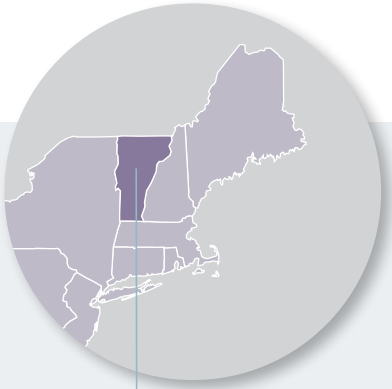
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



VERMONT (VT)

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 Vermont's EPSDT benefit was conducted by the AAP to promote the use of Bright Futures as the professional standard for pediatric preventive care.

Vermont'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 Vermont'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. Vermont'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

- Vermont's 2018 EPSDT requirements follow the Bright Futures/AAP Periodicity Schedule and screening recommendations. The state is undertaking a cross-agency effort to promote EPSDT and pediatric preventive care.
- The state's medical necessity definition, below, explicitly incorporates its preventive purpose.
  - Medically Necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by HCP in the same or general specialty as typically treat or manage the diagnosis or condition AND help restore or maintain the member's health OR prevent deterioration or palliate the member's condition OR prevent the reasonably likely onset of a health problem or detect an incipient condition. Additionally, for EPSDT-eligible members, medical necessity includes a determination that a service is needed to achieve proper growth and development or prevent the worsening of a health condition.
- According to CMS, in 2016, Vermont selected 9 of the 10 pediatric preventive care measures in the Child Core Set. The BMI documentation measure was not selected.
- The state's pediatric performance rates were higher than the national average for PCP visits, well child visits for all 3 child/adolescent age groups, chlamydia screening, and preventive dental services. Vermont's rates were lower than the national average for childhood and adolescent immunizations, and HPV vaccinations.
- Vermont has numerous pediatric preventive care performance improvement projects underway, including statewide initiatives related to increasing access to primary care and use of preventive care among infants, children, and adolescents; preventing infant mortality; and suicide prevention.

Promising Practices

- Vermont's Health Department's Division of Maternal and Child Health works closely through a grant agreement with the University of Vermont, called the Vermont Child Health Improvement Program (VCHIP). One of VCHIP's statewide projects involves pediatric and family medicine practices to accomplish preventive care quality improvement efforts "building on the momentum of Bright Futures and Vermont's health care reform activities." This network of providers, called Child Health Advances Measured in Practice (CHAMP), has access to current evidence-based resources and tools, collaborative QI efforts, and annual data collection. CHAMP is a partnership involving the University of Vermont, College of Medicine, the Vermont Department of Health, and the Vermont Chapters of the AAP and AAFP. Additional initiatives of the Vermont's Child Health Improvement Program are described at www.uvm.edu/medicine/vchip. In addition, as part of the VCHIP, since 2001, Vermont has operated a Youth Health Improvement Initiative (now called VT RAYS – Raise Awareness for Youth Services) to improve screening rates for risk behaviors and developmental tasks, coach practitioners to improve their office interventions and referral effectiveness, identify barriers and facilitators to annual well visits, and expand substance abuse and mental health services. They have also formed a Youth Health Advisory Council to provide evaluation and feedback about youth-friendly practice sites. This Council is involved in other state efforts, as well.
- Vermont has developed a network of Health Department School Liaisons throughout the state. These are public health nurses who work with schools, mainly with school nurses, to ensure that all children have insurance, a medical home, and a dental home. They also promote the Bright Futures Periodicity Schedule and screening requirements and help to assist with connections to the provider community.

Comparison of VT EPSDT and AAP/Bright Futures Periodicity Schedules

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

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/AAP Periodicity Schedule for complete information.

Number of Well Child Visits by Age	VT EPSDT	Bright Futures
- Birth through 9 months	7	7
- 1 through 4 years	7	7
- 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	VT 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

continued on next page

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

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/AAP Periodicity Schedule for complete information.

Universal (U) and Selected (S) Screening Requirements	VT EPSDT	Bright Futures
Early Childhood (Ages 1-4)		
- Length/height & weight	U	U
- Head circumference	U	U
- 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 Vermont's 2016 quality performance information on pediatric preventive care measures reported to CMS[6], as well as their use of financial incentives for pediatric preventive care.

Pediatric Preventive Care Quality Measures and Performance, 2016 Child Core Set	VT	US
- % of children with primary care visit		
• Ages 12-24 months (in past year)	97.2	95.2
• Ages 25 months-6 years (in past year)	90.6	87.7
• Ages 7-11 (in past 2 years)	95.1	90.9
• Ages 12-19 (in past 2 years)	94	89.6
- % of children by 15 months receiving 6 or more well-child visits	67.4	60.8
- % of children ages 3-6 with one or more well-child visits	72.6	68
- % of adolescents ages 12-21 receiving 1 well care visit	46.9	45.1
- % of children by 2nd birthday up-to-date on recommended immunizations (combination 3)	56.1	68.5
- % of adolescents by 13th birthday up-to-date on recommended immunizations (combination 1)	63.5	70.3
- % of sexually active women ages 16-20 screened for chlamydia	49.6	48.8
- % of female adolescents by 13th birthday receiving 3 HPV doses	18.6	20.8
- % of children ages 3-17 whose BMI was documented in medical records	—	61.2
- % of children ages 1-20 with at least 1 preventive dental service	53.6	48.2

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

References

[1]Hagan 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.

[2]Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Work Group. 2017 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2017;139(4):e20170254.

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

[4]*EPSDT – 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.

[6]Quality information from the CMS Medicaid/CHIP child core set for federal fiscal year 2016 was obtained from: https://data.medicaid.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under UC4MC28034 Alliance for Innovation on Maternal and Child Health. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.