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Health Resources and Services Administration
Maternal and Child Health Bureau

**Alliance for Innovation on Maternal and Child Health
Learning Collaborative on Improving Quality and Access to
Care in Maternal and Child Health
Cooperative Agreement UC4MC28034
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COLORADO STATE REPORT

**AIM Expanding Access to Care for Maternal and Child Health Populations
Learning Collaborative Cohort 2 - Colorado**

INTRODUCTION/BACKGROUND

As part of the Alliance for Innovation on Maternal and Child Health (AIM) program, the American Academy of Pediatrics (AAP) gathered background information to better understand access to care and coverage issues from the patient/family and provider perspectives. In addition, the AAP reviewed current state EPSDT programs to compare the services offered with the services recommended within the Bright Futures Guidelines for Health Supervision. This was accomplished through several different mechanisms: telephone interviews with pediatrician leaders, a survey of patients/families, telephone interviews with families to capture their stories, internet searches about state EPSDT programs, and discussions with state EPSDT coordinators. This data collection and analysis took place in April and May 2016. The intent of this information is to outline challenges and opportunities in each Cohort 2 state, and help to inform state team discussions during the Learning Collaborative meeting. Below is a summary of the findings.

PHYSICIAN INTERVIEW FINDINGS

A phone interview was held between AAP staff and two pediatrician leaders from the Colorado Chapter of the AAP. The goal of the interview was to obtain pediatrician insight into the health care financing environment in the state, including information about access, coverage, and payment for maternal and child health-related services. The interview highlights are documented below.

Pediatric Care Challenges	
Access to Care	<ul style="list-style-type: none"> • Few pediatricians/pediatric specialists in rural areas • Many rural areas rely on family physicians which can be problematic for screening and immunizations
Coordination of Care	<ul style="list-style-type: none"> • Some physician groups still implementing EHRs • The two children’s hospitals don’t always communicate • Difficult to coordinate care for children and youth with special health care needs (CYSHCN) • Lack of communication between primary care and behavioral health • Undocumented/immigrant families and foster care families have issues accessing and coordinating care
Delays in Treatment (Cost)	<ul style="list-style-type: none"> • Patients avoid seeing specialists and decline needed testing • Patients with chronic conditions sometimes do not fill prescriptions for recommended medications • Patients are unable to complete therapy (PT/OT/Speech) due to high costs
Medicaid	<ul style="list-style-type: none"> • Low payment rates forcing some pediatricians to dismiss or refrain from taking new Medicaid patients • Re-enrollment challenges • Frequent changes in available providers affecting continuity of care in the medical home • Long wait times (ie. months) for children to access specialty care

Pediatric Care Successes	
Medicaid	<ul style="list-style-type: none"> • Moving to a 12 month continuous enrollment system to improve continuity of care and encourage the use of medical homes

Opportunities	
<ul style="list-style-type: none"> • Increase mental health services for children • Improve collaboration between children’s hospitals and physicians • Increase Medicaid payment rates to Medicare payment rates 	

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

FAMILY SURVEY RESULTS

In an effort to better understand what patients and families were experiencing at the community level, the AAP partnered with Family Voices to create a survey to explore this topic in greater depth. The survey was disseminated through the Family-to-Family Health Information Center in each of the Cohort 2 states, as well as via other AAP information dissemination mechanisms. The survey explored whether patients/families had specific challenges in accessing care from providers, whether there were gaps in insurance coverage, and whether out of pocket costs were prohibitive. Respondents were also given the opportunity to provide additional information in an open-ended response.

The survey was available in both English and Spanish, and 53 complete responses were received from patients/families in Colorado. The three most common issues reported for access, coverage and payment are listed below:

Access	<ul style="list-style-type: none"> • None (49%) • The wait time to get an appointment is too long (40%) • My provider does not accept or no longer accepts my insurance plan (13%)
Coverage	<ul style="list-style-type: none"> • A recommended service is not covered by my insurance plan (42%) • Benefits are unclear (40%) • Recommended services were limited (35%)
Payment	<ul style="list-style-type: none"> • My child's health plan does not cover all the cost of care such as specific medications, therapy services, equipment, in-home services, etc (50%) • I quit work or cut back on my hours to care for my child (30%) • I delayed getting care for my child/children because I could not afford it (20%)

*% reflects the respondents that selected the listed option. Respondents were able to select more than one response for each survey question.

Common Themes:

Several sections of the survey invited respondents to provide additional comments. Many took the opportunity to offer information about their experience; and several recurring themes emerged:

- Behavioral Health: Poor access, poor coverage, little to no covered autism services, not enough providers, long wait time for appointments
 - *"ABA is not covered. Very long waits for behavioral health care."*
 - *"It is extremely difficult to find providers in our area who can deliver behavioral or mental health related services."*
 - *"Private insurance companies who do adhere to autism related regulations, are way too high for us to subscribe."*

- Coordination of Care: Little to no coordination of care for complex cases, benefits unclear
 - *"I need help with applying for/navigating the Medicaid maze."*
 - *"Need assistance knowing the best way to plan for all the services."*
 - *"It would be helpful to have a Care Coordinator familiar with our child's diverse needs and Medicaid state plans."*
 - *"It would be helpful to know who to go to for services. There are is so much need and so few providers."*
 - *"Need someone to help facilitate better access and options."*
 - *"It would be great to have a patient insurance advisor at the hospital to act as an intermediary with the insurance company."*

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

- *“There has to be an agency somewhere that we can go to when we are having trouble with the insurance companies that would compel them to comply with what they are contractually bound to do.”*
- *“We need any kind of intervention that could assist with making sure that there is not a mismanagement and intentional denials when there are rules that provide for these benefits.”*
- Cost: Unaffordable co-pays, do not qualify for assistance but cannot afford premiums and co-pays, high premiums (especially for private payers)
 - *“The rising cost of health insurance is a huge challenge.”*
 - *“Need better coverage by insurance with lower copays.”*
- Inadequate Coverage: Necessary services not covered or under-covered including DME, prescriptions, diapers for CYSHCN, music therapy, special needs strollers, PT, OT, home care
 - *“Better insurance options with coverage for my families’ needs without having to pay outrageous premiums required for the other coverage we won’t ever need as mandated by law.”*
 - *“Need more providers accepting my insurance as a new patient.”*
 - *“Need an easier qualifying process.”*
 - *“I need my insurance plan to be required to cover medications.”*
 - *“We need someone with the authority to compel the insurance companies to honor their obligations in a timely manner.”*

Conclusion:

Parents in Colorado are encountering many access, coverage and payment issues, and expressed frustration with the lack of available assistance based on AAP/Family Voices survey results. Many survey respondents were parents of CYSHCN, and several reported that they were unable to obtain recommended care due to issues coordinating care and unmanageable out-of-pocket expenses. There are opportunities to make meaningful improvements in the health care of maternal and child health populations in the state.

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

FAMILY STORIES

Family Story #1

Colorado: Lack of Transparency in Community Boards

Stacy lives in Colorado with her son, Noah, a 7-year-old boy. Noah suffered a birth injury (resulting in oxygen deprivation), and his diagnosis is Spastic Quadriplegia Cerebral Palsy. He is severely affected and can't sit, stand, walk, talk or self-feed. He requires 24 hours level of assistance with Medicaid and a waiver program. There's always something to ask for: wheelchairs, adaptive clothing because of his severe sensory processing disorder, home modifications, and more. He is homeschooled because he cannot be integrated into a school setting. Cognitively, he is very aware, he is on target intellectually because he communicates age appropriately.

Stacy's story exemplifies the challenges that many families in Colorado are currently facing when accessing waiver services. Children like Noah have unusual needs given the highly specialized level of care that they require, and like Stacy, they have to appeal denials of services almost every time they submit a request for coverage. Stacy has had to appeal decisions 5 times last year alone. After filing an appeal, there's a hearing. Families need to bring documentation, supporting that the denial was mistaken, then the judge sends out very detailed orders, usually stating that the rationale for the denial is inappropriate. But then the state goes against it, and overturns the judge's decision. It is called an "exception to initial decision", and it never goes before a judge again.

Even if families are as savvy as Stacy (she is a paralegal) to be able to file the appeals and provide all the necessary paperwork, the state always overturns the judge's decision. Stacy says that the only positive is that she has a paper trail to prove what is happening.

Noah is eligible to receive the CES waiver, which is administered by the Community Centered Boards (CCB). Colorado dissolved the waiting list, but there's still an 18 month wait to get on it. The waiver has a \$37,900 cap per child, and Noah has been receiving it for the past three years.

It has been very difficult to use all the funds available to Noah for several reasons. The first is that the CCB's charge a 3.5% service fee against the child's benefit every time there is a claim. This fee is not itemized and most parents don't even know it is there. Stacy found out about it when she was reconciling Noah's statements against the providers' actual charges. She noticed that the amounts taken out of his allowance were greater than what the providers had billed. When she inquired at the CCB, they said that there's a 3.5% service charge applied to all claims. Providers are also charged 3.5% off their service fees. There's no explanation of that fee published anywhere for parents to see.

Another problem that Stacy and other parents are facing when accessing the waiver is the unpredictability of payment for requests. Stacy explains that the CCB will find long lost rules and apply them whimsically to deny services. This happened to her when she applied for funds to pay for adaptive clothing and for a wheelchair adaptation. They denied coverage because the items were not made in the USA. Noah had to go without the wheelchair adaptation because no one in the US makes the device that he needed.

The CCB was very unreliable when the family was trying to financially plan for a bathroom modification that Noah needed. The project was going to be very costly, so Stacy decided to save up the year's benefit to ensure

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

that the much needed bathroom would be covered. The process turned out to be very complicated. After submitting detailed plans, Stacy had to fight for the addition of a toilet, a shower and a tub. The CCB argued that because Noah was not potty trained, he did not need a toilet. In addition, they denied the addition of a bathtub because they claimed that it was a luxury. To complicate matters further, the CCB denied much of the benefit because they said that it was too late in the year and all the work would not be completed by the end of the year. They said that they would give Stacy \$16,000 for that year, and give her the rest the next year. Stacy did not argue but then received a letter saying that she had gone over the allowance for the year. This left Stacy scratching her head since she had not used any of Noah's benefit throughout the entire year to save up for the bathroom event, for which they only paid \$16,000. Where had the other \$21,000 gone? An answer never came. [This is the link to the Newspaper Article on CCB's handling of funds.](#)

Stacy began taking on the cause to support transparency of the CCB's. She went on the media to talk about the irregularities, how rules were being applied whimsically and randomly, how account statements were opaque to the parents, and in general asking for transparency of where the money allocated for children was going. She and a few other families stepped forward, and retaliation came in the form of more denials. Stacy noticed that she was being denied benefits that other families were receiving, but they were afraid to come forward for fear of having their benefits taken away. This happened when Stacy noted that another child was receiving a therapy that Noah had been denied. When the CCB heard the complaint, they turned around and took away the therapy coverage for the other boy. That made Stacy afraid to speak up.

Stacy reports that the state called her a few weeks ago to let her know that they have instituted a new branch as a safe place to hear and deal with parent complaints. Stacy reports being cautious about it since her steps to call on CCB transparency have been met with retaliatory denials of coverage.

Families of children with complex medical needs are seeking improvements that will ensure uniform and reliable funding for their special needs.

Poor Communication between Medicaid Waiver Administrators and Families: Families don't have a clear way to ascertain all the rules and regulations that are applied when their claims are being considered. The CCB's reportedly use obsolete and little known rules to deny benefits in an unpredictable manner.

Lack of transparency of Community Centered Boards: Service fees are not itemized, and count against a child's yearly benefit. Discrepancies of funds availability like the one Stacy encountered when trying to fund her bathroom work go unexplained. SB- 38, a bill addressing transparency of CCB's passed with amendments that require more transparency from CCB's but does not yet go far enough to allow for public access to all their finances.

Lack of CCB Transparency when it comes to expenditure of Moneys: There is currently no law in CO requiring CCB's to be transparent about how they are handling Medicaid funds. To date, there have been no audits performed to evaluate CCB's handling of money.

Enforcement of a Parent Feedback Mechanism that ensures that parents can file complaints without fear of retaliation needs to be implemented.

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

Family Story #2

Refugee Health in Colorado: Picking up the Fragments

Colorado is home to a large and diverse population of refugees. Refugee families face a very particular set of circumstances when it comes to health care coverage. There is often a language barrier that delays access to health care and insurance coverage. In addition, cultural understanding of systems of care is very different for groups of people who often come from war torn countries. Their situation necessitates complex systems coordination and funding to ensure that the needs of these families are met in a timely manner.

A Note About the Interview:

The following is Anna's story, one that was difficult to gather. It is important to note that this story is nuanced by the perceptions of the interviewers, who found the need to rephrase questions many times over in order to get information about disability in particular. It was difficult to ascertain whether Anna did not understand the word "disability" or if revealing that a family member had a disability was a taboo subject, or the object of shame. The interviewers opted for asking whether anyone in her family received the services of any sort of therapist on a regular basis. This lent more specific answers, but yet without the admission of the existence of a disability or special health care need.

It is also important to add that the interviewers were referred to Anna by a refugee clinic in Colorado. This clinic receives funding specifically to take care of refugee health, and employs a variety of cultural brokers and interpreters to facilitate services and insurance coverage for refugees. Consequently, Anna's story will not identify the needs of those refugees that are outside of the service area of a refugee clinic.

Anna is the mother of two children. When Anna and her family came to the United States, they were immediately eligible for Medicaid. A year or two later, her husband joined.

One of Anna's children receives regular occupational and speech therapy services. It is unclear if the child also receives regular behavioral care, but Anna reported him having difficulty in school due to behavioral issues. Anna was quick to mention that he was being taken care of and that she was very grateful. She said that the refugee clinic provided everything that she needed.

Anna began working, and at that point she became ineligible for Medicaid. This change of status, while expected and "normal" for those familiar with government entitlement systems, was difficult to understand for Anna. Furthermore, when her husband joined the family from Iraq later on that year, their family healthcare became more complicated because he had access to Medicaid, while she was no longer eligible.

Making money from her job, Anna was now expected to pay high premiums to enroll in the ACA. Once she got diagnosed with breast cancer, the premiums and copays became unaffordable. As the cancer treatments became more aggressive, Anna became weaker, and unable to work. It made more sense for her to stop working. The decision to quit was also fueled by the high insurance premiums. Once she stopped working, she was once again eligible for Medicaid, and she no longer had to worry about not being able to afford high insurance premiums and copays for her cancer treatments.

Anna's insurance bind is not unheard of in the refugee community. Many refugees feel that the low paying jobs that they can get force them into an expensive health insurance marketplace. The wages that they earn are not

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

enough to pay for either ACA or private insurance premiums. So when they are faced with a catastrophic occurrence, they are left to choose between quitting their job to become eligible for Medicaid again, or going without the healthcare they need.

Anna's family's situation is complicated by the fact that she cannot speak English, so she can only communicate with her children's or her providers through an interpreter. The same is true of her communications with social services or insurance companies. All the correspondence comes to her in English, and she relies on the interpreters and translators at the refugee clinic to be available every time she needs correspondence translated.

Similarly, it was unclear to what extent having to go through an interpreter affected the knowledge that Anna had of her child's therapies. The interviewer surmises that lack of interpreted communication between therapists and parents who speak a language other than English has a sizable effect on the involvement of a parent in a child's therapy.

Anna's story leaves many questions unanswered. However, some facts are clear regarding the provision of healthcare to families in refugee communities.

Medicaid, ACA and Private Insurance Correspondence Should Be Translated: Anna and other refugees like her are heavily dependent on others to be able to translate important insurance notices and documents. When a refugee does not have immediate access to interpreters or translators, they may miss important information or deadlines that affect their healthcare coverage and options. Correspondence is routinely translated only to Spanish. Medicaid and Insurance providers need to dedicate more resources to translating all their notices to the language of the recipients.

Mixed Eligibility Status in Refugee Families is Confusing: Refugee families don't always arrive in the United States together. Like in Anna's case, Anna had already gotten a job and become eligible for the ACA when her husband arrived some time later, and had Medicaid. Many refugees come from countries without a tradition of government entitlements so the concept of qualifying for insurance alone is difficult to grasp, let alone have family members on different insurance systems.

It is Cheaper to Stay on Medicaid: When a family like Anna's is faced with a critical condition, it is often cheaper for the family to stop working to become eligible for Medicaid again. Refugees who work for low wages find it very difficult to afford high insurance premiums and still take care of their families.

Refugee Clinics Need More Comprehensive Funding for the Work They do: Refugee clinics, like the one that referred Anna to us, are doing a tremendous amount of work helping to enroll, inform and support the growing refugee community in Colorado. They provide translations for Medicaid documents without funding. They never turn anyone away, but they are not getting paid for it. They are also de facto advocates and navigators, and future funding to continue this work is uncertain. Without their help, refugees would not know where to go.

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

EPSDT AND BRIGHT FUTURES – COLORADO REPORT

Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics (AAP). It consists of a recommended set of health supervision services starting prenatally and continuing through age 21ⁱ and is recognized as the standard for pediatric preventive health insurance coverage under the Affordable Care Act.ⁱⁱ The Centers for Medicare and Medicaid Services (CMS) encourages state Medicaid agencies to use this nationally recognized pediatric periodicity schedule or consult with recognized medical organizations involved in child health care in developing their EPSDT schedules, which refers to Medicaid's coverage for children, known as the Early and Periodic Screening, Diagnostic and Treatment benefit.^{iii,iv} The following analysis of the Colorado EPSDT program was conducted by the AAP, with funding support from the federal Maternal and Child Health Bureau, to promote the use of Bright Futures as the professional standard for pediatric preventive care.

Colorado's profile compares the state's EPSDT Program with the Bright Futures periodicity schedule and screening recommendations. The state profile also contains information about Colorado's pediatric preventive care quality measures and performance, financial incentives, medical necessity definition, and best practices. Information was obtained from telephone interviews and/or email queries with the state EPSDT director; reviews of the Medicaid website, provider manual, and other referenced state documents; and analysis of CMS reports on child health quality. Additional information regarding Bright Futures and EPSDT in the seven states participating in the June 2016 "Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health" (Colorado, Minnesota, Montana, North Dakota, South Dakota, Utah, and Wyoming) is available on request.^v

Summary of Findings

- Colorado's EPSDT program has adopted the AAP's Bright Futures periodicity schedule and screening recommendations.
- The state's medical necessity definition for EPSDT addresses coverage for preventive purposes and mentions physical and mental conditions consistent with accepted standards without reference to Bright Futures as its professional standard for pediatric care.
 - Medically necessary means that a Medical Assistance program good or service: 1) will, or is reasonably expected to prevent diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a core of treatment that includes mere observation or no treatment at all; B. Is provided in accordance with professionally recognized standards for health care in the United States; C. Is clinically appropriate in terms of type, frequency, extent, site, and duration; D. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider; F. Is not experimental or investigational; and G. Is not more costly than other equally effective treatment options.
- According to CMS, in 2014, Colorado selected 9 of the 11 pediatric preventive care measures: child and adolescent access to PCPs, well visits in the 1st 15 months, well visits in years 3 through 6, adolescent well visits, childhood immunization status, Chlamydia screening, BMI assessment of children and adolescents, and preventive dental visits.
- According to a report from the federal Department of Health and Human Services (DHHS), Colorado's quality performance rates on several measures were higher than the national average: well visits for infants by 15 months, childhood and adolescent immunizations, BMI assessment, and preventive dental services. Performance rates for lower than the national average on primary care visits, well visits for children 3-6 and 12-21, and Chlamydia screening.^{vi} See examples below.

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 - Colorado

- Colorado's Accountable Care Collaboratives are implementing several child health performance improvement projects related to well child care, childhood immunizations, BMI assessment and follow-up communication between referring primary care providers and pediatric obesity specialty clinics. The state is also implementing financial incentives to encourage specific pediatric preventive care improvements.
- Colorado's Healthy Communities program connects Medicaid's EPSDT program and its separate CHIP program to ensure that children and pregnant women receive needed preventive care, connections to a medical and dental home, and needed referrals. Family coordinators provide an initial orientation to newly insured families about their benefits and available services, answer questions, troubleshoot enrollment issues, and follow-up on missed appointments.

Opportunities to Consider

1. Consider updating the state's EPSDT schedule to align with Bright Futures.
2. Share lessons learned from Colorado's innovative quality improvement projects for pediatric preventive care.
3. Consider reviewing the state's medical necessity definition for EPSDT in terms of reference to Bright Futures.
4. Consider strategies for increasing use of adolescent preventive care services aligned with CMS' recommendations and addressing transitions of care and coverage when youth are no longer eligible for EPSDT. Also, consider preventive dental care quality improvement initiatives.

**AIM Expanding Access to Care for Maternal and Child Health Populations
Learning Collaborative Cohort 2 - Colorado**

EPSDT RECOMMENDATIONS AND SELECTED PEDIATRIC QUALITY PERFORMANCE MEASURES

EPSDT Periodicity Schedule, 2016 (# of well child visits)	CO	Bright Futures
- Prenatal period	1	1
- Birth through 9 months	7	7
- 1 through 4 years	7	7
- 5-10 years	6	6
- 11 through 14 years	4	4
- 15 through 20 years	6	6

Pediatric Preventive Care Quality Measures and Performance, 2014	CO	US
- % of children with primary care visit		
o Ages 12-24 months in past year	95.0%	95.8
o Ages 25 months-6 years in past year	81.5	87.1
o Ages 7-11 years in past 2 years	85.8	88.9
o Ages 12-19 in past 2 years	85.7	88.0
- % of children by 15 months receiving 6 or more visits	62.4	61.7
- % of children ages 3-6 with one or more well child visits	61.0	67.1
- % of adolescents ages 12-21 receiving 1 well visit	38.3	45.5
- % of children up to date on recommended immunizations (combination 3) by 2 nd birthday	68.9	62.1
- % of adolescents up to date on recommended immunizations (combination 1) by 13 th birthday	65.3	64.9
- % of sexually active women ages 16-20 screened for Chlamydia	47.5	48.8
- % of female adolescents receiving 3 vaccine doses of HPV before age 13	NA	17.2
- % of children ages 3-17 whose weight was documented based on BMI percentile	55.2	41.7
- % of children ages 3-17 whose weight was documented based on BMI percentile	50.9	47.5
- % of children ages 1-20 with at least 1 preventive dental visit		

Pediatric Preventive Care Financial Incentives, 2016	CO	US
- Use of preventive care incentive for consumers	Yes	NA
- Use of preventive care incentive for providers	Yes	NA

**AIM Expanding Access to Care for Maternal and Child Health Populations
Learning Collaborative Cohort 2 - Colorado**

EPSDT Universal (U) and Selected (S) Screening Requirements, 2015	CO	Bright Futures
<i>Infancy (Prenatal-9 months)</i>		
- Length/height & weight	U	U
- Head circumference	U	U
- Weight for length	U	U
- Blood pressure	S	S
- Vision	S	S
- Hearing	U/S	U/S
- Developmental surveillance/screening	U	U
- Psychological/behavioral assessment	U	U
- Newborn blood screening	U	U
- Congenital heart screening	U	U
- Hematocrit or hemoglobin	S	S
- Lead screening	S	S
- Tuberculosis testing	S	S
- Oral health	U/S	U/S
<i>Early Childhood (Ages 1-4)</i>		
- Length/height & weight	U	U
- Head Circumference	S	S
- Weight for length	S	S
- Body mass index	S	S
- Blood pressure	S	S
- Vision	U/S	U/S
- Hearing	U/S	U/S
- Developmental surveillance/screening	U	U
- Autism screening	U	U
- Psychological/behavioral assessment	U	U
- Hematocrit or hemoglobin	U/S	U/S
- Lead screening	U/S	U/S
- Tuberculosis testing	S	S
- Dyslipidemia screening	S	S
- Oral health	U/S	U/S
- Fluoride varnish	U	U
<i>Middle Childhood (Ages 5-10)</i>		
- Length/height & weight	U	U
- Body mass index	U	U
- Blood pressure	U	U
- Vision	U/S	U/S
- Hearing	U/S	U/S
- Developmental surveillance	U	U
- Psychological/behavioral assessment	U	U
- Hematocrit or hemoglobin	S	S
- Lead screening	S	S
- Tuberculosis testing	S	S
- Dyslipidemia screening	U/S	U/S
- Oral health	U	U
- Fluoride varnish	U	U
<i>Adolescence (Ages 11-20)</i>		
- Length/height & weight	U	U
- Body mass index	U	U

Code:
 U= universal screening (all screened)
 S = selective screening (only those of higher risk screened)
 U/S = visits in that age group have universal and selective requirements.
See Bright Futures periodicity information for complete information.
 * = if not results for newborn screening on file, or did not pass, follow-up appropriate.
 + = if not done at 24 months
 ^ = for menstruating adolescents
 R = recommended for visit
 X = Risk assessment followed by appropriate action
 NS = not specified

**AIM Expanding Access to Care for Maternal and Child Health Populations
Learning Collaborative Cohort 2 - Colorado**

- Blood pressure	U	U
- Vision	U/S	U/S
- Hearing	U/S	U/S
- Developmental surveillance	U	U
- Psychological/behavioral assessment	U	U
- Alcohol & drug use assessment	S	S
- Depression screening	U	U
- Hematocrit or hemoglobin	S	S
- Tuberculosis testing	S	S
- Dyslipidemia screening	U/S	U/S
- Cervical dysplasia screening	U	U
- STI/HIV screening	U/S	U/S
- Oral health	-	-

EPSDT REFERENCES

Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Baltimore, MD: CMS, February 2014.

ⁱ Committee on Practice and Ambulatory Medicine. 2015 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2-15:136(3).

ⁱⁱ *FAQs about Affordable Care Act Implementation.* Washington, DC: US Department of Labor, Employee Benefits Security Administration, May 11, 2015.

ⁱⁱⁱ *ESPDT – A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents.* Baltimore, MD: Centers for Medicare and Medicaid Services, June 2014.

^{iv} *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits.* Baltimore, MD: Centers for Medicare and Medicaid Services, February 2014.

^v To obtain a copy of *ESPDT and Bright Futures in Colorado, Minnesota, Montana, North Dakota, South Dakota, Utah, and Wyoming*, please contact jgorlewski@aap.org.

^{vi} Quality information was obtained from *DHHS 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP*, February 2016.