

American Academy of Pediatrics

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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
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UTAH STATE REPORT

AIM Expanding Access to Care for Maternal and Child Health Populations

Learning Collaborative Cohort 2 – Utah

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 Utah 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	• Access to covered providers difficult • Insurers often restrict the number of covered visits • Primary care providers are providing care which may or may not be covered and they may not feel comfortable providing
Medicaid	• Delay in state's Medicaid expansion resulting in ineligible young parents • High rate of Medicaid and CHIP eligible children that are not enrolled • Enrollment process is onerous • Fragmentation of coverage making it difficult to develop medical homes
Narrow Networks	• A marketplace ACO recently excluded the state's only children's hospital
Continuity of Care for CYSHN	• State's largest insurer has a plan that does not cover screening tests common to patients with Down Syndrome • Difficult to find providers as pediatric patients transition to adulthood
Maternal Care Challenges	
Maternal Mental Health	• Mother's that are temporarily enrolled in Medicaid and will lose coverage 60 days postpartum • Must re-qualify every month of pregnancy

Pediatric Care Successes	
Medicaid	• CHIP initiated a small program to enroll eligible families • Foster care children are immediately enrolled in Medicaid • Enrollee information is shared to facilitate enrollment in other state programs
Maternal Care Successes	
Medicaid	• Enrollee information is shared across state agencies to facilitate enrollment in other state programs

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Opportunities
- Expand Medicaid eligibility and streamline enrollment and continued eligibility process - Increase pediatric Medicaid payment rates to adult rates - Reduce defragmentation of coverage by payers resulting in changes in plan provider networks and disruption in care

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

Access	- The wait time to get an appointment is too long (49%) - None – no access issues (33%) - The recommended doctor or service is not available in my area (27%)
Coverage	- A recommended service is not covered by my insurance plan (52%) - Recommended services were limited (46%) - Benefits are unclear (31%)
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 (56%) - Out of pocket (deductibles/co-pays) costs are too high (53%) - I delayed getting care for my child/children because I could not afford it (42%)

*% 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
 - "This is our second time trying the access behavioral/mental health care. It is difficult to find a provider who has the training and focus you need in their practice."*
 - "We had to wait over 6 months for an appointment."*
- Coordination of Care: Little to no coordination of care for complex cases, benefits unclear
 - "Need to know what kind of resources are available (grants, etc) and how to apply. All premiums co-insurance and therapies are expensive."*

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- *“It would be nice to have help from someone who has my family's best interest in mind to help me navigate things.”*
- *“I need to know what my other options are, need assistance with malpractice issues, issues with Medicaid mental health benefits coordinating with my other insurances.”*
- *“Would like someone just to be there to explain services and ability of providers.”*
- Cost: Unaffordable co-pays, do not qualify for assistance but cannot afford premiums and co-pays, high premiums (especially for private payers)
 - *“We cannot afford the Behavioral Health therapy appointments.”*
 - *“My son has not had a behavioral health evaluation because it is too expensive.”*
 - *“My daughter's medical bills are now coming in for the copays and I can't afford to pay them.”*
 - *“I am still trying to find a provider in my area or a provider four hours away that I can actually afford.”*
 - *“We have declared bankruptcy twice due to high medical costs. My husband and I are both college graduates with good insurance.”*
- Inadequate Coverage: Necessary services, supplies and therapies not covered or under-covered, inadequate number of in-network physicians
 - *“The durable medical equipment necessary to treat a physical degenerative condition is not covered so we cannot get it.”*
 - *“The biggest problem we have currently is getting insurance to cover necessary durable medical equipment. I'm tired of the uphill battle to have my kids' basic needs met.”*
 - *“Prescribed therapies and DME are not covered so my son doesn't get the care his doctor is recommending.”*
- Support Networks: Access to other families in similar situations for information and support; respite care
 - *“It would be great to have a local support network.”*
 - *“We really need respite care.”*

Conclusion:

Parents in Utah 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 in the health care of maternal and child health populations in the state.

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FAMILY STORIES

Family Story #1

Stephanie's story illustrates the emotional impact seeking needed health care for a child with special health care needs can generate, and the importance of having advocates to help negotiate health care systems.

Stephanie's daughter, Kaitlyn, has a rare chromosomal abnormality. Now 15 years old, Kaitlyn was first diagnosed at 18 months, though Stephanie suspected problems much earlier. Kaitlyn had what Stephanie was convinced were seizures at six months, but because the pediatrician never observed it, he dismissed it as "nervous new mom." He did note a hearing loss, and told Stephanie there are worse things, and she should just be grateful that it was "only" hearing loss.

Stephanie videotaped one of Kaitlyn's seizures and brought the tape to her pediatrician and requested a referral to a neurologist, who confirmed the seizures. The neurologist said Kaitlyn had "delayed myelination" but really didn't explain it well, telling Stephanie, "Don't you worry." The neurologist wanted to start 8-month-old Kaitlyn on phenobarbital, but Stephanie had misgivings and wanted time to think and to check into other options.

The neurologist pressed Stephanie for a decision with daily phone calls, and finally threatened to turn her in for "medical neglect." Stephanie "fired" the neurologist and found another one, who agreed with the wait-and-see approach. He didn't think that the seizures would affect her development, and the seizures went away on their own after six months.

The new neurologist, noting that Kaitlyn lacked ear bones as well as the delayed myelination, suggested contacting a geneticist, who was able to diagnose the rare chromosomal abnormality, and started Kaitlyn on multiple therapies. It became a full-time job to coordinate Kaitlyn's medical care.

Stephanie fought with the insurance company to cover her daughter's hearing aids that had to be replaced as Kaitlyn grew—costing \$4,000 a year. Initially the family had double insurance through Stephanie's work, and her husband's work. Stephanie had to quit work in order to care for Kaitlyn, which meant losing the better coverage of the two insurance policies.

Kaitlyn stopped growing, and an endocrinologist suggested growth hormones, saying that these had also been shown to help cognitively as well. Insurance would not pay for the growth hormones because they are not considered relevant for this particular genetic syndrome. Stephanie and her husband paid for these expensive hormones, and ultimately had to declare bankruptcy because of all of the medical bills. The state makes no distinction between medical bankruptcy and consumer debt bankruptcy. This causes unwarranted feelings of shame for families like Kaitlyn's, as if they had somehow used money frivolously instead of for life-saving medical care.

They applied for Medicaid waivers, meeting the criteria based on Kaitlyn's income, and intellectual disability and inability to care for herself. They applied and were put on a waiting list for four years, and now Medicaid covers everything, including the growth hormone and hearing aids. Stephanie noted that the day they got word that Kaitlyn would receive the waiver was "bittersweet" because while her daughter would finally get help, it meant accepting that her disabilities were severe and lifelong.

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Stephanie didn't realize it at the time, but that four year wait was short compared to some families who have been on the waiting list for 20 years or more. Decisions are made based on need, though Stephanie said that there are many families whose children are medically fragile. Kaitlyn is medically complicated, and the Medicaid keeps her healthy. For other families whose children are medically fragile, the delay could mean the difference between life and death.

Insurance issues continue, and thanks to an advocate at the Family-to-Family Health Information Center, they were recently able to get an issue resolved—not before spending time and energy fighting it.

Care coordination—or lack of it—has been an issue as well. They were never offered it through Medicaid, but did have someone through the private insurance who answered questions. The pediatrician tries to coordinate specialists, but doesn't help when fighting insurance companies.

Stephanie's story and struggles to get Kaitlyn timely, needed care and services illustrate key issues for the state of health care in Utah:

- **Challenges of getting initial diagnoses:** Accurate diagnoses and appropriate treatment options should require not only medical expertise, but also the input from the families as well.
- **Private insurance companies not basing coverage decisions on doctor's recommendations:** Especially for children with rare or complex medical conditions, the expertise of specialists should drive these decisions. Kaitlyn's recent need for oral surgery was complicated by the insurance company's unwillingness to pay for the procedure to be done in the hospital under general anesthesia—as recommended by her oral surgeon who was familiar with her history.
- **Availability of waivers:** Long waiting lists mean critical delays in treatment and services. The application and approval process should be more transparent.
- **Care coordination—of both medical services and insurance issues—is critically important.** Families need help navigating these issues.
- **Financial realities of medical expenses need to be better understood.** “Medical bankruptcy” is *not* the same as consumer debt bankruptcy, but credit score determination does not make this distinction. Families should not have to be embarrassed because they did what they had to for their children's health and well-being.

“When your child is diagnosed with a devastating medical condition, the last thing you need to deal with is fighting to get services. You need coverage—that should be a given. You shouldn't have to fight for it. It shouldn't just be for the wealthy. There is nothing more demoralizing, which destroys self-worth more, than not being able to provide for your child's needs. I will do anything for my daughter. We will never pay off our medical debt.”

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Family Story #2

Tristin's story illustrates the challenges of finding answers for a child who is medically complex with an undiagnosed and rare genetic condition, and the toll it can take on the health and well-being of the family, especially the mother. It also demonstrates how attitudes in the workplace towards parents of children and youth with special health care needs can affect the family dynamic.

Tristin and Michael are the parents of four-year-old Jayson, their only child. Jayson was born after several years of trying to get pregnant, and the pregnancy and delivery were typical and uneventful. Despite an Apgar score of 9, after a few hours a doctor wanted to run some tests because he thought Jayson looked “different”—although Tristin couldn't see anything of concern. The tests came back normal, and Jayson went home. The first couple of months were pretty normal, although Tristin noted that he didn't cry, was losing weight, and was a noisy breather. He seemed to get exhausted by eating.

By his second month, Tristin had gone back to work and was taking Jayson to daycare, where he contracted RSV (Respiratory Syncytial Virus) and ended up in the hospital, initially for just a few days, but he was getting worse rather than better.

At one point Tristin noticed that her son's hospital chart had “genetic syndrome” listed. That news was very upsetting—it was the first time that it really hit Tristin that there was something really wrong. She realized that to this point, she had been in denial about things she was seeing.

After Jayson took another bad turn, he was airlifted to a larger hospital, who determined he was aspirating, and they performed swallowing tests. They wanted to send him home, saying it was still just RSV, but Tristin didn't feel right about this. He was still struggling, and had stopped breathing in her arms, and she held him through the night to be on guard for future apnea episodes. She made a video of her son at night to show the daytime staff what she was seeing happen.

She called on some friends for advice, and they urged her to stand up to the staff and say “no” to the discharge. The staff said they would discharge him. Tristin responded, “If I take my baby home, he will die. And I will sue you.”

At this point, the hospital brought in a specialist, who listened to Tristin, watched the video with her, and within minutes had a likely diagnosis for an obvious condition that would require surgery in the future to repair. “The specialist listened to me. It really made a difference, and I calmed right down.”

Jayson stabilized enough to go home connected to an assortment of tubes, including high flow oxygen.

Tristin had insurance for Jayson through her work when he was born, but she really didn't understand how it all worked. “I grew up poor, and we didn't have insurance.” She panicked after the airlift, and called her insurance company and learned she had already reached her out-of-pocket maximum and so wouldn't have to pay for the helicopter ride.

She learned that even with insurance, medical bills add up. In addition to copays for multiple specialists, she found out that medications don't count towards the out-of-pocket total. They were paying \$1,200-1,500 a

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month for medicines, plus copays for the doctors, lab work, etc. And Jayson's apnea is considered an adult issue for insurance, and so sleep studies and the CPAP machines were not going to be covered.

After the first year, Tristin and Michael realized something needed to change. Michael started a new job, working for the city, with excellent insurance coverage. Tristin needed more flexibility in her work hours to provide the care that Jayson needed, so she went to part-time at her job, and they switched to Michael's insurance—and the city would pay the premiums. This was a big help, but they still had the other copays and expenses to cover.

Tristin worked one job under two employers, including the school district. The other employer was initially understanding about her need to take time off. She asked about using the Family and Medical Leave Act, but her employer was reluctant to start that, and suggested instead that she could work at odd times to make up for lost hours.

After seven months, the employer told her, "Clearly, this isn't going to get better. You need to figure this out—we can't be this flexible any longer. I need you to resign. If you don't resign, I'll fire you."

The other employer (the school district) was much more understanding, and spoke with the other boss's supervisor. Tristin got rehired, but the boss made her life miserable, telling her, "You don't belong here." She put up with workplace bullying for three years as a result of all of this.

Tristin needed the job, and continued despite the treatment she was getting. Most of her work was done at home, and often in the middle of the night. This next year, she has taken a new position with a different school district, but will have to be in the office more often, and worries about how this will work out.

After Jayson was born, Tristin applied for multiple waivers, filling out a "ridiculous" amount of paperwork—sometimes for waivers that she would only find out after the fact that Jayson would not qualify for. Tristin and Michael make too much money to qualify, but not enough to cover the bills. All requests for waivers were denied. They began putting bills on credit cards—\$8,000 in two years, and they were only able to make minimum payments, with a 25% interest rate.

Tristin heard about a new waiver being proposed—the Medically Complex Child waiver. She was invited to meetings to tell her story, and to talk about the help they needed. She got involved with the legislation, and was cautiously optimistic that it would pass. It did pass in that first year it was proposed, and a pilot program was established for just a few families. Tristin applied and got the word in November 2015 that they had been accepted—and that changed everything. She was able to get equipment and supplies without hassle. "We are now asked, 'what do you need?'"

Because of the waiver, Tristin and Michael have paid off their medical expenses and are working on paying down the credit card bill. They are even able to look to the future and make plans they hadn't considered before. And they are now able to afford therapies that have made a noticeable difference just in a short time.

They are still struggling to get a definitive diagnosis for Jayson—one that will require an additional level of testing to identify. This level of testing costs \$20,000 and insurance will not pay for it. Without an official diagnosis, Tristin and Michael are wary of trying to have another child, not knowing if this syndrome might show up in the next child as well.

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Tristin attended a “Utah Rare” conference in February 2015, and talked to people from Gene DX, who said they could help her with the financing and got the test set up. The results were inconclusive, with no additional information for him. But they now know what they are dealing with, and have made contact with some of the few people around the world with a similar syndrome. And Jayson’s geneticist and Gene DX are interested in pursuing a research study to help children like Jayson. Even better, testing of Tristin and Michael showed that the syndrome was likely a fluke, and not something they could expect with future children.

“We’ve had to fight. Things don’t come easy—some days you just have to break the mold, and not go through insurance to get what you need.”

Tristin set up a Facebook group for other parents with similar stories and she is helping provide support for these families to learn about resources available.

Tristin’s story illustrates key issues for the state of health care in Utah:

- **Gaps in what insurance will cover:** “Out-of-pocket” maximums do not count key items that families must pay, including medications and lab tests that add up quickly for a medically complex child.
- **The Medically Complex Child Waiver is necessary:** Starting with a small pilot group, it is now available for 90 families, and needs to be expanded further. It can make the difference for a family struggling to pay mounting medical bills.
- **Genetic testing is not just about giving a name to a syndrome:** It also means connecting with others who have similar issues, and can mean peace of mind for parents making decisions about future children.
- **Respite care is a necessary component of family-centered care:** Taking care of the many medical (and other) needs of a child with special health care needs is a 24/7 job, that often affords few—if any—needed breaks or downtime. Paying for respite care can be expensive and an added financial burden to already-stressed families.

Tristin’s story shows the power of persistence and advocacy, and of parents working with other parents. Some parents don’t have the energy to fight the system as Tristin did. And the fight takes its toll on parents.

“I don’t know how families do it with more than one child with medical issues, or if both parents have to work full-time, or with an unsupportive spouse. There are lots of sleepless nights—it never stops, and is overwhelming at times. I know I won’t stop—I don’t want it to stop, because that means that Jayson is no longer here. “

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EPSDT AND BRIGHT FUTURES – UTAH 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 Utah 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.

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

- Utah's EPSDT program has adopted the AAP's Bright Futures periodicity schedule and screening recommendations, but the state's website has a different schedule of preventive visits.
- The state's medical necessity definition for EPSDT does not specifically refer to Bright Futures as its professional standard for pediatric care.
 - When a Medicaid eligible child requires medically necessary services, these services may be covered by Medicaid. Necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services are available based on medical necessity.
- According to CMS, in 2014, Utah 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, Chlamydia screening, BMI assessment and preventive dental visits.
- According to a report from the federal Department of Health and Human Services (DHHS), Utah's quality performance rates were higher than the national average for primary care visits for infants/toddlers ages 12-24 months, preventive care visits for infants up to 15 months, childhood and adolescent immunizations, HPV vaccinations, BMI assessment, and preventive dental visits. They were lower than the national average for primary care visits for 7-11 year olds, preventive visits for ages 3 through 6, adolescent well visits, and Chlamydia screening.^{vi} See examples below.
- Utah has performance improvement projects underway related to well child care, childhood immunizations, and Chlamydia screening.

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- Utah's Early Childhood (Ages 0-4) Targeted Case Management Program is a statewide program operated by public health nurses in local health departments. Its aim is to promote the early identification of health, developmental, and behavioral issues using standardized screening questionnaires, to improve well child care utilization and immunization, and to link children to a medical home and families to community resources.

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 referencing Bright Futures as its pediatric preventive care standard.
4. Share lessons learned from achieving high performance on selected pediatric preventive quality measures.
5. Consider strategies for increasing 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.

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EPSDT RECOMMENDATIONS AND SELECTED PEDIATRIC QUALITY PERFORMANCE MEASURES

EPSDT Periodicity Schedule, 2016 (# of well child visits)	UT	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	UT	US
- % of children with primary care visit		
o Ages 12-24 months in past year	98.9%	95.8%
o Ages 25 months-6 years in past year	86.7	87.1
o Ages 7-11 years in past 2 years	85.5	88.9
o Ages 12-19 in past 2 years	87.7	88.0
- % of children by 15 months receiving 6 or more visits	71.6	61.7
- % of children ages 3-6 with one or more well child visits	61.5	67.1
- % of adolescents ages 12-21 receiving 1 well visit	42.4	45.5
- % of children up to date on recommended immunizations (combination 3) by 2 nd birthday	83.8	62.1
- % of adolescents up to date on recommended immunizations (combination 1) by 13 th birthday	68.9	64.9
- % of sexually active women ages 16-20 screened for Chlamydia	25.1	48.8
- % of female adolescents receiving 3 vaccine doses of HPV before age 13	20.2	17.2
- % of children ages 3-17 whose weight was documented based on BMI percentile	63.4	41.7
- % of children ages 1-20 with at least 1 preventive dental visit	48.1	47.5

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

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

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- 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 *EPSDT – 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.