered benefits?
- When you have a question about your child(ren)'s Medicaid, where do you go or who do you ask?



could adopt this model as a tactic to not only improve child health outcomes, but also to tackle social determinants of health related to asthma.

In North Carolina, the Greensboro Invest Health Team uses a multidisciplinary approach to address asthma, bringing together members of the community, nonprofit groups, a hospital system, and a state university. The Team maps the prevalence of asthma-related emergency room visits in the city to identify high-need areas. The maps can be used to target resources and interventions that improve neighborhood and residential health, as well as identify which areas could benefit from specific asthma action plans. This community-based asthma intervention brings the health care system into the community where medical providers and administrators gain insight about how household and environmental triggers are associated with asthma.<sup>50</sup> Using this social determinants of health approach, the Team works to address housing and environmental factors as a way to prevent emergency room visits.

### **Physical Health and Nutrition**

The Centers for Disease Control and Prevention (CDC) lists many objectives associated with child physical activity, nutrition, and obesity in Healthy People 2020.<sup>51</sup> There are many efforts to identify ways to ensure children are receiving the recommended amount of physical activity per day while eating healthy foods. Medicaid.gov provides information so that states can find guidance on ways they can develop programs to reduce obesity. More specifically, the Affordable Care Act created funding for the Childhood Obesity Demonstration Project led by the CDC, which focuses on children with low-incomes between the ages of 2 and 12 years.<sup>52</sup> Texas, Missouri, and Massachusetts were noted as states that developed programs (some were pilot programs) to address physical activity and healthy eating. Furthermore, Medicaid.gov reports that states with Medicaid managed care are working on obesity prevention by providing referrals for active living and healthy eating habits in addition to screening for body mass index.<sup>53</sup>



While there are several states initiating and evaluating pilot programs to address physical activity and healthy eating, there is additional work to identify policy changes that will allow more adults and children with food insecurity to gain access to healthy foods they need to work, go to school, play, and thrive. There was a demonstration led by the U.S. Department of Agriculture and Food and Nutrition Service to use Medicaid data to directly certify children for free school meals.<sup>54</sup> Children who belong to households with low incomes but are not

certified for school meals based on Supplemental Nutrition Assistance Program (SNAP) or other programs could very well be unaware that they qualify for school meals.

Some states are addressing health and nutrition by streamlining Medicaid and SNAP. Reports show that many households receiving SNAP have at least one household member that has health care through Medicaid or the Children's Health Insurance Program. Given the significant overlap, there are policy changes states can make to reduce the burden on program participants to enroll and maintain their eligibility for these programs.<sup>55</sup> South Carolina and Illinois participated in the Work Support Strategies initiative that focused on aligning SNAP and Medicaid by using electronic data from SNAP to auto-enroll individuals in Medicaid. This policy change also increased retention in both programs.<sup>56</sup> Oregon, West Virginia, Arkansas, and New Jersey received approval from the Centers for Medicare and Medicaid Services to enroll adults in Medicaid using SNAP data.<sup>57</sup> Even though these states may not be targeting children specifically, when parents have coverage and have access to services, children also have improved access to health and social services.<sup>58</sup>

**Integrating comprehensive behavioral health care practices into schools and medical offices allows for early and periodic screenings of depression and anxiety.**

The National Health Law Program conducted a study about state Medicaid and county behavioral health delivery in California that found several gaps in health care delivery. The recommendations, which can be applied to North Carolina's behavioral health care system, included:<sup>59</sup>

- **Clearer guidance on which agency is responsible for specific services;**
- **Greater investment in resources that improve continuity of care (such as care coordinators);**
- **Systematic implementation of routine screening tools to identify behavioral health needs early on;**
- **Targeted efforts to educate parents and caregivers and involve them in treatment plans.**

Comprehensive behavioral health care requires a holistic approach. The North Carolina State Board of Education recently implemented the North Carolina School Mental Health Initiative as a way to improve behavioral health outcomes. Since children spend the majority of their time at school, a school-based intervention is an effective and efficient method to provide preventative behavioral health services. Through universal screenings, early interventions, referrals, treatment, re-entry, and stakeholder engagement, the North Carolina School Mental Health Initiative encompasses many components of EPSDT.<sup>60</sup> The comprehensive model employs a continuum of supports and services that look for indicators of behavioral health needs among students so that students can fully participate in the learning process.<sup>61</sup> Care coordinators can be an integral part of the process by following up with consumers

and school staff to assist with identified health needs and ensuring continuity of care.

Additionally, American Academy of Pediatrics has proposed Mental Health Competencies for Pediatric Primary Care. The competencies encompass proficiency in billing and coding practices that support behavioral health services, maintaining of multidisciplinary collaborations for referrals and guidance, establishing a practice environment that systematically



integrates behavioral health, and enhancing interpersonal communication skills, among others.<sup>62</sup> These competencies can be built into EPSDT guidance to providers as a way to improve health care delivery for behavioral health needs. Care coordinators should be a part of the multidisciplinary collaboration and can act as a resource to refer consumers to community behavioral health agencies.

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## **EPSDT offers existing tools to improve child health priorities and social determinants of health**

This section highlights specific ways to leverage NC Health Check reimbursement codes. The reimbursement codes allow medical providers to bill for activities related to the identified child health priorities and social determinants of health.

### **EPSDT can be provided in a community-setting.**

EPSDT already covers periodic assessments, including health education. EPSDT does not mandate that health education services need to be completed in a clinical setting. In fact, any practitioner licensed by the state of North Carolina can become qualified to provide EPSDT.<sup>63</sup> As mentioned previously, care coordinators could hold this role and provide community-based symptom prevention strategies to families with children who receive Medicaid.

Medicaid reimbursement for asthma related services can be extended to include a broader range of medical practitioners by shifting the language in CMS Medicaid regulations. The change would allow Medicaid programs to reimburse for any preventative service *recommended* by a physician or other licensed professional, rather than performed by a physician. Medicaid law gives states discretion in defining where covered preventative

services can be administered. North Carolina should take this guidance to authorize Medicaid payment to asthma interventions performed in the home, school, or other community location.<sup>64</sup>

**Screenings for healthy weight are covered by EPSDT.**

One study from George Washington University found that state EPSDT standards do not typically focus on obesity and physical activity related activities. Strategies on obesity



prevention and treatment are not highlighted in Medicaid Managed Care contracts. EPSDT standards on obesity prevention and treatment are lacking, decreasing incentives and accountability for health care providers to administer obesity-related services. However, Medicaid is well-equipped to help providers manage obesity and physical activity. States need to further promote obesity services as part of EPSDT through healthy weight screenings. Billing codes must be clarified so that providers can more easily code for obesity and physical activity related services.<sup>65</sup>

**EPSDT provides specific guidance on preventative behavioral health care.**

Building on the growing body of evidence of the broad range of social and health effects of adverse childhood experiences that follow children into adulthood and knowledge that such experiences can be prevented, the Centers for Medicaid and Medicare Services shared policy guidance with states in 2013 to support and encourage the identification, assessment, and treatment of complex trauma.<sup>66</sup> More specifically, the guidance notes provisions in the Affordable Care Act and Medicaid that can help guide state work to address complex trauma. There is special focus on EPSDT's periodic and inter-periodic screenings to help identify suspected physical and/ or behavioral health needs. The CMS guidance notes that "a change or presentation of acute behavioral health needs" may warrant an inter-periodic screening to identify the need for additional diagnostic and treatment services for physical and behavioral health needs.

Access to a broad array of mental health care services is mandated under EPSDT. The North Carolina Department of Health and Human Services' Division of Medical Assistance states that child wellness visits follow guidelines outlined by the American Academy of Pediatrics

and Bright Futures. These guidelines recommend standard screenings to monitor mental, behavioral, and emotional health at every child wellness visit. Medicaid will reimburse for up to two units of psychosocial screenings per visit. In order to improve efficiency within the mental health care delivery system, coordination of care and ease of navigating the system are critical.

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### The opportunity in North Carolina is now

North Carolina faces a unique opportunity with plans to transform health care and social service delivery. State leadership is working to transition North Carolina's Medicaid system to a Managed Care model. This allows for an opportunity to establish a health care delivery process that is preventative, cost-effective, and patient- and community-centered. Furthermore, North Carolina's Section 1115 Waiver Application includes language to address social determinants of health such as housing, transportation, food insecurity, and toxic



stress. Transformation of Medicaid could represent an opportunity for North Carolina. Ensuring that it remains committed to supporting community-oriented services that consider social determinants of health is key to improving overall health and wellbeing.

There is currently already the potential to begin work on social determinants of health and drive better health outcomes for children. EPSDT can deliver a higher level of preventative care to North Carolina children today. Every child receiving health care through NC Health Check should receive

early and periodic diagnostic screenings and tests, the results of which should drive care that changes for the better children's environment, supports their community well-being, and improves their overall health trajectory.

Such an effort will support the state's goal of promoting healthy childhood development and strengthen families and communities by connecting systems and creating broader environments oriented towards the well-being of every child. ■

## How to Use the EPSDT and Social Determinants of Health Report

Health advocates, parents and caregivers, medical providers, policymakers, and researchers can use the EPSDT and Social Determinants of Health report to engage their communities in a conversation about how to use EPSDT to better address social determinants of health and to improve child health outcomes in North Carolina. Potential activities include the following:

- **Host a community meeting:** Gather friends and neighbors to talk about what EPSDT means for children's health and how to advocate for preventative screenings at the doctor's office. Additionally, identify social determinants of health that impact your community and talk about what can be done locally to address some of those factors.
- **Join the Health Advocacy Project's EPSDT Stakeholder Group:** Collaborate with a diverse group to discuss opportunities around EPSDT delivery in your community. If interested email [ciara@ncjustice.org](mailto:ciara@ncjustice.org)
- **Talk with your local elected officials:** Educate your policymakers about the importance of addressing social determinants of health and ensuring coordinated health and social services. Ask for their support of care coordinators and innovative approaches to maintain positive health outcomes that look at factors such as housing, nutrition, and toxic stress.
- **Work with agencies in your community that address social determinants of health:** Identify agencies that clearly focus on social determinants of health and promote these agencies to local medical offices as referral sources for social determinant of health needs.

The goal is to make EPSDT more well-known and to start a conversation about how to use EPSDT to deliver services that address social determinants of health.

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