American Academy of Pediatrics

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Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau

# Alliance for Innovation on Maternal and Child Health
# June Learning Collaborative
# State Reports
# June 2016

# MONTANA STATE REPORT

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

### 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, three pediatrician leaders and the executive director from the AAP Montana Chapter. 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 | • Access to pediatric specialists is challenging particularly in rural areas<br>• Transportation challenges increase access issues |
| Behavioral Health | • Extremely long wait times for psychiatric care<br>• Standard Applied Behavior Analysis (ABA) not available in most of the state<br>• Little communication between PCPs and mental health providers |
| High Deductible Insurance Plans | • Many families do not realize that they have enrolled in a high deductible plan<br>• Plans make it prohibitive for services like MRIs or referrals to specialists<br>• Some plans pay only $100 for well child visits requiring families to pay for immunizations at state health departments |
| Medicaid | • Difficult to obtain payment when children need care outside of Montana<br>• Does not pay for circumcision<br>• Consistent denials for therapies and durable medical equipment (DME)<br>• Often requires prior-authorization for drugs resulting in more administrative work<br>• Some pediatricians are limiting Medicaid patients due to low payments |
| **Maternal Care Challenges** | |
| Medicaid | • Many postpartum mothers lose Medicaid coverage after delivery<br>• Few psychiatric resources for postpartum mothers especially when they lose Medicaid coverage<br>• Anecdotal reports of increase in home births to avoid costs associated with a hospital birth |
| Private Insurance Coverage | • Delays in care due to enrollment issues when signing up for private insurance |

| **Opportunities** |
|---|
| • Recruit more pediatricians by declaring MT a rural state, attracting physicians through loan forgiveness<br>• Improve Medicaid payment rates and cover out-of-state referrals for specialty care<br>• Increase access through increased use of telemedicine |

## 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 87 complete responses were received from patients/families in Montana. The three most common issues reported for access, coverage and payment are listed below:

| | |
|---|---|
| **Access** | • The wait time to get an appointment is too long (41%)<br>• The recommended doctor or service is not available in my area (32%)<br>• My provider does not accept or no longer accepts my insurance plan (19%) |
| **Coverage** | • A recommended service is not covered by my insurance plan (44%)<br>• Recommended services were limited (31%)<br>• A recommended doctor / provider is out-of-network (24%) |
| **Payment** | • My child's health plan does not cover all the cost of care such as specific medications, therapy services, equipment, in-home services, etc (48%)<br>• Out of pocket (deductibles / co-pays) costs are too high (48%)<br>• I quit work or cut back on my hours to care for my child (28%) |

*% 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:

- Access: Limited access to pediatric providers due to small number of providers and geographic location
  - *"The closest pediatrician is 70 miles away."*
  - *"We need more providers of therapies so that we don't have to travel almost 2 hours one way to have access to therapies."*

- Behavioral Health: Poor access, poor coverage, little to no covered autism services, not enough providers, long wait time for appointments
  - *"There was a several month delay to receive care because mental health care wasn't available, during which his symptoms worsened."*
  - *"The cost of seeing psychiatrist is so high that we often have to put off going for several weeks. The number of recommended Counseling sessions also has to be reduced due to cost."*
  - *"Because behavioral therapy services are not covered in the state of MT, there is only one provider in my area. She is extremely busy. We are able to see her only once or twice a month. Plus, we are limited financially because we have to pay for her services out of pocket."*
  - *"There are currently only four acute care psychiatric beds available in the state for children under age 10, and we had to travel 5 hours round trip for routine psychiatric care."*

  - *"The cost of seeing psychiatrist is so high that we often have to put off going for several weeks. The number of recommended counseling sessions also has to be reduced due to cost."*
  - *"We are limited financially for behavioral appointments because we have to pay for her services out of pocket."*

- Lack of Specialists: Many do not accept public plans, very long wait time for appointments, high co-pays, some not accepting new patients
  - *"No doctors in this area that know much about autism, no one to diagnose autism, few therapists that are qualified to work with autistic kids, schools have very little training for working with autistic kids and not enough aides to support the kids."*
  - *"The closest provider for neurology, braces, MRI and special needs ID/DD testing is over 1-2 hours away."*

- Inadequate Coverage: Necessary services not covered or under-covered including DME, prescriptions and habilitative services
  - *"The process for getting medical equipment approved for a child with major documented physical disabilities needs to be streamlined. My son has private insurance, Medicaid, and a waiver and still can't get his supplies."*

- Travel Coverage: Many pediatric specialists and therapists are far from patients or located in another state
  - *"It would be nice to be able to go to South Dakota which is closer than Montana towns that have good docs."*
  - *"It would be very helpful to receive travel funds for out of state care."*

- Coordination of Care: Little to no coordination of care for complex cases, benefits unclear, access to families in similar situations for resources and support
  - *"If there are other resources that could help my child get care, it would be nice if someone could tell me about them. If there were a list of them on the internet or if private insurance was required to pay for services that Medicaid covered."*
  - *"Care managers would be helpful."*

- Cost: Unaffordable co-pays, do not qualify for assistance but cannot afford premiums and co-pays, high premiums (especially for private payers)
  - *"We didn't proceed with the recommended care. It was for informational purposes and since we were unable to afford it we chose to wait."*
  - *"We had to discontinue services due to loss of secondary insurance. Primary insurance does not cover."*
  - *"I see clearly how a working family with insurance goes BANKRUPT. Disgusted."*
  - *"We need lower affordable deductibles and more providers in network."*

**Conclusion:**
Parents in Montana 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 lack of access, 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.

## FAMILY STORIES

### Family Story #1

**Ella's story illustrates the complexity of identifying and getting affordable needed services in a timely way in a large state with few specialists.**

Ella is the mother of a six year old son Daniel who has autism and ADHD. Ella noticed some "strange behaviors" when Daniel was two—he was obsessed with the toothbrush, and very rigid and resistant. He was also late in speaking, but Ella attributed this to just being a boy, a notion reinforced by her pediatrician who noted that boys tend to speak later than girls. At his two-year well visit, she was given an autism assessment form to complete in the waiting room, but it just felt "procedural" and it didn't pick up on any of Daniel's symptoms as being on the autism spectrum. At age 4, Daniel's pediatrician said his behaviors sounded like OCD, and suggested distracting him as best they could. At age 5, Daniel was toe-walking and hand-flapping, and at this point the pediatrician said it was likely autism. To this point, Daniel had not had a full autism assessment. Ella felt her concerns were brushed off. Daniel didn't meet the classic autism criteria and his behaviors were just "quirky."

The pediatrician referred Daniel to a child psychologist—with a long waiting list. While they waited, Ella's husband contacted another local psychologist and was able to get an appointment in two weeks. She diagnosed Daniel with level 2 (moderate) autism, and Ella was relieved to finally have a diagnosis. When Daniel's turn came up for the first psychologist, the diagnosis was confirmed, and ADHD was also identified as an issue.

Because Daniel was five by the time he got the diagnosis, he had aged out of some of the services he might have qualified for when he was under three. He was put on a waiting list for Applied Behavior Analysis (ABA), and for a family support specialist who would act as a liaison between the family and services.

Ella turned to a local organization for help in sorting out support possibilities for Daniel, and received helpful tips. She had to ask for insurance approval, and thanks to the Montana Autism law, insurance has to cover unlimited therapy sessions for children with an autism diagnosis. However, while these sessions are covered, copay increases are allowed—thus keeping the burden on the family.

Occupational and speech therapies were recommended by the psychologist, and these services would be covered by Ella's private insurance, with them responsible for just the copay. Needed therapists were only in the bigger cities, necessitating time and travel.

At first, the copay was manageable, but Ella received a letter from the insurance company saying the copays for specialists would go up. Speech therapy alone would cost Ella $4,000 for copays, and she could not afford both occupational (OT) and speech (ST) therapies. Because speech issues seemed more significant, she chose speech.

Ella never applied for the Children's Autism Waiver for Daniel, because it cuts out for children over three. He qualified for Healthy Montana Kids (HMK), the state CHIP program, so she took him off of his parents' insurance and onto HMK. Copays dropped to a very reasonable $3 a visit, but because her three other children were still on the private insurance, it meant different doctors, and well child visits became a hassle.

Ella could now afford both ST and OT, but Daniel was on the waiting list for OT for nine months. Daniel also needed sensory issues therapy to help him self-regulate, but this therapy was denied by the insurance company. The HMK insurance company said they would cover OT, but not "experimental" sensory therapy, and Daniel's

occupational therapist would only do OT if he was also getting sensory therapy. The community liaison for the place that evaluated Daniel for OT offered Ella a deal—an hour appointment could include 15 minutes of sensory therapy that they would have to self-pay $35 for. Ella can't afford this, so Daniel currently has no OT—there are no other occupational therapists in HMK. He has been assessed for OT, but has never had a proper session.

As determined parents of children with special health care needs often do, Ella read books about her son's conditions and does what she can. She applied for Social Security disability, but was told the family doesn't qualify because they have too many assets—ignoring the fact that this is a family with four children (and another on the way). If they got rid of some of their assets they could qualify.

Ella's story and struggles to get Daniel timely, needed services illustrate key issues for the state of health care in Montana:

- **Lack of thorough and timely developmental assessments:** Children with autism benefit from early, more thorough diagnoses and services before they turn three. For children like Daniel who are not diagnosed till later on, the services disappear—but not the need for them. Programs like the Centers for Disease Control and Prevention's Learn the Signs, Act Early have very little impact in Montana.
- **Limited insurance options:** Insurance companies won't pay for some therapies, despite recommendations from doctors and psychologists. Despite the Autism law that guarantees unlimited therapies (of some kinds), copays can make this prohibitive.
- **Unrealistic eligibility definitions for income-based services:** "Assets" alone do not tell the financial status of a family.
- **Lack of support for providers:** The referral system in Montana is flawed, and further complicated by the small number of available therapists and specialists. In order to maintain their licenses to practice, providers need to see many children in a year, relying on referrals from colleagues—who are still making referrals to out-of-state clinics. This is difficult in a large, rural state, so providers leave the state in frustration for bigger cities and children's hospitals.
- **No mechanism for parent complaints:** Parents have nowhere to complain about problems they are having. There is no mechanism on the state level to listen to families and make needed changes. Families don't have a voice in decision-making for policies that might affect them.

Children like Daniel fall through the cracks trying to get the support and services they need.

*Names changed to protect confidentiality

## Family Story #2

**Christina's story is one of determination to ensure adequate health care for her daughter despite huge medical bills and other obstacles**.

Christina, her husband, and daughter Kennedy are a middle class family. Her husband is self-employed as of November 2014, and Christina stays home with her daughter. Kennedy, 14 years old, has Down's syndrome and other medical issues. They self-pay for insurance through Blue Cross Blue Shield (BCBS) of Montana, and opted for the best coverage they could get because of Kennedy's health issues. Their monthly premiums for the three of them run $1,100 a year with no deductibles, and $6,500 per person maximum out-of-pocket limit, so just to cover the insurance premiums for a year, they pay over $13,000.

Last year, Kennedy experienced a catastrophic emergency that required her being air-lifted to Seattle in order to get the care she needed. Prior to this emergency, she was misdiagnosed with migraines, in and out of the hospital for the next 2 months, and treated with medications whose side effects were awful. The misdiagnosis and wrong medications led to the life-threatening emergency that required the air-lift. Christina had suspected all along that Kennedy was having seizures, and kept telling the doctors that. Finally, her doctor suggested an extended (72 hour) EEG—something that is unavailable in Montana, so that required a multi-day car trip to Seattle—and travel costs that would not count as "out of pocket" expenses. That EEG confirmed what Christina had suspected all along—seizures. With the right diagnosis and appropriate medication, Kennedy has been seizure-free for a year.

Catastrophic health emergencies can also mean catastrophic financial emergencies that quickly show the limitations of even the "best" insurance options. Kennedy easily met her $6,500 out-of-pocket expenses last year, and that plus prescriptions, travel, and her parents' expenses ended up totaling over $30,000.

"Who has that kind of money?" Christina asked. And only because of her determination, that year's medical bills could have totaled more than $90,000. The bill for the air lift to Seattle from Summit Air was $85,363.64—and was waiting for them when they returned home. Her insurance would not pay for it because they don't pay claims for companies they don't have a contract with. At this time NO Montana insurance companies have a contract with Summit, and there are no other air lift options.

Christina—after hours on the phone—convinced BCBS to pay for some of that bill--$12,000, leaving her with a $73,000 bill. She tried to get Summit to come down, or BCBS to pay more, and was able to get BCBS to call this an "in network" bill and they agreed to pay an additional $9,000. Christina called the state Insurance Commissioner, but there was nothing he could do. He said that air ambulances are unregulated and so can bill as they choose—often different amounts for different families.

Christina finally took her case to Senator John Tester, who offered to see what he could do. After a letter to Summit from the Senator, the bill went away. Christina knows that the chances of her daughter needing these kinds of medical services—and another air lift—are great, given her medical issues, and given the lack of pediatric specialists in Montana.

Since this incident, Summit has been bought out by another company that is offering insurance to families who might need transport--$150 for three years will cover an entire family for air-lift fees. Too many families don't know about the insurance, or assume that their health insurance will cover these expenses. And faced with a life-or-death decision about getting a child to the help he or she needs, families will do what they have to.

There are talks going on in the legislature to find solutions to this problem. Either the services need to be covered by health insurance, or it needs to be made clear to families that it is not covered.

Another issue for Christina's family is that they make "just enough money to not get any extra help." Kennedy does not qualify for Social Security Disability benefits, Medicaid, etc., because her parents make $2,000 over the limit. "If we didn't work, we could get it all for free."

When Kennedy is 18, she will qualify for waiver benefits, but the waiting list is over 10 years! Because the state merged disability benefits with senior benefits, the wait is excessively long. Paperwork has to be processed and going several years, or benefits will not be available when needed.

Christina's story illustrates key issues for the state of health care in Montana:

- **Lack of providers:** Montana is a large state with a relatively low population. Families have to travel to neighboring states in order to get the specialized care their children with special health care needs must have.
- **Insurance premiums** are too high for most families.
- **"Out of pocket expense" limits** do not include other realities of getting needed health care, such as transportation and other travel expenses that add up quickly when interstate travel is a necessity.
- **The waiver system has incredibly long waiting lists.**

These issues have "thousands of families in tears. Families are losing homes, and it makes us want to leave Montana. We are nowhere near a pediatric hospital, and have to travel out of state for care. Who can afford that? On top of the medical bills are all the regular household bills. For families like us who are stuck in the middle—we make too much. We're going broke."

*Names changed to protect confidentiality

## AIM Expanding Access to Care for Maternal and Child Health Populations
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### EPSDT AND BRIGHT FUTURES – MONTANA 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 21[i] 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 Montana 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.

Montana's profile compares the state's EPSDT Program with the Bright Futures periodicity schedule and screening recommendations. The state profile also contains information about Montana'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

- Montana's EPSDT program has adopted the AAP's Bright Futures periodicity schedule and screening recommendations. Their member guide is being updated to incorporate a new schedule for well visits that is aligned with Bright Futures.
- Montana encourages its pediatric providers to use Bright Futures' preventive visit tools for infancy, early childhood, middle childhood, and adolescent visits.
- The state's medical necessity definition for EPSDT addresses coverage for preventive purposes, but does not specifically refer to mental health conditions or to Bright Futures as its professional standard for pediatric care.
    - Medically necessary service means a service or item reimbursable under the Montana Medicaid program, as provided in these rules: a) which is reasonably calculated to prevent, diagnosis, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: i) endanger life; ii) cause suffering or pain; iii) result in illness or infirmity; iv) threaten to cause or aggravate a handicap; or v) cause physical deformity or malfunction. b) A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all. c) Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana Medicaid program. Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the US Department of Health and Human Services, including the Medicare program, or the department's designated review organization or procedures and items approved by the US Department of Health and Human Services for use only in controlled studies to determine the effectiveness of such services.

- According to CMS, in 2014, Montana selected 8 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, adolescent immunization status, HPV vaccination for female adolescents, and preventive dental visits.
- According to a report from the federal Department of Health and Human Services (DHHS), Montana's quality performance rates were lower than the national average.[vi] See examples below.
- No child health performance improvement projects were identified.
- Montana is developing culturally appropriate strategies to educate health care professionals and Native American families to improve maternal and child health outcomes. The "Coming of the Blessing" is a March of Dimes initiative that includes prenatal education, training, and resources that incorporate transitional beliefs and lessons learned from their ancestors and their partners in the circle of support during pregnancy. The Medicine Wheel is used to guide the family through the cycle of childbearing – from the first trimester where the "blessing has been planted," (colored in yellow for the east and each new day), to the second trimester whether the mother "feels the blessing dance" (colored in blue for the west), to the third trimester where the "blessing is fulfilled" (colored in white for the north). The state is also implementing public health education and treatment strategies for drug-addicted pregnant women.

**Opportunities to Consider**

1. Ensure that all of the state's communications to providers and consumers consistently reference the pediatric preventive care schedule and recommendations aligned with Bright Futures.
2. Consider lessons learned from other rural states that rely on primary care case management programs and fee-for-service arrangements in selected pediatric preventive care quality measures and implementing related performance improvement strategies.
3. Consider reviewing the state's medical necessity definition for EPSDT in terms of reference to Bright Futures as its pediatric preventive care standard.
4. Consider strategies for increasing use of child and adolescent primary care visits, including financial incentives. In addition, examine options for increase adolescent preventive care visits aligned with CMS' recommendations and addressing transitions of care and coverage when youth are no longer eligible for EPSDT.

## AIM Expanding Access to Care for Maternal and Child Health Populations
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### EPSDT RECOMMENDATIONS AND SELECTED PEDIATRIC QUALITY PERFORMANCE MEASURES

| EPSDT Periodicity Schedule, 2016 (# of well child visits) | MT | 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 | MT | US |
|---|---|---|
| - % of children with primary care visit | | |
| ○ Ages 12-24 months in past year | 87.8% | 95.8 |
| ○ Ages 25 months-6 years in past year | 71.5 | 87.1 |
| ○ Ages 7-11 years in past 2 years | 74.9 | 88.9 |
| ○ Ages 12-19 in past 2 years | 76.2 | 88.0 |
| - % of children by 15 months receiving 6 or more visits | 41.8 | 61.7 |
| - % of children ages 3-6 with one or more well child visits | 43.0 | 67.1 |
| - % of adolescents ages 12-21 receiving 1 well visit | 28.4 | 45.5 |
| - % of children up to date on recommended immunizations (combination 3) by 2nd birthday | 27.3 | 62.1 |
| - % of adolescents up to date on recommended immunizations (combination 1) by 13th birthday | 30.7 | 64.9 |
| - % of sexually active women ages 16-20 screened for Chlamydia | NA | 48.8 |
| - % of female adolescents receiving 3 vaccine doses of HPV before age 13 | 7.0 | 17.2 |
| - % of children ages 3-17 whose weight was documented based on BMI percentile | NA | 41.7 |
| - % of children ages 1-20 with at least 1 preventive dental visit | 42.9 | 47.5 |

| Pediatric Preventive Care Financial Incentives, 2016 | MT | US |
|---|---|---|
| - Use of preventive incentive for consumers | No | NA |
| - Use of performance incentives for providers | No | NA |

## AIM Expanding Access to Care for Maternal and Child Health Populations
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| EPSDT Universal (U) and Selected (S)Screening Requirements, 2015 | MT | Bright Futures |
|---|---|---|
| ***Infancy (Prenatal-9 months)*** | | |
| - 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 |
| ***Early Childhood (Ages 1-4)*** | | |
| - 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 |
| ***Middle Childhood (Ages 5-10)*** | | |
| - 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 |
| ***Adolescence (Ages 11-20)*** | | |
| - Length/height & weight | 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

| | | |
|---|---|---|
| - 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 |
| - 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 *EPSDT 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 2*016.