

# Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): The Promise of Medicaid's Children's Health Benefit Versus the Reality of Implementation in Kansas

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# EXECUTIVE SUMMARY

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit—known in Kansas as KanBeHealthy (KBH)—is a cornerstone of primary and preventive care for children enrolled in Medicaid. EPSDT provides comprehensive preventive, diagnostic, and treatment services and guarantees coverage of medically necessary services needed to correct or ameliorate physical, developmental, behavioral, and mental health conditions. Effective delivery of EPSDT is critical to ensure that children receive timely identification of health concerns and access to services necessary to support healthy development.

Despite the importance of EPSDT, relatively little statewide information has been available regarding how consistently the benefit is delivered across Kansas or where challenges occur across the continuum of care. Existing administrative performance measures primarily assess receipt of preventive screenings but provide limited insight into provider knowledge and practices, referral processes, care coordination, or barriers encountered as children move from screening to medically necessary follow-up services.

To address these gaps, the University of Kansas School of Social Welfare, in partnership with the United Methodist Health Ministry Fund, conducted a statewide assessment of EPSDT implementation. The assessment included a survey of 118 healthcare providers and organizations serving Medicaid-enrolled children across Kansas and interviews with representatives from all three Kansas Medicaid Managed Care Organizations (MCOs). Together, these data provide insight into provider-reported implementation across the EPSDT continuum—from preventive screening through diagnostic assessment, referral, treatment, and ongoing care coordination—and the factors that may facilitate or hinder delivery.

**EPSDT is a cornerstone of primary and preventive care for children enrolled in Medicaid. However, relatively little statewide information has been available regarding how consistently the benefit is delivered across Kansas or where challenges occur across the continuum of care.**

# MAJOR FINDINGS

## **1. Provider-reported implementation and federal performance measures reveal different pictures of EPSDT implementation.**

Providers reported conducting many preventive components of EPSDT; however, federal administrative measures indicate continued gaps in children's documented receipt of preventive care, and important challenges remain as children move beyond screening and identification to additional assessment, referral, treatment, and ongoing care. The current assessment cannot determine whether this discrepancy reflects differences in the populations or constructs being measured, provider self-report, documentation or coding practices, incomplete visits, or children not receiving recommended care. The discrepancy itself represents an important finding and highlights the need to better understand the relationship between provider-reported practices and children's actual receipt of preventive care. Both provider-reported screening practices and federal preventive care measures capture only part of the broader EPSDT continuum.

## **2. EPSDT implementation is a systems challenge rather than simply a provider challenge.**

Provider knowledge was associated with implementation: providers with greater familiarity with EPSDT were significantly more likely to report conducting diagnostic assessments and making referrals than providers with little or no familiarity with the benefit. However, providers and MCO representatives identified barriers extending beyond provider knowledge, including workforce and specialty provider shortages, transportation barriers, fragmented referral pathways, administrative complexity, documentation requirements, and variation in local service capacity. The presence or absence of strong community partnerships and coordinated referral systems also influenced providers' ability to connect children with needed services. These findings suggest that strengthening implementation requires attention to both provider knowledge and skills and the broader systems that support EPSDT delivery.

## **3. Coverage of medically necessary services does not necessarily translate into timely access to those services.**

Although EPSDT provides for the broad coverage of medically necessary services of Medicaid-enrolled children, providers described significant challenges connecting children with recommended care after needs were identified. Long waitlists for behavioral health, developmental, and other specialty services; shortages of providers accepting Medicaid or new patients; transportation limitations; administrative processes; and family-level barriers could impede children's progression from referral to receipt of care. These findings highlight an important distinction between the scope of services

available through EPSDT and the service-system capacity and infrastructure necessary for children to access those services in practice.

#### **4. Successful EPSDT implementation requires shared responsibility across multiple levels of the Medicaid and healthcare systems.**

Providers and MCO representatives described EPSDT implementation as a coordinated, multilevel effort involving healthcare providers, Medicaid managed care organizations, the Kansas Department of Health and Environment, schools, early childhood programs, behavioral health providers, public health agencies, child welfare organizations, and community partners. Care coordination, referral infrastructure, quality improvement, provider support, and clear state-level guidance emerged as important components of implementation. Because EPSDT is a federal Medicaid policy and entitlement rather than a discrete clinical intervention, these findings reinforce that successful implementation depends on the systems and partnerships that translate federal requirements into routine practice.



# PRIORITY RECOMMENDATIONS

Based on findings from this statewide assessment, five priorities emerged for strengthening EPSDT implementation across Kansas:

- **Expand quality improvement efforts** beyond screening by monitoring children's progression from screening through diagnostic assessment, referral completion, treatment initiation, and receipt of medically necessary services.
- **Strengthen provider and family education regarding the full scope of EPSDT**, including covered services, documentation requirements, transportation benefits, referral pathways, and the meaning and application of medical necessity within EPSDT.
- **Improve access to covered services** by expanding specialty provider capacity, reducing wait times, increasing awareness and use of available transportation benefits, and strengthening referral infrastructure.
- **Invest in care coordination and cross-system collaboration** by supporting partnerships among healthcare providers, MCOs, state agencies, schools, early childhood programs, behavioral health providers, child welfare agencies, and community organizations to improve continuity of care.
- **Simplify administrative processes and clarify implementation expectations** by reducing documentation burden, streamlining provider enrollment and credentialing, improving consistency across MCOs, and developing clearer statewide guidance regarding EPSDT-covered services and implementation requirements.

## Overall conclusion

Provider reports indicate that many preventive components of EPSDT are routinely implemented in Kansas; however, important challenges remain as children move beyond screening and identification to additional assessment, referral, treatment, and ongoing care. The comprehensive nature of EPSDT requires systems capable of supporting children across this full continuum of care. Strengthening EPSDT implementation therefore requires attention not only to preventive screening but also to ensuring that children can access the medically necessary services to which they are entitled under the benefit.

By strengthening provider education and skills, referral infrastructure, workforce and service capacity, administrative supports, care coordination, and cross-system collaboration, Kansas can move closer to translating the comprehensive protections of EPSDT into timely access to care for Medicaid-enrolled children.

# INTRODUCTION

## What is EPSDT?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is the cornerstone of primary and preventive care for children enrolled in Medicaid and one of the nation's most comprehensive child health benefits. Established under Title XIX of the Social Security Act, EPSDT requires states to provide comprehensive preventive, diagnostic, and treatment services for Medicaid-enrolled children and adolescents younger than 21 years of age. Unlike traditional insurance benefits that define a limited package of covered services, EPSDT requires coverage of medically necessary services needed to correct or ameliorate a child's physical, developmental, behavioral, or mental health condition, provided the service is coverable under federal Medicaid law (Rosenbaum, 2016; CMS, 2024).

EPSDT is designed as a continuum of care. Periodic and inter-periodic screenings identify health concerns through comprehensive assessments of physical health, development, behavior, vision, hearing, oral health, and other age-appropriate preventive services. When concerns are identified, children must receive appropriate diagnostic assessment, medically necessary treatment, and ongoing follow-up to ensure identified needs are addressed (CMS, 2024).

In Kansas, KanBeHealthy (KBH) is the name used for the state's EPSDT program. Because many Kansas providers are more familiar with the term KanBeHealthy than EPSDT, the terms are used interchangeably throughout this report.

## Why EPSDT matters

**Nearly one-half of children enrolled in Medicaid nationally experience one or more social, developmental, behavioral, or health-related risk factors that increase their need for preventive and coordinated healthcare (Halfon et al., 2014).** Compared with privately insured children, Medicaid-enrolled children are disproportionately affected by poverty, adverse childhood experiences, chronic health conditions, developmental delays, behavioral health disorders, food insecurity, housing instability, and other social factors that influence lifelong health and well-being (National Academies of Sciences, Engineering, and Medicine, 2019). In Kansas, more than 225,000 children were enrolled in Medicaid in 2025, underscoring the substantial number of children for whom EPSDT serves as a critical source of preventive, diagnostic, and medically necessary healthcare (Annie E. Casey Foundation, 2026).

EPSDT was designed to address these risks by promoting prevention, early identification, and timely intervention. Routine well-child visits provide opportunities to monitor physical health while assessing developmental progress, behavioral health, family functioning, and health-related social needs. When concerns are identified, EPSDT requires access to appropriate diagnostic assessment, medically necessary treatment, referral, and care coordination (Rosenbaum, 2016).

By ensuring children receive appropriate services as early as possible, EPSDT promotes healthy development, improves access to care, reduces health disparities, and helps prevent health conditions from becoming more severe or costly over time (National Academies of Sciences, Engineering, and Medicine, 2019; Rosenbaum, 2016).

## The Kansas context

Kansas administers Medicaid through the KanCare program, with healthcare services delivered through contracted Managed Care Organizations (MCOs). Within KanCare, KanBeHealthy is the name used for the EPSDT benefit in Kansas.

Historically, Kansas has faced challenges meeting federal EPSDT screening targets. Using FY2017 CMS-416 data, the U.S. Government Accountability Office reported that 50%–59% of eligible Medicaid-enrolled children in Kansas received at least one EPSDT screening recommended under the state's periodicity schedule, compared with 59% nationally. At that time, CMS had established a participant-ratio goal of 80%, which only three states met (U.S. Government Accountability Office [GAO], 2019).

More recent federal Child Core Set data indicate continued opportunities to strengthen preventive care for Medicaid-enrolled children in Kansas. In the 2024 Child Core Set, 50.6% of Medicaid and CHIP beneficiaries ages 3–21 in Kansas received at least one comprehensive well-care visit with a primary care practitioner or obstetrician/gynecologist, compared with a median of 49.2% across reporting states and territories. Thus, while Kansas performed slightly above the national median, approximately half of eligible children and adolescents did not have a well-care visit captured by this measure (Centers for Medicare & Medicaid Services [CMS], 2025). These findings underscore the continued importance of improving access to preventive care while also examining implementation beyond the well-child visit.

While screening and well-child visit performance are important indicators of preventive care, they provide only a partial picture of EPSDT implementation. Determining whether children ultimately receive appropriate diagnostic assessment, treatment, referral, and care coordination requires examining implementation across the full continuum of care rather than screening alone.

## Why This Assessment Was Conducted

Despite the importance of EPSDT, relatively little statewide information exists regarding how consistently the benefit is implemented across Kansas or the factors that facilitate or hinder implementation in routine practice. Existing administrative measures primarily assess children's receipt of preventive services but provide limited information about provider awareness, referral processes, care coordination, implementation barriers, or access to medically necessary services after concerns are identified.

To address these gaps, this assessment examined implementation of EPSDT across the full continuum of care in Kansas. Specifically, the assessment sought to:

- Assess provider knowledge and understanding of EPSDT, including familiarity with the benefit and its purpose and requirements.
- Examine implementation across the continuum of care, including developmental screening, diagnostic assessment, referral, treatment, and follow-up.
- Identify provider-, organizational-, and systems-level barriers and facilitators that influence children's access to medically necessary services.
- Explore Medicaid MCO perspectives on implementation, quality improvement, care coordination, and opportunities to strengthen EPSDT delivery.
- Develop evidence-informed recommendations to improve implementation, strengthen referral and care coordination systems, and increase access to medically necessary services for Kansas children.

This assessment builds upon existing Child Core Set measures of preventive care by examining provider-reported implementation across the broader EPSDT continuum in Kansas.

**This assessment examined implementation of EPSDT across the full continuum of care in Kansas.**

# METHODS

## Study design

This assessment primarily employed a quantitative cross-sectional survey to examine implementation of the EPSDT benefit across Kansas. The statewide provider survey served as the primary source of data and assessed provider knowledge of EPSDT, implementation of recommended services, referral and care coordination practices, perceived barriers, and opportunities to strengthen implementation. The survey also included several open-ended questions that allowed respondents to elaborate on their experiences and provide recommendations.

To provide additional context for the survey findings, semi-structured key informant interviews were conducted with representatives from each of the three Kansas Medicaid MCOs. Because only three MCOs administer Medicaid services statewide, interviews were selected instead of a survey to capture more nuanced information about system-level implementation, quality improvement efforts, provider support, care coordination, and opportunities to strengthen EPSDT delivery. Interview findings were used to contextualize and illustrate quantitative results rather than serve as a separate source of evidence.

## Survey development

The provider survey was developed during Fall 2025 using an iterative process informed by federal EPSDT guidance, implementation science literature, and expert review. The survey was designed to assess provider knowledge of EPSDT, implementation of recommended clinical services, health-related social needs screening, referral and care coordination practices, perceived implementation barriers, and opportunities to strengthen EPSDT implementation across Kansas.

An initial draft was reviewed by an expert in pediatric medicine and Medicaid, with subsequent revisions focused on improving clinical relevance, question wording, response options, and survey organization. Additional feedback was obtained from national experts in children's behavioral health, Medicaid policy, and EPSDT implementation. Survey development was further informed by Centers for Medicare & Medicaid Services (CMS) guidance, federal EPSDT policy documents, and nationally recognized recommendations for preventive pediatric care.

The final survey consisted of four sections:

- Respondent and organizational characteristics;
- Provider knowledge and familiarity with EPSDT;
- Implementation of EPSDT in routine practice, including developmental screening, preventive services, diagnostic assessment, referral and care coordination, health-related social needs screening, experiences serving children with complex needs, and perceived barriers; and
- Recommendations for strengthening EPSDT implementation across Kansas.

## Participants and data collection

The electronic survey was distributed statewide during Spring 2026 to healthcare professionals and other providers serving Medicaid-enrolled children and families across Kansas. Recruitment targeted a broad range of provider disciplines and organizational settings to capture diverse perspectives regarding implementation of the EPSDT benefit.

Initial response rates were lower than anticipated, likely reflecting both survey length and competing demands on healthcare professionals' time. To improve participation, a modest incentive was introduced during the data collection period. Following implementation of the incentive, participation increased, and data collection concluded in March 2026.

A total of 118 respondents who completed all or the majority of the survey were included in the analyses. Respondents represented physicians, nurse practitioners, physician assistants, registered nurses, social workers, community health workers, and other professionals working in community health centers, federally qualified health centers, rural health clinics, hospitals and health systems, behavioral health organizations, private practices, and other organizations serving children throughout Kansas.

## Survey data analysis

Survey data were analyzed using IBM SPSS Statistics. Descriptive statistics, including frequencies and percentages, were calculated to summarize respondent characteristics, provider familiarity with EPSDT, implementation practices, referral and care coordination activities, health-related social needs screening, perceived barriers, and recommendations.

Bivariate analyses were conducted using chi-square tests of independence to examine relationships among provider characteristics, organizational factors, familiarity with EPSDT, implementation of recommended services, referral practices, care coordination activities, and perceived barriers. Statistical significance was evaluated using an alpha level of .05.

Responses to the survey's open-ended questions were analyzed using thematic analysis (Braun & Clarke, 2006). Themes were used to provide additional context for the quantitative findings and to highlight provider experiences and recommendations.

## Medicaid MCO Key Informant Interviews

As indicated previously, to better understand system-level implementation of EPSDT, semi-structured interviews were conducted with representatives from each of the three Kansas MCOs. Given the small number of organizations responsible for administering Medicaid services statewide, interviews were selected to obtain detailed information that would not have been captured through a structured survey.

Participants represented individuals responsible for EPSDT implementation, quality improvement, care coordination, provider engagement, and related Medicaid programs. Interview questions explored provider education and technical assistance, referral and care coordination processes, quality improvement initiatives, workforce challenges, barriers to accessing services, and opportunities to strengthen EPSDT implementation across Kansas.

Interview transcripts were analyzed using thematic analysis (Braun & Clarke, 2006). Rather than serving as a separate qualitative component, interview themes were used to contextualize survey findings, explain observed quantitative patterns, and provide examples of system-level implementation challenges and successes. As a form of member checking, representatives from the participating MCOs were subsequently emailed a summary of the key themes identified across the interviews and invited to review the findings for accuracy, identify missing context, and clarify any interpretations that did not reflect their perspectives.

## Use of multiple data sources

The statewide provider survey served as the primary source of evidence for this assessment. Findings from the survey's open-ended responses and the MCO key informant interviews were used to enrich interpretation of the quantitative results by providing examples, context, and system-level perspectives. Throughout the Results section, quantitative findings are presented first, followed by illustrative qualitative evidence where appropriate to clarify implementation challenges, explain observed patterns, and identify opportunities to strengthen EPSDT implementation across Kansas.



# RESULTS

**Results are presented in four sections.** First, sample characteristics are described to provide an overview of the organizations and respondents who participated in the survey. Findings are then organized according to the major sections of the survey. The first section examines respondents' knowledge and awareness of EPSDT, including familiarity with the benefit and conceptual understanding of its purpose and components. The second section focuses on the implementation and use of EPSDT, describing reported implementation of core EPSDT services, clinical components, health-related social needs screening, referral practices, and factors associated with implementation. The final section presents respondents' suggestions for improving EPSDT implementation in Kansas, highlighting perceived barriers, opportunities, and recommendations for strengthening awareness, implementation, and access to services.

## SECTION I: SAMPLE CHARACTERISTICS

A total of 118 respondents completed the survey. Respondents represented a diverse range of healthcare and community-based professions. The largest professional group was registered nurses (34.7%, n = 41), followed by respondents identifying as other professionals (20.3%, n = 24). Nurse practitioners comprised 11.0% (n = 13) of the sample, while pediatricians (8.5%, n = 10), community health workers (8.5%, n = 10), family practice physicians (6.8%, n = 8), social workers (5.9%, n = 7), licensed practical nurses (3.4%, n = 4), and physician assistants (0.8%, n = 1) represented smaller proportions of respondents.

Respondents were employed across a variety of healthcare settings. The largest proportion reported working in other healthcare settings (38.1%, n = 45), followed by community health centers/federally qualified health centers (23.7%, n = 28). Additional respondents represented private practices (11.9%, n = 14), rural health clinics (11.9%, n = 14), hospitals or health systems (10.2%, n = 12), and community behavioral health centers (4.2%, n = 5).

Most respondents reported serving predominantly rural communities (59.3%, n = 70), while 17.8% (n = 21) served a mix of urban and rural communities. Smaller proportions served predominantly urban or metropolitan communities (12.7%, n = 15) or predominantly suburban communities (7.6%, n = 9). Three respondents (2.5%) indicated they were unsure of the geographic classification of the population they served.

The majority of respondents primarily served Medicaid/CHIP populations (66.1%, n = 78), while 22.0% (n = 26) primarily served patients with private insurance. Fewer respondents primarily served uninsured or self-pay populations (6.8%, n = 8), and 5.1% (n = 6) indicated they were unsure.

Respondents reported a broad range of monthly patient volumes. The largest proportion (35.6%, n = 42) reported seeing 0–25 patients per month, followed by 28.8% (n = 34) who reported seeing more than 100 patients per month. An additional 20.3% (n = 24) reported seeing 26–50 patients per month, and 15.3% (n = 18) reported seeing 51–100 patients per month. Full sample characteristics are presented in *Table 1*.

**TABLE 1**

| CHARACTERISTIC                                            | n  | %    |
|-----------------------------------------------------------|----|------|
| <b><i>Professional role</i></b>                           |    |      |
| Registered nurse                                          | 41 | 34.7 |
| Other professional                                        | 24 | 20.3 |
| Nurse practitioner                                        | 13 | 11.0 |
| Pediatrician                                              | 10 | 8.5  |
| Community health worker                                   | 10 | 8.5  |
| Family practice physician                                 | 8  | 6.8  |
| Social worker or other behavioral health specialist       | 7  | 5.9  |
| Licensed practical nurse                                  | 4  | 3.4  |
| Physician assistant                                       | 1  | 0.8  |
| <b><i>Practice setting</i></b>                            |    |      |
| Other healthcare setting                                  | 45 | 38.1 |
| Community health center/federally qualified health center | 28 | 23.7 |
| Private practice                                          | 14 | 11.9 |
| Rural health clinic                                       | 14 | 11.9 |
| Hospital or health system                                 | 12 | 10.2 |
| Community behavioral health center                        | 5  | 4.2  |
| <b><i>Geographic area primarily served</i></b>            |    |      |
| Predominantly rural                                       | 70 | 59.3 |
| Mix of urban and rural                                    | 21 | 17.8 |
| Predominantly urban or metropolitan                       | 15 | 12.7 |
| Predominantly suburban                                    | 9  | 7.6  |
| Unsure                                                    | 3  | 2.5  |
| <b><i>Primary payer population served</i></b>             |    |      |
| Medicaid/CHIP                                             | 78 | 66.1 |
| Private insurance                                         | 26 | 22.0 |
| Uninsured or self-pay                                     | 8  | 6.8  |
| Unsure                                                    | 6  | 5.1  |
| <b><i>Organization size</i></b>                           |    |      |
| 0–25 patients                                             | 42 | 35.6 |
| 26–50 patients                                            | 24 | 20.3 |
| 51–100 patients                                           | 18 | 15.3 |
| More than 100 patients                                    | 34 | 28.8 |

## SECTION II: AWARENESS AND KNOWLEDGE OF EPSDT

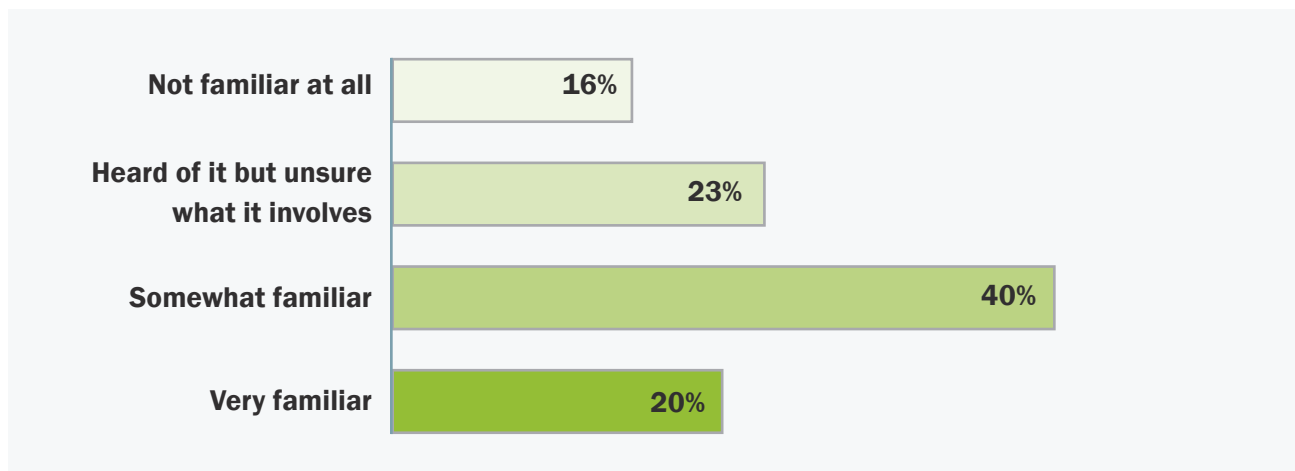
A foundational requirement for successful implementation of the EPSDT benefit is that providers understand its purpose, scope, and requirements. Accordingly, respondents were asked about their familiarity with EPSDT and several key components of the benefit. Open-ended survey responses and interviews with representatives from the Kansas MCOs were used to provide additional context regarding provider knowledge and to identify areas of confusion.

### Provider familiarity with EPSDT

Overall, respondents reported varying levels of familiarity with the EPSDT benefit (Figure 1). Approximately one-fifth of respondents (20.5%,  $n = 24$ ) indicated they were very familiar with EPSDT, while an additional 40.2% ( $n = 47$ ) reported being somewhat familiar. However, nearly two in five respondents reported limited familiarity with the program. Specifically, 23.1% ( $n = 27$ ) indicated they had heard of EPSDT but were unsure what it involved, and 16.2% ( $n = 19$ ) reported they were not familiar with the benefit at all. One respondent did not answer this question.

**FIGURE 1**

*Respondents' familiarity with EPSDT*



Given that EPSDT serves as the foundation of pediatric Medicaid services, these findings suggest that awareness remains inconsistent among professionals caring for Medicaid-enrolled children.

MCO interviews suggested that variation in provider familiarity extends beyond simply recognizing the term “EPSDT.” Representatives described persistent confusion regarding terminology and noted that providers often use KanBeHealthy, well-child visit, and EPSDT interchangeably. One participant observed that “it’s very gray...even to call it an EPSDT screening, that’s kind of vague,” reflecting the ambiguity surrounding how the benefit is discussed and documented across practice settings.

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## Knowledge of medically necessary services

Respondents were asked whether they were aware that EPSDT requires states to cover medically necessary services for children within the categories of medical assistance outlined in Section 1905(a) of the Social Security Act, even when those services are not covered for adults. Most respondents indicated they were aware of this federal requirement (72.0%, n = 85). However, approximately one-quarter either reported they were not aware (12.7%, n = 15) or were unsure (15.3%, n = 18).

While awareness of this defining feature of EPSDT was generally high, approximately one-quarter of respondents remained unaware or uncertain about the statutory guarantee of medically necessary services. Because this requirement distinguishes EPSDT from traditional insurance coverage, these findings suggest an important opportunity to strengthen provider understanding of the benefit.

MCO representatives similarly noted that providers often understand the preventive components of EPSDT but are less familiar with the broader statutory guarantee of medically necessary services. One participant explained that although EPSDT allows coverage of medically necessary services, requests must still meet Medicaid requirements, including provider enrollment and documentation of medical necessity. As another representative noted, “many providers don’t realize that they actually have to be registered with the State of Kansas,” highlighting how limited knowledge of Medicaid policies can affect children’s access to EPSDT services.

## Knowledge of Medicaid transportation benefits

Because Non-Emergency Medical Transportation (NEMT) is a covered Medicaid benefit that can facilitate access to services covered under EPSDT, the survey also assessed provider awareness of transportation assistance available to eligible Medicaid beneficiaries. This item reflects broader knowledge of Medicaid benefits rather than awareness of EPSDT specifically. Nearly three-quarters of respondents (73.7%, n = 87) reported being aware of transportation assistance, while more than one-quarter (26.3%, n = 31) indicated they were not. This distinction is important because successful EPSDT implementation depends not only on provider understanding of EPSDT requirements, but also on awareness of broader Medicaid benefits and supports that can facilitate access to recommended diagnostic and treatment services. Given that transportation barriers emerged as one of the most

frequently reported obstacles to referral completion, increasing provider awareness of available transportation assistance may help improve children's access to recommended services.

MCO representatives similarly described transportation as an available resource that remains underutilized because providers and families are often unaware of how to access it. They emphasized continued outreach and education regarding transportation assistance as an opportunity to improve referral completion.

## Awareness and use of the Kansas EPSDT Medical Necessity Form

Respondents were asked about their familiarity with the Kansas EPSDT Medical Necessity Form, a state-developed resource used to support requests for medically necessary services for children under age 21 that are not otherwise covered under the Kansas Medicaid State Plan. When additional information is needed to determine coverage, the form allows providers to document the child's individual clinical and functional needs, the requested service, alternatives considered, and the anticipated benefit to support an individualized medical-necessity determination. Awareness and use of this implementation resource were limited. Nearly three-quarters of respondents (73.7%, n = 87) reported being unfamiliar with the form, while 16.9% (n = 20) indicated they were aware of the form but had never used it. Only 5.9% (n = 7) reported occasional use, and just 3.4% (n = 4) indicated they used the form frequently.

The limited familiarity with the form is notable because it represents one of the mechanisms Kansas has established to operationalize EPSDT's broader coverage requirements when a child needs a medically necessary service that is not otherwise covered under the State Medicaid Plan. However, use of the form is not itself sufficient to establish coverage; requests remain subject to an individualized determination of medical necessity and applicable Medicaid requirements. Increasing provider awareness of when the form may be appropriate and how to navigate the associated request process may therefore represent an opportunity to strengthen implementation.

MCO representatives similarly described provider uncertainty regarding the process for requesting medically necessary services through EPSDT, including when and how the Kansas EPSDT Medical Necessity Form should be used. One participant emphasized that "there has to be a medical necessity component" when using the form to request services. Taken together, the survey and interview findings suggest a potential gap between the availability of a state-level mechanism for requesting services under EPSDT and providers' knowledge of how to use that mechanism in practice. This finding reinforces the importance of clear provider guidance regarding both the scope of the EPSDT benefit and the processes available for requesting medically necessary services that fall outside routine State Medicaid Plan coverage.

## Provider conceptualizations of EPSDT

To better understand providers' knowledge beyond self-reported familiarity, respondents were asked to describe—in their own words—what EPSDT covers. Responses revealed substantial variability in how providers conceptualized the benefit. Rather than representing a simple distinction between correct and incorrect responses, providers' descriptions reflected a continuum of understanding that ranged from comprehensive knowledge of the federal Medicaid benefit to limited or inaccurate understanding. Four distinct levels of understanding emerged from the qualitative analysis (*Table 2*).

### **Level IV: Comprehensive Policy Understanding:**

A relatively small number of respondents demonstrated a comprehensive policy understanding of EPSDT. These respondents recognized the benefit as more than a preventive healthcare program, instead describing it as a federal Medicaid entitlement that guarantees access to medically necessary services for children and adolescents enrolled in Medicaid through age 21. Their responses emphasized not only the screening, diagnostic, and treatment components of the benefit but also its defining statutory feature—that states must cover medically necessary services within the federal Medicaid benefit categories, even when those services are not covered for adults. One respondent explained that EPSDT “covers preventive, diagnostic, and treatment services...including any medically necessary follow-up care, even if those services are not typically covered for adults.” Another described EPSDT as requiring states to cover “whatever is medically necessary to treat a condition in a Medicaid-enrolled child—even beyond standard Medicaid limits.”

Interestingly, representatives from all three Kansas MCOs consistently described EPSDT in a manner that closely aligned with this highest level of understanding. Rather than characterizing EPSDT as simply an annual preventive examination, one participant explained, “I think of it as a well-child exam plus more...plus dental, plus labs, plus hearing, plus vision. It's not the standard well-child.” This perspective reinforces that comprehensive implementation requires providers to view EPSDT as a broad pediatric Medicaid benefit rather than a single preventive visit.

### **Level III: Clinical Understanding:**

Many respondents demonstrated a clinical understanding of EPSDT. These providers accurately described the benefit as including preventive screenings, diagnostic evaluations, treatment services, referrals, and eligibility for Medicaid-enrolled children and adolescents through age 21. Unlike respondents demonstrating a comprehensive policy understanding, however, these responses generally focused on the clinical services provided through EPSDT and omitted discussion of the statutory requirement that Medicaid cover medically necessary services beyond those available to adults. In other words, these respondents demonstrated a strong understanding of what EPSDT does clinically, but less awareness of the broader scope of the benefit and what makes it unique within the Medicaid program. This distinction has important implications for implementation. A narrower, clinically focused understanding may contribute to providers overlooking services and supports that facilitate access to necessary clinical care. For example, limited awareness of available transportation assistance may create an additional barrier to connecting children and families with recommended diagnostic or treatment services.

## Level II: Preventive Care Orientation:

The largest proportion of responses reflected a preventive care orientation, in which respondents primarily conceptualized EPSDT as a well-child or preventive screening program. These responses emphasized routine health maintenance activities, including well-child visits, developmental surveillance, immunizations, vision and hearing screening, lead testing, dental care, and referrals. While these respondents demonstrated an understanding of the preventive components of EPSDT, their descriptions generally did not include diagnostic assessment, treatment, or the broader Medicaid entitlement that distinguishes EPSDT from traditional preventive care. Representative responses described EPSDT as “Well checks, hemoglobin, development screenings; vision & hearing” or as “well baby visits for children with Medicaid” that provide an opportunity to assess children’s physical, emotional, and developmental health.

One of the clearest qualitative patterns supporting this finding was respondents’ frequent use of the term KanBeHealthy (KBH) when describing EPSDT. KanBeHealthy encompasses Kansas’s broader EPSDT program; however, respondents frequently used the term specifically when describing preventive screening and well-child visits. This pattern suggests that some providers may associate KanBeHealthy most readily with its preventive screening requirements rather than with the full scope of EPSDT, including diagnostic assessment, treatment, care coordination, and coverage of medically necessary services.

## Level I: Limited Awareness:

Finally, several respondents demonstrated limited awareness of the EPSDT benefit. These responses reflected uncertainty, misconceptions, or incorrect information regarding the program. Examples included incorrect age eligibility, descriptions of EPSDT as a general program for low-income families or pregnant women, confusion with other programs, and explicit acknowledgments of limited knowledge, including responses such as “I am not aware of EPSDT,” “Don’t know. Is that KanBe Healthy?” and “I’m really not sure.”

**TABLE 2**

*Levels of EPSDT understanding*

| Level                                        | Conceptualization                             | Hallmark                                                                                                    | What is Missing                                                          |
|----------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Level I: Limited Awareness                   | Does not understand EPSDT                     | Uncertainty or incorrect information                                                                        | Basic knowledge                                                          |
| Level II: Preventive Care Orientation        | EPSDT is a well-child visit screening program | Focus on prevention and periodic screens                                                                    | Diagnostic evaluation and treatment responsibilities                     |
| Level III: Clinical Understanding            | EPSDT is clinical care benefit.               | Understands screening plus diagnosis, treatment, and referrals                                              | Does not recognize the legal entitlement to medically necessary services |
| Level IV: Comprehensive Policy Understanding | EPSDT is a pediatric Medicaid entitlement     | Understands the statutory guarantee of medically necessary services and the distinction from adult Medicaid | No critical gap                                                          |

As a preliminary exploration of the open-ended responses, provider definitions of EPSDT were reviewed using the four-level conceptual framework developed through the qualitative analysis. Based on this preliminary application of the framework, approximately 63% of responses reflected a Level II (Preventive Care Orientation) understanding, describing EPSDT primarily as a well-child or preventive screening benefit. Approximately 16% demonstrated a Level III (Clinical Understanding) by recognizing that EPSDT includes diagnostic evaluation, treatment, referrals, and follow-up services in addition to preventive care. Approximately 9% of responses reflected a Level IV (Comprehensive Policy Understanding) by recognizing EPSDT as a unique Medicaid entitlement that guarantees coverage of medically necessary services beyond the standard adult Medicaid benefit. Finally, approximately 12% of responses were classified as Level I (Limited Awareness), reflecting respondents who reported little or no knowledge of EPSDT or provided incorrect descriptions of the benefit. These findings should be considered preliminary, as responses have not yet undergone formal coding using a standardized coding protocol or independent reliability assessment. Nevertheless, the distribution closely aligns with the qualitative themes presented in this report and suggests that many providers conceptualize EPSDT primarily as a preventive screening program rather than as the broader federal Medicaid benefit. The findings also indicate that some providers serving Medicaid-enrolled children have limited familiarity with the scope of EPSDT, including the services covered and the requirements associated with the benefit.

## Key takeaways

Findings from both the provider survey and MCO interviews indicate that provider knowledge of EPSDT exists along a continuum rather than as a simple distinction between familiarity and unfamiliarity. Most respondents recognized the preventive screening components of the benefit, but progressively fewer demonstrated an understanding of its diagnostic, treatment, and statutory medical necessity requirements. These findings suggest that educational efforts should extend beyond increasing awareness of EPSDT to strengthening providers' understanding of the benefit's comprehensive scope and legal requirements. Improving providers' conceptual understanding of EPSDT may promote more consistent implementation across practice settings and improve children's access to medically necessary services.

**Provider knowledge of EPSDT exists along a continuum rather than as a simple distinction between familiarity and unfamiliarity. Findings suggest educational efforts should extend beyond increasing awareness of EPSDT to strengthening providers' understanding of the benefit's comprehensive scope and legal requirements.**

## SECTION III: IMPLEMENTATION & USE OF EPSDT

Understanding the EPSDT benefit is only the first step toward successful implementation. Successful implementation requires children to progress through the full continuum of recommended services—from preventive screening and diagnostic evaluation to treatment, referral, care coordination, and follow-up. This section examines how EPSDT is implemented in routine practice.

### Implementation across the EPSDT Continuum

To examine implementation across the EPSDT continuum of care, respondents were asked whether their organizations routinely provided each of the core components of the benefit, including preventive care, developmental and behavioral screening, diagnostic assessment, treatment, referral, and follow-up services.

**“The biggest gap is not screening, but follow-up care.”**

Differences emerged in the frequency with which components of the EPSDT continuum were reported (*Figure 2*). Screening (82.2%) and referrals (80.5%) were the most consistently reported components, whereas fewer respondents reported routinely providing preventive care (57.6%), diagnostic assessments (48.3%), or treatment and intervention services (47.5%).

These findings indicate that respondents most consistently reported identifying developmental, behavioral, and physical health concerns and initiating referrals, while diagnostic assessment and treatment were reported less consistently. As one participant noted, “the biggest gap is not screening, but follow-up care.” However, these differences should be interpreted in the context of providers’ differing roles within the EPSDT continuum. The survey did not distinguish between diagnostic and treatment services delivered directly within the respondent’s organization and those obtained through referral to another provider. Consequently, lower reported rates of diagnostic assessment and treatment may partly reflect differences in organizational scope and service capacity rather than failure to implement these components of EPSDT. The survey also did not track whether children referred to outside providers ultimately received the recommended services.

The provider-reported findings should also be distinguished from population-level measures of preventive care. In 2024, 50.6% of Medicaid and CHIP beneficiaries ages 3–21 in Kansas received at least one well-care visit, compared with a median of 49.2% across reporting states and territories. This Child Core Set measure and the current survey assess different constructs: the Child Core Set measures the proportion of eligible children who received a well-care visit during the measurement year, whereas the survey asked organizations whether they routinely provided specific components of EPSDT. As such, the current survey cannot be used to estimate the proportion of Medicaid-enrolled children receiving EPSDT services statewide, and provider-reported practices were not independently validated through claims or medical record data.

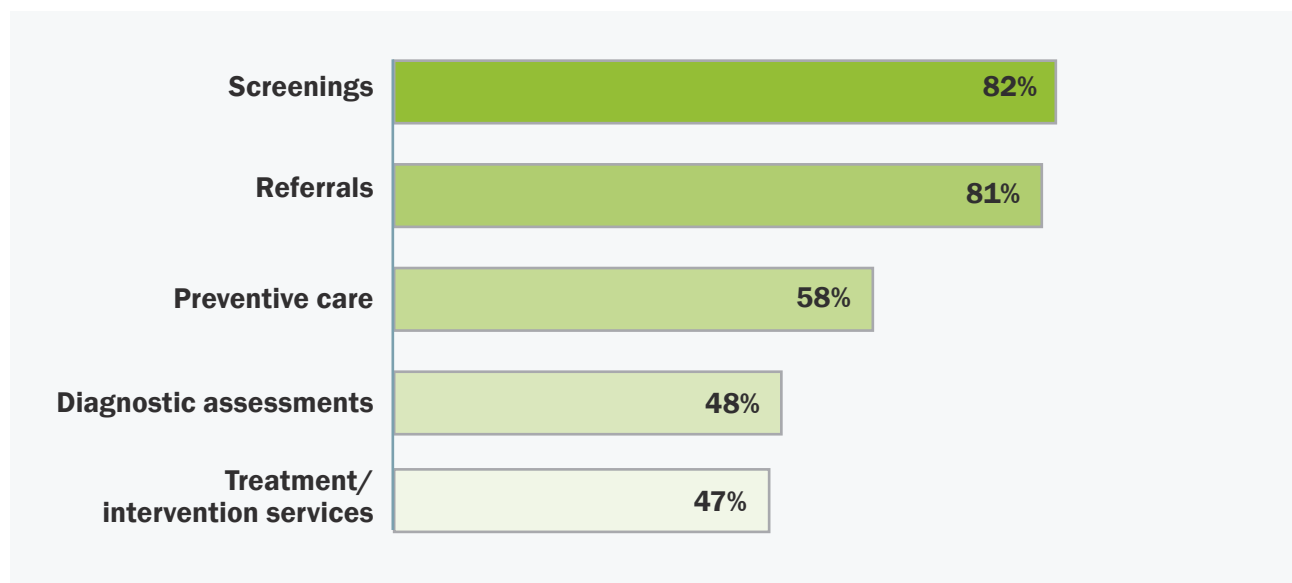
MCO interviews provided additional context regarding factors that may influence how preventive services are delivered and captured in administrative data. Representatives described instances in

which a visit may begin as a KanBeHealthy examination but shift toward acute medical concerns, as well as variation in completion, documentation, and coding of preventive services. One participant reflected, “How many 15-, 16-, 17-, 18-year-olds are going in for a full head-to-toe assessment?... That’s not happening.” Another described situations in which preventive and acute concerns occur during the same encounter but may not both be reflected in administrative measures. Again, these observations were not independently examined through claims or medical record data and therefore should be interpreted as potential explanations identified by MCO representatives rather than established causes of measured performance.

Taken together, these findings demonstrate the importance of examining EPSDT implementation across the full continuum of care while also distinguishing among provider-reported practices, population-level receipt of preventive care, and children’s receipt of recommended follow-up services. Future analyses linking provider-reported practices with claims or other administrative data would provide a more complete picture of where implementation gaps occur and whether children successfully progress from screening and identification to diagnostic assessment, treatment, and ongoing care.

## FIGURE 2

*Reported implementation across the EPSDT continuum*



*Note: Percentages represent respondents reporting that their organization routinely provides each component of the EPSDT continuum*

## Routine clinical implementation: Core clinical services

To better understand implementation during well-child visits, respondents were asked whether their organizations routinely provided recommended clinical components of EPSDT (*Table 3*). Overall, implementation was highest for screening and preventive care activities routinely incorporated into pediatric primary care, whereas components that may require additional assessment, specialized expertise, or follow-up were implemented less consistently.

Among foundational screening and preventive care activities, developmental screening (87.3%) and growth measurements (86.4%) were the most consistently implemented clinical activities, followed by nutritional assessment (79.7%), immunizations (78.0%), vision screening (72.0%), comprehensive physical examinations (70.3%), and hearing screening (67.8%).

Reporting declined for several clinical components that may require additional evaluation or follow-up. Approximately two-thirds of respondents routinely conducted lead screening (65.3%), behavioral or mental health screening (62.7%), and laboratory testing (61.0%), while 56.8% routinely conducted dental assessments and fewer than one-third routinely performed autism-specific screening (29.7%). Together, these findings suggest that many foundational components of EPSDT screening and preventive care are broadly integrated into routine practice, while other recommended components are implemented less consistently. These activities occur primarily within the screening and preventive care portion of the EPSDT continuum and may identify needs requiring subsequent diagnostic assessment, referral, or treatment.

MCO interviews highlighted that improving KanBeHealthy completion is a shared responsibility among MCOs and the Kansas Department of Health and Environment (KDHE). Representatives described a variety of collaborative quality improvement initiatives, including provider education, dissemination of Bright Futures<sup>1</sup> guidance, Ages and Stages Questionnaire (ASQ) training, provider performance monitoring and feedback, quarterly reminders, member outreach, and educational materials designed to improve screening completion. As one participant explained, “We have an EPSDT performance improvement project...we have nurses that do outreach to providers throughout Kansas,” illustrating that implementation extends beyond individual clinical encounters to coordinated statewide quality improvement efforts.

### TABLE 3

*Routine clinical EPSDT components reported by respondents*

| EPSDT Clinical Components   | Yes, n (%) |
|-----------------------------|------------|
| Growth Measurements         | 102 (86.4) |
| Comprehensive Physical Exam | 83 (70.3)  |
| Developmental Screening     | 103 (87.3) |
| Autism Specific Screening   | 35 (29.7)  |
| Behavioral/Mental Health    | 74 (62.7)  |
| Vision                      | 85 (72.0)  |
| Hearing                     | 80 (67.8)  |
| Dental                      | 67 (56.8)  |
| Nutritional Assessment      | 94 (79.7)  |
| Immunizations               | 92 (78.0)  |
| Lead                        | 77 (65.3)  |
| Laboratory Tests            | 72 (61.0)  |

<sup>1</sup>Bright Futures is a national health promotion and preventive care initiative of the American Academy of Pediatrics that provides evidence-informed guidance and a periodicity schedule for pediatric preventive care.

## Health-related social needs screening

Recognizing that children’s health and their ability to access care are influenced by both medical and social conditions, respondents were asked whether their organizations routinely screened for health-related social needs (HRSNs) that could affect child development, family well-being, and access to medically necessary or other recommended services. HRSN screening was examined separately from the clinical screening components of EPSDT and provides insight into whether providers identify social and environmental factors that may influence children’s ability to access and benefit from care. Overall, findings suggest that many providers routinely assess HRSNs as part of comprehensive pediatric care, although implementation varied across screening domains.

The most consistently reported HRSN screening activities included access to community resources (86.4%), exposure to violence or safety concerns (81.4%), child or caregiver mental health concerns (80.5%), and language or communication barriers (79.7%). Screening for food insecurity (72.9%), transportation barriers (69.5%), child maltreatment (69.5%), and financial strain (67.8%) was also routinely reported by most respondents. Screening occurred less consistently for housing instability (64.4%), utility insecurity (63.6%), caregiver social isolation (62.7%), and access to child care (60.2%).

When grouped into conceptually related domains, routine screening was most common for Safety and Family Well-being (77%), followed by Access to Care (74%) and Economic Stability (67%). Although respondents reported screening for a broad range of social needs, variability across domains suggests that integration of comprehensive HRSN screening remains uneven across organizations.

TABLE 4

*Health-related social needs screening by respondents*

| Domain                    | Mean Routine Screening |
|---------------------------|------------------------|
| Safety & Family Wellbeing | 77%                    |
| Access to Care            | 74%                    |
| Economic Stability        | 67%                    |

## Implementation beyond screening: Referral practices

Although screening is a critical component of EPSDT, successful implementation also depends on children’s ability to access appropriate follow-up services once concerns are identified. To better understand this transition from identification to intervention, respondents were asked about their organizations’ referral practices for commonly needed maternal, developmental, and behavioral health services.

Referrals to maternal and public health services—including obstetric care, WIC, home visiting, and local public health agencies—were routinely reported by most respondents (83.1%). Referrals to more specialized behavioral health services were reported less frequently. Approximately two-

thirds of respondents routinely referred children to community behavioral health or telebehavioral health providers (65.3%), whereas fewer than half routinely referred families for dyadic parent-child behavioral health services (47.0%), with nearly one-third reporting that they made dyadic referrals only sometimes. It is important to note that lower referral frequency does not necessarily indicate a gap in EPSDT implementation, as these data do not account for the proportion of children and families for whom specialized or dyadic services were clinically indicated. Rather, the findings describe variation in reported referral practices across service types.

Several respondents specifically emphasized the need to strengthen follow-through after concerns are identified, including tracking referral completion and ensuring that children ultimately receive recommended diagnostic and treatment services. These responses highlight the importance of referral processes that extend beyond initiating a referral to ensuring that children successfully connect with needed services.

**Providers suggested successful referrals depend heavily on strong community partnerships.**

Providers also suggested that successful referrals depended heavily on strong community partnerships. Respondents frequently described collaborations with public health departments, WIC programs, Early Head Start, hospitals, schools, behavioral health providers, and other community organizations as important mechanisms for connecting families to services. Several providers noted that referral processes had improved over time through stronger communication and more established relationships among community partners. These partnerships can support referral follow-through by helping families connect with appropriate services and facilitating communication between referring and receiving providers. However, the survey did not assess whether referrals were completed or whether information about referral outcomes was routinely communicated back to the referring provider.

MCO representatives described a distinct but complementary role in supporting families after a referral is made. Unlike individual providers, MCOs have dedicated infrastructure and personnel specifically designed to support care coordination across the service system. Representatives described care coordination teams that help families identify providers, schedule appointments, address transportation barriers, and navigate complex service systems. As one representative explained, “We have over 300 care coordinators located throughout the state,” illustrating the scale of infrastructure available to support children and families after concerns are identified. These findings highlight the importance of coordination between referring providers and MCO care coordination systems rather than suggesting that individual providers should independently replicate these functions.

**TABLE 5***Referral Practices Among Respondents*

| Referral Type                                                         | Yes, n (%) | Sometimes, n (%) | No, n (%) | Unsure, n (%) |
|-----------------------------------------------------------------------|------------|------------------|-----------|---------------|
| Maternal health providers (OB/GYN, WIC, home visiting, public health) | 98 (83.1)  | 14 (11.9)        | 4 (3.4)   | 2 (1.7)       |
| Community behavioral health/telebehavioral health                     | 77 (65.3)  | 26 (22.0)        | 7 (5.9)   | 8 (6.8)       |
| Dyadic (parent-child) behavioral health                               | 55 (47.0)  | 35 (29.9)        | 11 (9.4)  | 16 (13.7)     |

*Note: Referral frequency reflects practice-level referral patterns and does not account for the proportion of children for whom each service was clinically indicated. Lower referral frequency for specialized services should therefore not be interpreted independently as an EPSDT implementation gap.*

## Association between provider familiarity and EPSDT implementation

To examine whether provider knowledge was associated with implementation, respondents were categorized according to their self-reported familiarity with EPSDT. Providers reporting high familiarity were significantly more likely than those reporting low familiarity to routinely conduct diagnostic assessments (57.7% vs. 32.6%;  $\chi^2(1) = 7.07$ ,  $p = .008$ ) and make referrals for diagnosis or treatment (87.3% vs. 69.6%;  $\chi^2(1) = 5.57$ ,  $p = .018$ ). These represent distinct components of the EPSDT pathway: providers may conduct diagnostic assessments within their own practice or refer children to another provider for diagnostic evaluation or treatment when a screening or other clinical finding identifies a need for additional services. Thus, the higher frequency of referrals relative to diagnostic assessments is consistent with providers referring children for diagnostic services they do not provide directly. In contrast, familiarity was not significantly associated with routine screening, preventive care, or treatment services.

These findings suggest that provider knowledge may be particularly important for EPSDT implementation activities that extend beyond routine preventive care. While screening practices were relatively consistent regardless of familiarity, providers with greater familiarity with EPSDT were more likely to conduct diagnostic assessments and make referrals for diagnosis or treatment. This pattern highlights the potential importance of provider education in supporting the transition from initial identification of a concern to appropriate diagnostic evaluation and treatment.

Provider comments offered additional insight into these findings. Several respondents described feeling insufficiently prepared to operationalize EPSDT within their organizations, citing limited education and a need for additional implementation support. Together, these findings suggest that improving provider understanding of EPSDT may strengthen implementation of activities that extend beyond routine preventive screening, particularly diagnostic assessment and referral.

**TABLE 6**

*Association between provider familiarity with implementation of core EPSDT components*

| EPSDT Component                    | Low Familiarity | High Familiarity | X2   | p      |
|------------------------------------|-----------------|------------------|------|--------|
| Screening                          | 35/46 (76.1%)   | 61/71 (85.9%)    | 1.83 | .176   |
| Diagnostic assessments             | 15/46 (32.6%)   | 41/71 (57.7%)    | 7.07 | .008** |
| Treatment or intervention services | 20/46 (43.5%)   | 35/71 (49.3%)    | 0.38 | .538   |
| Referrals                          | 32/46 (69.6%)   | 62/71 (87.3%)    | 5.57 | .018*  |
| Preventive care                    | 23/46 (50.0%)   | 44/71 (62.0%)    | 1.64 | .201   |

Note:  $\chi^2$  = chi-square statistic.  $p < .05$ .  $p < .01$ . Percentages represent the proportion of providers within each familiarity group reporting routine implementation of the specified EPSDT component (Low Familiarity,  $n = 46$ ; High Familiarity,  $n = 71$ )

## Implementation barriers

Respondents were asked to select from a predefined list of challenges they experience when delivering care in alignment with EPSDT requirements, with the option to select multiple barriers and provide an additional free-text response under “other”. The most frequently reported challenge was lack of provider knowledge or training (45.8%), followed by confusion regarding EPSDT requirements (37.3%), documentation requirements (37.3%), time burden (37.3%), cultural or language barriers (33.1%), and inadequate staff capacity (31.4%). Fewer respondents identified prior authorization (22.0%) or general administrative burden (19.5%) as primary barriers. Overall, providers more frequently identified challenges related to understanding and implementing EPSDT than traditional administrative obstacles.

**TABLE 7**

*Reported barriers to delivering EPSDT services*

| Challenge                    | n  | %    |
|------------------------------|----|------|
| Lack of knowledge/training   | 54 | 45.8 |
| Confusion about requirements | 44 | 37.3 |
| Time burden                  | 44 | 37.3 |
| Documentation requirements   | 44 | 37.3 |
| Cultural/language barriers   | 39 | 33.1 |
| Lack of staff capacity       | 37 | 31.4 |
| Prior authorization          | 26 | 22.0 |
| Administrative burden        | 23 | 19.5 |
| Other                        | 15 | 12.7 |

Provider comments expanded upon these findings by illustrating how implementation barriers extend beyond provider knowledge alone. Respondents described challenges maintaining caregiver

engagement after referrals, shortages of providers accepting Medicaid, limited community resources, rural transportation barriers, and limited opportunities to develop EPSDT-specific expertise because relatively few KanBeHealthy visits were completed within some organizations. Together, these responses suggest that implementation is influenced by provider knowledge and experience with EPSDT, family engagement, practice setting, availability of community resources, and the broader service delivery system.

## Serving children with complex needs

Although most organizations reported routinely implementing the core components of EPSDT, respondents indicated greater challenges when caring for children with specialized developmental, behavioral health, or complex health needs. To better understand these challenges, respondents were asked about their experiences serving three populations that may require more intensive or coordinated services: children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs.

Children with behavioral health conditions (39.0%) and children with disabilities or complex health needs (37.3%) were identified as the most challenging populations to serve. In comparison, children in foster care were perceived as somewhat less challenging, with 27.1% of respondents reporting moderate or major challenges. Approximately one-third of respondents indicated that serving children in foster care presented little or no challenge, while between 16% and 19% reported that one or more of these populations were not routinely served within their organizations. Importantly, these categories are not mutually exclusive; children may have needs or circumstances represented in more than one population. The survey assessed providers' experiences with each population separately and did not examine whether challenges differed for children represented across multiple categories. Together, these findings suggest that EPSDT implementation may become more challenging as children's service needs become more specialized or complex. Meeting the needs of these populations may require access to specialty providers, coordination across multiple services and systems, and sustained communication among providers, families, and community partners.

## Cross-system care coordination

Because many children with complex needs receive services from multiple organizations, respondents were asked whether their organizations routinely coordinated EPSDT services with community systems commonly involved in children's care. Coordination occurred most frequently with early childhood programs, including Head Start (60.2%). Far fewer organizations reported formal coordination with local education agencies (8.5%) or juvenile justice, diversion, or reentry programs (0.8%), while nearly one-third (30.5%) indicated that they did not routinely coordinate with any of these systems.

Provider comments further illustrated the importance of established community partnerships in supporting care coordination. Respondents frequently described collaborative relationships with

Head Start, early intervention programs, schools, community mental health centers, developmental disability organizations, hospitals, and local public health agencies. Strategies described as supporting communication and continuity of care included warm handoffs, in which providers directly connect families with another provider or service rather than relying solely on the family to initiate contact, as well as co-located behavioral health services, multidisciplinary care teams, dedicated case managers, and regularly updated referral networks.

**Providers described substantial barriers to cross-system collaboration, especially in rural communities.**

Providers also described substantial barriers to cross-system collaboration. Workforce shortages, limited availability of behavioral health and specialty providers, fragmented community resources, staff turnover, communication difficulties across agencies, administrative complexity, and inconsistent caregiver engagement frequently disrupted care coordination. These challenges were particularly pronounced in rural communities, where families often traveled long distances to access specialty services and local resources were limited.

MCO representatives provided a complementary systems-level perspective, describing care coordination as statewide infrastructure rather than a discrete clinical activity. Their accounts highlighted the distinct role of MCOs in supporting coordination across providers and service systems and helping families navigate care beyond the capacity of any single provider or organization.

## Referral barriers

To better understand obstacles occurring after concerns were identified, respondents were asked about barriers encountered when referring children for follow-up services after an EPSDT screening. The most-frequently reported barriers were limited availability of specialty providers (63.6%), long waitlists for services (60.2%), and transportation (59.3%). Approximately half of respondents also identified limited awareness of available services (50.8%) and family scheduling or engagement challenges (49.2%). Language or cultural barriers (30.5%), insurance or reimbursement challenges (29.7%), and inadequate referral pathways or care coordination (27.1%) were reported less frequently.

Transportation findings illustrate the complexity of these barriers. More than one-quarter of respondents were unaware that Medicaid transportation assistance is available for eligible beneficiaries, suggesting that some families may not be connected with existing benefits. However, respondents also described communities in which transportation options themselves were limited or unavailable. Thus, addressing transportation barriers may require both increasing awareness and navigation of existing Medicaid benefits and strengthening transportation capacity where adequate resources do not exist.

**The most-frequently reported barriers were limited availability of specialty providers, long waitlists and transportation.**

**Geographic differences in referral barriers.** To examine whether reported referral barriers differed by geographic setting, individual barriers were grouped into three conceptually related domains representing service availability, family access, and health system barriers. Domain scores were calculated by summing endorsed barriers within each category, and Mann-Whitney U tests were used to compare organizations serving predominantly urban and rural communities.

Urban organizations reported significantly higher service availability barrier scores ( $U = 1246.50$ ,  $z = -2.03$ ,  $p = .043$ ,  $r = .19$ ) and health system barrier scores ( $U = 1213.50$ ,  $z = -2.21$ ,  $p = .027$ ,  $r = .21$ ) than rural organizations, although the magnitude of both differences was small. Family access barrier scores did not differ significantly by geographic setting ( $U = 1460.50$ ,  $z = -0.68$ ,  $p = .495$ ,  $r = .06$ ). Regardless of setting, transportation difficulties, scheduling constraints, and limited awareness of available services were commonly reported barriers to accessing referred services.

The finding that urban organizations reported greater service availability and health system barriers was unexpected and should be interpreted cautiously. These measures reflect providers' experiences with referral barriers rather than an objective assessment of community resources or service capacity. The survey did not assess potential explanations for the observed differences, such as referral volume, service demand, provider awareness of available resources, or differences in local service capacity. The findings therefore should not be interpreted as indicating that urban communities have fewer resources than rural communities, but rather that providers' experiences with referral barriers may vary by geographic setting in ways that warrant further investigation.

Provider comments provided additional context for these barriers. Respondents described shortages of behavioral health clinicians, developmental specialists, therapists, and other specialty providers, particularly those accepting Medicaid or new patients, as well as long waitlists for available services. After referrals were initiated, transportation limitations, competing caregiver responsibilities, scheduling difficulties, and challenges locating appropriate providers could further impede access. Providers also described administrative challenges associated with completing paperwork, identifying available services, and coordinating care across organizations with limited staffing and resources.

MCO interviews further illustrated the distinction between the broad scope of the EPSDT benefit and the processes required to operationalize it. Representatives described challenges related to provider enrollment, documentation of medical necessity, prior authorization when applicable, and coordination among healthcare providers, community agencies, MCOs, and families. They also described processes intended to preserve member choice that could add steps to referral coordination. Because the interviews did not establish whether all of these processes reflected federal or state Medicaid requirements or individual MCO policies, they are best understood as operational considerations rather than limitations inherent to EPSDT itself.

Taken together, the findings demonstrate that coverage of medically necessary services does not necessarily translate into timely access to those services. Provider shortages, waitlists, transportation limitations, administrative processes, family-level barriers, and local service capacity can im-

pede children's progression from referral to receipt of care. These findings underscore the distinction between the broad scope of services available through EPSDT and the service-system infrastructure and capacity necessary to ensure children can access those services in practice.

## Key takeaways

Across the quantitative survey findings, provider comments, and MCO interviews, a consistent implementation pattern emerged. Organizations routinely reported implementing foundational preventive services, developmental screenings, and many recommended components of EPSDT. However, implementation became less consistent as children moved beyond routine screening to services requiring additional assessment, specialty referrals, treatment, and ongoing care coordination.

Providers reported challenges connecting children to medically necessary follow-up services after concerns were identified. At the same time, the discrepancy between provider-reported screening practices and federal administrative measures suggests that challenges may also occur in ensuring that children receive and have documented recommended preventive care. Across the EPSDT continuum, providers' ability to support children was influenced by their knowledge and experience with EPSDT, workforce and specialty provider availability, administrative processes, the strength of community partnerships, and the availability of coordinated referral systems.

Taken together, these findings indicate that strengthening EPSDT implementation in Kansas will require attention not only to provider education but also to the organizational and health system infrastructure that supports children beyond screening. Continued collaboration among providers, Medicaid managed care organizations, community agencies, and families will be essential to translating the comprehensive coverage provided by EPSDT into timely access to medically necessary services.

**Findings indicate that strengthening EPSDT implementation in Kansas will require attention not only to provider education but also to the organizational and health system infrastructure that supports children beyond screening.**

## SECTION IV: PROVIDER RECOMMENDATIONS FOR STRENGTHENING EPSDT IMPLEMENTATION

The final section of the survey asked respondents to identify strategies for strengthening implementation of EPSDT across Kansas. Responses resulted in five overarching recommendations that closely mirrored the implementation challenges identified throughout the evaluation.

### Increase awareness and understanding of EPSDT

The most frequently identified recommendation was to improve awareness of the EPSDT benefit among both families and providers. Respondents consistently noted that many families were unaware of the purpose of well-child visits, the range of services available through EPSDT, or additional benefits available through Medicaid. Providers similarly described uncertainty regarding covered services, documentation requirements, referral pathways, transportation benefits, and the distinction between KanBeHealthy and the broader federal EPSDT benefit.

Recommendations included statewide educational campaigns targeting families, routine provider education, multilingual educational materials, plain-language communication, and greater promotion of available benefits through schools, public health agencies, community organizations, and MCOs. Respondents emphasized that education should extend beyond the KanBeHealthy screening visit to include developmental services, behavioral health treatment, therapies, transportation assistance, and medically necessary follow-up care.

### Reduce barriers to access

Respondents consistently identified structural barriers that limited families' ability to participate in both preventive screening and follow-up care. Transportation emerged as the most frequently cited challenge, followed by long travel distances, limited appointment availability, language barriers, childcare needs, work schedules, Medicaid enrollment challenges, and interruptions in Medicaid coverage.

Providers recommended expanding transportation options, increasing appointment flexibility, strengthening reminder systems through text messaging and other electronic communication, integrating services within schools, WIC, local health departments, and other community settings, and increasing access to interpreters and culturally responsive services. These recommendations reflect both barriers to accessing existing services and broader gaps in the availability and accessibility of services and supports within some communities.

### Strengthen referral systems and care coordination

Providers emphasized that identifying developmental, behavioral health, or medical concerns is only the first step in EPSDT implementation. Across the open-ended questions, respondents described

substantial challenges after screening, when families must navigate referrals, specialty providers, and multiple service systems.

Recommendations focused on strengthening care coordination through dedicated case managers or community health workers, improving communication among healthcare providers, MCOs, schools, behavioral health organizations, public health agencies, and community partners, and investing in referral infrastructure that supports children in accessing needed diagnostic assessment, treatment, and ongoing follow-up services. Respondents also recommended mechanisms for improving communication about referral status and whether families ultimately connected with recommended services.

## Expand workforce capacity and support providers

Respondents identified workforce shortages and limited provider availability as persistent barriers to implementation. Recommendations included increasing reimbursement rates, investing in the developmental and behavioral health workforce, improving access to pediatric specialists, strengthening rural healthcare capacity, expanding telehealth, and providing additional education regarding EPSDT implementation, billing, and documentation.

Providers also recommended investments in workforce recruitment, retention, and financial incentives to increase the availability of providers serving Medicaid-enrolled children. Although these workforce challenges extend beyond EPSDT, respondents described them as directly affecting the ability of children enrolled in Medicaid to access medically necessary services identified through EPSDT.

**Workforce shortages and limited provider availability are persistent barriers to implementation.**

## Simplify Medicaid and managed care processes

Finally, respondents emphasized the need to reduce administrative complexity associated with EPSDT implementation. Providers described challenges related to billing requirements, credentialing processes, provider enrollment procedures, prior authorization requirements, reimbursement processes, documentation requirements, and variation across MCOs. Respondents recommended standardizing forms, streamlining documentation requirements, simplifying credentialing and enrollment processes, strengthening communication among Medicaid, MCOs, and providers, improving family outreach regarding due screenings, and enhancing accountability for ensuring children receive recommended services.

Providers may also benefit from clearer, standardized guidance regarding covered services, documentation expectations, referral processes, and implementation of the EPSDT benefit. Respondents emphasized that reducing administrative complexity and clarifying implementation expectations could allow providers to devote more time to patient care while supporting more consistent implementation of the full EPSDT benefit.

MCO interviews provided additional context for these recommendations by highlighting persistent uncertainty regarding the scope of EPSDT-covered services and the documentation required to establish medical necessity. As one representative explained, “It’s not black and white. It’s not like we have a list that says all of these things fall under services or medical necessity for EPSDT.” Another participant suggested that clearer statewide guidance could reduce provider uncertainty, noting, “Some states put out a list and it tells you exactly what can be approved under EPSDT. And that would be super helpful if the state would do that.”

## Key takeaways

Provider recommendations closely mirrored the implementation barriers identified throughout this evaluation and reinforced the central finding that implementation extends beyond completion of the KanBeHealthy screening visit. Respondents emphasized opportunities to strengthen family and provider awareness, referral systems, care coordination, workforce availability, and administrative processes that influence children’s ability to access medically necessary follow-up services.

Taken together, the recommendations suggest that strengthening EPSDT implementation in Kansas will require coordinated action across multiple levels of the healthcare and service delivery systems. Respondents identified opportunities for improvement at the provider, organizational, managed care, community, and state policy levels, underscoring that implementation depends not only on identifying children’s needs but also on having the services, infrastructure, and coordination necessary to connect children with diagnostic assessment, treatment, and ongoing care.

**Findings showed that implementation extends beyond completion of the KanBeHealthy screening visits. Opportunities exist to strengthen family and provider awareness, referral systems, care coordination, workforce availability and administrative processes that influence children’s ability to access medically necessary follow-up services.**

# DISCUSSION

This assessment represents one of the first statewide assessments of EPSDT implementation in Kansas. By combining survey findings from healthcare providers with interviews from representatives of all three Kansas MCOs, the assessment provides insight into how the EPSDT benefit is understood, implemented, and operationalized across different practice settings. Four overarching findings emerged: a discrepancy between provider-reported implementation and federal performance measures; the importance of system-level conditions in shaping implementation; the distinction between coverage and access; and the shared responsibility required to implement EPSDT across multiple levels of the Medicaid and healthcare systems.

## **Provider-reported implementation and federal performance measures reveal different pictures of EPSDT implementation.**

Federal administrative measures indicate persistent gaps in children's receipt of preventive care in Kansas. Historical federal EPSDT screening data indicate that Kansas has remained below the established benchmark for receipt of at least one recommended screening, while more recent Child Core Set data indicate that 50.6% of Kansas Medicaid and CHIP beneficiaries ages 3–21 received at least one well-care visit in 2024. Improving children's receipt of preventive care therefore remains an important priority.

At the same time, participating providers reported routinely conducting many of the screening and preventive care activities examined in this assessment. Providers consistently reported conducting developmental screening, preventive care, and recommended clinical activities during well-child visits, as well as identifying concerns and initiating referrals for additional services. Diagnostic assessment, treatment, and ongoing care coordination were reported less consistently. These findings suggest that important implementation challenges may occur both in ensuring children receive recommended preventive care and after concerns are identified, as children move toward diagnostic assessment, specialty services, treatment, and ongoing follow-up.

The contrast between provider-reported practices and child-level administrative measures raises important questions about where the disconnect occurs between organizational practice and children's documented receipt of care. MCO interviews suggested several possible explanations, including incomplete KanBeHealthy examinations, documentation and coding practices, and differences between services delivered during clinical encounters and those captured through administrative data. However, the current assessment cannot determine the extent to which the discrepancy reflects differences in the populations or constructs being measured, provider self-report, documentation or coding practices, incomplete visits, or children not receiving recommended care. These observations therefore should not be interpreted as evidence that administrative measures underestimate actual performance. Rather, the discrepancy itself represents an important area for further investigation.

Importantly, neither provider-reported screening practices nor federal measures of preventive care provide a complete picture of EPSDT implementation. Screening is the entry point to EPSDT rather than the endpoint. Fully assessing implementation requires attention not only to whether children receive recommended screenings and well-care visits, but also to whether identified concerns result in appropriate diagnostic assessment, referral, treatment, and coordinated follow-up. Although continued efforts to improve KanBeHealthy screening and well-care visit participation are warranted, quality improvement strategies should also examine children's progression across the broader EPSDT continuum.

## **EPSDT implementation is a systems challenge rather than simply a provider challenge.**

A second major finding is that implementation is dependent upon considerably more than provider knowledge alone. Providers who reported greater familiarity with EPSDT were significantly more likely to report conducting diagnostic assessments and making referrals for diagnosis or treatment, suggesting that provider education, training, and skills development remain important implementation strategies. At the same time, providers and MCO representatives consistently emphasized that education and training alone cannot overcome many of the barriers affecting children's access to care.

Across quantitative and qualitative findings, implementation challenges included workforce and specialty provider shortages, transportation barriers, fragmented referral pathways, administrative complexity, documentation requirements, reimbursement concerns, and variation in providers' experience with EPSDT. The presence or absence of strong community partnerships and coordinated referral systems also shaped providers' ability to connect children with additional services. These findings suggest that implementation challenges arise not only within clinical practice but also from characteristics of the broader healthcare and service delivery systems.

MCO interviews further reinforced this systems perspective. Representatives described ongoing collaboration with KDHE through provider education, performance improvement initiatives, quality monitoring, member outreach, care coordination, and technical assistance designed to strengthen KanBeHealthy implementation. Taken together, these findings suggest that strengthening implementation requires coordinated attention to provider knowledge and skills, workforce and service availability, referral and care coordination infrastructure, administrative processes, and continuous quality improvement.

## **Coverage of medically necessary services does not necessarily translate into timely access to those services**

Although EPSDT provides broad coverage of medically necessary services for Medicaid-enrolled children, providers described significant challenges connecting children with recommended care after needs were identified. Long waitlists for behavioral health, developmental, and other specialty services; shortages of providers accepting Medicaid or new patients; transportation barriers; fragmented referral systems; administrative processes; and competing family demands were

frequently reported as obstacles to obtaining diagnostic assessment and treatment. Transportation findings illustrate the distinction between coverage and access particularly well. More than one-quarter of respondents were unaware that transportation assistance is available to eligible Medicaid beneficiaries, while transportation was also among the most-frequently reported barriers to accessing referred services. However, limited awareness represents only one component of the transportation challenge. In some communities, transportation options themselves may be insufficient or unavailable. Consequently, addressing transportation barriers may require both improving awareness and navigation of existing Medicaid benefits and addressing gaps in local transportation capacity. Respondents' comments suggest that access depends not only on whether a benefit or service is technically available, but also on whether families can feasibly navigate and use it. Several respondents described transportation, incentives, and other supports that were available in principle but difficult to access reliably in practice.

**Transportation was among the most-frequently reported barriers to accessing referred services.**

A similar distinction applies more broadly across EPSDT. Coverage of a medically necessary service does not ensure that an appropriate provider is available, accepts Medicaid, is accepting new patients, has appointment capacity, or can be reached by the child and family. Access may also vary according to the complexity of an individual child's needs, with providers reporting greater challenges serving children requiring specialized behavioral health, developmental, or multidisciplinary services. These findings highlight an important distinction between the broad scope of services available through EPSDT and the service-system capacity and infrastructure necessary for children to access those services in practice.

## **Successful EPSDT implementation requires shared responsibility across multiple levels of the Medicaid and healthcare systems.**

A final overarching finding is that successful EPSDT implementation requires shared responsibility extending beyond individual clinical encounters. Providers emphasized collaboration among healthcare providers, MCOs, schools, early childhood programs, behavioral health providers, public health agencies, child welfare organizations, and community partners. Likewise, MCO representatives described implementation as an ongoing quality improvement process involving provider outreach, family engagement, care coordination, performance monitoring, and collaboration with state Medicaid leadership. Care coordination, referral infrastructure, quality improvement, provider support, and clear state-level guidance therefore represent important components of implementation.

These findings are consistent with implementation science and policy implementation frameworks that emphasize the multilevel nature of implementation. This perspective is particularly relevant to EPSDT because EPSDT is a federal Medicaid policy and entitlement rather than a discrete clinical intervention. Policy-focused implementation frameworks emphasize that successful implementation depends on interactions among the policy itself, the broader system and policy environment, organizational contexts, and the mechanisms that connect policy requirements to frontline practice (Crible et al., 2022).

Applied to EPSDT, this perspective suggests that implementation is shaped not only by provider knowledge and clinical practices, but also by state Medicaid policies and guidance, managed care structures, organizational capacity, financing and workforce conditions, communication across systems, and the infrastructure available to translate federal requirements into routine care. The findings of this assessment reflect this multilevel implementation process and reinforce the need to examine and strengthen EPSDT implementation across provider, organizational, managed care, and state system levels.

## Implications for policy and practice

Several practical implications emerged from this assessment. First, Kansas should continue monitoring federal preventive care performance measures while examining why provider-reported implementation differs from child-level administrative measures of EPSDT screening and well-care visit receipt. Quality improvement projects should consider both whether organizations routinely implement recommended practices and whether Medicaid-enrolled children ultimately receive and have documented the recommended care. Importantly, efforts to understand this discrepancy should not replace continued efforts to improve screening and well-care participation; rather, they can help identify where gaps occur between organizational practice and children's receipt of care.

Second, quality improvement projects should extend beyond screening to examine implementation across the broader EPSDT continuum. Screening represents an essential entry point, but successful implementation also requires that identified concerns lead to appropriate diagnostic assessment, referral, treatment, and follow-up. Monitoring referral completion, treatment initiation, and receipt of medically necessary services would provide a more complete picture of EPSDT implementation than screening measures alone.

Third, provider education should extend beyond screening recommendations to include documentation requirements, medically necessary services, referral pathways, transportation benefits, and the broader scope of the EPSDT entitlement. Findings demonstrating an association between EPSDT familiarity and diagnostic assessment and referral practices suggest that strengthening provider knowledge and skills remains an important component of implementation improvement.

Fourth, investments in referral infrastructure, care coordination, workforce development, transportation capacity, and specialty service availability may strengthen children's access to services identified through EPSDT. These investments are particularly important because coverage alone cannot ensure access when appropriate providers or other resources are unavailable.

Finally, providers and MCO representatives identified opportunities to simplify administrative processes and provide clearer statewide guidance regarding implementation of medically necessary services under EPSDT. Continued collaboration among providers, MCOs, KDHE, and community partners may help clarify implementation expectations, identify system-level barriers, and strengthen continuity across the EPSDT continuum.

Overall, the findings suggest that challenges arise not only in implementing EPSDT consistently across healthcare settings but also in meeting the differing needs of children within those settings. EPSDT provides a comprehensive framework for prevention, early identification, and coverage of medically necessary care, but implementation depends on the systems and resources necessary to translate that coverage into access. Greater attention to provider education, service availability, organizational supports, standardized implementation guidance, continuous quality improvement, and cross-system collaboration may help narrow the gap between policy and practice. Because no single stakeholder is responsible for the entire EPSDT continuum, strengthening implementation will require coordinated action among providers, healthcare organizations, Medicaid MCOs, community partners, and state agencies.

## Strengths

**This assessment has several notable strengths. It represents one of the first statewide assessments of EPSDT implementation in Kansas and examined implementation across the continuum of care rather than focusing exclusively on preventive screening measures.**

The inclusion of providers representing diverse disciplines and organizational settings provided perspectives regarding implementation in routine clinical practice. In addition, interviews with representatives from all three Kansas MCOs provided system-level context that helped interpret survey findings and identify opportunities for quality improvement. Together, these complementary data sources provided a broader understanding of EPSDT implementation than either source could provide independently.

The inclusion of both provider-reported practices and contextual information from MCO representatives also allowed the assessment to identify questions not readily apparent from administrative performance measures alone. In particular, the discrepancy between provider-reported implementation and federal measures of children's receipt of preventive care highlights an important area for future quality improvement and research.



## Limitations

Several limitations should be considered when interpreting these findings. First, the assessment relied primarily on self-reported provider practices rather than direct observation of clinical encounters or analysis of administrative claims. Consequently, reported implementation may differ from actual clinical practice or child-level receipt of services, and responses may be influenced by recall or social desirability bias. The assessment therefore cannot determine whether the discrepancy between provider-reported practices and federal administrative measures reflects differences in measurement, documentation and coding, provider self-report, incomplete visits, differences in the populations represented, or actual gaps in children's receipt of care.

Second, participation was voluntary, introducing the possibility of response bias if providers with greater interest or familiarity with EPSDT were more likely to participate. In addition, a participation incentive was introduced after data collection began to improve response rates, which may have influenced the composition of later respondents. Although respondents represented a range of provider disciplines, practice settings, and organizations across Kansas, the sample was not intended to be statistically representative of all providers serving Medicaid-enrolled children.

The survey also did not distinguish in all instances whether recommended services were delivered directly by respondents or obtained through referral to outside providers. As a result, lower reported implementation of diagnostic assessment or treatment should not necessarily be interpreted as providers failing to deliver recommended care and may instead reflect differences in provider roles within the EPSDT continuum. Importantly, the assessment also did not determine whether referrals were completed or whether children ultimately received recommended services. Thus, provider-reported referral activity should not be interpreted as evidence of successful connection to care.

Finally, MCO interviews were conducted to provide system-level context and illustrate survey findings rather than serve as an independent qualitative investigation. Although representatives from all three Kansas Medicaid MCOs participated, their perspectives may not reflect the experiences of every healthcare organization, provider, or community across the state.

## Future directions

Future assessments should integrate provider surveys with administrative claims data, encounter data, and child-level outcomes to examine children's progression across the complete EPSDT continuum. A particularly important next step is to better understand the discrepancy between provider-reported implementation and federal administrative measures of EPSDT screening and well-care visit receipt. Linking provider-reported practices with administrative data could help determine whether differences are associated with provider self-report, documentation and coding practices, incomplete KanBeHealthy examinations, differences in the populations or constructs measured, or other system-level factors.

Future work should also examine referral completion, timeliness of diagnostic and specialty services, treatment initiation, receipt of medically necessary care, and subsequent child outcomes. Such analyses would provide a more comprehensive assessment of EPSDT implementation than either provider-reported practices or screening and well-care performance measures alone.

## Conclusion

EPSDT remains one of Medicaid's most comprehensive child health benefits and provides an important framework for prevention, early identification, and access to medically necessary services for Medicaid-enrolled children. This assessment suggests that participating Kansas providers routinely implement many preventive components of EPSDT, while federal administrative measures indicate that a substantial proportion of Medicaid-enrolled children do not have documented receipt of recommended screening or well-care visits. Understanding this discrepancy represents an important opportunity for future quality improvement and evaluation.

At the same time, the findings demonstrate that EPSDT implementation extends well beyond screening. Strengthening implementation in Kansas requires attention to children's progression through diagnostic assessment, referral, treatment, care coordination, and receipt of medically necessary services. Achieving this goal will require coordinated investments in provider education and skills development, workforce and service capacity, referral infrastructure, administrative simplification, transportation and other access supports, cross-system collaboration, and continuous quality improvement.

By simultaneously examining who receives preventive care, how providers implement recommended practices, and what happens after concerns are identified, Kansas may be better positioned to identify where gaps occur across the EPSDT continuum and ensure that Medicaid-enrolled children receive the services to which they are entitled.

**Strengthening EPSDT implementation in Kansas requires attention to children's progression through diagnostic assessment, referral, treatment, care coordination, and receipt of medically necessary services.**

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