American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

WYOMING STATE REPORT

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

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 physician leaders of the AAP Wyoming 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	• Shortage of primary care, medical/surgical specialty pediatricians throughout the state • Only one pediatric specialist • Most children are referred to tertiary centers out of state • Geographic distance to care an issue
ACA Marketplace Plans	• Benefits are not as comprehensive as CHIP, Medicaid or private insurance plans • Often delay sick visits due to high deductibles
Maternal Care Challenges	
Access	• Due to geographic constraints, can be difficult to access timely obstetric services • Access issues reported among ACA Marketplace Plans

Pediatric Care Successes	
Coordination of Care	• Several hospitals have satellite clinics to increase access • Many services offered through public health departments • School districts help facilitate care, particularly with CYSHCN
Maternal Care Successes	
Public Health	• Many state public health department resources • Access to home birth providers

Opportunities
• Recruit more pediatricians including subspecialists • Reduce patient caseloads to increase opportunities to participate in community health programs

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

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

Access	• The recommended doctor or service is not available in my area (61%) • The wait time to get an appointment is too long (50%) • None – no access issues (22%)
Coverage	• A recommended service is not covered by my insurance plan (55%) • A recommended doctor/provider is out-of-network (50%) • Recommended services were limited (35%)
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 (60%) • Out of pocket (deductibles/co-pays) costs are too high (30%) • I have had to borrow money due to medical bills (35%)

*% 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
  - *"My son desperately needs a med wash and Medicaid will not pay for it. Consequently, we are experiencing many challenges with this child. The alternate suggestions they made to us are being followed and honestly, not much progress has been made and in fact, he seems to be worse in many ways behavior-wise."*

- Coordination of Care: Little to no coordination of care for complex cases, benefits unclear
  - *"It would be great to have help with coordination of care."*

- Inadequate Coverage: Necessary services, supplies and therapies not covered or under-covered, inadequate number of in-network physicians
  - *"In April the provider told us he could no longer pay out of pocket without getting payment from our insurance company. It is May 11, 2016 and they still have not paid on the first claim submitted 11/2/2015."*

- Lack of Specialists: Many do not accept public plans, very long wait time for appointments, high co-pays, some not accepting new patients, far travel
  - *“We had to travel 100 miles to a children's hospital to get care of a pediatric rheumatologist and pediatric orthopedic doctor. Wait is a couple months to get an appointment.”*
  - “I wish there were more providers in my state/community.”
  - *“We need more pediatric specialists - our area lacks these doctors and we must travel over 100 miles only to have insurance company deny coverage because they see it as not medically necessary and told to see someone local. Local is over 100 miles.”*
  - *“Would like a pediatric specialist closer to my location and more of them to provide care without the long waits. I reside in Cheyenne.”*

Conclusion:

Parents in Wyoming 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 a lack of local pediatric specialists and inadequate insurance coverage. 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

Rick's story illustrates the need for comprehensive mental and behavioral health services that are responsive to the family as a unit, and not just the person in crisis, and that a lack of such care can lead to a transition from health care to the juvenile justice system. His story also shows the need for resources for young adults as they transition to adult care.

Rick and his wife have eight adopted children with varying degrees of physical, mental, and behavioral conditions. In addition they have one biological son.

Tyler has been with the family since he was adopted at nine months. He is now 22 years old, is non-verbal, has intellectual as well as physical disabilities, including seizures, scoliosis, and probably autism. He was originally diagnosed with a metabolic disorder of unknown cause.

As they have for all the children they have taken into their family, Rick and his wife were determined from the start to provide the best life for Tyler, and have continually advocated for his needs.

Finding the right kind of wheelchair for Tyler's mobility issues has been challenging—with many different kinds to choose from it was hard to know which one would be best for Tyler's specific conditions. No one in Wyoming seemed to have the kind of knowledge they were seeking. Finally, they linked up with the Shriner's Hospital in Salt Lake City, and received recommendations for the best chair for Tyler.

Tyler has a seizure disorder that probably started at birth. At first Rick wasn't sure what was happening, and brought him to Fort Collins, CO, to see a neurologist when he was having hundreds of seizures a day. They used a series of medications to control the seizures, and then found out about surgical implants that might help. They switched neurologists, and Tyler had his first implant in 2008. A few years later that neurologist was no longer practicing medicine and had disappeared. A third neurologist told them that the implant might not really have been the best option for Tyler.

Today, Tyler is still on the same medications he's been on for years, taking them three to four times a day. If the medications do not stop the seizures, they call an ambulance to take him to the hospital in nearby Laramie. These visits have been problematic. "They don't listen to us," notes Rick. Laramie visits have ended up with Tyler on a respirator or with pneumonia, and then they would transfer him 80 miles south to Fort Collins. By this time Tyler is stressed from hours of seizures. Tyler's mother would prefer that Tyler just be taken directly to Fort Collins, but that doesn't happen.

Another issue in the local hospital is the hospitalist system. Family doctors are not allowed to practice in the hospitals—they use on-staff doctors (hospitalists) only, and these doctors are on a rotating schedule. So not only are these doctors unaware of Tyler's history, and make no effort to contact the local pediatrician that has known Tyler for years, but the frequent change of doctors is especially upsetting when there are mental health issues.

They went to the Children's Hospital in Denver to be monitored for days. The specialists now suspect Tyler is having "non-seizures"—more of a mental health issue. Rick said, "We don't know where to go next on the

mental health issue. How do you counsel an individual with low intellectual ability? For Tyler it is a constant battle."

Now 22, Tyler has aged out of the Shriner's Hospital care. His orthopedic specialist said, "Now that Tyler is going to be 21, you better find another provider."

There is a bone and joint clinic available, and while many people go there, Rick says they do not know how to work with a young adult like Tyler. "We don't feel valued," he added.

Rick's son Michael is now 26. He was adopted at age 14 and has both intellectual disabilities as well as emotional issues. After making a bomb threat in high school, he was expelled and charges filed against him. His intellectual disabilities were not taken into account at the hearing. He was let off on first offender status, but not given any mental health support. At 17, he attacked Rick and himself. Rick tried to take him to the hospital but they refused to take him at first since they didn't think he was any danger to himself or others. Rick insisted, and got him in. The hospital kept calling for him to come get Michael. The hospital monitored him for a week, and he came home on probation. He got a knife, got really mad, and busted windows on the car and slit tires. His mother called the police, and Michael ended up in the state mental hospital. The school district stepped in and got funding for him to go to a private organization. He has since gotten on medications and is doing better, living in a townhouse with 2 other people and a caretaker. Rick and his wife still don't feel safe around him, and neither do the other kids, so he can't be included in family gatherings. And through all of this, there was no effort to provide help for the family in how to deal with what was happening.

Covering the family's medical expenses has been challenging. They have Medicaid, in addition to private insurance. The Medicaid was a critical component of adopting children with special needs. "We can't go to the poor house for adopting kids!" And while Medicaid copays are low, they recently went up an extra $5 over what they expected. "When we adopted, we were told that everything would be covered. It is just irritating." And even small increments on the bills can add up over time with children and youth with special health care needs.

Rick noted the difference in the care the Shriner's Hospital in Salt Lake City extended to the patient and family versus the care in the local hospital. At the Shriner's Hospital, "We were given a room, and all the doctors came to us. We never had to leave that room unless we wanted lunch. And the lunches were cheap, but good. Everybody there was respectful and very caring. We weren't rushed from one part of the hospital to another. Their philosophy was 'how can we make this experience at the hospital work for you?' There's nothing like that in Wyoming. Shriner's is an example of what hospitals should look like for families."

Wyoming lacks enough doctors for the state's needs. "We have some great nurse practitioners, but we don't have medical doctors." Rick said his wife saw a different doctor every month and a half through the pregnancy with their biological son—and beyond.

Rick's story illustrates key issues for the state of health care in Wyoming:

- **Lack of doctors and hospitals:** Doctors are scarce, especially in the smaller towns. And because the local doctors are not able to practice in the hospitals, there is little incentive for them to stick around. Families prefer to go out of state for hospital care and specialists—that often have long waiting lists.
- **Hospitalist system is challenging for patients and families:** Rotating on-call physicians who do not know the patient are less likely to provide comprehensive care that takes medical history into account. The frequent change can be especially upsetting to children and youth with mental and behavioral issues.

- **Lack of comprehensive mental and behavioral health that addresses the family as a unit.** Children and youth in crisis are still integral to the family unit, and their care and treatment need to address the issues the family faces as well.
- **Lack of family-centered care:** Families are not included as full partners in the care of their children.
- **Lack of transition planning:** Moving from pediatric to adult care is often abrupt, and is even more of a challenge for families with youth with intellectual disabilities.

"Wyoming is a harsh place to live…. It's not a healthy place to get sick."

Family Story #2

Jeanne's story illustrates how lack of providers and unrealistic income eligibility requirements can create serious challenges for families with children with serious medical issues.

Jeanne has a five-year-old son with autism and epilepsy. She recognized right away after Avery's birth that something was "not right." She brought him to the emergency room and was told it was just colic. By 18 months, Avery was not talking, and showing some developmental regression. At two years of age, he had his first seizure, and before long was having 300 seizures per day. At that point an EEG helped diagnose epilepsy, with no identified cause. He was also being looked at for possible autism but the doctors thought that the symptoms might be a result of the epilepsy and would not give that diagnosis.

Jeanne was still concerned that autism might be involved, but couldn't get additional services for Avery unless he had that diagnosis, so she requested he be evaluated every six months. Finally, after a move from South Dakota to Wyoming, doctors referred her to Colorado, where she could get a specialized diagnosis, confirming what she'd suspected all along—that her son has autism in addition to the epilepsy. Avery received Early Intervention services at home until he turned three, and then received services at his preschool.

While living in South Dakota, because she was a single mother with low income, Medicaid paid for Avery's health care. With the move to Wyoming, she went back to work, and then lost Medicaid because she was over the income limit by just $300. She has insurance through her work, but it is inadequate to cover needed services and therapies for Avery. Even after insurance covered $800 a month for one medication, another one still cost her $400. Despite physical, occupational, and speech therapies being recommended by Avery's doctor, her insurance won't cover them. She is paying for speech therapy out of pocket, because that was the one area that Avery seemed to need the most immediate help with. The insurance company was only willing to pay for therapies that showed "measurable improvement." In addition, in Wyoming private insurance is not required to pay for habilitative therapies, like speech, occupational, and physical therapies, that can make a significant difference in the lives of children like Avery.

Wyoming doctors also recommended that Avery receive Applied Behavior Analysis (ABA) therapy, but her insurance would not cover that either, and neither would Medicaid. ABA is not considered an Essential Health Benefit in Wyoming.

While in South Dakota and still on Medicaid, Avery qualified for wraparound services through Magellan, a program for mental health waivers. Jeanne said these services were "fantastic, and kept everybody on the same page," something especially important for someone like Avery with high behavioral needs. Once she lost Medicaid, wraparound services were no longer covered. She had to cancel an EEG for Avery at Denver Children's Hospital because she couldn't pay for it.

Jeanne has applied for Mental Health Waivers in Wyoming, which works primarily through Medicaid, and is on an 18-month waiting list for funding, paying out of pocket in the meantime for needed services. These waivers do not cover ABA, and only after participating in this interview did she learn that a different funding stream—through the Developmental Disability Waiver—will cover ABA therapy.

Once he gets on the waiver services, he will be eligible for Medicaid—and have his "income" independent of his parents. "We are over [the limit] by $300, but his care is costing us $1,000." Medically, Avery is eligible for Social

Security, but only for survival benefits should one of the parents die. Jeanne's private insurance also makes Avery ineligible for CHIP.

Jeanne's story and struggles to get Avery timely, needed care and services illustrate key issues for the state of health care in Wyoming:

- **Lack of providers:** Wyoming is a large state but relatively sparsely populated. Families often have to travel to neighboring states for specialized care. Health care providers find more opportunities near larger cities, such as Denver, Colorado.
- **Long waiting lists for waivers:** An 18 month waiting list is a lifetime for a young child, causing missed opportunities for treatment and progress that will be harder to make up as the child gets older.
- **Insurance companies won't pay for habilitative therapies unless they can see "measurable improvement"—**a term that is defined differently by the insurance companies than the families who see even incremental improvements as worth the time and cost.
- **Income alone does not tell the full story for families with children with complex medical needs:** Children such as Avery have a "full slate" of regular health care appointments for multiple diagnoses. The total monthly bill for these appointments, needed medications, and therapies can easily exceed the income of a family deemed "over the limit."

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

EPSDT AND BRIGHT FUTURES – WYOMING 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 Wyoming 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.

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

- Wyoming's EPSDT program has adopted the AAP's Bright Futures periodicity schedule and screening recommendations. The state's member handbook includes a chart for what should be done during the checks in each of four age groups, not during the specific ages specified by the AAP.
- The state's medical necessity definition for EPSDT does not specifically mention mental health conditions or refer to Bright Futures as its professional standard for pediatric care:
  - "A health service that is required to diagnose, treat, cure, or prevent an illness, injury or condition which has been diagnosed or is reasonably suspected, to relieve pain or to improve and preserve health and be essential to life. The services must be consistent with the diagnosis and treatment of the recipient's condition; recognized as the prevailing standard or current practice among the provider's peer group; required to meet the medical needs of the recipient and undertaken for reasons other than the convenience of the recipient and the provider; and provided in the most efficient manner and/or setting consistent with appropriate care required by the recipient's condition."
- According to CMS, in 2014, Wyoming selected 10 of the 11 pediatric preventive care measures: child and adolescent access to primary care providers, well visits in the 1st 15 months, well visits in 3-6 years, adolescent well visits, childhood immunization status, adolescent immunization status, HPV vaccination (human papillomavirus, which can cause cervical cancer), Chlamydia screening, BMI (body mass index) assessment, and preventive dental visits. The only measure that was not included was developmental screening in the first three years.

- According to a report from the federal Department of Health and Human Services (DHHS), Wyoming's quality performance rates for these pediatric preventive care measures were lower than the national average. [vi] See examples below.
- Wyoming has performance improvement projects underway related to preventive dental care for young children.
- Wyoming's Medicaid program has partnered with its Department of Health and an Oral Health Coalition to improve access to preventive services for young children. They have launched a "Community Oral Health Coordinator Program" in counties with the highest risk for dental disease. Dental hygienists in this program perform oral health screenings for children 6 months to 5 years of ages, assist with referrals to other dental services, and provide fluoride treatment for children in daycare settings and schools. In addition, Wyoming Medicaid has expanded its parent and provider education to encourage the first dental visit when the child turns one year old and to promote the use of dental sealants.

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 and also the availability of interperiodic visits.
2. Consider linking guidance on health education/anticipatory guidance to Bright Futures.
3. Consider reviewing the state's medical necessity definition for EPSDT in terms of specifically mentioning mental health conditions and referencing Bright Futures as its pediatric preventive care standard.
4. Consider lessons learned from other rural states that rely on fee-for-service arrangements in selecting specific pediatric preventive care quality measures and implementing related performance improvement projects, including provider education related to BMI assessment and HPV vaccinations.
5. Consider strategies for increasing children's access to primary care providers and increasing the use of 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
Learning Collaborative Cohort 2 – Wyoming

EPSDT RECOMMENDATIONS AND SELECTED PEDIATRIC QUALITY PERFORMANCE MEASURES

EPSDT Periodicity Schedule, 2016 (# of well child visits)	WY	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	WY	US
- % of children with primary care visit		
○ Ages 12-24 months in past year	#	95.8%
○ Ages 25 months-6 years in past year	74.0%	87.1
○ Ages 7-11 years in past 2 years	59.7	88.9
○ Ages 12-19 in past 2 years	61.5	88.0
- % of children by 15 months receiving 6 or more visits	#	61.7
- % of children ages 3-6 with one or more well child visits	37.6	67.1
- % of adolescents ages 12-21 receiving 1 well visit	18.0	45.5
- % of children up to date on recommended immunizations (combination 3) by 2nd birthday	NA	62.1
- % of adolescents up to date on recommended immunizations (combination 1) by 13th birthday	NA	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	3.0	17.2
- % of children ages 3-17 whose weight was documented based on BMI percentile	1.2	41.7
- % of children ages 1-20 with at least 1 preventive dental visit	43.4	47.5

Pediatric Preventive Care Financial Incentives, 2016	WY	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
Learning Collaborative Cohort 2 – Wyoming

EPSDT Universal (U) and Selected (S)Screening Requirements, 2015	WY	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
- 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

- 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 was obtained from *DHHS 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP, February* 2016.