

# State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States

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# **State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States**

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Finally, it is important to note that the views presented here are those of the authors. Any errors or omissions are ours.

The views presented here are those of the authors and not necessarily those of the directors, officers, and staff of The Commonwealth Fund.

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## EXECUTIVE SUMMARY

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Early childhood experiences influence brain development, establishing neural connections that provide the foundation for language, reasoning, problem solving, behavior, and emotional health. Developmental delays are prevalent in young children, especially low-income children, and are significantly under-detected. Many young children are not identified with developmental problems until school entry or until they demonstrate school failure. Although more than 95 percent of young children see a child health care clinician in the first three years of life,<sup>1</sup> most of these clinicians are missing opportunities to detect developmental problems, counsel parents of young children about developmental issues, or refer children to needed services in the community. Fortunately, there are health care delivery and policy options that can be adopted to increase the detection of children with developmental problems as well as facilitate access to assessment and treatment services for those children and families in need of follow-up care.

Since 2000, the National Academy for State Health Policy (NASHP) and The Commonwealth Fund have conducted two state learning consortia dedicated to improving the delivery of child development services to young children who are Medicaid beneficiaries. The work of the eight ABCD states has shown that state policies, especially Medicaid policies, can effectively promote improvements in the quality of preventive and developmental services provided to young children. This paper provides a starting point for states seeking to identify and implement policy improvements to achieve two main objectives:

1. improve the identification of young children with or at risk for developmental delays through promoting use of an objective, standardized screening tool; and
2. improve families' access to follow-up services, including assessment, referral, and care coordination.

The policies that govern the operation of any state program can be divided into three groups – policies that define what services the program will cover for which people (coverage), those that establish how much the program will pay for a qualified service (reimbursement), and those that establish how services will be delivered (performance). The paper presents specific policy improvements that emerged from efforts of the eight ABCD states that can serve as models and inspiration for states interested in improving developmental services for young children. An overview and some examples of policy changes in the three areas are listed below.

- **Improving program coverage (eligibility and benefits).** Most of the policy improvements focused on changes to covered benefits instead of eligibility. The most frequently reported improvement to benefit coverage was to clarify the state's expectations to individual providers (including pediatricians) to encourage the use of formal, valid screening tools as part of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen. The most frequently reported eligibility improvement was to

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<sup>1</sup> Olson, Lyn, et al. "Overview of the Content of Health Supervision for Young Children: Reports from Parents and Pediatricians." *Pediatrics* 133 (6) (2004), 1907-1916.

clarify that children with specific mental health problems were eligible for the state's Early Intervention (Part C) program. Some specific examples include:

- Minnesota, Utah, and Illinois changed their Medicaid provider manuals to encourage clinicians to use a standardized developmental screening instrument during well-child visits.
  - North Carolina Medicaid changed its EPSDT requirements to require primary care providers to use a formal, validated developmental screening tool at selected well child visits.
  - Illinois Medicaid modified its contracts with managed care organizations to require that providers use developmental screening instruments (general developmental, social-emotional, and maternal depression) at age-appropriate preventive care visits.
  - Iowa and Washington developed encounter forms to facilitate structured surveillance of young children for developmental problems.
  - Illinois' Part C program clarified that a child can receive Early Intervention Services if his or her parent, or other primary caregiver, has been diagnosed with a severe mental disorder, including perinatal depression.
- **Improving Reimbursement.** Improvements to reimbursement policies to promote developmental services include both how much the program pays for a service, as well as how payment is structured. The most frequently reported reimbursement policy improvement among the ABCD states relates to clarifying that providers (including primary care clinicians) can bill for conducting a developmental screen with a formal and valid screening instrument. Some specific examples include:
    - Illinois, Iowa, and Minnesota have clarified that primary care physicians who use a standardized developmental screening tool may bill for that service under CPT code 96110.
    - Minnesota Medicaid plans to pay a financial incentive to contracted health plans in 2007 for increasing use of objective general developmental screening tools (for children under age 7) and mental health screening tools (for children under 21 years of age.)
    - Illinois clarified that pediatricians may bill Medicaid for screening mothers for perinatal depression and, if the mother is not herself eligible for Medicaid, Illinois allows the screening to be billed as a risk assessment for the infant, under the infant's identification number for up to one year postpartum.
- **Improving Performance.** States can change a number of policies to promote improved performance by physicians and others who provide developmental services to young children. These changes range from requiring managed care organizations to embark on quality improvement projects on developmental screening, to developing processes to ensure feedback from follow-up service providers to the primary pediatric clinician. Many states also implemented policies to support measuring performance in delivering child development services. Specific state examples include:
    - In Minnesota, three agencies – Medicaid, Children's Mental Health, and Early Intervention – jointly established standards for developmental and behavioral health

- screening of young children. The standards call for use of common screening instruments across systems and are publicly announced on the state’s website.
- Illinois and Utah Medicaid both required contracted health plans to conduct Performance Improvement Projects (PIPs) designed to support children’s referral to follow-up services (Illinois) and coordination of care (Utah).
  - Minnesota, Illinois, and North Carolina all ‘unbundled’ the procedure code for standardized developmental screening from the well-child visit so that state officials can track an overall screening rate as well as the screening rate of individual health plans or providers.

Several factors led the ABCD states to implement policies to improve developmental services for young children. The most common and critical factors associated with each state’s success are:

- a strategic plan (clarity about goals, objectives, and policy priorities);
- broad stakeholder participation (making sure that leadership from all potentially affected agencies are actively engaged from the beginning);
- grounding proposed improvements in experience (pilot-test new ideas with local physician practices, collect data to show progress over time), and
- creating opportunity (build on complementary state and local initiatives).

Collectively, the ABCD states changed state statutes, state regulations, contracts, provider manuals, Web sites, and other documents that define state policies designed to improve the delivery of child development services. They have also changed eligibility and claims processing systems to implement the policies described in the documents, conducted quality improvement projects designed to assess performance and foster change, and helped providers better understand new and existing policies. The ABCD experience has yielded a plethora of policy models that can serve as examples or inspiration for other states interested in improving preventive care for young children.

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## INTRODUCTION

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The first five years of life are critical to a child’s lifelong development. Early experiences influence brain development, establishing the neural connections that provide the foundation for language, reasoning, problem solving, social skills, behavior, and emotional health.<sup>2</sup> Approximately 15-18 percent of children in the United States have a developmental or behavioral disability and 39 percent of Medicaid children under age 5 are estimated to be at risk of a developmental, behavioral, or emotional problem.<sup>3,4</sup> Yet, only 20-30 percent of children with or at risk for problems are identified prior to starting school.<sup>5</sup> Many other young children are not identified with developmental problems until they demonstrate school failure in the early grades. More than 95 percent of young children see a child health care clinician in the first three years of life<sup>6</sup> and most receive at least one well-child visit.<sup>7</sup> However, most of these clinicians are missing opportunities to detect developmental problems, counsel parents of young children about developmental issues, or refer children to needed services in the community. Fortunately, there are health care delivery and policy options that can be adopted to increase the detection of children with developmental problems as well as facilitate access to assessment and treatment services for those children and families in need of follow-up care.

The states that participated in the Assuring Better Child Health and Development (ABCD) Initiative have demonstrated that state policies – especially Medicaid policies – can effectively support the delivery of child development services. This paper is intended to provide a starting point for states seeking to identify and implement policies that better support the delivery of child development

*Developmental services* are “preventive pediatric services focused on optimizing healthy development.” Developmental services include:

- Ongoing assessment to identify developmental risks and problems. Includes reviewing parental concerns, monitoring children’s physical and mental development, periodic structured evaluation (often referred to as developmental screening), and diagnostic assessment, if warranted.
- Education for parents on child development and ways of promoting learning and growth. Also called anticipatory guidance.
- Intervention for developmental concerns, either within the pediatric practice or by specialists or community programs.
- Coordination of intervention and treatment services, including referral and follow-up.

Source: Modified from N. Halfon, et al. *Quality of Preventive Health Care for Young Children: Strategies for Improvement*, (New York: The Commonwealth Fund, May 2005).

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<sup>2</sup> Shonkoff, J. and Phillips, D. eds, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. (Washington, DC: National Academies Press, 2002). [www.nap.edu](http://www.nap.edu).

<sup>3</sup> Glascoe FP, “Early Detection of Developmental and Behavioral Problems” *Pediatrics in Review* Vol. 21, No. 8 (2000): 272-280.

<sup>4</sup> Bethell, Reuland, et al. PHDS-Plus data.

<sup>5</sup> Frances P. Glascoe and Henry L. Shapiro, *Introduction to Developmental and Behavioral Screening, Developmental and Behavioral Screening Tutorial*. DBPeds Revised 2/13/2006, Accessed 11/06/06. <https://www.dbpeds.org/tutorial/main.cfm?TutorialID=1&SessionLogUID=BF13B507-3048-2906-EAABFA467071F0FE>.

<sup>6</sup> Olson, Lynn, et al., op cit.

<sup>7</sup> Selden, T., “Compliance With Well-Child Visit Recommendations: Evidence From the Medical Expenditure Panel Survey, 2000–2002” *Pediatrics* Vol. 118, No. 6 (December 2006): pp. e1766-e1778.

services – not just in the Medicaid program but also in the other major state programs that serve young children

Since 2000, the National Academy for State Health Policy (NASHP) and The Commonwealth Fund have conducted two state learning consortia dedicated to improving the delivery of child development services to young children who are Medicaid beneficiaries. The work of the eight states that form these collaboratives has shown that states can be effective agents for improvement. Indeed, because states administer Medicaid programs they can affect the services delivered to more than 25 percent of all children in the United States (and more than half of all poor and low-income children).<sup>8</sup>

States, within federal guidelines, determine who is eligible for Medicaid, which services are covered, and how services are delivered and paid for. The policies that states have in place in each of these areas can either promote effective delivery of care or present a barrier to effective delivery of care. States administer other programs that support children’s development, including maternal and child health (Title V) programs, early intervention (Part C) programs, and public mental health programs. The policies in place in these programs can also help or hinder the identification and treatment of children with or at risk for developmental delays.

The ABCD collaborative experience has shown that states have both the ability to support young children’s healthy development and an interest in doing so. Supporting children’s development enables them to grow into productive adults, and preventive and early intervention services have the potential to head off the need for more costly interventions at a later point in a child’s life.

The remainder of this paper is divided into three major sections:

1. The first section provides background on both the ABCD collaboratives and the major state programs that serve young children.
2. The second section examines representative examples of the specific policy improvements developed by the eight collaborative states. This section of the report presents the primary goal of each improvement, the aspect of the program the change is intended to improve, and the mechanism(s) used to implement the improvement.
3. The third section examines the processes used by the ABCD states to develop and implement policy improvements. This discussion focuses on three critical elements of the process: partnering with stakeholders, developing a strategic plan, and creating opportunity.

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<sup>8</sup> Kaiser Family Foundation, Health Coverage For Low-Income Children, Fact Sheet, September 2004. Retrieved September 25, 2006. <http://www.kff.org/uninsured/upload/Health-Coverage-for-Low-Income-Children-September-2004-UPDATE.pdf>.

## SETTING THE CONTEXT

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In this section we examine two aspects of the context in which the improvements examined in this paper were developed. It describes:

- the two ABCD collaboratives, which are the source of these improvements; and
- the major state programs the collaborative states sought to improve.

### The ABCD Collaboratives: Laboratories for Improvement

The Assuring Better Child Health and Development (ABCD) Program is funded by The Commonwealth Fund, administered by the National Academy for State Health Policy (NASHP), and designed to assist states in improving the delivery of child development services to low-income children and their families. The program's goals are:

- To create models of service delivery and financing that promote good quality services supporting children's healthy development for Medicaid eligible children, 0-3, especially those with less intense needs (those who need only preventive care and those who are identified as "at risk" or in need of low-level intervention);<sup>9</sup> and
- To develop policies and programs that assure that health plans and pediatric providers serving these children and their parents have the knowledge and skills needed to furnish health care in a manner that supports a young child's healthy development.

To achieve these goals, NASHP and Commonwealth have convened two, three-year state consortia under the ABCD program.

- ABCD I was created in 2000 and provided grants to four states (North Carolina, Utah, Vermont, and Washington) to develop or expand service delivery and financing strategies aimed at enhancing healthy child development for low-income children and their families. The program concluded in 2003.
- ABCD II, launched in 2003, is designed to assist states in building the capacity of Medicaid programs to deliver care that supports children's healthy mental development. The initiative is supporting the work of five states (California, Illinois, Iowa, Minnesota, and Utah) and will conclude in December 2006.

States were selected for participation in the consortia through a competitive process – each applicant described the status of the delivery of developmental services in their state and proposed a project designed to improve that delivery. Each state in the consortia committed to participating in the consortia and implementing the proposed project. In return, states received

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<sup>9</sup> The consortia focused on those who need only preventive or low-level intervention because we believed that these children were less likely to be identified than those with more intense needs, the potential benefit of preventive care, and the lack of resources/systems to meet this groups' needs.

grant funding – which was eligible for matching funds from Medicaid – and technical assistance, including opportunities to learn from each other.<sup>10</sup>

Although the state projects differed, they all fostered change at both the policy and practice level in order to improve the delivery of developmental services – and sustain those improvements. These states' experiences also demonstrated the effectiveness of working simultaneously to improve both policy and practice. Private sector involvement and pilot testing allowed the ABCD project staff to ground their proposed policy changes in real-world experience. This was critical to identifying and making the case for specific changes, as well as gaining provider acceptance of (and adherence to) the changes.

## Overview of Relevant State-Administered Programs

Medicaid is the major program that states administer and which delivers health services to children, providing comprehensive health coverage to more than half of all poor and low-income children.<sup>11</sup> Medicaid, however, is not the only state-administered program that can affect the delivery of child development services, including prevention, identification, assessment, treatment, and care coordination services. In particular, state maternal and child health (MCH), early intervention, and mental health programs have the potential to promote improvement, because these agencies deliver relevant services, pay others to deliver those services, and/or provide information to providers and parents about good practices in delivering these services. Several of the ABCD collaborative states identified policy changes in these programs that promoted improvements in the delivery of child development services.

Examples of the policy improvements the ABCD states made to all four relevant programs (Medicaid, MCH, early intervention, and mental health) are included in the next section. The remainder of this section offers an overview of these four major programs. Each of these programs operates under different federal rules, has a different history and purpose – and has evolved to meet the unique environment and policy goals of each state. Thus, the short descriptions presented here are intended to provide readers with sufficient background to understand the policy improvements described in the next section and do not convey the complexities of each program.<sup>12</sup>

### Medicaid

Medicaid is a program that pays for comprehensive medical benefits for certain low-income people, including families and children. It is jointly funded by federal and state governments. According to the Centers for Medicare & Medicaid Services, which is the federal agency

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<sup>10</sup> Details on the specific projects conducted by each state are available at [www.nashp.org](http://www.nashp.org).

<sup>11</sup> Kaiser Family Foundation, Health Coverage For Low-Income Children, Fact Sheet, September 2004. Retrieved September 25, 2006. <http://www.kff.org/uninsured/upload/Health-Coverage-for-Low-Income-Children-September-2004-UPDATE.pdf>.

<sup>12</sup> Much of the following discussion is drawn from D. Bergman and N. Kaye, *ABCD Glossary: Selected Terms Related to the Healthy Mental Development of Young Children*. Accessed 09/25/06. [http://www.nashp.org/\\_docdisp\\_page.cfm?LID=7FF4EF61-4886-429A-922579C44D434CE0](http://www.nashp.org/_docdisp_page.cfm?LID=7FF4EF61-4886-429A-922579C44D434CE0).

responsible for the program: “Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program.”<sup>13</sup>

Among the groups states are required to cover are pregnant women and children age 0-5 from families with incomes at or below 133 percent of the federal poverty level (FPL), children age 6-18 from families with incomes up to 100 percent FPL, and parents from families that would have qualified for the state’s AFDC program under the rules in place on July 16, 1996. States can choose to go beyond these minimum requirements, and all have chosen to do so for one or more groups. When states cover additional groups they must do so within certain constraints established in federal law.

Federal regulations also set minimum requirements for covered services, both in terms of the types of service that states must cover (e.g., inpatient hospital services) and the amount of services that they must cover (e.g., they must cover a sufficient level of services to reasonably achieve the purpose of the benefit).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is “one of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems.”<sup>14</sup> This is a particularly important benefit for children with or at risk for developmental delays as under Medicaid law (1) an EPSDT screen must include a developmental assessment, and (2) a state must provide any service that it could choose to cover under federal Medicaid law that is needed to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services” even if the state has chosen not to cover those services under other conditions.<sup>15</sup>

## **Maternal and child health (MCH)**

The purpose and flexibility in the design of the Maternal and Child Health (MCH) Program creates opportunities for states to use Title V funding to support and enhance child development services. The MCH program is a federal/state partnership dedicated to improving the health of all mothers and children. All states have an MCH agency that receives funding through the federal MCH block grant (also known as Title V). The MCH block grant is administered by The Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA). Federal Title V funding is capped and states must match the federal funding (at least three state dollars for every four federal). There are two types of federal Title V funding. Most of the funding is allocated according to a federal formula (formula grants). Some however, is competitively awarded as discretionary grants – either as Community Integrated Service Systems

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<sup>13</sup> Centers for Medicaid and Medicare Services, *Medicaid Program – General Information: Overview*. Washington, DC: U.S. Department of Health and Human Services.) Retrieved 13 November 2006. <http://www.cms.hhs.gov/MedicaidGenInfo/>.

<sup>14</sup> Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2002), pg. 107. Retrieved 13 November 2006. <http://www.kff.org/medicaid/2236-index.cfm>.

<sup>15</sup> §1905(r)(5) of the SSA. Retrieved 09/27/2005. [www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

(CISS) grants or Special Projects of Regional and National Significance (SPRANS) grants. Because it is a block grant, Title V (unlike Medicaid) does not create an individual federal entitlement to services.

States have considerable flexibility about how they spend the Title V funding, that is, both how they define and deliver Title V services. They may deliver services directly or provide broadly targeted grants to qualified communities and entities (as defined by the state). State MCH agencies must submit annual applications and reports to HRSA that include reports of their progress on key performance indicators – some of which are established by the federal government and others of which are selected by the state agency. There are also some requirements for coordination between Medicaid and MCH. In particular there are requirements for coordination on the delivery of EPSDT services and in the identification and enrollment of Medicaid-eligible pregnant women and infants. Both agencies (Medicaid and MCH) are also required to develop an agreement that addresses the relationship between the agencies and the services each provides. The MCHB identifies the following purposes (among others) for the MCH Services Block Grant Program. It should:

- Significantly reduce infant mortality;
- Provide comprehensive care for women before, during, and after pregnancy and childbirth;
- Provide preventive and primary care services for infants, children, and adolescents;
- Provide comprehensive care for children and adolescents with special health care needs; and
- Put into community practice national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents.<sup>16</sup>

## Early intervention

The Early Intervention Program for Infants and Toddlers with Disabilities was authorized by Congress under Part C of the Individuals with Disabilities Education Act (IDEA); the program is usually often referred to as “Part C”. This program is administered at the federal level by the Department of Education and at the state level by a lead agency designated by each state, usually the education, health, or social services department. The program helps states fund and provide early intervention services to families with children under age three with a developmental delay or a diagnosed mental or physical condition that is likely to result in a delay. States define

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<sup>16</sup> This discussion drawn from

1. Health Resources and Services Administration. *Maternal and Child Health Services Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report* (Washington, DC: U.S. Department of Health and Human Services). Retrieved November 13, 2006. <http://mchb.hrsa.gov/> , and
2. Sara Rosenbaum, Michelle Proser, Andy Schneider, et al. *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services*. (New York, NY: The Commonwealth Fund, 2002). Retrieved November 13, 2006. [http://www.cmwf.org/usr\\_doc/rosenbaum\\_titlev\\_481.pdf](http://www.cmwf.org/usr_doc/rosenbaum_titlev_481.pdf).

developmental delay and choose whether or not to serve children at risk for a developmental delay.<sup>17</sup> Thus, there is variation among the states in which children qualify for the program.<sup>18</sup>

## **Mental health**

State mental health agencies administer the public mental health system and also operate programs intended to promote mental health. These agencies primarily serve children and adults who have been diagnosed with a mental disorder – and within those groups often focus on those with severe emotional disabilities. Some states have a separate children’s mental health agency within the broader mental health agency. The federal Substance Abuse and Mental Health Administration (SAMHSA) offers funds through grants for various purposes. For example, The Comprehensive Community Mental Health Services Program for Children and Their Families currently provides grant funding to 61 states, communities, territories, Indian tribes, and tribal organizations. These funds are specifically dedicated to the “improvement and expansion of systems of care to meet the needs to the estimated nationwide 4.5 to 6.3 million children with serious emotional disturbances and their families.”<sup>19</sup>

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<sup>17</sup>National Early Childhood Technical Assistance Center. Early Intervention Program for Infants and Toddlers with Disabilities (Part C of IDEA). (Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center). Retrieved 13 November 2006, <http://www.nectac.org/partc/partc.asp>.

<sup>18</sup> J. Shackelford. *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA*, NECTAC Notes No.18. (Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center, 2005). Retrieved 09/30/2005. <http://www.nectac.org/~pdfs/pubs/nnotes18.pdf>.

<sup>19</sup> Substance Abuse and Mental Health Services Administration. SAMHSA’s National Mental Health Information Center: Center for Mental Health Services. U.S. Department of Health and Human Services. Retrieved 13 November 2006. <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0013/default.asp>.

## POLICY IMPROVEMENTS DEVELOPED BY THE ABCD COLLABORATIVE STATES

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The policies that govern the operation of any state healthcare program can be divided into three groups – policies that define what services the program will cover for which people (coverage), those that establish how much the program will pay for a qualified service (reimbursement), and those that establish how services will be delivered (performance). The policies that states establish in each of these three areas can facilitate or hinder the delivery of child development services. Thus ABCD collaborative states identified changes (or clarifications) to policies in each of these areas that would improve the delivery of developmental services to young children.

This section of the report presents the specific policy improvements (changes *and* clarifications) that emerged from the efforts of the eight ABCD states. Note that this is not a complete list of all policy options open to states. These eight states made changes to Medicaid and other programs, as well as changes meant to improve general development services *and* those specific to social and emotional development services. The common element in all of these policy changes is their overarching goal – to improve the delivery of child development services, especially to young children who participate in Medicaid. For ease of understanding, the policy improvements developed by the ABCD collaborative states within each of the three program areas have been further divided into two categories based on the primary purpose of the change:

1. *Improving the identification of young children with or at risk for developmental delays through promoting use of an objective, standardized screening tool* – The ABCD states pursued this goal as a result of the scientific evidence that indicates that physicians more effectively identify children with or at risk of developmental delay when they use a validated developmental screening tool.
2. *Improving families' access to follow-up services, including assessment, referral, and care coordination* – Once a child has been identified as having or being at risk for delay, he or she needs follow-up services. Therefore, the ABCD states pursued policy improvements intended to improve access to follow-up services for families with children with positive screens. These services included assessment to determine level of need and specific needs, referral to meet the specified needs, and care coordination to ensure that the family accesses needed services and remains in a system that identifies and supports access to any further care needed.

A final consideration in understanding the policy improvements developed by the ABCD states are the mechanisms these states used to implement the improvement. These states used a variety of mechanisms to establish expectations, communicate them to providers, and ensure (or encourage) providers to meet these expectations. Examples of the mechanisms used most often by the ABCD states include:

1. *Documents used to convey expectations to providers* – States use a variety of documents to convey their expectations to individual providers, such as physicians. These include provider billing manuals, claims forms, and state websites.

2. *Contracts* – States contract with a variety of organizations, including managed care plans, state and local agencies, and early intervention providers to assist in the delivery of care. Contracts define the duties of the contractor and state agency, including those duties in the areas of coverage, performance, and payment.
3. *Claims Processing Systems* – States establish the criteria a provider needs to meet to receive payment for providing a service. These criteria address who may provide a service, which services are eligible for payment, and the circumstances under which each service will be paid. Their claims processing system enforces these criteria through edits.

Other mechanisms states can use to improve policy include amending their Medicaid state plan, changing the eligibility determination system, conducting quality improvement projects, changing state statute, or establishing a new budget item. At least one ABCD state has used each of these mechanisms to improve policy in its Medicaid, early intervention, MCH, or mental health programs.

## **Improving Program Coverage (Eligibility and Benefits)**

All programs have policies that govern coverage – what services the program will cover for which people.<sup>20</sup> The ABCD collaborative states made changes to both of these aspects of coverage. Table 1 summarizes the specific policy improvements the ABCD collaborative states made to participant eligibility and covered benefits.

1. Improvements to participant eligibility include changes (or clarifications) to policies governing who is eligible to be served by a program. For example, the Illinois Early Intervention (Part C) program clarified that children whose mothers suffered from maternal depression are eligible for the program.
2. Improvements to covered benefits include changes (and clarifications) to policies governing which services are covered, how much of each service is covered, and how a service is defined. For example, Minnesota created the Children's Therapeutic Services and Supports (CTSS) benefit. CTSS is available to children who have been diagnosed with an emotional disturbance of any severity and includes a wide range of mental health services, including skill building services for the child and the child's family. CTSS services can be provided both by traditional mental health providers and a variety of approved social service agencies, including Head Start. Also, North Carolina Medicaid began requiring providers to use a formal, validated developmental screening tool at specified EPSDT visits – thus changing their definition of the EPSDT benefit

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<sup>20</sup> As discussed in pages 7 to 10, states set these policies for the programs they administer, but state flexibility to establish policies in any area is limited by factors such as federal rules

**Table 1 ABCD state improvements to program coverage: eligibility and Benefits**

*Note: The notation [Web resource] in the Table indicates that a Web-accessible document or resource is available that provides more details. The URLs that will take you to these resources are linked from each notation, below, and are also provided in the Appendix.*

	Improve the identification of children with or at risk for developmental delay through use of an objective screening tool	Support families' access to follow-up services, including assessment, referral, and care coordination
<b>Eligibility</b>		<p><b>IL's</b> Part C program clarified that a child can receive Early Intervention services if his or her primary caregiver has been diagnosed with a severe mental disorder, including perinatal depression</p> <p><b>MN's</b> Part C program is examining its current program eligibility criteria and is expected to clarify that it serves children with mental development needs.</p> <p><b>NC's</b> Part C program revised its eligibility criteria for a number of reasons. ABCD experience caused them, as part of this review, to include attachment disorder per the DC: 0-3 as an established risk category.</p>
<b>Benefits</b>	<p><b>IL, IA, MN, UT, and WA</b> made changes to various documents that communicate Medicaid's EPSDT expectations to service providers that clarify that these agencies encourage providers to use an objective developmental screening tool as part of an EPSDT screen.</p> <ul style="list-style-type: none"> <li><b>IL, MN, and UT</b> changed provider manuals; [<a href="#">Web resource 1</a>, <a href="#">Web resource 2</a>, and <a href="#">Web resource 3</a>.]</li> <li><b>IL</b> changed its HMO contracts [<a href="#">Web resource 4</a>];</li> <li><b>IA</b> changed the website dedicated to communicating EPSDT requirements [<a href="#">Web resource 5</a>];</li> <li><b>IA</b> developed an encounter form to facilitate structured surveillance (Clinical Health Maintenance Notes) to include questions designed to identify children with or at risk for delays in social and emotional development [<a href="#">Web resource 6</a>];</li> <li><b>WA</b> created a new series of encounter forms for the provider to use at well-child visits. Each form incorporates age-appropriate developmental questions – and directs providers to use a standardized screening tool or refer for further assessment when certain responses are given to the questions. WA encourages providers to use the form when providing EPSDT screens to all children and requires their use for children in foster care.</li> </ul> <p><b>IL</b> Medicaid plans to require providers participating in its new PCCM program to include an objective developmental screening as part of an EPSDT visit.</p> <p><b>NC</b> Medicaid changed its EPSDT requirements to require primary care providers to use a formal, validated developmental screening tool as part of specified EPSDT visits. Medicaid billing guides were changed to reflect this new policy. [<a href="#">Web resource 7</a>]</p>	<p><b>IL, IA, NC, and VT</b> Medicaid expanded the types of providers that can provide services.</p> <ul style="list-style-type: none"> <li><b>IL</b> now allows independent certified nurse practitioners and clinical nurse specialists to serve Medicaid beneficiaries;</li> <li><b>IA</b> now allows Licensed Independent Social Workers,</li> <li><b>NC</b> now allows independently enrolled mental health providers, and</li> <li><b>VT</b> allows family support workers to provide home visiting.</li> </ul> <p><b>IA</b> [<a href="#">Web resource 8</a>], <b>MN</b>, and <b>UT</b> have all clarified that providers may use the DC:0-3 diagnosis classification system to diagnose young children, crosswalk that diagnosis to a DSM diagnoses and bill Medicaid for treatment services.</p> <p><b>MN</b> has created a new benefit (CTSS) to treat children with an emotional disturbance of any severity that includes a wide range of mental health services for the child and the child's family. Both traditional mental health providers and a variety of social service agencies may provide the benefit. [<a href="#">Web resource 9</a>].</p> <p><b>UT</b> Medicaid implemented a targeted case management (TCM) program for infants. The TCM/Early Child Development initiative provides case management to infants, including home visits. [<a href="#">Web resource 10</a>].</p> <p><b>UT</b> clarified inconsistencies between Medicaid EPSDT billing policies and the mental health agency's audit procedures that were discouraging community mental health centers from providing services needed to treat or ameliorate a condition identified in an EPSDT screen unless a DSM-IV diagnosis could be assigned.</p>

	<b>Improve the identification of children with or at risk for developmental delay through use of an objective screening tool</b>	<b>Support families' access to follow-up services, including assessment, referral, and care coordination</b>
	<p><b>NC's</b> MCH agency changed its policy on the use of developmental and behavioral screening tools for Title V. The Denver developmental screening test was discontinued and a menu of acceptable tools was created that included the Ages and Stages Questionnaire® (ASQ), Parents Evaluation of Developmental Status (PEDS), and BRIGANCE® System. The agency also requires screenings at 6, 12, 18 or 24, 36, 48 and 60 months.</p>	<p><b>VT</b> Medicaid modified an existing program designed to provide comprehensive preventive services to support early child development. Covered services include home visiting with case management, phone consultation, targeted educational parent material that highlights child development, and group education for parents and care givers.</p>

Table 1 indicates that most of the improvements to coverage policies were improvements to covered benefits. Further, the most frequently reported improvement in this policy area was to change provider manuals and other documents to clarify that the state encouraged providers (including pediatricians) to use an objective developmental screening tool as part of an EPSDT screen. In addition, North Carolina changed its billing requirements (and billing manuals) to require providers to use an objective tool at specified visits.

Regarding eligibility, none of the ABCD collaborative states made changes to Medicaid eligibility policies to promote child development services. Three states, however, identified changes needed to the eligibility policies of their early intervention (Part C) programs to promote access to follow-up services.

## Improving Reimbursement

Improvements to reimbursement policies include both how much the program pays for a service, as well as how payment is structured. For example, Washington offered enhanced reimbursement to Medicaid providers who, when caring for children in foster care, used the EPSDT screening forms developed under their ABCD project. Table 2 summarizes the changes to reimbursement policies made by the ABCD collaborative states.

**Table 2 ABCD state improvements to reimbursement**

*Note: The notation [Web resource] in the Table indicates that a Web-accessible document or resource is available that provides more details. The URLs that will take you to these resources are linked from each notation, below, and are also provided in the Appendix.*

<b>Improve the identification of children with or at risk for developmental delay through use of an objective screening tool</b>	<b>Support families' access to follow-up services, including assessment, referral, and care coordination</b>
<p><b>IA</b> Medicaid is considering allowing primary care providers who use the Iowa Health Maintenance Notes form developed through its ABCD project as part of well-child care to bill for use of that form under CPT code 99420 (Administration and Interpretation of Health Risk Assessment Instrument). <a href="#">[Web resource 11]</a>.</p> <p><b>IA</b> Medicaid is considering allowing providers to bill for well-child care provided on the same day as a sick visit.</p>	<p><b>IA</b> Medicaid clarified that follow-up services for diagnosis that are not specifically covered by their contracted behavioral health organization (BHO) may be billed to Medicaid through the fee-for-service system.</p> <p><b>IL</b> Medicaid clarified that pediatricians may bill for screening mothers for perinatal depression and, if the mother is not herself eligible for Medicaid, allows the screening to be billed as a risk assessment for the infant, under the infant's ID number for up to one year post-partum. <a href="#">[Web resource 14]</a>.</p>

Improve the identification of children with or at risk for developmental delay through use of an objective screening tool	Support families' access to follow-up services, including assessment, referral, and care coordination
<p><b>IL, IA, and MN</b> Medicaid have clarified that providers (including primary care providers) who use a standardized developmental screening tool may bill for that service under CPT code 96110.</p> <ul style="list-style-type: none"> <li>• <b>IA</b> does not allow providers to bill using their Health Maintenance Notes form under this code.</li> <li>• <b>IL</b> allows for two developmental screenings on the same day to enable providers to use both a general developmental and a social/emotional tool. <a href="#">[Web resource 12]</a></li> <li>• <b>MN</b> instructs providers to attach a modifier (UC) to this code to indicate a mental health screen (distinct from a general developmental screen).</li> </ul> <p><b>MN</b> Medicaid plans to pay a financial incentive to contracted health plans in 2007 for increasing use of objective developmental screening tools, based on use of the 96110 code. Plans will receive:</p> <ul style="list-style-type: none"> <li>• \$20 for each developmental screening above the previous year's rate for children ages 0 through 6.</li> <li>• \$25 for each mental health screening of a child age 0 to 21.</li> </ul> <p><b>NC</b> Medicaid requires providers to include the 96110 code on claims for specified EPSDT (well-child) visits to indicate that the provider used an objective screening tool as part of the screen. <a href="#">[Web resource 13]</a></p> <p><b>WA</b> Medicaid will pay providers who use the previously described EPSDT screening forms when caring for children in foster care an enhanced fee for the exam.</p>	<p><b>NC</b> Medicaid is allowing pediatricians in 4 county Medicaid networks to bill for using the Edinburgh screening tool for maternal depression as a risk assessment for the infant.</p>

The most frequently reported reimbursement policy improvement among the ABCD collaborative states relates to clarifying that providers (including primary care providers) can bill for conducting a developmental screen with a formal standardized screening tool. Illinois and Minnesota Medicaid both allow providers to bill for screenings conducted with an approved tool under CPT code 96110 – and Iowa is considering that change. Minnesota Medicaid is also negotiating with the agency's contracted HMOs to add an incentive payment for increasing the number of children screened with an objective tool – as evidenced by encounter records reporting the 96110 code. (This is reported as a reimbursement rather than coverage improvement because the use of an objective screening tool was previously covered – the change is that now primary care providers may bill for that specific service using a dedicated code.)

## Improving Performance

The ABCD states changed a number of policies to improve system performance. These actions are summarized in Table 3; they range from requiring Part C providers to send a completed referral form back to providers who refer families to the Part C program, to targeting managed care quality improvement efforts to improve the quality of child development services. Some of these efforts are aimed at improving provider screening practices and others are designed to

improve follow-up services. For example, Utah is using its managed care quality improvement requirements to improve the delivery of follow-up services available to children identified with potential delays in mental development. In Utah, physical health services are delivered by health plans that deliver a comprehensive set of benefits, while mental health services are delivered by health plans that deliver only mental health services. The state directed its contracted External Quality Review Organization (EQRO)<sup>21</sup> to conduct a medical chart review to determine whether the two types of plans were coordinating the care of enrollees who were served by both systems. Based on the study findings the Medicaid program required both types of plans to conduct a performance improvement project to improve coordination between the two systems.

The ABCD states also implemented policies to support measuring performance in delivering child development services. Measurement can be conducted as part of a quality improvement effort but the resulting information can also be used for other purposes, such as reporting to stakeholders and creating performance incentives. Iowa’s MCH program, for example, selected two measures that assess the delivery of developmental services to be part of its required annual report to the federal government, including the percent of maternal depression screenings. In addition, North Carolina Medicaid requires providers to ‘detail bill’ for EPSDT screens so that the agency can produce measures that show changes in the use of an objective screening tool (based on the presence of the 96110 CPT code).

**Table 3 ABCD state improvements to measure and improve system performance**

*Note: The notation [Web resource] in the Table indicates that a Web-accessible document or resource is available that provides more details. The URLs that will take you to these resources are linked from each notation, below, and are also provided in the Appendix.*

	<b>Improve the identification of children with or at risk for developmental delay through use of an objective screening tool</b>	<b>Support families’ access to follow-up services, including assessment, referral, and care coordination</b>
Performance Improvement	<p><b>IL</b> Medicaid requires contracted health plans to conduct a performance improvement project (PIP) to evaluate the content of well-child care provided to children under age three, including whether an objective developmental screening tool was used.</p> <p>In <b>MN</b> the agencies that administer Part C, Medicaid, and children’s mental health programs established a joint website that communicates the screening expectations of all three programs, and encourages providers to use an objective screening tool. <a href="#">[Web resource 15]</a>.</p> <p><b>NC</b> supports “ABCD” as a quality improvement through its enhanced primary care case management (PCCM) program, which delivers services through North Carolina Community Care Networks. It is a</p>	<p><b>IA</b>’s legislature allocated funding to the public health agency to spread the ABCD model for providing access to follow-up services through local EPSDT coordinators. Three sites have been selected for expansion.</p> <p><b>IL</b> Medicaid created a protocol for use by pediatric providers who screen mothers for perinatal depression. The protocol offers guidance on what to do when a woman has a positive screen. <a href="#">[Web resource 16]</a>.</p> <p><b>IL</b> and <b>UT</b> Medicaid both required contracted health plans to conduct PIPs designed to support families’ access to follow-up services.</p> <ul style="list-style-type: none"> <li><b>IL</b> requires a PIP on screening referral, treatment, and tracking of perinatal depression.</li> </ul>

<sup>21</sup> External Quality Review Organizations (EQROs) may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body. (Source: CMS Glossary, Accessed 09/25/2006. <http://www.cms.hhs.gov/apps/glossary/>).

	<b>Improve the identification of children with or at risk for developmental delay through use of an objective screening tool</b>	<b>Support families' access to follow-up services, including assessment, referral, and care coordination</b>
	<p>requirement listed on each network's agreement with Medicaid.</p> <p><b>NC</b> has formed an "ABCD" quality improvement group that meets quarterly to discuss opportunities and challenges with the program.</p>	<ul style="list-style-type: none"> <li>• <b>UT</b>, which uses different contractors to deliver mental and physical health services, requires a PIP on improving coordination between the two types of plans – for both children and adults.</li> </ul> <p><b>NC</b> clarified referral process to facilitate exchange of information between providers and Part C early intervention program.</p> <p><b>UT's</b> public health agency modified its contract with Part C providers to require them to return a form completed by Medicaid providers who make a referral to the Part C provider. The form provides information about follow-up services provided. Part C providers are monitored to ensure use of the form.</p> <p><b>UT's</b> public health agency worked with the University of Utah's Department of Pediatrics to modify its medical home Web site to provide clinicians information about best practices in screening and treatment for developmental delays. This site features links to Medicaid manuals, supporting scientific evidence, and local resource agencies. <a href="#">[Web resource 17]</a></p> <p><b>VT</b> created a Child Development Division that brought together three child development programs (MCH, early intervention, and early childhood mental health) in order to support the delivery of integrated services. The division created a website to communicate its expectations and services to providers and families. These include information about the previously described Medicaid benefit and training designed to enhance communication between providers and families.) <a href="#">[Web resource 18]</a>.</p> <p><b>VT</b> reduced administrative burden on providers by simplifying and reducing referral forms from 5 to 2.</p>
Measurement	<p><b>IL</b> and <b>NC</b> Medicaid both 'unbundled' the billing codes for their EPSDT (well-child) visits so that providers now include the 96110 procedure code on the claim to indicate that they used an objective screening tool. This allows the agencies to use administrative data to measure both the overall screening rate and the screening rate of individual primary care providers.</p> <p><b>IL</b> Medicaid plans to require providers participating in its new PCCM program to include an objective developmental screening as part of an EPSDT visit. <b>IL</b> will monitor and provide feedback to individual providers on performance in this area.</p> <p><b>IA</b> MCH has selected two relevant measures to be part of its required annual report to the federal government, including the percent of maternal depression screenings</p>	

The only policy improvements designed to improve the delivery of child development services that were reported by more than one state were based on two sets of federal regulations – Medicaid managed care (HMO: Illinois and Utah; PCCM: Illinois and North Carolina) and EPSDT (Illinois and North Carolina).

1. Medicaid managed care – Federal Medicaid rules require states to have a written strategy for assessing and improving the quality of care provided by most contracted health plans (and all plans that provide comprehensive services). States are required to audit and ensure that MCO’s comply with state-established standards. States are also required to measure HMO performance and to use an External Quality Review Organization (EQRO) to review the care provided by capitated managed care entities. Both Illinois and Utah found enough flexibility within these federal regulations to use these requirements as the basis for improving child development services. In addition, North Carolina built on the medical homes established for children under its enhanced PCCM program – and Illinois plans to do so under the PCCM program the state is currently implementing.
2. EPSDT – Federal EPSDT requirements establish requirements for both screening and follow-up services. Illinois and North Carolina both used these requirements to improve the delivery of child development services.

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## **CRITICAL FACTORS FOR THE POLICY IMPROVEMENT PROCESS**

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Each of the eight states that participated in the ABCD consortia conducted individual projects. All of these projects featured some level of policy improvement – and all the states needed to engage in a process to identify, develop, and decide whether or not to implement various policy improvements. Examining these state processes reveals four critical factors that each incorporated to some degree:

1. Strategic plan for improvement,
2. Stakeholder participation,
3. Grounding proposed improvements in experience, and
4. Creating opportunities for improvement.

This section summarizes the ABCD consortia states' experience in addressing each of these four critical factors and identifies common features that led to success in each area. Each of these subsections ends with an illustrative example from an ABCD state. Please note that each is an example. The summaries are not intended to provide comprehensive information about the policy improvement process in each state or a complete catalogue of all the work these states completed in each area.<sup>22</sup>

### **Strategic Plan for Improvement**

The ABCD experience indicates that having a strategic plan for policy improvement increases the chances of success. Since policy improvement is a goal of the ABCD initiative, identifying policy barriers and solutions entered the discussions at the very beginning. It is also important to note that most of the ABCD states did not identify and implement all of their policy improvements at once. Rather, some (such as clarifying EPSDT coverage) were identified and implemented relatively close to the start of the projects – others were made as (and sometimes after) the projects ended. Examining the ABCD experience reveals that an effective strategic plan includes:

- A method for identifying policy barriers based on practical experience. To achieve this, ABCD states involved pediatric clinicians in their policy improvement processes and implemented pilot projects to test improvements.
- A method for prioritizing potential improvements. Policy improvements vary in cost and outcomes. It is not realistic to expect that all potential improvements can be made. Explicitly recognizing that state resources are limited and developing a method for prioritizing changes is important not only to the success of the process, but to ensuring that stakeholder expectations can be met.
- Participation by appropriate state program staff. It is critical to include in the process representatives of the program that the process seeks to improve. It is not necessary that staff from that agency lead the effort. They do, however, need to understand the effort and believe it to be credible and reasonable – goals that are easier to achieve by involving

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<sup>22</sup> For more comprehensive information on these states efforts please refer to NASHP's website ([www.nashp.org](http://www.nashp.org)).

the agency staff in the process. In some cases, more than one representative of an agency may need to be involved in the process. For example, an analyst may be best suited to analyzing barriers and developing solutions, but someone with decision-making authority may also need to be involved both to give the process credibility with other stakeholders and to ensure that the result of the process is clearly communicated to the ultimate decision maker.

- A process for analyzing the identified barriers. The ABCD experience shows that some barriers are misunderstandings of existing policy, some are within the purview of the state agency to change, some require federal approval, and some require changes to state legislation. It is important to examine the barriers to determine the root cause, identify workable solutions, and identify what authority is needed to implement those solutions.
- A method for communicating policy improvements (and correcting misconceptions about existing policy) to providers. Providers, including pediatric clinicians, will not change their practices in response to policy improvements that they do not know have been made. Further, the ABCD experience indicates that providers often have misconceptions about what they can and cannot do (and can and cannot bill for) under state program policies. Some of these misconceptions can form barriers to care. Therefore an important part of improving program policies is effectively communicating them to providers.<sup>23</sup>

### **State example: Iowa's Medicaid barriers process**

Iowa established a Medicaid Barriers workgroup as part of its ABCD project. The workgroup membership consists primarily of Medicaid staff and clinicians who were involved in the project's development and pilot site planning. The workgroup developed a Medicaid barriers document that begins with a set of guiding principles for acting on any barriers that current Medicaid policies create to implementation of the statewide system for identifying and treating young children with or at risk for delay in social or emotional development. The document then describes each barrier identified during ABCD planning, as well as the Medicaid agency's proposed response to each barrier. This process identified both 'real' barriers that would require a change of Medicaid policy to resolve and 'perceived' barriers that do not require a change in policy (but rather a communication strategy) to address. This document has been reviewed by a broad group of stakeholders, including the Medicaid Director, who is now in the process of deciding how to respond to the recommendations. In complementary efforts the state legislature authorized the Department of Public Health to spend \$325,000 to spread the ABCD model to more sites and ABCD project staff were awarded \$75,000 in funding from the state empowerment board for provider training, one feature of which will be clarifications of existing state policy.

## **Stakeholder Participation**

The ABCD states found that engaging stakeholders in the policy improvement process was an effective way to identify and address policy barriers. Among the stakeholders included were state agencies, clinicians, and provider organizations. It was particularly important to engage primary

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<sup>23</sup> H. Pelletier. *How States Are Working with Physicians to Improve the Quality of Children's Health Care* (Portland, ME, National Academy for State Health Policy, April 2006).

care providers who serve children because the major reason for improving policy was to better support these clinicians in providing developmental services to young children.

Each ABCD consortia state formed a stakeholder group dedicated to its ABCD project – and most also used other existing stakeholder groups to help them with different aspects of their program, including forming policy improvement recommendations. Stakeholders helped identify which existing policies were serving as barriers to delivery of child development services. They also played critical roles in developing effective solutions to these barriers that would be credible to clinicians, building support for policy improvement, and communicating those changes to their colleagues. Stakeholders also served as links to other complementary efforts in the state, such as the State Early Childhood Comprehensive Systems Grant (SECCS).<sup>24</sup> In turn, stakeholders valued their participation in these processes because it gave them an avenue to affect state policy – and thus deliver the care they wanted to provide. The elements to success in engaging stakeholders include the following:

- Stakeholder group membership, structure, and role was specified at the start of the projects. In all cases these evolved over time, but the core structure remained the same. Illinois had the largest stakeholder group with participation from other complementary state partnerships as well as clinicians, health care facilities, local and state government agencies, advocacy groups, and local funders. The participation of other state agencies with a role in delivering child development services and pediatric providers appeared to be particularly important.
- Stakeholders were actively engaged in project design, including policy improvement, from the start. Illinois and Iowa both formed active subcommittees that were assigned specific tasks such as identifying policy improvements. These committees were expected to report on their progress and seek feedback from the broader group.
- Stakeholders saw the results of their efforts. They saw that the projects changed as a result of their input – and that the project and Medicaid agency seriously considered their suggestions for policy improvements.

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<sup>24</sup> State Early Childhood Comprehensive Systems Grant (SECCS) grants are available to states through the Health Resources and Services Administration. “The purpose of the State Maternal and Child Health Early Childhood Comprehensive Systems (SECCS) Grant Program is to assist States and territories in their efforts to build and implement Statewide Early Childhood Comprehensive Systems that support families and communities in their development of children that are healthy and ready to learn at school entry.” (Source: <http://www.hrsa.gov/grants/preview/guidancemch/hrsa05033.htm#1> [Accessed 08/31/2005] ).

### **State example: Illinois Stakeholder Group**

Illinois formed a broad stakeholder group at the start of its project. The members of this group, which was chaired by the Medicaid Director, actively participated in the design and implementation of the intervention and pilots, identified policy barriers and solutions, developed and conducted the evaluation, and participated in dissemination of policy and practice improvements. The stakeholder group was divided into subcommittees that took responsibility for specific tasks, such as developing policy improvements. These subcommittees met independently of the stakeholder group to complete their tasks – and reported the results of their work to the broader group for final approval. The stakeholder group also formed a leadership team that met monthly in order to coordinate all activities. The stakeholder group included at last one representative of each of the following groups.

#### **State and local government agencies**

State Medicaid agency  
State Human Services agency (including Bureau of Early Intervention (Part C))  
State Maternal and Child Health Block Grant Administrator  
Chicago Department of Public Health

#### **Professional associations, including**

Illinois Chapter of the American Academy of Pediatrics  
Illinois Academy of Family Physicians

#### **Physicians from hospitals, medical centers, universities, FQHCs, and public health departments**

#### **Others**

The Chicago Community Trust (local funder)  
Erikson Institute  
Illinois Association for Infant Mental Health  
Illinois Birth to Five PAC  
Illinois Healthy Steps Program  
Illinois Maternal and Child Health Coalition  
Illinois Primary Health Care Association  
Infant Welfare Society of Chicago  
March of Dimes  
Michael Reese Health Trust (local funder)  
Ounce of Prevention Fund  
University of Illinois at Chicago  
University of Chicago, Pritzker School of Medicine  
UIC, Institute of Disability & Human Development  
Voices for Illinois Children

## **Grounding Proposed Improvements in Experience**

Each state implemented pilot projects designed to (among other purposes) help surface policy barriers and test potential solutions. The interaction between policy and practice was critical to identifying real barriers and realistic solutions. The pilots also built credibility both within and outside the state government, because the proposed policy improvements were based on practical experience that was supported by local data. All of the ABCD states collected data about the percent of children screened, referred, or treated at the practice, health plan, or statewide level. The stakeholder policy groups reviewed both preliminary and final quantitative data, as well as qualitative information collected through focus groups, interviews, or surveys of clinicians, office staff, and parents. In almost all states, both policy and practice improvements occurred over the term of the project, not only at the end. In the case of North Carolina, the effect of the pilot experience on policy improvement continued after the end of the formal project.

### **State example: North Carolina Pilot**

The North Carolina ABCD project is a model of the dynamic interplay between practice improvement, policy improvement, and the role of data to promote sustainability and statewide expansion. The North Carolina ABCD project started with a demonstration to integrate a standardized developmental screening tool (the ASQ) with one practice – Guilford Child Health – where the project’s leading pediatrician, Marian Earls, MD, is the medical director. Results from each child’s ASQ were entered into a database and used to calculate screening rates (percent of children screened with a standardized tool at selected well child visits), which were compared to baseline data collected through chart review. The data showed marked improvement throughout Guilford Child Health – 76 percent of children were screened with an ASQ in 2004, compared to only 5 percent of children screened with any formal and validated tool in 1999. Furthermore, the referral rate (for early intervention services) for the pilot practice jumped to 7%, compared with 2.9% statewide. Preliminary and final results from the pilot sites were shared with a statewide advisory committee that included leadership from multiple state agencies (e.g., Medicaid, rural health, early intervention) and the state pediatric society. Evaluation results were also critical in helping to replicate the model to other counties in North Carolina. The advisory committee met periodically during and after the project period to work with Dr. Earls and the ABCD project director to discuss the evaluation results as well as policy barriers identified through the experience of the demonstration. As a result of this interaction, the advisory committee developed and implemented several Medicaid policy changes, including the July 2004 policy change requiring Medicaid providers to use a standardized screening tool (such as the ASQ) at selected well-child visits. The recommended tools and periodicity schedule reflected the one developed and tested at Guilford Child Health.

## **Creating Opportunities for Improvement**

The ABCD experience indicates that a policy improvement process is more likely to be successful when it capitalizes on existing efforts, such as Iowa’s Empowerment Zone initiative to enhance communities for young children, Illinois’ All-Kids coverage (which increased attention to health care quality issues for children), American Academy of Pediatrics/Maternal Child and Health Bureau’s (AAP/MCHB) initiative on medical home, and the federal Early Childhood Comprehensive Systems grants. This does not imply that the successful states simply waited for other efforts to develop and then attached their goals to those efforts. Rather, the ABCD states actively sought out opportunities to partner with and build on complementary efforts – almost always to the benefit of both. The other facets of policy improvement already discussed lend themselves to this effort. Engaging stakeholders creates a network of people working toward a common goal and who can help identify potential opportunities and offer lines of communication to other complementary efforts. Implementation of a strategic plan ensures that project staff are ready when opportunity presents itself. They have specific suggestions that have been developed through a credible process.

### **State example: The Minnesota Mental Health Action Group**

State agency staff responsible for the ABCD initiative in Minnesota participate as members of the Minnesota Mental Health Action Group (MMHAG), a public-private partnership that reviews policy and makes recommendations for state-level policy change. This participation ensured that MMHAG was familiar with the ABCD initiative and used ABCD results to inform its work. As a result of this relationship, MMHAG developed recommendations that support efforts of ABCD. For example, MMHAG created a common benefit set that would meet needs of early childhood population and successfully promoted co-locating primary care and mental health providers. The governor's major mental health initiative built on the recommendations from this group to call for the integration of mental health and primary health care.

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## CONCLUSION

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There is evidence in the literature that many young children are not diagnosed with developmental problems until school entry, even though the vast majority of young children see a child health care clinician and receive at least one well-child visit. There is also evidence that physicians who use an objective screening tool as part of standard well-child care more effectively identify children with potential developmental delays. The eight ABCD states have identified and implemented a broad range of policy improvements that encourage and support physician use of such tools – and these can serve as examples or inspiration for other states interested in improving preventive care for young children.

Collectively, the ABCD states changed state statutes, state regulations, contracts, provider manuals, Web sites, and other documents that define state policies designed to improve the delivery of child development services. They have also changed eligibility and claims processing systems to implement the policies described in the documents, conducted quality improvement projects designed to assess performance and foster change, and helped providers understand new and existing policies. Examples of policy improvements made by the eight ABCD states include:

- **Improvements to program coverage (eligibility and benefits).** Seven of the eight ABCD states reported improvements to the policies that define program coverage. All seven reported improvements to benefit coverage policies and three reported improvements to eligibility policies. The most frequently reported improvement to benefit coverage was to clarify the state’s expectations to individual providers (including pediatricians) to encourage the use of formal, valid developmental screening tools as part of an EPSDT screen. The most frequently reported eligibility improvement was to clarify that children with specific mental health problems were eligible for the state’s Early Intervention (Part C) program.
- **Improvements to reimbursement.** Five of the eight ABCD states reported one or more improvements to reimbursement policies – either how much the program pays or how payment is structured. Three of these states reported improvements that relate to clarifying that providers (including primary care clinicians) can bill for conducting a developmental screen with a formal and valid screening instrument using CPT code 96110. One state (Minnesota) is planning a reimbursement strategy specific to managed care. In 2007 this state plans to pay a financial incentive to Medicaid-contracted health plans for increasing use of objective general developmental screening tools and mental health screening tools.
- **Improvements to performance.** Six of the eight ABCD states reported one or more policy improvements designed to enhance program performance, including performance measurement. There was greater variability among this type of improvement than among those designed to improve coverage and reimbursement. The only policy improvements designed to improve the delivery of child development services that were reported by more than one state were based on two sets of federal regulations – Medicaid managed care (HMO: Illinois and Utah; PCCM: Illinois and North Carolina) and EPSDT (Illinois and North Carolina).

Examining the experience of the eight ABCD states also reveals four factors that appear to be associated with successful policy improvement efforts. They are:

- a strategic plan (clarity about goals, objectives and policy priorities);
- broad stakeholder participation (making sure that leadership from all potentially affected agencies are actively engaged from the beginning);
- grounding proposed improvements in experience (pilot-test new ideas with local physician practices, collect data to show progress over time); and
- creating opportunity (build on complementary state and local initiatives).

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## APPENDIX

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Following are the Web resources that are noted in Tables 1, 2, and 3. Below are the titles of the linked documents or sites, along with the complete URLs. These resources are also linked from within the Tables.

### **Resources from Table 1 (page 13), ABCD state improvements to program coverage: eligibility and benefits**

#### Web resource 1:

Handbook for Healthy Kids Services, Chapter HK-200, Policy and Procedures for Healthy Kids Services, Illinois Department of Public Aid

<http://www.hfs.illinois.gov/assets/041404hk200.pdf>

#### Web resource 2:

C&TC Screening Components Standards and Guidelines, Minnesota Department of Human Services

<http://edocs.dhs.state.mn.us/lfserver/Legacy/MS-1812A-ENG>

#### Web resource 3:

Utah Medicaid Provider Manual, CHEC Services

<http://health.utah.gov/medicaid/pdfs/CHEC/CHEC7-06.pdf>

#### Web resource 4:

Contract for Furnishing Health Services by a Managed Care Organization, Division of Medical Programs, Illinois Department of Healthcare and Family Services

[http://www.hfs.illinois.gov/assets/080706\\_mco.pdf](http://www.hfs.illinois.gov/assets/080706_mco.pdf)

#### Web resource 5:

Provider Web site, Iowa EPSDT Care for Kids

<http://www.iowaepsdt.org/>

#### Web resource 6:

Child Health Maintenance Clinical Notes, Iowa EPSDT Care for Kids

<http://www.iowaepsdt.org/ScreeningResources/ClinicalNotes.htm>

#### Web resource 7:

Health Check Billing Guide 2006, Division of Medical Assistance, North Carolina Department of Health and Human Services

<http://www.dhhs.state.nc.us/dma/bulletin/HealthCheck0406.pdf>

#### Web resource 8:

Billing Codes for Iowa's EPSDT Care for Kids Services

<http://www.iowaepsdt.org/Services/BillingCode.htm#screening>

Web resource 9:

Partners and Providers page, MHCP Provider Manual, Children's Therapeutic Services and Supports (CTSS), Minnesota Department of Human Services

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_058361](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058361)

Web resource 10:

Utah Medicaid Provider Manual, Targeted Case Management:Early Childhood Development for Medicaid Eligible Children

<http://health.utah.gov/medicaid/pdfs/TARGETED/earlychild/TCMchildhood4-01.pdf>

**Resources from Table 2 (page 14), ABCD state improvements to reimbursement**

Web resource 11:

(Please see number 8, above.)

<http://www.iowaepsdt.org/Services/BillingCode.htm#screening>

Web resource 12:

Appendix 1: Anticipatory Guidance Topics, Handbook For Healthy Kids Services, Illinois Department of Public Aid

<http://www.hfs.illinois.gov/assets/072202hk200appendices.pdf>

Web resource 13:

(Please see number 7, above.)

<http://www.dhhs.state.nc.us/dma/bulletin/HealthCheck0406.pdf>

Web resource 14:

Notice to Providers on Screening for Perinatal Depression, Illinois Department of Public Aid

<http://www.hfs.illinois.gov/assets/112904pd.pdf>

**Links from Table 3 (page 16), ABCD state improvements to measure and improve system performance**

Web resource 15:

Overview on Developmental Screening of Young Children in Minnesota, Minnesota Department of Health

<http://www.health.state.mn.us/divs/fh/mch/devscrn/>

Web resource 16:

Provider Notice Screening for Perinatal Depression, Illinois Department of Healthcare and Family Services

[http://www.hfs.illinois.gov/mch/ppd\\_notice.html](http://www.hfs.illinois.gov/mch/ppd_notice.html)

Web resource 17:

Screening and Prevention Web page, Utah MedHome Portal

[http://www.medhomeportal.org/sections/index.cfm?section\\_id=6&section\\_content\\_id=99](http://www.medhomeportal.org/sections/index.cfm?section_id=6&section_content_id=99)

Web resource 18:

Health Babies, Kids and Families Web page, Child Development Division, Vermont Department for Children and Families

<http://www.dcf.state.vt.us/cdd/programs/prevention/hbkf/index.html>

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