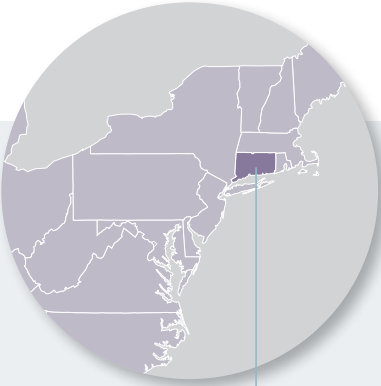


Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

CONNECTICUT (CT)



Medicaid's EPSDT benefit provides comprehensive health care services to children under age 21, with an emphasis on prevention, early detection, and medically necessary treatment. Each state Medicaid program establishes a periodicity schedule for physical, mental, developmental, vision, hearing, dental, and other screenings for infants, children, and adolescents to correct and ameliorate health conditions.

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA). The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th Edition)¹ and the corresponding Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)² provide theory-based and evidence-driven guidance for all preventive care screenings and health supervision visits through age 21. Bright Futures is recognized in federal law as the standard for pediatric preventive health insurance coverage.³ The Centers for Medicare and Medicaid Services (CMS) encourages state Medicaid agencies to use this nationally recognized Bright Futures/AAP Periodicity Schedule or consult with recognized medical organizations involved in child health care in developing their EPSDT periodicity schedule of pediatric preventive care.^{4,5} The following analysis of Connecticut's EPSDT benefit was conducted by the AAP to promote the use of Bright Futures as the professional standard for pediatric preventive care.

Connecticut's profile compares the state's 2018 Medicaid EPSDT benefit with the [*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*](#), and the [*Bright Futures/AAP Recommendations for Preventive Pediatric Health Care \(Periodicity Schedule\)*](#) published in *Pediatrics* in April 2017.² This state profile also contains information about Connecticut's 2016 Medicaid pediatric preventive care quality measures and performance based on the state's voluntary reporting on selected Child Core Set measures. Information about the state Medicaid medical necessity definition used for EPSDT and a promising practice related to pediatric preventive care is also found here. Connecticut's profile is based on a review of the state's Medicaid website, provider manual, and other referenced state documents, and an analysis of 2016 state Medicaid data reported to CMS on child health quality.⁶ This profile was also reviewed by state Medicaid EPSDT officials. Information is current as of February 2018.

Summary of Findings

- Connecticut’s 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations.
- The state’s medical necessity definition, below, incorporates a preventive focus.
 - “Medical necessity or medically necessary” mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual’s medical condition, including mental illness, or its effects, in order to attain or maintain the individual’s achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual’s illness, injury or disease; (3) not primarily for the convenience of the individual, the individual’s health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual’s illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. (b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.
- According to CMS, in 2016, Connecticut selected all 10 pediatric preventive care measures in the Child Core Set.
- Connecticut’s quality performance rates, as shown in the table below, were higher than the national average for all but the BMI assessment measure.
- Connecticut has performance improvement projects underway related to behavioral health screening, lead screening, immunizations, oral health, and well child and adolescent visits.

Promising Practice

Connecticut has committed to expanding medical home practices throughout the state with a strong emphasis on preventive care for children and families. The state Medicaid agency offers practices/clinics support to become an NCQA-certified medical home, including assistance with the application process and differential payments based on their status as NCQA Level 1, Level 3, or on a “Glide Path” toward eventual NCQA certification. Connecticut Medicaid also offers additional incentives based on a practice’s performance on pediatric preventive care measures as well as on adult measures. Their medical home/quality improvement payment structure allows practices to compare themselves to peers as well as to their own change over time.

Comparison of CT EPSDT and AAP/Bright Futures Periodicity Schedules

The following tables provide information on Connecticut’s EPSDT periodicity schedule and screening recommendations by age group, comparing 2018 Connecticut Medicaid EPSDT requirements with the 2017 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care.²

Code	Number of Well Child Visits by Age	CT EPSDT	Bright Futures
U = Universal (all screened)	- Birth through 9 months	7	7
S = Selective screening (only those of higher risk screened)	- 1 through 4 years	7	7
U/S = visits in that age group have universal and selective requirements.	- 5 through 10 years	6	6
	- 11 through 14 years	4	4
	- 15 through 20 years	6	6

Universal (U) and Selected (S) Screening Requirements	CT EPSDT	Bright Futures
Infancy (Birth-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 screening	U	U
- Developmental surveillance	U	U
- Psychosocial/behavioral assessment	U	U
- Maternal depression screening	U	U
- Newborn blood screening	U	U
- Critical congenital heart screening	U	U
- Anemia	S	S
- Lead	S	S
- Tuberculosis	S	S
- Oral health	U/S	U/S
- Fluoride varnish	U	U
- Fluoride supplementation	S	S

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Comparison of CT EPSDT and AAP/Bright Futures Periodicity Schedules *continued*

Code	Universal (U) and Selected (S) Screening Requirements	CT EPSDT	Bright Futures
U = Universal (all screened)	Early Childhood (Ages 1-4)		
S = Selective screening (only those of higher risk screened)	- Length/height & weight	U	U
U/S = visits in that age group have universal and selective requirements.	- Head circumference	U	U
See Bright Futures/AAP Periodicity Schedule for complete information.	- Weight for length	U	U
	- Body mass index	U	U
	- Blood pressure	U/S	U/S
	- Vision	U/S	U/S
	- Hearing	U/S	U/S
	- Developmental screening	U	U
	- Autism spectrum disorder screening	U	U
	- Developmental surveillance	U	U
	- Psychosocial/behavioral assessment	U	U
	- Anemia	U/S	U/S
	- Lead	U/S	U/S
	- Tuberculosis	S	S
	- Dyslipidemia	S	S
	- Oral health	S	S
	- Fluoride varnish	U	U
	- Fluoride supplementation	S	S
	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
	- Psychosocial/behavioral assessment	U	U
	- Anemia	S	S
	- Lead	S	S
	- Tuberculosis	S	S
	- Dyslipidemia	U/S	U/S
	- Oral health	S	S
	- Fluoride varnish	U	U
	- Fluoride supplementation	S	S
	Adolescence (Ages 11-20)		
	- Length/height & weight	U	U
	- Body mass index	U	U
	- Blood pressure	U	U
	- Vision	U/S	U/S
	- Hearing	U	U
	- Developmental surveillance	U	U
	- Psychosocial/behavioral assessment	U	U
	- Tobacco, alcohol or drug use assessment	S	S
	- Depression screening	U	U
	- Anemia	S	S
	- Tuberculosis	S	S
	- Dyslipidemia	U/S	U/S
	- Sexually transmitted infections	S	S
	- HIV	U/S	U/S
	- Fluoride supplementation	S	S

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

Included in the tables below are Connecticut's 2016 quality performance information on pediatric preventive care measures reported to CMS⁶, as well as their use of financial incentives for pediatric preventive care.

Pediatric Preventive Care Quality Measures and Performance, 2016 Child Core Set	CT	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	98.4	95.2
• Ages 25 months-6 years (in past year)	93.8	87.7
• Ages 7-11 (in past 2 years)	96.2	90.9
• Ages 12-19 (in past 2 years)	95.4	89.6
- % of children by 15 months receiving 6 or more well-child visits	80	60.8
- % of children ages 3-6 with one or more well-child visits	84.9	68
- % of adolescents ages 12-21 receiving 1 well care visit	68.2	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	79.1	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	86	70.3
- % of sexually active women ages 16-20 screened for chlamydia	57.8	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	23.6	20.8
- % of children ages 3-17 whose BMI was documented in medical records	60.5	61.2
- % of children ages 1-20 with at least 1 preventive dental service	62.7	48.2

Pediatric Preventive Care Financial Incentives, 2016	CT	US
- Use of preventive incentives for consumers	No	NA
- Use of performance incentives for providers	Yes	NA

References

- ¹Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2017.
- ²Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Work Group. 2017 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2017;139(4):e20170254.
- ³FAQs about Affordable Care Act Implementation. Washington, DC: US Department of Labor, Employee Benefits Security Administration, May 11, 2015.
- ⁴EPSDT – A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents. Baltimore, MD: Centers for Medicare and Medicaid Services, June 2014.
- ⁵*Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits*. Baltimore, MD: Centers for Medicare and Medicaid Services, February 2014.
- ⁶Quality information from the CMS Medicaid/CHIP child core set for federal fiscal year 2016 was obtained from: <https://data.medicare.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy>.



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