

BRIGHT FUTURES AND EPSDT: A NATIONAL REVIEW

White Paper Prepared by
Margaret McManus, MHS
Consultant, American Academy of Pediatrics
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Introduction

Thirty-seven million children were enrolled in Medicaid in 2016.¹ Since 1967, Medicaid has advanced the importance of prevention and early intervention for low income children. The original design of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage standard for Medicaid-insured children was articulated by President Johnson: "...In education, in health, in all of human development, the early years are the critical years...Our goal must be clear – to give every child the chance to fulfill his promise."²

Central to the EPSDT benefit is comprehensive screening services, which encompass health and developmental history; unclothed physical examination; immunizations; laboratory tests; anticipatory guidance and health education; vision, dental, and hearing services; and other necessary health care, diagnostic services, and treatment.³ According to the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies must ensure that children receive coverage for EPSDT comprehensive preventive services consistent with reasonable standards of medical and dental practice, including the nationally recognized Bright Futures, developed by the American Academy of Pediatrics (AAP).⁴ Bright Futures provide evidence-driven guidance for all pediatric preventive care screenings and health supervision visits through age 21.

The purpose of this report is to examine the extent to which state Medicaid agencies have adopted the current Bright Futures' periodicity schedule and preventive care screening recommendations. It is also intended to analyze states' selection of pediatric preventive care quality measures and performance rates, and inclusion of a preventive purpose in Medicaid medical necessity definitions used for EPSDT. In addition, this report identifies a range of best practices and recommendations. Detailed state-specific tables are included. Funding for this report was provided to the AAP by the federal Maternal and Child Health Bureau as part of a project, called the Alliance for Innovation in Maternal and Child Health (AIM).

Methods

Information for this 2018 EPSDT report was obtained based on reviews of state Medicaid provider manuals and referenced documents, administrative rules, and websites. For each state, an EPSDT and Bright Futures profile was originally prepared in 2016/17 and updated in 2018, with reviews by state EPSDT officials (available online at: <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Childrens-Health-Care-Coverage-Fact-Sheets.aspx>). Each profile compares state EPSDT requirements with the 2018 *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th edition)⁵ and the 2017 AAP Recommendations of Preventive Pediatric Care (Periodicity Schedule).⁶ States' pediatric preventive care quality measures and performance rates were obtained from CMS, based on federal fiscal year 2016 information.⁷ States provided information about their pediatric preventive care performance improvement projects, use of provider and consumer financial incentives, EPSDT medical necessity definitions, and program strengths and best practices.

Bright Futures and EPSDT Alignment

In 2018, a total of 37 states, including the District of Columbia, used Bright Futures (4th edition) as their EPSDT pediatric preventive care screening recommendations, as shown in Table 1. An additional 8 states used preventive care recommendations that are very similar to Bright Futures, leaving 6 states with the greatest divergence from Bright Futures. The periodicity schedule called for by Bright Futures/AAP recommends 30 visits from birth through age 20, the age limit to which EPSDT extends. Eleven of the 51 states called for fewer visits than recommended by the AAP. When comparing state EPSDT and Bright Futures' periodicity schedules by age group, Table 2 shows the difference in recommended visits most often affected young children, from birth through age 4. Importantly, states note that additional visits are allowable, if medically necessary.

Pediatric Preventive Care Quality Measures, Performance, and Financial Incentives

To ensure that more infants, children, and adolescents benefit from recommended screening, diagnostic, and treatment services, CMS has invested significantly over the last decade in defining, measuring, and publicly reporting on child health quality of care. In its third annual report to Congress on quality of care in Medicaid and CHIP, CMS provided detailed information about states' federal fiscal year (FFY) 2016 Child Core Set measures.⁷ Published in 2018, this was the most current state-specific quality data available at the time this report was written. Briefly, the Child Core Set measures were designed to analyze various dimensions of pediatric health care quality related to primary care access and preventive care, maternal and perinatal health, treatment and management of acute and chronic conditions, behavioral health care, and dental and oral health services. State reporting on these measures is voluntary until federal fiscal year (FFY) 2024, when reporting on all Child Core Set measures will become mandatory.

The expansion of Medicaid managed care in the form of risk-based managed care organizations, often with value-based payment methodologies, has facilitated the widespread adoption of pediatric quality measures in the CMS Child Core Set.⁸ As shown in Table 3, 36 states (including DC) had 75% or more of their Medicaid populations, including children, in MCOs in 2017. Only 3 states – AK, CT, and WY – relied exclusively on fee-for-service arrangements.

The 10 child core measures selected for this analysis were those that specifically pertained to preventive care, including primary care provider (PCP) access:

- Primary care provider access (PCP visit in past year for children 12-24 months, PCP visit in past year for children 25 months-6 years, PCP visit in past 2 years for children 7-11 years, and PCP visit in past 2 years for adolescents 12-19 years)
- Well child care in the first 15 months
- Well child care among 3-6 years of age
- Well child care among adolescents
- Childhood immunizations

- Adolescent Immunizations
- HPV vaccinations
- Chlamydia screening
- BMI assessment
- Preventive dental visit

Table 4 reveals that in FFY 2016, 30 states reported on all 10 of these pediatric preventive care measures. In contrast, 5 states reported on 5 or fewer of these measures. Not including the preventive dental visit measure, which was obtained from states' CMS-416 report, the pediatric preventive care measures most often selected were the well care visit measures for the 3 child age groups as well as the PCP access measures. Least likely to be selected were BMI documentation, HPV vaccination, and childhood immunization measures.

With respect to PCP access (Table 5), which is fundamental to the delivery of preventive care, all 46 states reporting this measure were considered "higher-performing" states. That is, their reported quality performance rates were at or above 75%, which CMS determined to be the threshold for higher performance.⁹ In fact, 10 states were at or above 90% performance rates for the percentage of children with access to a PCP for all 4 age groups.

With respect to the other pediatric preventive care measures examined in this report, state quality performance rates were much lower than the rates for PCP access. As shown in Table 6, the well visit performance rate in the first 15 months of life averaged 61%. Only 3 of the 46 reporting states had a performance rate at 75% or above, and 7 states had a rate at 50% or below. The percentage of children receiving at least one well child visit in the third, fourth, fifth, and sixth years of life averaged 68% among the 47 states reporting this measure. Twelve states performed at or above 75%, and 4 states scored at 50% or below. The adolescent well visit, measured as the percentage of adolescents ages 12 to 21 receiving at least one well visit, was reported on by 46 states, but at a significantly lower average rate of 45% compared to the well visit rates for younger children. In fact, no state performed above 75%, and 31 states scored at 50% or below.

Childhood immunization performance, measured as the percentage of children up to date on recommended immunizations by their second birthday,¹⁰ averaged 69% among the 41 reporting states. Seven states scored at or above 75%, while 5 states scored at 50% or less. Adolescent immunization rates were about the same: on average – 70% among the 43 states that selected this measure; 16 scored 75% or higher and 8 were in the lower half.

HPV vaccination performance was sharply lower in the 41 states that selected this measure, defined in the CMS core measurement set as the percentage with 3 doses of HPV vaccine by their 13th birthday. The average performance was 21%. Chlamydia screening, measured as the percentage of sexually active women ages 16 to 20 receiving at least one test for chlamydia, was reported in 45 states with average rate of 49%. Only one state scored above 75% for chlamydia screening.

Among the 39 states that selected to report on the percentage of children whose weight is classified based on BMI percentile, the average rate was 61%. Five states performed in the top quartile. During interviews, many states commented that low rates for this measure often had to do with lack of provider documentation in claims, not necessarily the lack of provision of the service. Preventive dental care visit rates averaged 48% among 50 states. No state performed above 75%, and 33 states had rates at or below 50%.

Financial incentives were used in more than two-thirds of state Medicaid programs to encourage pediatric preventive care, as shown in Table 8. More often states used provider financial incentives (n=33 states) compared to consumer financial incentives (n=25 states). Still, 20 states used both provider and consumer financial incentives to improve quality performance, particularly linked to the use of well care visits for infants, children, and adolescents.

Preventive Purpose in EPSDT Medical Necessity Definitions

The EPSDT benefit was originally enacted not only to provide comprehensive preventive care but also, as its name conveys, diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions. Interestingly, the large number of rejections for new military draftees due to untreated childhood diseases was a major impetus for this benefit. In 1989, the EPSDT benefit was amended to require that states provide children all medically necessary services allowed under the Medicaid statute even if they are not covered under the state plan. This federal standard for children goes beyond what is covered for Medicaid-insured adults. Based on reviews of each state's medical necessity definition used for coverage under EPSDT, Table 9 shows that 41 states (including DC) specifically included preventive language. Often states specified that medically necessary services include *preventive*, diagnostic, and treatment services for an illness, condition, injury, or disability. One state had no EPSDT medical necessity definition, leaving the remaining 9 states without explicit mention of a preventive purpose.

EPSDT Program Strengths and Best Practices

When asked about the greatest strengths of their EPSDT programs, state officials offered a range of responses that demonstrated extensive state interagency collaboration and, in several states, reliance on local health department infrastructures to support ongoing provider and consumer outreach, education, and follow-up. States also consistently mentioned close partnerships with their MCOs to improve access and quality preventive care for children. They also noted involvement with health professional groups, most often their American Academy of Pediatrics state chapter to update EPSDT requirements, as well as partnerships with pediatric academic centers to guide quality improvement initiatives. Repeatedly, states commented that the comprehensiveness of the EPSDT benefit enables them to proactively address the needs of infants, children, and adolescents. Table 10 summarizes examples of states' EPSDT best practices.

Conclusions and Recommendations

A total of 37 states (including the District of Columbia) followed Bright Futures as their EPSDT standard for pediatric preventive screening recommendations in 2018. If the additional 8 states with very similar recommendations to Bright Futures are counted, 45 states used or closely followed the AAP's current pediatric preventive care screening recommendations. Despite this positive finding, state articulation of their EPSDT recommendations and periodicity schedules was often not easy to locate on state Medicaid websites, and links to AAP's Bright Futures website (www.brightfutures.aap.org) are inconsistent. Importantly, however, several states stood out as having clear, concise EPSDT information on their state Medicaid website. These include Alaska, Colorado, District of Columbia, Kentucky, Maryland, and Nevada.

State EPSDT and Medicaid officials and their contracted providers have made extensive investments in addressing pediatric preventive care quality measurement, and improvement, often linked to financial incentives. Moreover, states' efforts to align primary care/medical home access with preventive care quality efforts were evident. Pediatric preventive care quality performance in state Medicaid programs was highest for PCP access, but precipitously dropped for well care visits, especially the adolescent well visit and for childhood and adolescent immunizations. Further, additional areas of needed preventive care improvement included chlamydia screening, preventive dental visits, BMI documentation, and especially HPV vaccinations.

Medical necessity definitions for EPSDT in 41 states incorporated a preventive purpose. No state, however, referenced Bright Futures in its EPSDT medical necessity standard. It is important to note, however, that more than half of states included a general reference to coverage decisions based on medical standards of practice. States may want to review their medical necessity definition for EPSDT to more closely align with the program's preventive purposes, broad coverage scope, and its relationship to medical professional standards, such as Bright Futures. States may also compare their medical necessity definitions to that of the AAP as found in the Academy's *Essential Contract Language for Medical Necessity* policy statement (online at: <http://pediatrics.aappublications.org/content/132/2/398>).

Best practices identified by state Medicaid officials revealed the comprehensiveness, reach, and pride that states have in their EPSDT efforts. EPSDT has become strategically connected to Medicaid's broader policy directions and program infrastructure, linked to efforts of sister state agencies, and aligned with managed care organization initiatives.

In February 2017, the AAP released its 4th edition of Bright Futures, with updated changes to the preventive care recommendations and resources.¹¹ It is important for state EPSDT programs to remain abreast of these and future changes and ensure that their websites as well as their provider manuals, MCO contracts, consumer materials, and administrative rules are up-to date and easily accessible, with links to the AAP Bright Futures website.

Recognizing the intersection of the pediatric preventive care performance measures examined in this review, states and their MCOs may want to consider aligning their pediatric quality improvement efforts by child population age group. States could, for example, align CMS core set measures related to pregnant women and infants, young children (ages 1-4), school-age children (ages 5-10), and adolescents (ages 11-20). This population health strategy may allow for more comprehensive, efficient, and targeted interventions.

In summary, this national review revealed enormous state Medicaid investment and leadership in EPSDT benefit coverage, service delivery, and quality improvement. Continued efforts are needed to ensure that states follow current Bright Futures recommendations and share this updated information with their MCOs, participating providers, and families/caregivers. Efforts to document the strategies used by higher-performing states on child preventive care core measures should be shared along with best practices for implementing pediatric preventive care innovations.

TABLE 1. USE OF BRIGHT FUTURES AS BASIS FOR STATE EPSDT SCREENING RECOMMENDATIONS

| States | Use of Bright Futures |
|-----------------|------------------------------|
| Region 1 | |
| CT | Yes |
| ME | Yes |
| MA | No* |
| NH | Yes |
| RI | No* |
| VT | Yes |
| Region 2 | |
| NJ | No* |
| NY | Yes |
| Region 3 | |
| DE | No |
| DC | Yes |
| MD | No* |
| PA | No* |
| VA | Yes |
| WV | Yes |
| Region 4 | |
| KY | Yes |
| MS | Yes |
| NC | Yes |
| TN | Yes |
| AL | No |
| FL | Yes |
| GA | Yes |
| SC | Yes |
| Region 5 | |
| IL | Yes |
| IN | Yes |
| MI | Yes |
| MN | No* |
| OH | Yes |
| WI | No |
| Region 6 | |
| AR | Yes |
| LA | Yes |
| NM | Yes |
| OK | Yes |
| TX | No* |
| Region 7 | |
| IA | Yes |
| KS | Yes |
| MO | No |
| NE | Yes |
| Region 8 | |
| CO | Yes |
| MT | Yes |
| ND | Yes |
| SD | Yes |

| | |
|------------------|-----|
| UT | No |
| WY | Yes |
| Region 9 | |
| AZ | No |
| CA | Yes |
| HI | Yes |
| NV | Yes |
| Region 10 | |
| AK | Yes |
| ID | Yes |
| OR | Yes |
| WA | No* |
| Tally | |
| Yes | 37 |
| *Similar | 8 |
| No | 6 |

*States that did not reference Bright Futures but had screening recommendations that were very similar.

TABLE 2. COMPARISON OF RECOMMENDED NUMBER OF PREVENTIVE CARE VISITS BY AGE CALLED FOR BY BRIGHT FUTURES AND STATE EPSDT PERIODICITY SCHEDULES

| States | Birth-9 mos. | 1-4 yrs. | 5-10 yrs. | 11-14 yrs. | 15-20 yrs. | Total |
|-----------------------|--------------|----------|-----------|------------|------------|-------|
| Bright Futures | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 1 | | | | | | |
| CT | 7 | 7 | 6 | 4 | 6 | 30 |
| ME | 7 | 7 | 6 | 4 | 6 | 30 |
| MA | 7 | 6 | 6 | 4 | 6 | 29 |
| NH | 7 | 7 | 6 | 4 | 6 | 30 |
| RI | 7 | 7 | 6 | 4 | 6 | 30 |
| VT | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 2 | | | | | | |
| NJ | 6 | 6 | 6 | 4 | 6 | 28 |
| NY | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 3 | | | | | | |
| DE | 7 | 5 | 6 | 4 | 6 | 28 |
| DC | 7 | 7 | 6 | 4 | 6 | 30 |
| MD | 7 | 7 | 6 | 4 | 6 | 30 |
| PA | 7 | 7 | 6 | 4 | 6 | 30 |
| VA | 7 | 7 | 6 | 4 | 6 | 30 |
| WV | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 4 | | | | | | |
| KY | 7 | 7 | 6 | 4 | 6 | 30 |
| MS | 7 | 7 | 6 | 4 | 6 | 30 |
| NC | 7 | 7 | 6 | 4 | 6 | 30 |
| TN | 7 | 7 | 6 | 4 | 6 | 30 |
| AL | 6 | 6 | 6 | 4 | 6 | 28 |
| FL | 7 | 7 | 6 | 4 | 6 | 30 |
| GA | 7 | 7 | 6 | 4 | 6 | 30 |
| SC | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 5 | | | | | | |
| IL | 7 | 7 | 6 | 4 | 6 | 30 |
| IN | 7 | 7 | 6 | 4 | 6 | 30 |
| MI | 7 | 7 | 6 | 4 | 6 | 30 |
| MN | 6 | 7 | 6 | 4 | 6 | 29 |
| OH | 7 | 7 | 6 | 4 | 6 | 30 |
| WI | 5 | 7 | 4 | 2 | 3 | 21 |
| Region 6 | | | | | | |
| AR | 5 | 6 | 4 | 4 | 6 | 25 |
| LA | 7 | 7 | 6 | 4 | 6 | 30 |
| NM | 7 | 7 | 6 | 4 | 6 | 30 |
| OK | 7 | 7 | 6 | 4 | 6 | 30 |
| TX | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 7 | | | | | | |
| IA | 7 | 7 | 6 | 4 | 6 | 30 |
| KS | 7 | 7 | 6 | 4 | 6 | 30 |
| MO | 6 | 6 | 4 | 2 | 3 | 21 |
| NE | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 8 | | | | | | |
| CO | 7 | 7 | 6 | 4 | 6 | 30 |

| | | | | | | |
|------------------|----|----|----|----|----|----|
| MT | 7 | 7 | 6 | 4 | 6 | 30 |
| ND | 7 | 7 | 6 | 4 | 6 | 30 |
| SD | 7 | 7 | 6 | 4 | 6 | 30 |
| UT | 6 | 6 | 4 | 4 | 6 | 26 |
| WY | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 9 | | | | | | |
| AZ | 7 | 6 | 6 | 4 | 6 | 29 |
| CA | 7 | 7 | 6 | 4 | 6 | 30 |
| HI | 7 | 7 | 6 | 4 | 6 | 30 |
| NV | 7 | 7 | 6 | 4 | 6 | 30 |
| Region 10 | | | | | | |
| AK | 7 | 7 | 6 | 4 | 6 | 30 |
| ID | 7 | 7 | 6 | 4 | 6 | 30 |
| OR | 7 | 7 | 6 | 4 | 6 | 30 |
| WA | 5 | 6 | 6 | 4 | 6 | 27 |
| Tally | | | | | | |
| Same # as BF | 43 | 42 | 47 | 49 | 49 | 40 |
| Not same # | 8 | 9 | 4 | 2 | 2 | 11 |

TABLE 3. SHARE OF STATE MEDICAID POPULATIONS IN DIFFERENT DELIVERY SYSTEMS, 2017

| States | Managed Care Types | % in MCO | % in PCCM | % in FFS |
|-----------------|--------------------|----------|-----------|----------|
| Region 1 | | | | |
| CT | FFS | -- | -- | 100% |
| ME | PCCM | -- | NR | NR |
| MA | MCO and PCCM | 48% | 21% | 31 |
| NH | MCO | 73 | -- | 4 |
| RI | MCO | 90 | -- | 10 |
| VT | PCCM | -- | 63 | 37 |
| Region 2 | | | | |
| NJ | MCO | 96 | -- | 4 |
| NY | MCO | 83 | -- | 17 |
| Region 3 | | | | |
| DE | MCO | 78 | -- | 22 |
| DC | MCO | 94 | -- | 6 |
| MD | MCO | 89 | -- | 11 |
| PA | MCO | 82 | -- | 18 |
| VA | MCO | 76 | -- | 24 |
| WV | MCO | 80 | -- | 20 |
| Region 4 | | | | |
| KY | MCO | 91 | -- | 9 |
| MS | MCO | 70 | -- | 30 |
| NC | PCCM | -- | 90 | 10 |
| TN | MCO | 100 | -- | -- |
| AL | PCCM | -- | 86 | 14 |
| FL | MCO | 92 | -- | 8 |
| GA | MCO | 73 | -- | 27 |
| SC | MCO | 76 | -- | 24 |
| Region 5 | | | | |
| IL | MCO and PCCM | 63 | 10 | 26 |
| IN | MCO | 80 | -- | 20 |
| MI | MCO | 75 | -- | 25 |
| MN | MCO | 76 | -- | 24 |
| OH | MCO | 89 | -- | 11 |
| WI | MCO | 67 | -- | 33 |
| Region 6 | | | | |
| AR | PCCM | -- | NR | NR |
| LA | MCO | 92 | -- | 8 |
| NM | MCO | 88 | -- | 12 |
| OK | PCCM | -- | 75 | 25 |
| TX | MCO | 85 | -- | 15 |
| Region 7 | | | | |
| IA | MCO | 93 | -- | 7 |
| KS | MCO | 95 | -- | 5 |
| MO | MCO | 76 | -- | 24 |
| NE | MCO | 100 | -- | 0 |
| Region 8 | | | | |
| CO | MCO and PCCM | 11 | 73 | 17 |
| MT | PCCM | -- | 72 | 28 |
| ND | MCO and PCCM | 25 | 40 | 35 |
| SD | PCCM | -- | 80 | 20 |

| | | | | |
|------------------|--------------|-----|----|-----|
| UT | MCO | 85 | -- | 15 |
| WY | FFS | -- | -- | 100 |
| Region 9 | | | | |
| AZ | MCO | 93 | -- | 7 |
| CA | MCO and PCCM | 79 | -- | 21 |
| HI | MCO | 100 | -- | -- |
| NV | MCO and PCCM | 72 | 6 | 22 |
| Region 10 | | | | |
| AK | FFS | -- | -- | 100 |
| ID | PCCM | -- | 95 | 5 |
| OR | MCO | 89 | -- | 11 |
| WA | MCO and PCCM | 85 | 2 | 13 |

FFS = Fee-for-service arrangements

PCCM = Primary care case management arrangements

MCO = Managed care organizations

NR = Not reported

Note: Numbers may total greater than 100% due to rounding.

Source: Gifford K, Ellis E, Edwards BC, Lashbrook A, Health Management Associates; and Hinton E, Antonisse L, Valentine A, Rudowitz R, Kaiser Family Foundation. *Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*. Washington, DC: HMA and Kaiser, October 2018.

TABLE 4. PEDIATRIC PREVENTIVE CARE QUALITY MEASURES IN STATE MEDICAID AND CHIP PROGRAMS, FFY 2016

| States | PCP Access * | Well Visits- 1 st 15 mos. | Well Visits- 3-6 yrs. | Well Visits Adol. | Child Im-mun. | Adol. Im-mun. | HPV Vacc. | Chlamy-dia Screen. | BMI Assess. | Prev. Dental Visit ** |
|-----------------|--------------|--------------------------------------|-----------------------|-------------------|---------------|---------------|-----------|--------------------|-------------|-----------------------|
| US | 46 | 46 | 47 | 46 | 41 | 43 | 41 | 45 | 39 | 50 |
| Region 1 | | | | | | | | | | |
| CT | X | X | X | X | X | X | X | X | X | X |
| ME | X | X | X | X | -- | -- | -- | X | -- | X |
| MA | X | X | X | X | X | X | X | X | X | X |
| NH | X | X | X | X | X | X | X | -- | X | X |
| RI | X | X | X | X | X | X | X | X | X | X |
| VT | X | X | X | X | X | X | X | X | -- | X |
| Region 2 | | | | | | | | | | |
| NJ | X | X | X | X | X | X | X | X | X | X |
| NY | X | X | X | X | X | X | X | X | X | X |
| Region 3 | | | | | | | | | | |
| DE | X | X | X | X | X | X | X | X | X | X |
| DC | X | X | X | X | X | X | X | X | X | X |
| MD | X | X | X | X | X | X | X | X | X | X |
| PA | X | X | X | X | X | X | X | X | X | X |
| VA | X | X | X | X | X | X | X | X | X | X |
| WV | X | X | X | X | X | X | X | X | X | X |
| Region 4 | | | | | | | | | | |
| KY | X | X | X | X | X | X | X | X | X | X |
| MS | X | -- | X | X | X | X | X | X | X | X |
| NC | X | X | X | X | X | X | X | X | X | X |
| TN | X | X | X | X | X | X | X | X | X | X |
| AL | X | X | X | X | X | X | X | X | X | X |
| FL | X | X | X | X | X | X | X | X | X | X |
| GA | X | X | X | X | X | X | X | X | X | X |
| SC | X | X | X | X | -- | -- | X | X | X | X |
| Region 5 | | | | | | | | | | |
| IL | X | X | X | X | X | X | X | X | X | X |
| IN | X | X | X | X | X | X | X | X | X | X |
| MI | X | X | X | X | X | X | X | X | X | X |
| MN | X | X | X | X | X | X | X | X | X | X |
| OH | X | X | X | X | -- | -- | -- | X | -- | X |
| WI | -- | -- | -- | -- | -- | -- | -- | -- | -- | X |
| Region 6 | | | | | | | | | | |
| AR | X | X | X | X | X | X | X | X | -- | X |
| LA | X | X | X | X | X | X | X | X | X | X |
| NM | X | X | X | X | X | X | X | X | X | X |
| OK | X | X | X | X | X | X | X | X | X | X |
| TX | X | X | X | X | -- | X | X | X | X | X |
| Region 7 | | | | | | | | | | |
| IA | X | X | X | X | X | X | X | X | X | X |
| KS | X | X | X | X | X | X | X | X | X | X |
| MO | -- | X | X | X | X | X | -- | X | -- | X |
| NE | X | X | X | X | X | X | X | X | X | X |
| Region 8 | | | | | | | | | | |
| CO | X | X | X | X | X | X | -- | X | X | X |
| MT | -- | -- | -- | -- | -- | -- | -- | -- | -- | X |

| | | | | | | | | | | |
|------------------|----|----|----|----|----|----|----|----|----|----|
| ND | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| SD | -- | -- | -- | -- | -- | -- | -- | -- | -- | X |
| UT | X | X | X | X | X | X | X | X | X | X |
| WY | X | X | X | X | -- | X | -- | -- | -- | X |
| Region 9 | | | | | | | | | | |
| AZ | -- | -- | -- | -- | -- | -- | -- | -- | -- | X |
| CA | X | -- | X | -- | X | X | X | X | X | X |
| HI | X | X | X | X | X | X | X | X | X | X |
| NV | X | X | X | X | X | X | X | -- | X | X |
| Region 10 | | | | | | | | | | |
| AK | X | X | X | X | -- | -- | X | X | -- | X |
| ID | X | X | X | X | X | X | X | X | -- | X |
| OR | X | X | X | X | X | X | -- | X | -- | X |
| WA | X | X | X | X | X | X | X | X | X | X |

*PCP access measures include the percentage of children with a primary care visit for:

- ages 12-24 months in past year
- ages 25 months-6 years in past year
- ages 7-11 years in past 2 years
- ages 12-19 years in past 2 years

**Preventive dental visit performance information obtained from CMS Form 416.

Source: Quality 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>

TABLE 5. PEDIATRIC PRIMARY CARE PROVIDER (PCP) ACCESS QUALITY PERFORMANCE, FFY 2016

| States | PCP Access 12-24 mos. | PCP Access 25 mos.-6 yrs. | PCP Access 7-11 yrs. | PCP Access 12-19 yrs. |
|-----------------|----------------------------------|--------------------------------------|---------------------------------|----------------------------------|
| US | 95.2% | 87.7% | 90.9% | 89.6% |
| Region 1 | | | | |
| CT | 98.4 | 93.8 | 96.2 | 95.4 |
| ME | 96.9 | 89.3 | 92.8 | 91.4 |
| MA | 96 | 94.7 | 97.6 | 96.1 |
| NH | 97.5 | 91.1 | 95 | 93.3 |
| RI | 94.2 | 92.5 | 97 | 95.9 |
| VT | 97.2 | 83.6 | 88.4 | 87.7 |
| Region 2 | | | | |
| NJ | 97.3 | 93.2 | 95.5 | 93.1 |
| NY | 95.4 | 93.9 | 96.7 | 94.5 |
| Region 3 | | | | |
| DE | 95.8 | 88.4 | 91.2 | 87.6 |
| DC | 93.5 | 87.9 | 92.7 | 90.5 |
| MD | 97 | 93.1 | 94.9 | 92.6 |
| PA | 96.9 | 89.3 | 93.2 | 92 |
| VA | 97.9 | 92.3 | 94.3 | 91.2 |
| WV | 94.2 | 87.9 | 93.4 | 92.4 |
| Region 4 | | | | |
| KY | 97.2 | 89.8 | 94.3 | 92.9 |
| MS | 96.2 | 89.8 | 91.3 | 86.9 |
| NC | 95.8 | 88.4 | 89.5 | 85.1 |
| TN | 91.8 | 85.1 | 91.1 | 87.8 |
| AL | 92.2 | 84.3 | 88.2 | 85.7 |
| FL | 94.6 | 88 | 87.1 | 83.6 |
| GA | 94.4 | 84.4 | 88.5 | 85.1 |
| SC | 82.5 | 94.1 | 87.7 | 85.3 |
| Region 5 | | | | |
| IL | 92.8 | 86.1 | 89.1 | 89.8 |
| IN | 95.6 | 87.4 | 90.6 | 90.9 |
| MI | 96.2 | 88.8 | 90.9 | 89.9 |
| MN | 94.9 | 87.4 | 91.1 | 91.4 |
| OH | 91.1 | 86.2 | 88.8 | 88 |
| WI | NR | NR | NR | NR |
| Region 6 | | | | |
| AR | 90.5 | 91 | 91 | 87.9 |
| LA | 95.6 | 88.2 | 88.2 | 86.8 |
| NM | 93.1 | 86 | 86 | 82.8 |
| OK | 96.2 | 89.8 | 92.1 | 92.8 |
| TX | 96.2 | 92.7 | 92.7 | 90.4 |
| Region 7 | | | | |
| IA | 96.6 | 90.9 | 90.9 | 91.9 |
| KS | 94.2 | 86.1 | 89.5 | 88.9 |
| MO | NR | NR | NR | NR |
| NE | 95.5 | 86.4 | 85.4 | 89.6 |
| Region 8 | | | | |
| CO | 91.8 | 79.2 | 83 | 82.7 |
| MT | NR | NR | NR | NR |

| | | | | |
|------------------|------|------|------|------|
| ND | NR | NR | NR | NR |
| SD | NR | NR | NR | NR |
| UT | 96.9 | 85.8 | 87.7 | 88.6 |
| WY | 93.8 | 82.9 | 72.8 | 75.5 |
| Region 9 | | | | |
| AZ | NR | NR | NR | NR |
| CA | 90.3 | 81.4 | 86.1 | 83.4 |
| HI | 97 | 90.5 | 91.8 | 89.5 |
| NV | 94.5 | 83.9 | 87.3 | 84.7 |
| Region 10 | | | | |
| AK | 92.2 | 80.5 | 83.7 | 85.5 |
| ID | 93.2 | 78.5 | 67.1 | 66.2 |
| OR | 94.8 | 86.7 | 90.1 | 90.6 |
| WA | 94.9 | 83.6 | 88.4 | 87.7 |

Source: Quality 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>

TABLE 6. PEDIATRIC PREVENTIVE CARE QUALITY PERFORMANCE RATES IN STATE MEDICAID AND CHIP PROGRAMS, FFY 2016

| States | Well Visits-1 st 15 mos. | Well Visits-3-6 yrs. | Well Visits-Adol. | Child Im-mun. | Adol. Im-mun. | HPV Vacc. | Chlamy-dia Screen | BMI Assess. | Prev. Dental Visit |
|-----------------|-------------------------------------|----------------------|-------------------|---------------|---------------|-----------|-------------------|-------------|--------------------|
| US | 60.8% | 68% | 45.1% | 68.5% | 70.3% | 20.8% | 48.8% | 61.2% | 48.2% |
| Region 1 | | | | | | | | | |
| CT | 80 | 84.9 | 68.2 | 79.1 | 86 | 23.6 | 57.8 | 60.5 | 62.7 |
| ME | 69.9 | 67 | 45 | NR | NR | NR | 39.8 | NR | 38.3 |
| MA | 82.7 | 85.8 | 68.4 | 81.1 | 82.4 | 20.9 | 68.7 | 83.4 | 54.6 |
| NH | 72.7 | 79.4 | 60.9 | 71.8 | 70.3 | 23.5 | NR | 69.4 | 54.8 |
| RI | 80.9 | 80 | 60.2 | 81.6 | 87.2 | 30.8 | 63.9 | 85 | 47.4 |
| VT | 67.4 | 72.6 | 46.9 | 56.1 | 63.5 | 18.6 | 49.6 | NR | 53.6 |
| Region 2 | | | | | | | | | |
| NJ | 65.7 | 77.7 | 59.4 | 61.4 | 82.8 | 20.4 | 50.2 | 68.6 | 49.2 |
| NY | 64.6 | 83.9 | 64.9 | 74.8 | 74.4 | 30.8 | 71.9 | 77.2 | 43.5 |
| Region 3 | | | | | | | | | |
| DE | 70.6 | 77.3 | 56.4 | 73.8 | 69.5 | 23.2 | 58.8 | 62.3 | 48.5 |
| DC | 56 | 78 | 59.6 | 68.5 | 75.6 | 42.8 | 77.8 | 75 | 52.5 |
| MD | 67.3 | 81.4 | 65.6 | 82.2 | 85 | 28.1 | 57.5 | 64.3 | 53.7 |
| PA | 69.6 | 76.4 | 56.9 | 75.2 | 84.8 | 26.7 | 53.7 | 70.2 | 46.1 |
| VA | 62.1 | 74.1 | 50.3 | 73.3 | 58.8 | 20.3 | 45.1 | 62.6 | 49.7 |
| WV | 64.1 | 73.6 | 46.9 | 70 | 83.6 | 22 | 36.5 | 61.2 | 50 |
| Region 4 | | | | | | | | | |
| KY | 62.4 | 70.5 | 44.8 | 64.1 | 72.3 | 17.6 | 50 | 56.2 | 46.7 |
| MS | NR | 53.7 | 35 | 75.5 | 47.3 | 20.2 | 47.2 | 29 | 50 |
| NC | 61.4 | 68.8 | 38.6 | 66.5 | 65.5 | 17 | 53.5 | 23.2 | 50.6 |
| TN | 57.6 | 68 | 43.3 | 71.1 | 67.1 | 15.9 | 48.2 | 69.6 | 47.9 |
| AL | 61.3 | 60.3 | 42.2 | 67.5 | 73.9 | 25.2 | 57.9 | 6.9 | 49.5 |
| FL | 57.5 | 74.2 | 51.4 | 71.9 | 67.2 | 20.8 | 56.5 | 61.7 | 35.9 |
| GA | 66.7 | 70 | 52.3 | 79.6 | 85.6 | 22.5 | 51.1 | 62.8 | 51.8 |
| SC | 54.2 | 55.2 | 32.7 | NR | NR | 6.3 | 47.9 | 18.8 | 49.5 |
| Region 5 | | | | | | | | | |
| IL | 60.3 | 71.1 | 47.1 | 58.7 | 64.8 | 21.8 | 45.9 | 7.6 | 42.5 |
| IN | 72.4 | 75.1 | 63.5 | 69.1 | 77.3 | 22.9 | 44.7 | 66.9 | 45.3 |
| MI | 66.2 | 75.1 | 54.7 | 71.1 | 87 | 20.4 | 60.8 | 74.9 | 41.8 |
| MN | 57.5 | 57.4 | 33.5 | 64.7 | 79.1 | 21.6 | 51.5 | 3.8 | 36.7 |
| OH | 49.8 | 64.6 | 41.6 | NR | NR | NR | 50.8 | NR | 34.6 |
| WI | NR | NR | NR | NR | NR | NR | NR | NR | 29.5 |
| Region 6 | | | | | | | | | |
| AR | 35.3 | 59.6 | 35.2 | 67.6 | 47.5 | 9.3 | 42.7 | NR | 48.4 |
| LA | 51.3 | 62.8 | 45.1 | 68.3 | 88 | 25.1 | 57.3 | 39.7 | 46.7 |
| NM | 48.9 | 55.8 | 32.6 | 61 | 44.2 | 16.2 | 47.7 | 53.7 | 53.1 |
| OK | 68.1 | 56.7 | 22.4 | 6 | 22.2 | 11.8 | 55.4 | 3 | 47.6 |
| TX | 54.4 | 76.4 | 61.3 | NR | 79.3 | 21.6 | 47.5 | 50.1 | 67.4 |
| Region 7 | | | | | | | | | |
| IA | 50.3 | 64.9 | 38.1 | 24.2 | 37.7 | 8.7 | 40.8 | 3.3 | 50.6 |
| KS | 58.7 | 64.8 | 46.8 | 70.6 | 62.3 | 18.4 | 41.3 | 48.6 | 45.8 |
| MO | 57.6 | 64.5 | 46.9 | 52 | 49.6 | NR | 44.4 | NR | 34.1 |
| NE | 41.2 | 56.3 | 41.2 | 15.8 | 53.4 | 13.8 | 26.4 | 1.7 | 53.9 |
| Region 8 | | | | | | | | | |
| CO | 44.6 | 57.4 | 32.7 | 52.7 | 65.2 | NR | 47.9 | 60.7 | 50.6 |
| MT | 42.5 | 45.4 | 31.6 | 25.8 | 37.8 | 9.4 | 40.7 | 0.8 | 30.1 |
| ND | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| SD | NR | NR | NR | NR | NR | NR | NR | NR | 44.8 |
| UT | 58.8 | 64 | 44.5 | 74.6 | 79.4 | 26.1 | 37.7 | 74.6 | 52.6 |

| | | | | | | | | | |
|------------------|------|------|-------|------|------|------|------|------|------|
| WY | 29.3 | 44.7 | 28.66 | NR | 19.6 | NR | NR | NR | 47.5 |
| Region 9 | | | | | | | | | |
| AZ | NR | NR | NR | NR | NR | NR | NR | NR | 43.1 |
| CA | NR | 71.3 | NR | 70.6 | 74.2 | 14.5 | 57.9 | 78.4 | 35.9 |
| HI | 72.9 | 75.8 | 46.5 | 57.8 | 52.3 | 17.2 | 55.6 | 66.6 | 63 |
| NV | 53.3 | 65.4 | 41.9 | 68.5 | 76.8 | 27.7 | NR | 67.7 | 42.2 |
| Region 10 | | | | | | | | | |
| AK | 73.1 | 47.6 | 29.3 | NR | NR | 1 | 47.8 | NR | 46.1 |
| ID | 57.5 | 48.3 | 29.1 | 38.2 | 56.5 | 13.4 | 41.1 | NR | 59.3 |
| OR | 62.5 | 61.3 | 37.5 | 64.3 | 62.3 | NR | 45.1 | NR | 39.1 |
| WA | 52.8 | 62.5 | 36.1 | 63.3 | 71.9 | 25.4 | 48.8 | 45.8 | 56.1 |

Source: 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>

TABLE 7. PEDIATRIC PREVENTIVE PERFORMANCE IMPROVEMENT PROJECTS, 2018

| States | PCP Access | Well Child/ Adol. Visits | Child/ Adol. Immun. | BMI Assess./ Obesity | Oral Health/ Prev. Dental Visit | Dev. Screen. | Behav. Screen. | Lead Screen. | Other |
|-----------------|------------|--------------------------|---------------------|----------------------|---------------------------------|--------------|----------------|--------------|----------------|
| Region 1 | | | | | | | | | |
| CT | | X | X | | X | | X | X | |
| ME | | X | | | X | | X | X | |
| MA | | | X | X | | | | | |
| NH | | X | | X | | | | | |
| RI | | X | X | | | X | | | X ¹ |
| VT | X | X | | | | | | | X ² |
| Region 2 | | | | | | | | | |
| NJ | | X | | X | X | | | X | |
| NY | | X | X | X | | | | | |
| Region 3 | | | | | | | | | |
| DE | | | | | | | | X | |
| DC | | | | | | | | | X ³ |
| MD | | X | X | | | | | X | |
| PA | | | | X | X | | | | |
| VA | | | | | | | | | |
| WV | | X | X | X | | | | | |
| Region 4 | | | | | | | | | |
| KY | | X | X | X | X | | X | X | |
| MS | | | | X | | | | | |
| NC | | | | | | | X | | X ⁴ |
| TN | | X | X | X | | | X | X | |
| AL | | X | X | X | X | | X | X | |
| FL | | X | X | X | X | | X | X | X ⁵ |
| GA | | X | X | X | | | | X | |
| SC | | X | | | | | | | |
| Region 5 | | | | | | | | | |
| IL | | X | X | X | | | X | X | |
| IN | | X | | | | | X | | |
| MI | | X | X | X | | | | X | |
| MN | | | | | | | | | X ⁶ |
| OH | | | | | | | | | X ⁷ |
| WI | | | X | | X | | X | | |
| Region 6 | | | | | | | | | |
| AR | | X | | X | | | | | |
| LA | | | X | | | | | | |
| NM | | | X | | X | | | | |
| OK | | X | X | | | | X | | |
| TX | | X | | | X | | | | |
| Region 7 | | | | | | | | | |
| IA | | X | | X | | | | X | |
| KS | | | X | | | | | | |
| MO | | | X | | X | | X | | |
| NE | | | X | X | | | X | | |
| Region 8 | | | | | | | | | |
| CO | | X | X | X | | | | | |
| MT | | | | | | | | | |
| ND | | X | X | | X | | | | |
| SD | | | | | | | | | |
| UT | | X | X | | | | | | |
| WY | | | | | X | | | | X ⁸ |

| | | | | | | | | | |
|------------------|---|----|----|----|----|---|----|----|----------------|
| Region 9 | | | | | | | | | |
| AZ | | | | | | X | | | |
| CA | | X | | X | X | | X | | |
| HI | X | X | X | X | | | | | |
| NV | | X | X | X | | | X | | |
| Region 10 | | | | | | | | | |
| AK | | | X | | | | | | |
| ID | | X | | X | | | | | |
| OR | | X | | | | X | | | X ⁹ |
| WA | | X | X | | | X | | | |
| Totals | 2 | 31 | 27 | 22 | 14 | 4 | 15 | 13 | 9 |

¹ RI has a PIP on consumer outreach and education.

² VT has a PIP on suicide prevention and on preventing infant mortality.

³ DC has a PIP on improving perinatal care.

⁴ NC has a PIP on maternal depression.

⁵ FL has a PIP on functional assessment of children with special needs.

⁶ MN as a broad set of MCH PIPs, but information was not available on specific PIPs.

⁷ OH has a PIP on premature birth reduction.

⁸ UT has a PIP on chlamydia screening.

⁹ OR has a PIP on adverse childhood experience and trauma-informed care.

TABLE 8. USE OF PEDIATRIC PREVENTIVE CARE FINANCIAL INCENTIVES, 2018

| States | Provider Financial Incentives | Consumer Financial Incentives |
|-----------------|--|--|
| Region 1 | | |
| CT | Yes | -- |
| ME | Yes | -- |
| MA | -- | -- |
| NH | Yes | Yes |
| RI | Yes | -- |
| VT | Yes | -- |
| Region 2 | | |
| NJ | Yes | Yes |
| NY | Yes | -- |
| Region 3 | | |
| DE | -- | -- |
| DC | Yes | Yes |
| MD | Yes | Yes |
| PA | Yes | -- |
| VA | -- | Yes |
| WV | -- | Yes |
| Region 4 | | |
| KY | Yes | Yes |
| MS | -- | Yes |
| NC | -- | -- |
| TN | Yes | Yes |
| AL | -- | -- |
| FL | Yes | -- |
| GA | Yes | Yes |
| SC | Yes | -- |
| Region 5 | | |
| IL | Yes | -- |
| IN | Yes | Yes |
| MI | Yes | Yes |
| MN | Yes | Yes |
| OH | Yes | Yes |
| WI | Yes | Yes |
| Region 6 | | |
| AR | -- | -- |
| LA | -- | -- |
| NM | -- | Yes |
| OK | Yes | -- |
| TX | Yes | Yes |
| Region 7 | | |
| IA | Yes | Yes |
| KS | Yes | -- |
| MO | Yes | Yes |
| NE | Yes | Yes |
| Region 8 | | |
| CO | Yes | -- |
| MT | -- | -- |

| | | |
|------------------|-----|-----|
| ND | -- | -- |
| SD | -- | -- |
| UT | -- | -- |
| WY | -- | -- |
| Region 9 | | |
| AZ | Yes | Yes |
| CA | Yes | Yes |
| HI | Yes | -- |
| NV | -- | Yes |
| Region 10 | | |
| AK | -- | -- |
| ID | -- | -- |
| OR | Yes | Yes |
| WA | Yes | Yes |
| Tally | 33 | 25 |

TABLE 9. STATE EPSDT MEDICAL NECESSITY DEFINITIONS WITH EXPLICIT PREVENTIVE PURPOSE

| States | Preventive Purpose Mentioned In EPSDT Medical Necessity Definition |
|-----------------|---|
| Region 1 | |
| CT | Yes |
| ME | Yes |
| MA | Yes |
| NH | Yes |
| RI | Yes |
| VT | Yes |
| Region 2 | |
| NJ | Yes |
| NY | Yes |
| Region 3 | |
| DE | Yes |
| DC | Yes |
| MD | Yes |
| PA | Yes |
| VA | Yes |
| WV | Yes |
| Region 4 | |
| KY | No |
| MS | No |
| NC | Yes |
| TN | Yes |
| AL | Yes |
| FL | Yes |
| GA | Yes |
| SC | No |
| Region 5 | |
| IL | No |
| IN | No |
| MI | Yes |
| MN | Yes |
| OH | Yes |
| WI | Yes |
| Region 6 | |
| AR | Yes |
| LA | Yes* |
| NM | Yes |
| OK | Yes |
| TX | Yes |
| Region 7 | |
| IA | No |
| KS | Yes |
| MO | Yes |
| NE | No |
| Region 8 | |
| CO | Yes |
| MT | Yes |
| ND | No |

| | |
|------------------|-----|
| SD | Yes |
| UT | Yes |
| WY | Yes |
| Region 9 | |
| AZ | NA |
| CA | Yes |
| HI | No |
| NV | Yes |
| Region 10 | |
| AK | Yes |
| ID | Yes |
| OR | Yes |
| WA | Yes |
| Tally | |
| Yes | 40 |
| No | 9 |
| NA | 2 |

NA = not available for review

*LA's medical necessity definition mentions a preventive purpose but only in relation to worsening of a condition.

Table 10. Examples of State EPSDT Best Practices*

- **Alabama's** EPSDT Care Coordination effort, a partnership of Medicaid and the Department of Public Health, involves outreach to children who are behind on EPSDT visits and provides assistance with referrals, transportation, and provider recruitment.
- **Alaska's** EPSDT program is leading a statewide effort to promote developmental screening, with online training, a collaborative learning network, and referral into their early intervention program.
- **Arizona's** Medicaid program, with EPSDT involvement, created an extensive set of cultural competency requirements for its MCOs, including an assessment of linguistic needs, comparative member satisfaction surveys, outcomes for certain cultural groups, and review of member complaints.
- **Arkansas** has incorporated pediatric preventive care quality metrics, targets, and shared savings incentive payments into its patient-centered medical home program.
- **California's** Medi-Cal's program, with EPSDT staff, established managed care requirements for a health education and cultural and linguistic group needs assessment with a plan to identify member's needs, disparities, and service gaps.
- **Colorado's** "Healthy Communities" program, involving Medicaid's EPSDT and the state's separate CHIP program, works to ensure that children and pregnant women have a medical and dental home and receive needed preventive care and referrals.
- **Connecticut's** EPSDT/Medicaid program has invested in supporting practices to become certified medical home providers, with incentives based on performance related to pediatric preventive care measures as well as to adult measures.
- **Delaware's** EPSDT/Medicaid and Maternal and Child Health program are participating in a multi-year collaborative to reduce infant mortality, including improving safe sleep, reducing smoking, promoting optimal women's health, addressing social determinants, and ensuring high-risk deliveries at appropriate facilities.
- **District of Columbia's** EPSDT program has played a major role in the integration of mental health and primary care for children, encouraging screening for perinatal and postnatal mood and anxiety disorders, creating a perinatal mental health toolkit, and allowing billing of developmental and behavioral health screenings.
- **Florida's** Physician Incentive Program offers enhanced payment in the form of a per member per month capitation to providers who achieve specific access and preventive quality performance for children. The state also prepares health plan report cards with this information for consumers and providers.
- **Georgia's** pediatric preventive care performance improvement project is called "Bright Futures PIP," and it follows a defined framework and data collection methodology to identify successful and unsuccessful efforts in order to expand effective preventive care interventions.
- **Hawaii's** EPSDT program participates in the state's interagency partnership to encourage evidence-based practices in developmental screening, professional training, and timely access to early intervention services.
- **Idaho's** EPSDT program has been part of a public/private partnership, called the Children's Healthcare Improvement Collaborative, to work on a variety of pediatric preventive care topics, including adolescent depression screening, immunizations, childhood obesity, transition to adult care, and patient-centered medical home in rural areas.
- **Illinois'** EPSDT guidance provides detailed information and referral resources for mental health and substance abuse screening, perinatal depression risk factors, and associated reimbursement codes.

- **Indiana's** EPSDT/Medicaid program has focused substantial attention with its MCOs on pediatric preventive care, including monthly meetings to monitor performance rates, corrective action plans, and use of financial incentives.
- **Iowa's** EPSDT program has been an active partner in the state's "First Five" initiative to encourage use of standardized developmental screening tools and timely referrals.
- **Kentucky** has extended its EPSDT benefit to children enrolled in the state's separate CHIP program, which has enabled the state to have consistent and comprehensive benefit coverage for children's preventive, diagnostic, and treatment services.
- **Maine's** EPSDT program has aligned its pediatric quality measures, EHR computer systems, clinical workflows, training, quality improvement strategies, and data reporting and exchange with Bright Futures.
- **Maryland's** EPSDT program includes a team of nurses serving as regional consultants, who provide outreach and provider training on EPSDT, conduct quality improvement activities, and help to ensure use of recommended preventive care recommendations and referrals.
- **Massachusetts'** EPSDT program has been actively involved in ensuring that its providers use approved standardized behavioral screening tools, and they have developed a set of billing guidelines to encourage the provision of mental health services in primary care settings.
- **Michigan's** EPSDT program issued a policy bulletin to its providers on coverage for trauma-informed services for children, with background on adverse childhood experiences and long-term impacts, use of suggested screening tools, billing information, and referral sources for behavioral health services.
- **Minnesota's** Medicaid program, with its EPSDT staff, has developed an Integrated Health Partnership program as an accountable care organization to integrate physical, mental health, chemical dependency, social services, safety net supports, and county and public health resources. To guide this effort, a multi-year study of family risk factors was conducted.
- **Mississippi's** MCOs, with involvement of EPSDT/Medicaid officials, have instituted a variety of incentive programs for parents to encourage obtaining preventive care for their children. One plan has a MasterCard reward card for completion of well child visits in a specified time. This is combined with a personalized interactive tool with text/email appointment reminders.
- **Missouri's** EPSDT/Medicaid agency and MCOs send a birthday newsletter to each child through their 20th birthday, which includes age-specific news, preventive care reminders, and links to health and community resources.
- **Montana's** EPSDT program, as part of a March of Dimes initiative called "Coming of the Blessing," developed culturally appropriate strategies to educate health care providers and Native American families to improve maternal and child health outcomes.
- **Nebraska's** EPSDT program eliminated diagnostic exclusions for autism and development disabilities to allow for coverage of behavioral modification services.
- **Nevada's** Medicaid program, involving EPSDT staff, submitted an 1115 waiver, called REACH (Resources for the Advancement of Child Health), to address behavioral risk early on. Prior to entering 7th grade, Nevada youth receive a risk assessment provided by traditional and non-traditional providers. Youth identified as "rising risk" are enrolled in a supported intervention program, and those identified as "at risk" are referred to appropriate community providers.
- **New Hampshire's** Medicaid agency has the Cent Account Program to promote the use of recommended preventive services. Families receive a prepaid MasterCard debit card and credit is added to the balance when preventive services are used.
- **New Jersey's** Medicaid program, with involvement of EPSDT staff, has established MCO contract requirements for lead case management services to monitor individual provider screening, outreach to those not receiving lead screening, and annual MCO reporting of lead outreach and activities.

- **New Mexico** has created an EPSDT Resource Handbook with all needed preventive care requirements and coding information. The state also works closely with Envision NM, based at the University of New Mexico, on child and adolescent health quality outreach, education, interdisciplinary training, technical assistance, and evaluation.
- **New York's** EPSDT plays a key role in the state's 5-year preventive agenda, which includes several pediatric preventive goals related to obesity prevention, tobacco use, immunization, sexually transmitted infections, breastfeeding, well visits, teen pregnancy prevention, underage age drinking, and suicide prevention.
- **North Carolina's** EPSDT program has developed a 3-page age-specific periodicity schedule and coding guide, with links to recommended screening tools.
- **Ohio's** EPSDT staff partnered with the Ohio Perinatal Quality Collaborative, its managed care plans, the county Pregnancy-Related Coordinators, and the Ohio Board of Pharmacy to reduce the number of premature births by ensuring continued Medicaid eligibility during pregnancy, creating a web-based pregnancy risk assessment tool, and ensuring timely notification of risk to consumers, providers, and plans, and receipt of needed progesterone.
- **Oklahoma's** EPSDT participated in the development of an Interconception Care Program, which provides case management services to teen mothers in counties with high fetal mortality rates.
- **Oregon's** Health Authority prepared a guidance document on improving adolescent well care with background from Bright Futures, discussion of the importance of well visits, Oregon's results from the state's Youth Risk Behavior Survey, health care transition information with links to Got Transition, and identification of common challenges and best practices.
- **Pennsylvania's** Medicaid program, with EPSDT staff involvement, established contact requirements for its MCOs to create a special needs unit to help families navigate the health care system and transition their children with complex needs to adult health care.
- **Rhode Island's** EPSDT program is partnering with the state's Department of Education to expand developmental screening for young children. The state has a cross-departmental shared Early Learning Data System that incorporates developmental screening results and integrates them into a secure data base on children's health.
- **South Carolina's** EPSDT program is creating a new web page on EPSDT to serve as a one-stop location for all EPSDT information needed by providers and consumers.
- **South Dakota's** EPSDT staff have achieved very high provider participation rates and commented on the importance of its decision to expand EPSDT benefits to children in their separate CHIP program.
- **Tennessee's** EPSDT program partners with its MCOs on needed areas of pediatric preventive care improvements. Currently, they are working together as an Adolescent Screening Group, involved in planning, joint events, including a teen newsletter.
- **Texas'** EPSDT program has implemented a comprehensive "First Dental Home" initiative to improve oral health of infants and young adults, from 6 months to 3 years of age. This includes developing simple messages for parents, training for providing a dental home, specification of content of first dental visit, caries risk assessment, and dental anticipatory guidance.
- **Utah's** EPSDT staff work closely with its Statewide Early Childhood Targeted Case Management Program, operated by local health departments, to promote the use of standardized screening, improvements in well child care use and immunizations, and linkages to medical home and community resources.
- **Vermont's** EPSDT program is involved in developing a network of health department school liaisons throughout the state to ensure that all children have health insurance, a medical home, and a dental home. This nurse network promotes the Bright Futures periodicity schedule and facilitates connections to local providers.

- **Virginia's** EPSDT staff has collaborated with the state pediatric provider community to establish a consistent set of evidence-based coverage policies, provider qualifications, licensure requirements, training resources, and reimbursement for behavior therapy for children with autism.
- **Washington** has a value-based purchasing initiative that links provider incentives and withholds to selected quality outcomes, including well-child visits for the 3-6-year-old age group, developmental screening, and childhood immunization.
- **West Virginia's** EPSDT program partners with its Department of Education to ensure all children have a medical and dental home and that all children receive regular preventive medical and dental care. Children progressing to grades 2, 7, and 12 must have a record of receipt of EPSDT screening.
- **Wisconsin's** EPSDT program works with its Department of Children and Families to implement Care4Kids for children in foster care. Care4Kids establishes a medical home team and an individualized treatment plan that includes trauma-related care, cross-system coordination, and use of well-being outcomes.
- **Wyoming's** EPSDT, with its Department of Health and an Oral Health Coalition, has launched a Community Health Coordinator Program in counties with the highest risk for dental disease. Dental hygienists perform oral health screenings for children ages 6 months to 5 years of age, assist with dental referrals, and provide fluoride treatment for children in day care settings and schools. They also have a parent and provider education effort to encourage the first dental visit when the child turns one and to promote the use of dental sealants.

*No best practice information was provided by Kansas, Louisiana, and North Dakota.

REFERENCES

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- ³ Section 1905 of the Social Security Act.
- ⁴ *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. Baltimore: Centers for Medicare and Medicaid Services, June 2014.
- ⁵ 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.
- ⁶ Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Work Group. 2017 recommendations for preventive pediatric health care. *Pediatrics*. 2017;139(4):e20170254.
- ⁷ 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>
- ⁸ Shugarman LR, Foster J. *White Paper: The Value of Medicaid Managed Care*. Washington, DC: Health Management Associated, November 2015.
- ⁹ Medicaid/CHIP Health Quality Measures Technical Assistance and Analytic Support Program. *The State of Children's Health Care Quality in Medicaid and CHIP: Who Are the Higher-Performing States?* Baltimore, MD: CMS, May 2015.
- ¹⁰ This childhood immunization (Combination 3) measure calculates the percentage of children identified as having the following vaccinations: 4 diphtheria, tetanus, and pertussis (DTaP); 3 inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); 3 Haemophilus influenzae type B (HiB); 3 hepatitis B; one varicella-zoster virus (chicken pox or VZV); and 4 pneumococcal conjugate vaccinations on or before the child's second birthday.