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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
Learning Collaborative on Improving Quality and Access to
Care in Maternal and Child Health
Cooperative Agreement UC4MC28034
June 2016**

MINNESOTA STATE REPORT

AIM Expanding Access to Care for Maternal and Child Health Populations Learning Collaborative Cohort 2 – Minnesota

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 several physician leaders of the AAP Minnesota 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	
Behavioral Health	<ul style="list-style-type: none"> • Narrow networks • Few clinicians in many (especially rural) areas • Some patients avoid treatment due to high out-of-pocket costs
Bright Futures	<ul style="list-style-type: none"> • Payment for developmental screening (including vision/hearing) is problematic • Families are refusing care if they are being billed for a service
Coordination of Care	<ul style="list-style-type: none"> • Competing children’s hospitals resulting in fragmentation and duplication of services • Little focus on collaboration between pediatric providers and hospitals
Delays in Treatment (Cost)	<ul style="list-style-type: none"> • Patients avoid seeing specialists and decline needed testing • Frequently do not fill prescriptions for recommended medications to treat chronic conditions • Patients that should go to the ED present in primary care offices to avoid a co-pay
Culturally Effective Care	<ul style="list-style-type: none"> • Need for increased translation and appropriate language services • Access to transportation services for those without vehicles • Lack of focus on culturally effective care (translators, etc)
Maternal Care Challenges	
Medicaid	<ul style="list-style-type: none"> • Limited number of OB/GYN practices that accept Medicaid • Lack of access to mental health providers that accept Medicaid • Shortened post-partum hospital stays

Pediatric Care Successes	
Insurance Coverage	<ul style="list-style-type: none"> • High Medicaid coverage rates for eligible children due to 12 months of continuous eligibility

Opportunities	
<ul style="list-style-type: none"> • Increase access to mental health services for children and pregnant women • Improve collaboration between competing children’s hospitals • Improve transportation services, culturally effective care and language resources 	

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

Access	<ul style="list-style-type: none"> • None – no access issues (50%) • The wait time to get an appointment is too long (38%) • The recommended doctor or service is not available in my area (31%)
Coverage	<ul style="list-style-type: none"> • A recommended service is not covered by my insurance plan (43%) • Recommended services were limited (43%) • My insurance takes a long time to tell me whether I'm covered for specific things (21%)
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 (44%) • I or another family member work extra hours to pay for care or related healthcare costs (38%)

*% 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
 - *"Need more services for autism in rural areas, especially ABA."*
 - *"More local providers in pediatric mental health would be helpful."*
- Inadequate Coverage: Necessary services, supplies and therapies not covered or under-covered, inadequate number of in-network physicians
 - *"Need greater insurance coverage for lab tests."*
 - *"Outside referrals to other capable doctors who are not necessarily within my health care network would be helpful."*
- Coordination of Care: Little to no coordination of care for complex cases, benefits unclear, access to family networks
 - *"Need a case manager that follows-up!"*
 - *"Care coordination is all on me, and I'm not a trained medical professional."*
 - *"Need to know who to call to get an answer."*

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- Support Networks: Access to other families in similar situations for information and support
 - *“Finding other families to network with is very valuable. Besides the personal support, other families with children with special health needs can often point you in the right direction to getting the needs of your child met.”*
 - *“Identifying other parents with similar challenges is helpful. In this way, both families can support each other through their struggles.”*

Conclusion:

Parents in Minnesota 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 to improve health care to maternal and child health populations in the state.

FAMILY STORIES

Family Story #1

Living with complex medical needs in rural MN

Jessica's son, Isaac, is 4 years old, energetic, and a happy boy who loves to play with his dad. The family lives in a small rural town of MN with a population of less than 200 people. The closest shopping area is about 30 miles away.

Isaac was born 17 weeks premature, has Cerebral Palsy, epilepsy and an optic nerve disorder. Isaac has been covered from day one by private insurance through his parents' work in addition to having qualified for medical assistance. He qualified for medical assistance automatically because of his low birth weight. Isaac has TEFRA, a Medicaid waiver program that allowed Isaac to qualify for assistance without taking into consideration his parents' income, however there is a parental fee based on the parent's income for participating in this Medicaid Waiver program. His story exemplifies the difficulties of living in a rural area and having to travel significant distances on a regular basis to access specialists. Additionally, his story illustrates the added difficulty of finding adequate care for a child with complex medical needs, and the repercussions that this has for the family's work arrangements and opportunities for respite.

When Isaac came home from the hospital, he started receiving early intervention right away. Jessica welcomed a team of therapists regularly into her home, and they were always eager to include her and Isaac's dad on his care plan, teaching them how to work with their son at home. Both parents felt like a part of Isaac's team, and developed wonderful relationships with his therapists. He saw occupational, physical and speech therapists on a regular basis throughout his first four years. Through early intervention Isaac received the assistance of a birth to 3 teacher, physical/occupational/speech therapists, and a vision specialist. In addition, he was taken to nearby hospital for weekly therapy services including physical, occupational, and speech therapy.

This year was one of transition for the family and for Isaac. After much worrying about how the change would affect their smooth routine, Isaac started going to preschool 3 mornings per week. Jessica was very happy to see that he was thriving and making friends. All of Isaac's therapies are now taking place at school, a definite change from having all providers come to work with Isaac at home. (He continues to attend PT, OT, and ST on an outpatient basis as well. He is taking a break from therapy over the summer, his first one since he started in January 2013.) He receives, PT, OT, speech, vision therapy, adaptive technology and has a mobility specialist while he is in school. Jessica worried initially that the communication with Isaac's team would not be as smooth as it was when he received services at home, but the team has been very open to Jessica's ideas and input.

The rural nature of the school and the town, however, do impact the nature of the therapies that Isaac receives. Jessica reports that while the team has great intentions, they are not as familiar with a child with complex medical needs, and thus don't have knowledge of the latest CP specific interventions. Jessica often does research and brings the knowledge to the team. It was also recommended by his specialists that Isaac attends vision therapy and participates in hippotherapy and aquatic therapy. There is no local resource for vision therapy, and the two providers in the metro area do not accept Medical Assistance. There is no local availability of hippotherapy (with a therapist present) but Isaac does participate in a therapeutic riding program and rides a horse with his mom at home as well. The facility where Isaac has been receiving his physical therapy, unfortunately does not have adequate access for aquatic therapy. Insurance will not cover this at another facility

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with an additional physical therapist because it is considered dual enrollment. To participate in aquatherapy as recommended by his specialists, Isaac would have to transfer care and leave the facility he has been attending for the past 4 years.

Aside from his regular therapies, Isaac sees specialists on average once a month. The family needs to make arrangements to travel for three hours each way, which takes a toll on Isaac as he is very tired by the time they arrive to see the specialist. Because it is an all-day affair, Jessica needs to make arrangements at work on the days of the appointments. Because she works part time, Jessica is able to schedule these appointments on the days that she doesn't work. Specialists are notoriously absent from rural areas, and most families end up traveling 3, 4 and 5 hours one way to see one. On the plus side, Medical Assistance provides mileage reimbursement to and from medical appointments with appropriate documentation and prior authorization.

Living in a rural area has also presented challenges to how much Jessica is able to work outside the home. Isaac requires round the clock care, but Jessica hasn't always worked part time to provide this care. She used to work full time as a nurse, but ever since they were unable to find qualified care providers for Isaac, Jessica and her husband had to make the difficult decision to cut back on Jessica's hours so she could care for their son. The family faces the same issue when finding respite care providers. Jessica and her husband, as any parent of a child with complex health care needs live from day-to-day thinking about Isaac's needs. They rarely have the chance to go out by themselves, or to do anything unrelated to Isaac. Up to this point, they consider themselves lucky to have a family member that can look after Isaac once a week while Jessica works. But there isn't a lot of support for families who need a break. There isn't "a big bench of caregivers", leaving parents exhausted with no place to turn to for a break.

Isaac has been lucky to have access to several other waivers that MN has to offer. While the waiting lists can be long, and sometimes children age out before they have the chance to make it off the waiting list, it took Isaac "only" 2 years to get on the waiver that provides additional services Isaac needs. While he was on the waiting list for the CADI waiver, they were able to use a Community Support Grant which was helpful but did have a significantly smaller budget to work with. The lack of appropriate funding for the waivers make Isaac a shining exception. Additionally, Jessica reports that many of the benefits that their family receives such as funding for respite care, are unknown to most of the population. Jessica expressed concern that families who are in dire need are the last ones to find out about supports that might be available, and that the process to follow is so cumbersome, that families are too exhausted to even apply.

Isaac's family's story is one that highlights some of rural MN's most salient concerns as far as access to healthcare for children with complex needs is concerned:

Lack of availability of specialists in rural areas: Families have to travel many miles to access the necessary specialists, requiring all-day round trip travel for the family impacting work and school schedules. They face transportation challenges, travel expenses and isolation.

Lack of availability of qualified care provider personnel: Parents often have to make the difficult decision to quit work in order to care for their children full time, leaving the family in a financial bind. Many families end up facing bankruptcy.

Lack of appropriate funding for waivers: because the funding is allocated on a triage basis, many children who have significant healthcare needs are never even considered before they age out of the waiver.

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Lack of information dissemination regarding waivers: Many families do not know that there are waivers that could potentially cover additional services not typically covered by Medicaid including respite care. Most parents find out this information from Family Voices or via family networks.

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Family Story #2

Hmong Families in Minnesota: A Nuanced Story of Access to Behavioral Care and Long Term Health Care Coordination

Jim is the Father of two children, Ty, 9, and Thee, 7. Jim was born in the United States to Hmong parents. He is part of Generation 1.5, a term that evolved to refer to the first generation of Hmong children born in the US. The average age of this generation is in the 20's, and Jim is one of the oldest at 35. Jim explained that there is a myth that most Hmong were born outside of the US, and the reality is that the majority of the current Hmong population in the US were actually born and raised in the US. This myth or assumption carries with it its consequences when Jim and the Hmong families in general access healthcare. His story will illustrate ways in which these cultural perceptions affect the way in which his family experiences the care that they receive.

When Ty was born, Jim and his wife did not have any concerns. Ty seemed to enjoy “being in his own world”, and Jim did not think that there was a concern as this was their first child. It was not until Ty started preschool at 4 years old, that his teachers brought up behavioral concerns. He was not transitioning well or self-regulating, and routines were difficult. While the teacher's concerns were difficult to accept at first, Jim and his wife decided to move forward to have Ty assessed.

Jim and his wife brought up the concerns to the pediatrician, who in turn referred them to a specialist. Finding a specialist proved very difficult as they often have long waiting lists. By the time Ty was 5 going on 6, he saw a child psychiatrist for a series of assessments that would take 6 months. She gave Ty cognitive and behavioral diagnoses, but noted no physical delays, under the label of ADHD. Jim and his wife used this diagnosis to seek school services.

When asked about it now, Jim says that pediatricians don't seem to notice behavioral concerns, so children like Ty tend to miss the early intervention window. While Ty's pediatrician was on board when providing a referral to a specialist for a full assessment, Jim felt that he was not proactive enough. Jim feels that many doctors focus on physical symptoms only and don't screen for possible behavioral issues early enough.

One of the main problems that Jim is facing with Ty is that he does not qualify for behavioral interventions because he “only” has an ADHD diagnosis. Jim says that Ty is in dire need of a behavioral therapist that can provide covered services “to help him deal with all the emotions that he is having.” However, while the family had private insurance, the coverage was expensive, and since his ADHD diagnosis does not qualify him for behavioral therapy, the only option was to pay out of pocket, which was prohibitive. Once Jim went back to school full time, the family qualified for medical assistance, but Ty's therapy still did not qualify for coverage. The lack of coverage for behavioral therapy is a prevailing challenge for many families like Ty's.

Thee is Ty's younger brother. In contrast to Ty, Thee can access behavioral therapists because he has a diagnosis of autism. Having had experience with Ty, Jim and his wife noticed delays in Thee much sooner. They had him evaluated by age 18 months after facing several waiting lists to see a neurologist and a child psychiatrist. The longest waiting list was 3 months. After getting his autism diagnosis at 4, Thee has been able to receive many more needed therapies than his brother Ty. Nevertheless, Jim feels that it took very long to get the actual autism diagnosis.

Jim and his wife had to do most of the care coordination for both children as care coordination is not consistently available in pediatric clinics in Minnesota, and the level of care coordination varies from clinic to

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clinic. Jim noted that as of now, there are few behavioral health home services available in Minnesota, although a couple of pediatric clinics are working to incorporate this component into their clinics. This means that families are left to do the behavioral care coordination by themselves, a task that feels overwhelming. Jim says that the ideal would be for a coordinator to bring everything together, rather than leaving the family to connect what the speech pathologist says to what the OT recommends, and try to make it come together with what the child psychiatrist may find. Jim feels that the behavioral care piece is being treated in a reactionary manner, rather than proactively.

Similarly, the burden feels even heavier because Jim feels that there is no mechanism to help them plan and cope with effects of the long term care that their children, and especially Thee will require. There's no continuity in providers, and they feel left out of the decisions made by therapists. They feel that several of their children's therapists don't see them as partners in the care of Thee and Ty, making the idea of long term care a solitary one.

Jim's family also faces the erroneous perception about Hmong families when accessing care. Jim says that "before we set foot in a clinic, we are not seen as capable, active participants making any kind of change that needs to happen. We get treated like children ourselves. This barrier happens before we even set foot in the clinic. Barriers are internalized so we keep the barriers alive. This was a specific barrier with the pediatrician. We didn't speak up because we felt like we would be seen as oppositional, it's internalized that she is the professional, she knows best, and questioning authority is dangerous."

Jim feels that if providers don't have a good cultural understanding of the barriers that the Hmong face, they seem like they don't care. "Equity doesn't get exercised until both providers and families exercise it together." Hmong families need to work on the tradition that makes it feel dangerous to question authority, and providers need to work on being respectful of the Hmong culture and treating everyone as an equal partner in the care of their children. Cultural reciprocity training would be a very important aspect when trying to achieve equity.

Jim also expressed that when given the choice, he would choose to go to a Hmong provider because "they have the capability of reaching another level of understanding that others can't, like, 'I know you know me, sort of thing.'" He feels like the conversations that need to happen with providers to reach equity in the interaction are not always comfortable, so someone who has experience in the community is far more likely to have a better understanding of certain worries that are probably very culturally bound. For example, Jim and his wife worry about long term care, and they feel that their idea of long term care is different from that of non-Hmong people. A Hmong provider would be able to provide more culturally appropriate care in this respect.

The story of Jim's family exemplifies several challenges that many families in MN face:

Private Medical Insurance is Very Expensive: Before Jim became a full time student, he had to pay very high insurance fees for coverage. Luckily, he was able to transition into full time student status, and his family was able to access Medicaid coverage.

Lack of Pediatric Care Coordination: Care coordination services are not consistently offered or available for children with special health care needs or those who are at risk.

Behavioral Care is Seen as an Afterthought: Jim and his family have had to take on all the behavioral care coordination for their sons. They are hoping that the Behavioral Care Home pilots that are currently underway in MN will be expanded.

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Poor Cultural Understanding of the Hmong Population: Jim's family feels discounted by providers. They feel like they are not being treated as partners, and that affects the care that their children are receiving. Jim feels like the Hmong are treated like children before they even set foot in a provider's office. Cultural reciprocity training would be an important first step to equalize interactions.

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EPSDT AND BRIGHT FUTURES – MINNESOTA 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 Minnesota 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.

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

- Minnesota's EPSDT periodicity schedule calls for fewer visits (20) compared to Bright Futures (31) beginning prenatally and continuing through age 20. Their EPSDT schedule states that this is a minimum standard and more visits or screening should be done and billed for as medically necessary.
- EPSDT screening recommendations are similar to Bright Futures. During the infancy and early childhood periods, Minnesota recommends an additional service – maternal depression screening. Certain other requirements in Bright Futures were not specified, and a few others differed in terms of whether the specific screen was recommended or required.
- Minnesota's EPSDT medical necessity definition addresses coverage for preventive purposes and mentions physical and mental conditions consistent with prevailing standards without reference to Bright Futures.
 - Medical necessity definition: Medically necessary or medical necessity means a health service that is consistent with the recipient's diagnosis or condition and A) is recognized as the prevailing standard or current practice by the provider's peer group' and B) is rendered in response to a life-threatening condition or pain; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or C) is a preventive health service under part 9505.0355.
- According to CMS, in 2014, Minnesota selected 5 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, overweight counseling and preventive dental visits.
- According to a report from the federal Department of Health and Human Services (DHHS), Minnesota's quality performance rate on child and adolescent access to PCPs and overweight counseling was higher than the national average. Performance rates for well visits for infants and young children and for preventive dental visits was lower than the national average.^{vi} See examples below.

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- Minnesota’s managed care plans are implementing a broad set of maternal and child health performance improvement projects, combining financial incentives for consumers to complete recommended services and pay-for-performance incentives to encourage specific pediatric preventive care improvements.
- The Integrated Health Partnership (IHP) program was designed as an accountable care model for Medicaid recipients in managed care and fee-for-service arrangements. The care delivery model is intended to integrate physical health care with mental health and chemical dependency services, safety net providers, social service agencies, counties, and public health resources. The program works to meaningfully engage patients and families as partners in the care they receive as well as in quality improvement activities and leadership roles. It also intends to support providers who serve the most vulnerable members by considering family risk factors in their payment methodologies. Guiding the current and future design of this program are the results from a multi-year study of family risk factors among Minnesota publicly insured children.^{vii} The family risk factors that were examined include 1) income and other tangible resources (<100% FPL, resident in high poverty census tract, parent/family homeless in last 5 years, family lacks vehicle worth at least \$2,500); 2) family structure risk factors (parent unmarried, 4 or more children in household, child is medically complex, parent is disabled or has high health care utilization); 3) language and immigration (parent non-English speaking most of time, child immigrated to US, parent immigrated to US); 4) child maltreatment or diminished parental functioning (parent with chemical dependency diagnosis in last 18 months, parent with serious mental illness in last 18 months, child received child protection services in last 5 years). Through the Integrated Health Partnership program, the state Medicaid agency and its EPSDT program seeks to strengthen the healthy development of its youngest generation by more effectively integrating services and working with Minnesota’s most vulnerable children and families.

Opportunities to Consider

1. Consider updating the state’s EPSDT schedule to align with Bright Futures.
2. Ensure that EPSDT’s preventive care periodicity schedule and screening recommendations are described consistently in the state’s website, provider manual and bulletins, and consumer materials. Encourage links to the AAP Bright Futures Guidelines website whenever possible for the most current information.
3. Share lessons learned from Minnesota’s innovative quality improvement projects for pediatric preventive care.
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 strategies for increasing preventive dental visits.
5. Consider re-examining the state’s medical necessity standard for EPSDT in terms of referencing Bright Futures.

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EPSDT RECOMMENDATIONS AND SELECTED PEDIATRIC QUALITY PERFORMANCE MEASURES

EPSDT Periodicity Schedule, 2016 (# of well child visits)	MN	Bright Futures
- Prenatal period	0	1
- Birth through 9 months	5	7
- 1 through 4 years	6	7
- 5-10 years	4	6
- 11 through 14 years	2	4
- 15 through 20 years	3	6

Pediatric Preventive Care Quality Measures and Performance, 2014	MN	US
- % of children with primary care visit		
o Ages 12-24 months in past year	96.3%	95.8
o Ages 25 months-6 years in past year	89.0	87.1
o Ages 7-11 years in past 2 years	91.4	88.9
o Ages 12-19 in past 2 years	91.2	88.0
- % of children by 15 months receiving 6 or more visits	57.5	61.7
- % of children ages 3-6 with one or more well child visits	60.6	67.1
- % of adolescents ages 12-21 receiving 1 well visit	NA	45.5
- % of children up to date on recommended immunizations (combination 3) by 2 nd birthday	NA	62.1
- % of adolescents up to date on recommended immunizations (combination 1) by 13 th birthday	NA	64.9
- % of sexually active women ages 16-20 screened for Chlamydia		
- % of female adolescents receiving 3 vaccine doses of HPV before age 13	NA	48.8
- % of children ages 3-17 whose weight was documented based on BMI percentile	NA	17.2
- % of children ages 1-20 with at least 1 preventive dental visit	85.0	41.7
	38.0	47.5

Pediatric Preventive Care Financial Incentives, 2016	MN	US
- Use of MCO preventive incentive for consumers	Yes	NA
- Use of MCO/HEDIS performance incentives	Yes	NA

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

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

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* (Feb. 2016).

^{vii} Nelson J, Schiff J. *How Prevalent are Family Risk Factors among Minnesota Children Who Receive Medical Assistance or MinnesotaCare?* St. Paul, MN: Minnesota Department of Human Services, April 2015.