

NEW OPPORTUNITIES AND CONTINUING
CHALLENGES:

A Report from the NASHP EPSDT Forum

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EXECUTIVE SUMMARY

Early access to high-quality health care, such as that specified in Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, increases the likelihood that children will grow strong physically, emotionally, and socially. States, however, face ongoing challenges in bringing that promise into reality. A small group of key stakeholders examined these challenges in light of several new opportunities; most came to the following six conclusions:

1. Some groups of children might gain from access to a benefit package tailored to their needs. However, states choosing to use a tailored benefit package will need to closely manage the interface among available packages.
2. It is important that Medicaid agencies maintain a single common definition of medical necessity, so as to have one that applies to all children.
3. New technology along with the revised Bright Futures guidelines offer states new opportunities to support primary care providers in delivering EPSDT services, conducting outreach, and providing support to families.
4. Strong working relationships and alignment of reimbursement strategies to support the broader goal of high-quality care for all patients is critical for supporting primary care providers participation in delivering EPSDT services.
5. In many states, targeted case management is critical to helping families access care for their children; new federal regulations, although currently under moratorium*, may limit that tool.
6. The federal government should consider new and more effective ways to collect and use data about EPSDT services, especially in light of the advances in health information technology and measurement.

*On June 30, 2008, President Bush signed into law a supplemental war appropriations bill (HR 2642) with a provision that will delay for one year six new Medicaid regulations proposed by his administration, including the Targeted Case Management (TCM) regulations. The regulations, as currently proposed, could take effect as early as April 2009 without future congressional action.

INTRODUCTION

Early access to high-quality child health care and development programs builds a foundation that ensures each child the optimum chance to grow strong physically, emotionally, and socially. “The capacity to prevent many traditional threats to child health – particularly from acute infectious diseases – coupled with progress in screening for developmental and other disorders have greatly intensified both the cadence and the content of early preventive services for children.”¹

Medicaid, the primary insurer for more than a quarter of all children in the United States,² is the critical link to building this foundation for poor and low-income children. In 1967, in response to documented, widespread, preventable mental and physical illnesses among poor children, Congress added Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for beneficiaries under the age of 21. EPSDT is Medicaid’s comprehensive and preventive child health program that ensures that each child’s health and developmental needs are assessed through initial and periodic examinations and evaluations, and that health and developmental problems found are identified and treated early.³ Each state administers its own program within rules established by the federal government. These federal rules can be thought of as defining three components of the EPSDT benefit:

1. *EPSDT screening services*: These visits are analogous to well-child visits. Each Medicaid agency establishes a periodicity schedule for these visits (which often follow American Academy of Pediatrics [AAP] guidelines) and also allows for as-needed (interperiodic) visits. Federal law requires agencies to provide EPSDT screens to 80 percent of the children who participate in Medicaid. A screen must include:
 - a. Comprehensive health and developmental history, including an assessment of physical and mental health development;
 - b. Comprehensive unclothed physical exam;
 - c. Appropriate immunizations;
 - d. Laboratory tests, including blood lead level assessments; and
 - e. Health education and anticipatory guidance.
2. *Diagnosis and treatment*: Under federal law states must cover all services that can be covered under federal Medicaid law, even if not covered for adults. In addition, federal law specifies that children must receive not only the covered services needed to improve or cure a condition, but also those needed to ameliorate a condition or prevent deterioration. This requirement essentially establishes a medical necessity definition that includes preventive and early intervention services.
3. *Support services to access care*: These include activities such as:
 - a. Informing families about EPSDT;
 - b. Helping families access services, including assistance with scheduling, transportation, and translation; and
 - c. Care coordination, including links to other agencies.

Previous work by NASHP and others has shown that states face many challenges in ensuring that children receive comprehensive, high-quality EPSDT services. Several events over the past few years have presented new challenges as well as opportunities:

- : The Deficit Reduction Act of 2005 (DRA) increased states’ ability to develop specialized benefit

packages for subgroups of Medicaid beneficiaries and restricted use of case management services. A few states have changed their programs in response to the DRA. The Centers for Medicare & Medicaid Services (CMS) has issued draft regulations on both issues.⁴

- : States are working to implement Health Information Technology and Health Information Exchange (HIT and HIE) efforts to, among other goals, improve the care delivered to Medicaid beneficiaries, including children. In particular, the Medicaid Information Technology Architecture (MITA) developed by CMS creates a framework to help states improve their Medicaid Management Information Systems (MMIS) in order to improve support program administration and health outcomes for beneficiaries.⁵
- : AAP recently released the 3rd edition of its *Bright Futures* guidelines for health supervision of infants, children, and adolescents. These comprehensive health supervision guidelines include recommendations regarding immunizations, routine health screenings, and anticipatory guidance.⁶

In January 2008, with the support of the Robert Wood Johnson Foundation, NASHP convened a small group of state Medicaid and Maternal and Child Health (MCH) staff, CMS and provider representatives, and other experts on Medicaid and EPSDT to begin to help states address both the ongoing challenges and the recent changes outlined above. This group examined effective state strategies for maximizing Medicaid-enrolled children's access to timely, appropriate, and comprehensive health services through the EPSDT benefit. Participants identified challenges to effective delivery of the benefit as well as opportunities for its improvement.

This report summarizes the discussion at the meeting and is designed to help states learn of innovations, challenges, and opportunities, especially those related to the DRA, in efforts to ensure the best access to care for Medicaid-covered children.⁷ It examines four general areas of EPSDT services delivery:

- : Ensuring effective coverage, including both the structure of the benefit package and the definition of medical necessity;
- : Securing the participation of primary care providers in delivering EPSDT services and subsequent support of those providers;
- : Care coordination and case management; and
- : Data collection, reporting, and quality.

ENSURING EFFECTIVE COVERAGE

States have long been able to manage their Medicaid programs by establishing medical necessity definitions and utilization controls to ensure that individuals received services only when medically necessary. They have also been able to ‘split’ the benefit package so that a package of services similar to a commercial package is delivered through one system (e.g., HMOs), while other services are delivered through another system. The DRA, however, provided states with new flexibility to manage their programs by creating different benefit packages for different groups of Medicaid beneficiaries. According to CMS, the DRA:

...provides States with the flexibility to change their Medicaid benefit packages to mirror certain commercial insurance packages through the use of benchmark plans. States may use this authority to leverage employer-sponsored coverage of Medicaid beneficiaries. While only certain groups of beneficiaries may be mandated into a benchmark plan, States may also use this flexibility to provide tailored benefits to meet the special health needs of other groups of beneficiaries on a voluntary basis. Within these packages, states have the option to amend their State Medicaid Plan to provide State flexibility in benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements.⁸

As of January 2008, nine states had obtained approval from CMS for state plan amendments under the DRA.⁹ These states used the DRA to make changes in both of the ways envisioned by CMS: in “comprehensive” benefits and in “tailored” benefits.

- : Three states made comprehensive changes to their Medicaid benefit package: Idaho, Kentucky, and West Virginia.
- : Eight states made ‘tailored’ changes, either (1) adding a single service to the entire program (for example, disease management personal assistance), or (2) adding new benefit packages for a small group of beneficiaries (for example, pregnant women with incomes between 200 and 250 percent of the federal poverty level adults with certain conditions): Idaho, Kansas, Kentucky, Missouri, South Carolina, Virginia, Washington, and Wisconsin.
- : Two states made both comprehensive and tailored changes: Idaho and Kentucky.

Some meeting participants believed it important to challenge the assumptions they saw behind the DRA: private coverage is better than public coverage; substantial co-pays introduce more personal responsibility; and benefit packages with substantial limits for specialized care for “healthy populations” are the most appropriate course. However, most concluded that the DRA did not greatly increase states’ flexibility to manage benefits, but did create a new path that states could use to obtain federal approval for targeting benefits to specific groups of Medicaid beneficiaries. As such, the DRA creates an opportunity for states to re-examine their benefit packages, delivery systems, and medical necessity definition. In terms of children’s coverage, meeting participants felt DRA provisions will allow states to:

- : Consider how (and if) they should tailor coverage for some groups of children; and
- : Ensure that the process of deciding whether an individual child qualifies for a specific service continues to use the broad, preventive criteria established in federal EPSDT law.

TAILORING BENEFIT PACKAGES AND DELIVERY SYSTEMS

The first question that arises when considering how to design tailored benefit packages is, “What should be tailored for whom?” States now have many options for establishing different groups of benefits that

may be delivered through different delivery systems to different groups of children. The options chosen at each of these decision points can either promote or prevent children's access to services. Some meeting participants felt that states need more information in order to make more informed decisions. This information would also help them to identify specific high-need subpopulations with common characteristics and target for whom an organized and focused health delivery system (with flexible or enhanced benefits) could deliver significant improvements in quality and cost-effectiveness. Two such subpopulations were identified in the discussion:

- : *Adolescents*. Several participants agreed that it could be beneficial to craft a specialized adolescent benefit package that recognized the age group's unique needs, strengths, and vulnerabilities, including sexual and mental health needs. If states were to use the DRA to articulate clearly a set of covered services for adolescents, a preventive focus for children's health - a focus reserved traditionally for children ages birth to three - could be migrated into additional age groups.¹⁰
- : *Children in foster care*. One participant stated that, within this group, segmenting care *would not prevent* but rather *allow* appropriate care. For example, children in foster care should automatically receive a full assessment to identify any health or developmental needs, based on the assumption that these children are at high risk and should be guaranteed services.

Even though meeting participants agreed that targeted groups of children could benefit from tailored benefit packages – and that states had long implemented them – participants also expressed two concerns about the practice. First, they noted that ‘customizing’ doesn’t change federal EPSDT requirements, but could change physicians’ perceptions of covered services. This change could prevent children from receiving the full benefit of EPSDT. Second, participants noted that some states may use DRA flexibility to cover additional children and improve appropriate coverage for age-specific preventive services. They expressed concern, however, that some states may use this flexibility to limit coverage, which could ultimately result in increases to emergent care costs or in legal battles for cases where these changes resulted in failure to meet EPSDT requirements.

One participant expressed an additional concern: under the DRA, states must allow many groups of children with complex needs (such as children who qualify for Medicaid because they have a disability) to choose between the standard Medicaid coverage and the benchmark package.¹¹ As a result, any state that chooses to use the DRA to tailor a benefit package for one or more of these groups runs the risk that not all of the children for whom the package is designed will choose the package. Therefore, those who do not would not have access to the specialized services.

Tailored packages of benefits and delivery systems require much coordination

While meeting participants saw several potential opportunities to improve the care provided to children by tailoring benefit packages and delivery systems for some subpopulations, they also expressed concern that doing so may be difficult to implement and would make the system more complex. Participants believed that an effective system of tailored benefit packages would require improved coordination among delivery systems and state agencies.

Rhode Island is an example of a state that has developed a system of tailored programs. In 1994, Rhode Island began requiring that most children receive the majority of services through health plans (behavioral health and dental services being among the major services to remain in the fee-for-service delivery system). Then, in 1998, the state decided to take an active role in promoting health (in addition to paying for health services). The state combined several separate agencies serving children into a single new agency to fulfill this role. This agency, the Center for Child and Family Health, used the EPSDT statute as a tool to design a continuum of services for children with special health care needs

(CSHCN). In 2003, the agency opted to select one health plan that CSHCN clients could choose as an alternative to the standard plans. This plan is responsible for all services provided to enrollees; it includes those benefits that remain as fee-for-service for other children along with several new benefits designed for CSHCN, such as a Personal Assistance Services and Supports program. Rhode Island considers the tailored program to be very successful. Eighty percent of eligible children have opted into the program, and participants' behavioral health care costs have dropped by 25 percent.

Policy makers in Rhode Island believe that a critical factor in their success is extensive coordination among Medicaid, Title V, HMOs, and advocacy groups. This coordination is critical, not only to developing tailored programs that work for beneficiaries, but also in ensuring that beneficiaries can move among the programs as their health needs and conditions warrant. Other meeting participants also cited an increasing need for coordination among state agencies, health plans, and providers as the complexity of the system increases – as it would in a system with multiple, tailored benefit packages.

Rhode Island's experience indicates that bringing the state agencies involved in delivering care to children into a single agency can improve coordination at the state level. A participant from another state cautioned that experience indicated that combining agencies by itself may not sufficiently increase coordination among those who administer state programs or with stakeholder groups.

Meeting participants saw health information technology as an important tool for increasing coordination, both among agencies and in delivering care to individuals. Agencies and providers can better meet the needs of the constituencies and individuals they serve if they can efficiently share both aggregate- and individual-level data. However, participants reported that there were many barriers to effective data sharing. Some are technological; others stem from a lack of agreement about how and when to share information. Further, it was noted that it is easier to reach agreement about sharing information needed for program operation. Yet, even then, some agencies are reluctant to share information for fear of violating privacy laws.

MEDICAL NECESSITY

Benefit packages define what benefits are available. Medical necessity defines under what conditions an individual child may receive a covered service. Therefore, the definition of medical necessity is just as critical to ensuring effective coverage as the benefit package itself. As previously described, federal EPSDT requirements establish a very broad medical necessity standard for children, one entitling them to receive any covered benefit needed to prevent, ameliorate, or treat a health condition. Most meeting participants believed that it was important that Medicaid agencies maintain a single common definition of medical necessity that applies to all children, even if subgroups of children have access to different benefit packages.

Prior authorization and other utilization controls are methods for putting the state's definition of medical necessity into operation. Thus, it is critical that these controls be designed to support the definition of medical necessity and that there be a mechanism for updating them as medical knowledge advances. Participants discussed several ideas for meeting both criteria. Arkansas, for example, contracts with a non-profit agency that is charged with determining whether services provided to Medicaid eligible children are, in fact, medically necessary. Virginia has an automatic second review in the utilization management and prior authorization process when the beneficiary is a child. One participant suggested that states might benefit from creating advisory bodies of primary care providers to provide expert opinion on medical necessity decisions.

SUPPORTING PRIMARY CARE PROVIDERS IN DELIVERY OF EPSDT SERVICES

Primary care providers play a key role in the delivery of EPSDT services. Ideally, they conduct the comprehensive EPSDT screens that are a linchpin of EPSDT and identify any needed follow-up services (further assessment, treatment, or care coordination). However, states face challenges in recruiting primary care providers, in helping them understand the EPSDT benefit and their role in its delivery, and in supporting physicians to deliver the benefit.

While roughly two-thirds of any given state's pediatricians accept new Medicaid patients,¹² there remains more that states can do to ensure that children covered by Medicaid have access to physicians who will provide the services to which they are entitled. Meeting participants focused on two issues deemed critical to supporting primary care providers' participation in delivering EPSDT services:

- : Structuring payment to better support and provide incentive to primary care providers who provide early and comprehensive health care to children covered by Medicaid; and
- : Creating strong working relationships with the physician community, to build upon the compatibility of the EPSDT benefit with the broader goal of high-quality care for all patients.

STRUCTURING PAYMENT TO SUPPORT CARE

Providers cite several reasons for non-participation in Medicaid. Administrative processes are seen as confusing, burdensome, and divergent from the practices of commercial insurers. Providers may feel that Medicaid-enrolled patients are more difficult to manage, due to other social problems that exacerbate physical health issues and often result in missed appointments and noncompliance with treatment plans.

The most commonly cited reason for low physician participation in Medicaid, however, is that low payment rates and payment strategies that do not emphasize primary care are a disincentive to participation, and especially to follow-through with the various requirements of ESPDT. Medicaid payment rates usually fall far below the rates paid by commercial insurers, and are often even lower than the rates paid by Medicare.¹³ Rates that may not meet a provider's overhead expenses are likely to discourage participation in the program. For example, although the requirements of EPSDT may, by law, give a state's Medicaid enrollees access to a richer benefit package than those enrolled in the State Children's Health Insurance Program (SCHIP), in practice, higher reimbursements in a state's SCHIP program may provide incentive to see these patients as preferred over Medicaid patients.

Meeting participants had several ideas as to how states could address the issue of low reimbursement. The first is to simply raise payment rates for existing procedures. While meeting participants stressed that children's services are not a major driver of Medicaid costs (i.e., fee increases for physicians' services would likely be less expensive than increases for other types of services), rate increases often require legislative approval. This may not be feasible in a restrictive budget environment. A second idea is the establishment of incentive programs, such as pay-for-performance, for physicians agreeing to take on a certain level of Medicaid participation. A third suggestion is for Medicaid programs to identify areas in which providers incur costs that may not be reimbursable, such as provision of translation services or participation in Health Information Technology initiatives. Even if Medicaid cannot reimburse providers directly for such services, a state might help mitigate costs by organizing a central resource for providers to use.

The Massachusetts Child Psychiatry Access Project, which includes a hotline that primary care providers can call free-of-charge for assistance in assessing patients' mental health conditions, was cited as a good example of a state-organized specialty resource. The hotline allows primary care providers to deliver

a better service (and gain confidence in providing this type of care). It also benefits the state in the form of lowered emergency room visits and psychiatric hospital admissions. The state's Department of Mental Health pays for the resource, while primary care physicians may call for assistance with any child, regardless of Medicaid eligibility.¹⁴

One approach that states could take to improve providers' ability to capture funding for all of the services they provide is to reevaluate how they pay for the comprehensive EPSDT screen. A state might allow physicians to be reimbursed separately for discrete procedures provided during an office visit. For example, rather than paying physicians a bundled rate that includes all services provided during a visit, states might pay separately for some procedures that occur during the course of a visit, such as developmental screening. Although the incremental difference in payment might result in a small increase in Medicaid costs, the cumulative effect could make a difference in provider behavior. For example, Virginia attributes doubling the amount of claims submitted for developmental screenings in the past year to the fact that the state informed providers of their ability to bill separately for such screens, adding outreach efforts to encourage the use of the screenings.

In a similar vein, physicians may find it difficult to provide all of the services that states consider part of a comprehensive EPSDT screen in the limited time that they have available during a single patient appointment. Some meeting participants suggested that states might consider devising a method to allow physicians to provide portions of the comprehensive EPSDT screen over multiple patient visits. Implementing such a policy would be complex, as states would need to:

- : Develop clinical guidelines for how best to subdivide the comprehensive screening;
- : Establish data collection processes that can track the provision of the separate pieces of the screen;
- : Ensure that the increased number of visits is manageable for both providers and patients; and
- : Monitor that the new flexibility is not being abused.

However, such a policy might allow physicians to manage their time better. This could potentially increase provider compliance regarding provision of all necessary components of the EPSDT screen.

Moreover, meeting participants urged broader reconsideration of how payment structures of Medicaid, Medicare, and private payers undervalue primary care and patient management in relation to subspecialty care, and how health care payment incentives are weighted toward paying more for late-stage treatment of disease than for early prevention.

PRIMARY CARE CASE MANAGEMENT AND THE MEDICAL HOME

Illinois' experience in building a primary care case management (PCCM) network was cited as an example demonstrating willingness among primary care providers to serve the Medicaid population, especially in a context where financial incentives are aligned with desired improvements in health care delivery.

Illinois recently implemented the Health Connect program, a primary care case management (PCCM) program that serves more than 1 million children. In this program, the state contracts with primary care providers (PCPs) to serve as medical homes for enrollees and manage their care. Medical homes offer a conceptual approach for partnership between pediatric health professionals and families, allowing them to come together in the primary care setting to address all of a child's health and non-health related needs. PCPs receive fee-for-service payments for the services they provide, as well as a monthly per-person payment for providing care management services. Illinois Medicaid provides PCPs with ongoing information and support, such as monthly panel rosters, patient claims information, a provider help desk, provider service representatives in the field, and regular newsletters to help them fulfill their role as a medical home.

For example, each month PCPs receive a panel roster that identifies, based on claims data, which of their Medicaid enrollees are due for an EPSDT screening visit. PCPs also receive regular reports showing their performance on almost 20 measures. More than 5,000 providers have enrolled in the Illinois Health Connect program to serve as PCPs. They have pledged more than 5.3 million slots for enrollees – more than four times the capacity needed.¹⁵

The idea of using the PCCM model to strengthen PCPs' ability to serve as a medical home was attractive to meeting participants, who suggested further exploration of PCCM strategies that have been successful in other states.

STRENGTHENING TIES TO THE PROVIDER COMMUNITY

Meeting participants stressed that, while providers may encounter some difficulties in Medicaid participation, most continue to participate because of their desire to provide high quality care and their commitment to serving children in families with low incomes. States can build upon this foundation of goodwill by partnering with providers and their associations to identify problems and craft solutions, by involving providers in advisory roles, and by recognizing the good work of each EPSDT provider.

A natural partner is the state's chapter of the American Academy of Pediatrics (AAP). Meeting participants felt that the AAP's Annual Leadership Forum, a national meeting of all state AAP chapters, might offer a promising venue for disseminating information about the innovative practices states are using to improve their EPSDT performance. States could also gather advice from the provider community as to the best ways to align messages about EPSDT with the other tools that providers receive regarding standards of care.

The most important of these other tools is AAP's Bright Futures, which focuses on health promotion and disease prevention standards. Meeting participants felt that it was important for states' EPSDT screening visit standards and guidance to be as compatible as possible with Bright Futures. This way, providers could view participation in EPSDT as an extension of their profession's commitment to high-quality care for all children, rather than as a set of requirements separate from their own core mission. New York, for example, has redesigned its Medicaid provider handbooks to read like the Bright Futures manual.¹⁶ Likewise, participants suggested that states might need to revise their EPSDT periodicity schedules to better align them with the new AAP standards. Participants also suggested that Medicaid agencies consider using "V codes" (i.e., International Classification of Diseases diagnosis codes that are used for "unclassified" conditions) for purposes of billing prevention-oriented and early-intervention EPSDT services versus standard pediatric diagnosis codes. Meanwhile, participants felt that the unique requirements of EPSDT, which go beyond well-child visits, should be maintained as a standard distinct from Bright Futures.

State EPSDT coordinators can also work closely with provider advisory groups, quality improvement groups, and their own state AAP chapters to develop common approaches to improving providers' awareness of and compliance with EPSDT requirements. Drawing on the expertise of physicians to help craft plans for change can help the plans to be seen as credible, practical, and self-generated, rather than imposed from outside. In Illinois, for example, the state AAP chapter and the Illinois Academy of Family Physicians were instrumental in developing training materials and conducting in-office trainings for the Healthy Beginnings project. The project engages practitioners and their medical office staff (who are a critical point of contact between the patient and the practice) in peer-to-peer learning on ways to integrate a standardized developmental screening tool into their office visits.¹⁷

CARE COORDINATION AND CASE MANAGEMENT

Care coordination and case management are terms used interchangeably to describe an array of activities that help link families to services, avoid duplication of effort, and improve communication between families and providers. In this paper, we use case management to refer to both terms and define it to include both the services necessary to bring children into the system, as well as those necessary to help a child and his or her family gain access to needed care

Federal Medicaid rules recognize two types of case management:

1. Administrative case management is meant to assist in efforts to help all Medicaid beneficiaries access services. It includes activities such as: outreach, service coordination, case planning and monitoring, and service identification. The federal government reimburses states 50 percent of the cost of administrative case management services.
2. Targeted case management services are meant to assist a defined group of Medicaid beneficiaries (for example, pregnant women or children with severe mental health conditions) with accessing needed care. The federal government also reimburses states for a portion of the cost of targeted case management services – the same portion it contributes to cover the cost of other benefits. This rate varies by state, but is never less than 50 percent.

The DRA included several provisions relevant to case management, including case management services, under EPSDT. In November 2007, CMS published regulations implementing these provisions. The proposed regulations, currently under moratorium, define case management as: “services which help beneficiaries gain access to needed medical, social, educational, and other services.” (On June 30, 2008, President Bush signed into law a supplemental appropriations bill (HR 2642), which included a provision that will delay for one year six Medicaid regulations proposed by his administration, including the targeted case management regulations. The regulations, as currently proposed, could take effect as early as April 2009 without future congressional action.) The regulations further define these services to include: assessment, development of a care plan, referral to services, and monitoring and follow-up. Excluded services include:

- : those integral to another Medicaid service,
- : those including direct delivery of an underlying service to which the person has been referred,
- : those involving foster care program administration,
- : those that constitute the administration of another non-medical program (child welfare or special education), or
- : those claimed as necessary for the administration of the State Medicaid Plan.

CASE MANAGEMENT TO HELP FAMILIES OBTAIN EPSDT SCREENS

As discussed previously, one aspect of case management for EPSDT is to help children enter the health care system through periodic EPSDT screens. Meeting participants identified two important avenues to achieving that goal: 1) conducting outreach and education to encourage families to seek services, and 2) making preventive services more accessible to families.

Outreach and education

Meeting participants felt it was crucial for states to conduct outreach and provide support to families accessing services. The state of Minnesota believes it can increase its EPSDT screening rate by better in-

forming and educating families as to the importance of preventive care. Minnesota Medicaid agency staff believes that an important element of outreach involves sharing *why* it is important to go in for preventive visits; to that regard, they share information about tests or services the child will receive. The state has developed specialized software to conduct outreach by using claims data to generate reminder letters for each visit due. Data are downloaded monthly and fed into county software to determine who has been in for certain visits and for whom reminder letters should be generated. One county included a brochure on lead screening with all reminder letters for one year-old visits. The brochure describes the importance of lead screening and also explains that, often, there are no associated symptoms evident with lead poisoning. The response of families calling to schedule visits for their one year-olds jumped significantly when compared to previous mailings containing the reminder letter alone. Now, the state is working to develop other topical information (such as the importance of developmental screening), which can be included in reminder letters for children of other ages. Rhode Island's managed care contracts include requirements that serve a similar function. These requirements include: welcome calls or letters, health risk assessments, member handbooks, and a monthly newsletter.

Meeting participants agreed that one challenge states need to address through outreach and education is the value families place on preventive care. For example, Virginia's MCOs conducted focus groups of Medicaid beneficiaries. The MCOs found that health care prevention was a very low concern for beneficiaries, and that they did not consider 'survival and safety' as linked to health care. Meeting participants felt that addressing this conceptual barrier would require a significant investment of resources and perhaps a 'paradigm shift' among providers and consumers in general.

Finally, participants agreed that primary care providers play an important role in educating families about the importance of preventive care, including the need for periodic screens. One state reported it very effective to work with primary care providers to encourage them to give families materials describing the purpose of the next periodic screening visit at the end of each visit.

Making services accessible

Participants agreed that it is important to enable families to obtain services in the communities in which they live and at the times that fit their needs. Participants believed that doing so will help families obtain preventive care for their children and, at the same time, help states to meet EPSDT screening requirements.

For example, since it is difficult for some beneficiaries to take time off from work to visit the doctor, some participants believed it important to encourage providers to offer service hours outside of normal business hours and, perhaps, for states to pay more for visits occurring during those hours. Some participants pointed out that it was also important to persuade employers to grant their employees appropriate time off from work so they could keep appointments during business hours.

In addition, one participant mentioned that she was considering working with retail clinics, such as those within Wal-Mart, to allow such clinics to provide EPSDT screenings if they passed along documentation to the child's primary care provider. Participants debated the relative merits of this approach, but were unable to reach agreement. Several participants strongly believed that retail health clinics could increase EPSDT screening rates by making the services more convenient for parents to access. Others expressed concern that children who received their screens from a retail clinic would not receive comprehensive primary care as envisioned in EPSDT since these clinics do not provide such care.

A representative from the American Academy of Pediatrics mentioned that the organization is working to

develop strategies to encourage physicians to institute office hours that are better suited to Medicaid patients' schedules. AAP is also trying to appropriately incorporate retail clinics (which usually do not provide comprehensive primary care) into the delivery system.

CASE MANAGEMENT TO HELP FAMILIES ACCESS FOLLOW-UP SERVICES FOR IDENTIFIED CONDITIONS

All meeting participants agreed that many families needed assistance in accessing diagnoses and treatment services for conditions identified during an EPSDT screen. They also identified a role for case management in ensuring that the primary care provider is informed of the results of any referrals made as the result of a screen. Primary care providers reported that they were least likely to be informed of the results of referrals to community organizations – a clear function of case management. Participants felt that increased use of health information technology would help resolve some of these issues. Others suggested conducting case conferences that include the primary care provider by telephone or through web-based technology.

Meeting participants discussed the proposed federal case management rules. These raised many questions and concerns among participants. Of particular concern was the requirement for a single case manager for a child. Participants acknowledged the real risk for potential inefficiencies when no one person is responsible to assure services are received or appropriate referrals are being made. Also, they share CMS's concern about unnecessary duplication of services. Participants, however, felt it unreasonable for one case manager to know all systems a child may need to access well enough to meet the child's needs. Also of concern was the potential for these new rules to reduce the incentive for coordinating across systems by reducing available resources.

Some participants expressed interest in case studies of best state practices in different types of care coordination and case management, such as: medical home and PCCM, linkage, resource and referral, and disease management models. Several also expressed interest in working with CMS to create effective guidelines that would define, among other things, the conditions under which a single child might best be served by multiple case managers.

Finally, as one participant pointed out, recent administrative actions, including the revised targeted case management regulations,¹⁸ could cause states to limit case management and care coordination services provided by Medicaid and, instead, shift the provision of those services onto other state agencies' systems, such as child welfare. These other agencies, unlike Medicaid, are not focused primarily on children's health needs and may not be familiar with EPSDT.

COLLECTION AND USE OF DATA

Reporting is an integral part of federal EPSDT requirements. The main method states use to report their EPSDT performance is the Annual EPSDT Participation Report, more commonly known as the CMS-416 form. This form requires states to provide information, by age cohort and eligibility category, as to the number of EPSDT screens provided and the numbers of children screened, referred for treatment, receiving dental services, and receiving tests for lead. It also requires states to report information that helps interpret those numbers, such as the number of eligible children and the number of children enrolled in managed care.¹⁹

Some states have gone beyond this basic requirement and have begun to apply managed care quality improvement strategies while developing health information technology to support screening. Examples of state efforts include the following:

- : Illinois uses its External Quality Review Organization to conduct a chart review to determine whether contracted Managed Care Organizations were providing all components of a screen (including developmental screening). As a result of this study, the state changed its MCO contract to improve definition of expectations and worked with the MCOs and local AAP chapter to offer training to MCO-contracted physicians.²⁰
- : Rhode Island uses a comprehensive performance incentive program that includes performance requirements for delivering well-child visits to infants and adolescents.²¹
- : Wisconsin employs a third-party contractor to generate rates of EPSDT screens from administrative data and uses a pay-for-performance strategy. As a result, “the rate for children receiving seven or more EPSDT exams by age two has increased from 45.5 percent in 2000 to 69.1 percent in 2006.” In addition, ten HMOs have conducted performance improvement projects (PIPs) on EPSDT since 2000.²²

THE CMS-416 AND HEDIS MEASUREMENTS

Ideally, the annual CMS-416 report provides a basis for measuring a state’s progress in providing required EPSDT services over time and for comparing performance among states. There are, however, several recognized shortcomings with the form. Almost all meeting participants agreed that these problems limit the usefulness of the reports in gauging progress and fostering improved care, both for individual states and nationally. Among the identified issues is incomplete information on services paid through capitated payments or encounter rates. Also, most meeting participants believed that the form does not capture important information in areas such as referrals for treatment of identified medical problems.

Additionally, the accuracy of the CMS-416 is dependent upon the completeness and quality of the information on which it is based. It is relatively straightforward for a Medicaid program to identify EPSDT screening services provided in a fee-for-service reimbursement system, where the state directly receives claims for payment that detail the services (such as an EPSDT screen) provided during a visit. This information, however, may not be as readily available for services that the state pays for through other arrangements.²³ Meeting participants identified two examples of payment arrangements that reduce the agency’s ability to produce complete and accurate information:

1. States often contract with MCOs that deliver a defined package of benefits to a specific group of beneficiaries for a fixed per-person monthly fee (capitation). In this arrangement, the MCO (not the Medicaid agency) pays for the services delivered by providers. Although all states require contracted MCOs to provide information about the services they deliver to enrolled beneficiaries, the information

provided by the MCO is not always timely, detailed, and complete.

2. States also pay some providers such as Federally Qualified Health Centers (FQHCs), a fixed per-visit rate (encounter rate). Many states do not receive detailed information about the services provided during a visit on the claims for payment that these providers submit.

Even when a state has direct access to detailed claims information, it may still be unable to reliably track all of the information that the CMS-416 requires. For example, the CMS-1500 claim form (the standard claim form for submitting fee-for-service medical claims) does not contain a field to report whether a child received a referral for further treatment (which is reported in Element 11 of the CMS-416). This makes it difficult to track whether the state is succeeding in fulfilling the “Treatment” requirement of EPSDT.

States have worked with their vendors and managed care contractors to develop mechanisms for reporting encounter data that can be used for EPSDT reporting and other monitoring purposes. Meeting participants, however, reported continuing difficulties with securing accurate and complete data. Unreliable data produces CMS-416 reports that are not consistent across states, and which may include very inaccurate measures of EPSDT screens and services provided.

The development of better bridges between encounter data and CMS-416 reporting categories was cited as a field of research that would greatly help state efforts to comply with federal requirements. CMS is seeking ways to improve the CMS-416 as a measurement tool, such as withholding publication of CMS-416 reports for states with identified problems; reinstating a Technical Advisory Group for oral health issues, which will include a focus on improving reporting; and moving responsibility for EPSDT into its Division of Quality, Evaluations, and Health Outcomes.

Several meeting participants advocated moving away from the CMS-416 entirely, and toward a different set of performance measures, such as the HEDIS (Healthcare Effectiveness Data and Information Set) measures. HEDIS is a set of quality measures developed by the National Committee for Quality Assurance (NCQA). NCQA also defines acceptable procedures for producing each measure that uses clinical and administrative data. HEDIS measures are used widely by health plans for their commercial and Medicaid business. Some meeting participants felt these measures were more reliable than those reported in the CMS-416 report and allowed for easier comparison of performance across plans, populations, and states. One meeting participant even suggested that greater use of HEDIS measures for Medicaid might cause MCOs to adopt quality improvement goals for the state’s commercially insured populations. Again, meeting participants were interested in finding ways to bridge the two measurement methods by examining states’ use of HEDIS benchmarks for child health, and instances where states have developed HEDIS-like measures to track performance of their fee-for-service delivery systems.

The CMS-416 and HEDIS measures are not the only methods states use to measure performance. States also use surveys of enrollees’ assessments of: the care provided by their health plan or provider,²⁴ their perception of their health status,²⁵ and the quality improvement activities conducted by EQROs. Several meeting participants reported that their states combined information from these methods to help guide their efforts to improve the delivery of EPSDT services.

PHYSICIAN PARTICIPATION IN HEALTH INFORMATION TECHNOLOGY EFFORTS

Ultimately, though, the quality of the program lies in the ability to collect timely, reliable information about the services that are provided. Providers need to be educated, willing, and able to bill for EPSDT screens. They need to do the same when reporting the required information accurately, or else that information cannot be captured by the Medicaid system. In addition, claims may not include all of the information needed to assess performance. For example, a claim for laboratory services is unlikely to indicate the

results of the laboratory tests or document any referrals or anticipatory guidance offered by the primary care provider. States are working to implement technology-driven solutions such as electronic medical records to increase providers' ability both to report more complete information and to use it to help coordinate children's care. Meeting participants identified several barriers to such initiatives that states must overcome:

- : Health information technology requires two levels of infrastructure that may be costly. First, physicians' offices must purchase electronic health record systems. Second, states must invest in systems that allow exchange of the information in the records among providers, insurers, and public programs. Participants suggested two ways for states to help finance adoption of HIT. States might link provider use of HIT to payment incentives, as Rhode Island is doing for providers participating in its PCCM program who use electronic medical records.²⁶ States might also look for ways to use federal MITA funds to finance the development of statewide data-sharing systems.²⁷
- : Convincing primary care providers to adopt new health information technology tools involves challenges similar to any other state effort to introduce an operational change. That is, providers will most willingly adopt new technology if they believe that it will help them. States can address this potential barrier by involving primary care providers in systems design, as well as creating systems that provide primary care providers with useful, timely information, such as data about the services a patient received from other providers or aggregate data about the provider's performance. For example, if a state is using HIT to track the care provided by specialists, primary care providers may find it helpful to have access to information provided by those specialists on diagnoses, medications, and other data that could facilitate the primary care provider in managing their patients' care.
- : Electronic medical records will not necessarily contain all of the information that states and primary care providers need to know to manage their programs or care for their patients. Busy providers may skip over or omit information, such as referral information or completion of a health history, if the software does not require them to provide it. Requiring records to be entirely complete, however, may not be seen as helpful by providers if it means that using the new technology is slower and more cumbersome than using a paper medical record. Striking a balance between enhanced data collection and practicality for the end user is something that states need to consider carefully.

SUMMARY OF FINDINGS

Early access to high-quality health care, such as that specified in the EPSDT benefit, increases the chances that children will grow strong physically, emotionally, and socially. States, however, face ongoing challenges in bringing that promise into reality. Additionally, several recent developments (including the passage of the DRA and the release of the new Bright Futures program) offer both new opportunities and new challenges for addressing those issues. A small group of key stakeholders examined existing strategies, identifying new opportunities and challenges for states, and found that most agreed with the following conclusions:

- : States have many options for establishing different groups of benefits that may be delivered through different delivery systems to different groups of children. Some groups of children (such as adolescents and children in foster care) might gain from access to a benefit package tailored to their needs. However, states choosing to use such options need to closely manage the interface among packages, so that all children retain access to the full scope of EPSDT services.
- : Federal EPSDT requirements establish a standard for determining when a service is medically necessary for children, one which entitles them to receive any covered benefit needed to prevent, ameliorate, or treat a health condition. It is important that Medicaid agencies maintain a single common definition of medical necessity that applies to all children – even if subgroups of children have access to different benefit packages.
- : Two factors are particularly critical for supporting primary care providers’ participation in delivering EPSDT services: strong working relationships with physicians that build upon the compatibility of the EPSDT benefit with the broader goal of high-quality care for all patients, and alignment of reimbursement strategies with the goal of providing early and comprehensive health care to Medicaid-enrolled children.
- : It is crucial that states conduct outreach and provide support to families accessing services. Particularly promising strategies for provision of such support can be built using new IT infrastructures and by recognizing the critical role primary care providers and employers play in helping families understand the benefits of preventive care and accessing that care.
- : In many states, targeted case management plays a critical role in helping families access care for their children. The new CMS regulations will limit states’ ability to use targeted case management in that way.
- : In many states, targeted case management plays a critical role in helping families access care for their children. The proposed CMS regulations currently under moratorium, without future congressional action, will limit states’ ability to use targeted case management in that way.
- : The CMS-416 report is the primary tool CMS uses to ensure that states are fulfilling EPSDT requirements. Many states, however, have gone beyond that basic requirement to collect and use other data to help them assess and improve their delivery of EPSDT services. Meeting participants suggest that the federal government consider new and more effective ways to collect and use data about EPSDT services, especially in light of the advances in HIT and measurement.

NOTES

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- 3 Centers for Medicare and Medicaid Services, "Medicaid Early Periodic Screening, Diagnosis, and Treatment Benefit," 2007, U.S. Department of Health and Human Services. Retrieved 23 July 2007. <http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/>.
- 4 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Deficit Reduction Act," http://www.cms.hhs.gov/DeficitReductionAct/01_Overview.asp#TopOfPage
- 5 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "MITA Information Series," <http://www.cms.hhs.gov/MedicaidInfoTechArch/Downloads/mitaoverview.pdf>.
- 6 American Academy of Pediatrics, "Bright Futures," <http://brightfutures.aap.org>
- 7 This report represents a first step toward helping state Medicaid agencies improve delivery of EPSDT services. NASHP, with the support of The Commonwealth Fund, plans to continue this work over the next two years via a series of webinars, on-line and in-person discussions, and additional policy reports.
- 8 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Deficit Reduction Act," <http://www.cms.hhs.gov/DeficitReductionAct/>.
- 9 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Deficit Reduction Act," http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage.
- 10 More information about the needs of adolescents, including a recommended benefit package, is available in: Harriette Fox, Stephanie Limb, and Margaret McManus. *Preliminary Thoughts on Restructuring Medicaid to Promote Adolescent Health*. Incenter Strategies, January 2007.
- 11 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Deficit Reduction Act," http://www.cms.hhs.gov/DeficitReductionAct/21_Benefits.asp#TopOfPage.
- 12 A survey in 2000 by the American Academy of Pediatrics found that 67 percent of pediatricians accepted all new Medicaid-enrolled patients who contact them, although this ranged from a low of 48 percent in Oklahoma to a high of 94 percent in Massachusetts. B.K. Yudkowsky, S.F. Tang, A.M. Siston. *Pediatrician Participation in Medicaid/SCHIP. Survey of Fellows of the American Academy of Pediatrics, 2000*. (Elk Grove Village, IL: American Academy of Pediatrics, 2000). Retrieved 14 March 2008. Available at: www.aap.org.org/statelegislation/med-schip/USdpc.pdf
- 13 For a comparison of the ratio of Medicaid fees to Medicare fees for certain pediatric procedures, see Table 4 of S. Berman, J. Dolins, S. Tang, and B. Yudkowsky, "Factors That Influence the Willingness of Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics* 110:2 (August 2, 2002): 239-248.
- 14 Massachusetts Child Psychiatry Access Project, "Information Sheet," http://mcpap.typepad.com/mcpap_child_psychiatry_in/files/mcpap_information_sheet.doc.
- 15 Presentation by meeting participant Stephen Saunders, Illinois Department of Healthcare and Family Services.
- 16 New York State Department of Health, Office of Medicaid Management. *EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid)* (Albany, NY: NYS DOH, 2005). Retrieved 14 March 2008. <http://www.emedny.org/ProviderManuals/EPSDTCTHP/PDFS/EPSDT-CTHP.pdf>.
- 17 See Neva Kaye and Jill Rosenthal, *Improving the Delivery of Health Care That Supports Young Children's Health Mental Development: Update on Accomplishments and Lessons from a Five-State Consortium* (Portland, ME: National Academy for State Health Policy, February 2008), and Helen Pelletier, *Working with Physicians to Improve the Quality of Children's Healthcare* (Portland, ME: National Academy for State Health Policy, April 2006.).
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- 20 Department of Healthcare and Family Services, State of Illinois, "Illinois Health Connect, Primary Care Provider Handbook," http://www.illinoishealthconnect.com/files/downloads/IHC_PCP_Handbook.pdf.
- 21 Center for Child and Family Health, Rhode Island Department of Human Services, "Rite Care's Performance Goal Program, 2005 and 2006 Results," Oct. 2006. http://www.ritecare.ri.gov/documents/reports_publications/final%20PGP%20report%2010-2-06.pdf.
- 22 Wisconsin Department of Health Services, "Wisconsin Medicaid Managed Care Quality Reports," http://dhs.wisconsin.gov/medicaid7/reports_data/quality_reports/index.htm.
- 23 Deborah Curtis, Lynda Flowers, Neva Kaye, and Colleen Sonosky. *Assuring Children's Access to Medicaid Covered Services: State Approaches to Administering EPSDT*. (Portland, ME: National Academy for State Health Policy, unpublished, draft dated July 2002), 43-68.
- 24 Such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey: <https://www.cahps.ahrq.gov/default.asp>.

25 Such as the Promoting Healthy Development Survey, which surveys parents on the health status of very young children (ages 3 to 48 months), and measures how well health systems do at providing families with appropriate health education and anticipatory guidance: <http://www.ahrq.gov/chtoolbx/measure6.htm>.

26 Connect Care Choice Program, *Connect Care Choice: Participating Community Provider Reimbursement*. Rhode Island Department of Human Services, June 2007.

27 MITA stands for Medicaid Information Technology Architecture, a federal effort to modernize, streamline, and consolidate all of the different data activities that state Medicaid programs deal with: claims processing, eligibility, managed care payments, disease management efforts, specialized contracts for services like pharmacy or dental, and so on. It is intended to replace the Medicaid Management Information Systems (MMIS) that states have used for about 30 years. MMIS systems were designed primarily as claims-payment engines, but over time, have had additional tools and functions grafted on as states' circumstances and programs evolved. The goal of MITA is to provide national guidelines and funding for a common data architecture that will allow better communication and comparison of data between states, and interoperability with patient-centered HIT tools like electronic health records. See R. Friedman, "Medicaid Information Technology Architecture: An Overview," *Health Care Financing Review* 28:2 (Winter 2006-2007) 1-9.