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for STATE HEALTH POLICY

The Role of Children's Coverage Programs in a Changing Health Care Landscape: EPSDT, CHIP, and Health Care Reform

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Introduction

Medicaid and the Children's Health Insurance Program (CHIP) served more than 42 million children in federal fiscal year (FFY) 2010.[1] Together, these two public programs provide the backbone of health care coverage for low and moderate-income children. The passage of national health care reform has ushered in new opportunities for states to work toward continuous and improved coverage for children, not just through Medicaid and CHIP, but also through private health insurance, publicly supported and subsidized insurance Exchanges, and other options provided through the Affordable Care Act (ACA). Medicaid and CHIP programs can exert important leadership roles in promoting access to seamless, quality care for children and in implementing necessary health systems reforms for sustaining continuous coverage and coordination across programs.

Medicaid EPSDT and CHIP

- EPSDT is Medicaid's comprehensive program of early screening, diagnostic, and treatment program for low-income children.
- CHIP provides coverage for uninsured low to moderate-income children who are ineligible for Medicaid.

The National Academy for State Health Policy (NASHP) held a small, invitational leadership forum entitled "EPSDT, CHIP and Health Reform: A Discussion with State EPSDT and CHIP Leaders" in November 2010, supported by The Commonwealth Fund and The David and Lucile Packard Foundation. The purpose of this meeting was to discuss opportunities and challenges common to both programs, including improving the quality of health care for children, coordinating benefits and provider networks across public and private programs, and optimizing opportunities in the ACA to enhance the provision of coverage and care to children. Participants were drawn from state Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and CHIP programs; also included were representatives of Maternal and Child Health (MCH) Title V, the Centers for Medicare and Medicaid Services (CMS) and other experts in children's health care. This brief captures the themes and discusses the opportunities and challenges identified in that meeting to lay out a vision for how Medicaid's EPSDT and CHIP can work together to improve health coverage for children in the context of health care reform.

Major Themes of the Meeting

When EPSDT and CHIP programs consider working together on common strategies for improving children's health care, they can get beyond the challenges that often arise from having differing federal and state structures and requirements. The program leaders and experts at this meeting found common, unifying themes in considering the roles of the programs in the context of health care reform.

- **EPSDT and CHIP can keep a focus on children.** With states concentrating resources and efforts on preparing for expansion of Medicaid coverage to all individuals up to 138 percent of the federal poverty level (FPL),[2] implementation of health insurance Exchanges, and a myriad of other provisions in the ACA, it would be easy to lose sight of the need to solidify and build on the great strides this country has taken in reducing the level of uninsurance among children and the lessons that have been learned by EPSDT and CHIP programs in providing quality health care. While there is still work to be done, these programs have an impressive track record in improving coverage for children. Continuing these efforts in the coming years can achieve further improvements for children and provide lessons for broader reforms. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided resources and tools to improve both Medicaid and CHIP coverage of children, and the ACA maintained support for children's coverage through the lead up to and implementation of reform.
- **"No wrong door" can mean more than integrating enrollment across Medicaid, CHIP, and the Exchanges.** While the ACA's provisions for integration among programs focus on enrollment, meeting participants agreed the concept should be taken to the next level to promote consistency in benefits and providers to support continuity in services that children need during their critical periods of growth and development. The ACA provides challenges as well as new opportunities for promoting continuous coverage, access, and quality of care for children across Medicaid, CHIP, and the Exchanges.
- **Both EPSDT and Bright Futures serve as models of care for children.** EPSDT can serve as a model for child health coverage, as it is grounded in concepts of pediatric medical necessity that recognize the unique developmental needs of children, focuses on prevention and early intervention, links follow-up treatment to screening and diagnosis, and incorporates care coordination and other services that enable appropriate use of services. Bright Futures, developed by the Health Resources and Services Administration (HRSA) in collaboration with the American Academy of Pediatrics (AAP) and other experts, provides standardized guidelines for health supervision of infants, children, and adolescents and takes this model a step further by incorporating a set of principles, strategies, and tools that are systems-oriented, theory-based, and evidence-informed. It is family centered and addresses the community of health care providers and programs providing and financing coverage to ensure that children receive accessible, high quality care. Both of these models provide tools for improving the provision of care to children that can be integrated into other programs that share similar goals, with the result of strengthening those programs.
- **Medicaid and CHIP can be strong forces in promoting family-centered, seamless health care, particularly when they work together.** In providing coverage to one-third of all children and more than half (59 percent)[3] of low-income children in the country, Medicaid and CHIP are in a position of strength to effectively improve children's coverage, not just within their own programs, but across all coverage programs, provided they work together and share resources, strategies, and goals. With

the increased availability of coverage for parents through Medicaid expansion[4] and the Exchanges, the ACA provides the opportunity for a family approach to health coverage and an increase in parents' engagement in their children's health care. Because children will move across insurance programs, it is important to coordinate and use the resources available within Medicaid, CHIP, the Exchanges, and other resources in the ACA in relation to each other and, where possible, braid these resources together to support a seamless system of care for children. Medicaid and CHIP, which includes separate programs that are implemented through private plans, can provide a framework for children's health coverage and serve as an effective bridge between the public and private sectors, particularly in the implementation of the Exchanges.

Opportunities for Effective Medicaid and CHIP Collaboration

State program leaders attending the NASHP meeting discussed a number of aims in working together to provide leadership in the context of health care reform, including promoting seamless quality health care for children as they move across programs, using health information technology and exchange to measure and improve the delivery of care, and helping to transform primary care practices. Participants discussed current program initiatives that address these aims, as well as opportunities and challenges in advancing them.

Promoting Seamless, Quality Health Care for Children as They Move Across Programs

The ACA requires states to provide seamless coordination and transition in enrollment among programs to ensure continuous coverage and avoid breaks in health care. This coordination is not just between Medicaid and CHIP, but also with the insurance Exchanges. The aim is that there will be "no wrong door," so that individuals seeking coverage will be screened for eligibility for all programs, without having to submit additional materials or undergo multiple eligibility determinations. This is important since children's program eligibility will change over time as their parents' income fluctuates.

While the law's language pertains to simplified enrollment with a seamless transition across programs, Medicaid and CHIP leaders discussed the opportunities the ACA provides to take this concept to the next level of promoting consistency of benefits and access to providers in coordinating children's coverage across Medicaid, CHIP, and the Exchanges. They also discussed the importance of their roles in working across programs and integrating policies that can help move in this direction. State programs can strengthen and build on currently implemented efforts, some of which are noted below, to prepare the way for health care reform.

- Some states' Medicaid and separate CHIP programs have contracted with the same providers and plans, so that when a child's eligibility and enrollment change, the child's care is not disrupted and the child can remain with the same provider.
- State Medicaid and CHIP programs have collaborated with other state and community agencies to coordinate children's care. For example, Alabama's separate CHIP program coordinates benefits with the state's MCH Title V program for children with special health care needs (CSHCN) and other programs. State EPSDT programs have long worked with state MCH Title V programs to promote access to benefits for children consistent with a pediatric medical necessity standard. Since the medical necessity standard defines the conditions under which a child receives covered services, it is just as critical as the benefit package.

Pediatric Medical Necessity Standard

Medicaid EPSDT's definition of medically necessary services for children includes services and benefits that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.

ACA Provisions that Support Seamless, Quality Care

Meeting participants considered provisions in the ACA that help support consistency and coordination of benefits across programs.

- Effective in 2014, the national minimum Medicaid income eligibility level will be 133 percent of the FPL or 138 percent when a standard 5 percent income disregard is applied. While there already is a minimum Medicaid eligibility level of 133 percent of the FPL for children less than age six, for children ages six to 19, the minimum is 100 percent of the FPL. In states with separate CHIP programs, these older children with incomes from 100 up to 138 percent of the FPL will be moved to Medicaid. This change in program eligibility will mean that all children with incomes at or below 138 percent of the FPL will have the same Medicaid benefits that importantly include EPSDT.
- Effective January 1, 2014, the ACA establishes health insurance Exchanges where eligible individuals and small employers can purchase qualified health insurance plans. Individuals and families with income up to 400 percent of the FPL will have subsidized coverage. Coverage provided by qualified plans within the Exchanges must include essential health benefits, which the Secretary of the Department of Health and Human Services will define. Several benefit categories that specifically address children's needs must be included in the Secretary's definition, such as newborn care, pediatric services including oral and vision care, and preventive care. The degree of specificity with which the benefits will be defined at the federal level is unknown at this time, but Medicaid and CHIP programs have the opportunity to work together and inform federal guidance on benefits that are important to include and that would promote consistency across programs. States also have the ability to require additional benefits beyond those required as essential benefits, and although they must bear the cost of any additional benefits, the investment may prove worthwhile over the long term by providing children with needed services that contribute to their future healthy growth and development.
- The ACA requires the Secretary to certify which plans in each Exchange have benefit and cost-sharing provisions comparable to the CHIP program in the state in which the Exchange operates. Although the requirement for this certification does not require plans to provide CHIP comparability, it does provide a tool families can use in comparing available plans, which might pressure plans to enhance benefits so that they meet the CHIP bar. In designing their Exchanges, states could work on achieving comparability in benefit packages for children across programs. This is a role to which Medicaid and CHIP programs could jointly contribute as work is being done within the state on developing requirements for plans participating in the Exchanges.
- The use of Bright Futures—the guidelines developed by HRSA as a standard for preventive care—has been reinforced by its inclusion in the ACA. Private plans must provide these preventive services to children without cost sharing. Medicaid and CHIP have the opportunity to adopt the Bright Futures preventive standard in their programs, so that children have consistency in this area, regardless of the public or private insurance in which they are enrolled.
- The ACA established the Center for Medicare and Medicaid Innovation (the Innovation Center) to test innovative payment and delivery system models in Medicare, Medicaid, and CHIP, providing a potential testing platform for states to implement a model of care that improves the coordination, quality, and efficiency of health care services for children across all programs.

Challenges and Strategies

- Coordinating benefit packages and networks for children who transition between different insurers will be challenging. There are Medicaid and CHIP programs that use the same medical necessity definition for children, which recognizes developmental needs. Using this as common ground can provide focus and a starting point for programs to work together, as this definition is as essential as defining the benefit package.
- Provider shortages, particularly of specialists and dentists, may be exacerbated as more children are enrolled in coverage, putting access to benefits at risk. State programs will have to develop multiple strategies to address these shortages. Strategies can include working closely together to maximize available resources across programs; working with safety net providers, such as community health centers to help fill the gap; and utilizing new approaches to care delivery and scope of practice, such as primary care providers applying fluoride treatments and sealants to children's teeth.
- State programs often cut provider rates in difficult financial times to stay within limited budgets. Medicaid and CHIP programs may increasingly scrutinize and seek to reduce costs in care delivery for children because the ACA maintenance of effort requirement for both programs restricts them from seeking cost savings by decreasing eligibility levels or adopting more restrictive eligibility processes for children until 2019. Reductions in provider rates could limit the availability of services, making access to care more difficult and affecting the quality of care received by children.
- The future of CHIP is uncertain, particularly after 2015, when the federal funding for the program ends. The question of whether or not CHIP will still exist makes planning difficult for CHIP programs, although states by and large are still maintaining and improving their programs.

Using Children's Quality Measurement, Health Information Technology, and Health Information Exchange to Improve Care

Standardized children's health care quality measurement can serve as the basis for evaluating the continuity, process and outcomes of care across programs. Attending states agreed that promoting robust quality measurement and improvement for children's health care is a focal point for collaboration between Medicaid and CHIP programs. Both of these programs have collected and reported health care quality measures for years, but each program uses significantly different measures. They also differ in the methodology for collecting and analyzing data, and in the data collection systems. CHIPRA required development of a national, standardized, core set of children's quality measures. Consequently, an initial set of 24 pediatric quality measures was developed for Medicaid and CHIP programs to voluntarily report. While there will be numerous collection and standardization issues that will need to be worked through with implementation, the availability of standard measures for use across both programs is intended as a start to creating a national measurement and quality improvement program and will provide programs with important information for evaluating children's access to and quality of services. As pioneers in this area, EPSDT and CHIP can provide leadership in quality measurement and improvement across both the public and private sectors as states move into health care reform.

Leveraging Health Information Technology and Health Information Exchange to Improve Child Health

States at the meeting agreed that using a health information technology (HIT) and health information exchange (HIE) infrastructure to support quality measurement and drive system performance will result in improving the delivery of care at the program and provider levels for children. They also agreed that there was room for improvement, with many challenges, in getting this infrastructure in place.

The positive impact of sharing data at both the program and provider levels to promote robust quality measurement and improvement for children's health care is illustrated by Illinois, which has developed an effective data exchange among multiple state programs through integration into a Centralized Medical Data Warehouse. The participation by multiple state health agencies is authorized through interagency agreements and state legislation. The warehouse allows participating agencies to exchange both clinical and non-clinical data, which serve multiple purposes. At the program level, it has been used for quality measurement. At the provider level, it has been used to give providers tools for improving care. For example, a list of registered patients in the practice can be generated, along with a reminder system for immunizations, preventive services, developmental screenings and well-child care. It also generates a semi-annual profile for providers with their rates for providing these services, and allows for follow-up by quality assurance nurses. Also available to providers is a compilation of all claims for each client for the past two years, a two-year prescription summary, and an immunization summary for the past five years. This data helps paint a clearer picture for the provider of patients and their needs, so they can be adequately addressed.

States viewed the implementation and evolution of electronic health records (EHRs) as allowing better coordination of care at the provider level and providing a means for families to take part in discussions about their children's health care. Incentive payments to eligible providers made available through the HIT Economic and Clinical Health Act (HITECH), passed into federal law as part of the American Recovery and Reinvestment Act (ARRA), will encourage provider adoption of certified EHR technology and successful demonstration of its "meaningful use" in ways that improve quality, safety and the effectiveness of patient-centered care. As the capacity for collecting structured, clinical data from EHR systems becomes more robust, more readily available data and timely information on the care being received by patients will be available and new opportunities will become available for providers to improve quality outcomes.

CHIPRA, HITECH, and ACA Opportunities that can be used to Help Support Quality Measurement and Improvement

Federal support has been made available to Medicaid and CHIP programs to adopt standardized quality measures for children and to use an HIT and HIE infrastructure to drive system performance in assessing and improving the delivery of care through successive federal laws.

- Because the CHIPRA initial core set of quality measures was developed by a committee of experts, issued and subject to public comment, the Medicaid and CHIP directors concurred that although not perfect, they are credible measures for assessing the provision of children's health care.
- CHIPRA also provided for a Pediatric Quality Measures Program (PQMP), with grant awards made (since the November meeting) by the U.S. Agency for Healthcare Research and Quality (AHRQ) to seven Centers of Excellence to work on refining and enhancing the initial core children's measures and developing new children's health care quality measures for Medicaid, CHIP, and other payers, plans, and providers. These improved measures will be incorporated with the initial core set by January 1, 2013 and will be updated annually.
- Medicaid and CHIP programs have the opportunity to work with other insurers in the Exchanges to align their billing policies with national procedure and diagnosis coding standards to help ensure the same data is being submitted across programs, making the claims data more reliable for performance measurement.
- Through the national network of Regional Extension Centers (RECs), additional technical support is provided to primary care and safety net providers in rural areas to help integrate EHRs into their clini-

cal practices and meet federally defined requirements for the "meaningful use" of HIT. This also creates an opportunity to engage with RECs to address Medicaid and CHIP quality measurement and reporting priorities in building provider EHR capacity.

Challenges and Strategies

- There are implementation hurdles in collecting, reporting, and using the measures in the core set. Programs may not be in a position to collect consistent, reliable data on certain measures and selecting too many quality measures on which to report can be a strain. State programs need to carefully consider which quality core measures to select and the number of measures they will adopt.
- Developing data-use agreements and sharing data across state-based programs, including programs besides Medicaid and CHIP, such as public health, can take a great deal of time to implement and may require state legislation. States will need to start work on defining the parameters and developing these agreements in the very near future.
- Fewer than half of pediatric practices are going to receive EHR incentive payments under the HITECH Act, making it important for programs to identify or develop other methods of encouraging pediatric providers to adopt interoperable EHRs.

Helping Transform Primary Care Practices

The second day of the November 2010 meeting focused on EPSDT efforts in transforming primary care practices into family-centered practices that engage parents in their children's health care and provide coordinated, quality health care. Many EPSDT programs have used a multi-pronged approach that can be adopted by other state programs, including CHIP.

Utilizing the Medical Home as a Platform to Enhance Patient Care and Help Transform Practices

One of the most promising approaches in transforming primary care practices has been the implementation of the medical home model, an enhanced model of primary care. Having originated in the pediatric community in the 1960s, AAP formalized the concept in 1992 as care that is accessible, family-centered, continuous, comprehensive, coordinated and compassionate and updated it in 2002 to add "culturally effective" and reaffirmed that every child should have a medical home.[5] The strength of the medical home lies in enhancing access to primary care and improving coordination and linkages to specialists, services, and programs. Many states have worked to promote this model. Since 2006, 37 state Medicaid and CHIP programs have taken steps to advance medical homes.[6] Colorado has found that utilizing the medical home approach has helped in significantly increasing its EPSDT screening rates from 69 percent in 2006 to 74 percent in 2008, and increasing the number of eligible children referred for corrective treatment from approximately 188,000 in 2006 to approximately 249,000 in 2008. The state also has seen the number of eligible children receiving dental services increase from approximately 122,000 in 2006 up to approximately 161,000 in 2008.[7]

Educating and Identifying Available Resources for Primary Care Practices and Improving the Accessibility of Services for Children

States at the meeting talked about their efforts in developing resources and support for provider practices, which have resulted in both improved care for patients and an increased willingness by providers to participate in public programs. Just as important is making sure that providers and office staff are educated about the availability of these services for their eligible patients, so that referrals to necessary services occur on a timely basis. States stressed how important it is for them to be responsive in developing these services, and to

listen and pay attention to providers' needs. The following examples of work currently underway in this area were discussed.

- Access to mental or behavioral health services often is of particular concern to providers, and state programs are developing ways to improve coordination among mental health centers, federal community health centers, primary care physicians, and mental health providers, such as psychiatrists, psychologists, and social workers. Colorado addressed this concern by having an on-call children's mental health specialist available for primary care providers to speak with directly by phone. Another program noted success in improving access by co-locating a mental health provider in a pediatric health clinic.
- States discussed the importance of thinking outside the box and being creative in providing needed support—Colorado's participating physicians were unaware that there were care coordination services available through EPSDT, so the program situated program navigators in doctors' and other providers' offices, making this support readily available.
- EPSDT programs also have informed providers that non-emergent medical transportation is available for program patients and have connected with patients so they can get to their appointments. Not only does this improve access for patients, it also has served as an effective way of reducing appointment no-shows, which have been a barrier in recruiting providers to participate in public programs.
- States frequently used toll-free provider help lines to provide referrals to available medical and non-medical community programs.

Promoting Provider Buy-In

Provider buy-in can be promoted by leveraging the expertise of peers and professional organizations. State programs have found that providers are an extremely effective vehicle for recruiting other providers to participate in programs, in providing information and education to peers. and in encouraging practice changes. States have promoted providers' investment in Medicaid and CHIP programs by using feedback to make meaningful changes and restructure components of state programs.

- In Alabama, the Medicaid program is partnering with primary care physicians to redesign its medical home program, known as Patient 1st.
- Alabama also collaborated with pharmacy associations, independent pharmacists, and others in efforts to recognize and reimburse pharmacists' professional involvement in dispensing drugs.
- One state conducted a survey of primary care physicians to determine the best way to restructure case management fees to influence the quality of care provided.
- Bright Futures makes available a wide array of tools and resources for use by primary care practices.

Helping Empower Families and Giving Them a Strong Voice in the Health Care Their Children Receive

Engaging families and making them active partners in their children's health care is a significant factor in transforming provider practices, not just in helping to ensure that children receive the medical and support services they need, but also in providing an important voice in assessing how well the needs of their child are being met and in providing input on potential improvements.

- The medical home serves as a model of comprehensive, family-centered care that integrates parents as partners in their child's care. States talked about the benefits of this model in meeting children's needs and the potential for expanding its adoption and use in Medicaid and CHIP programs.

- Peer navigators have been used in helping families understand how they can better use the medical home system.
- Programs use patient help lines to assist patients with a broad range of issues, and they are sometimes staffed with parents to facilitate communication with families.
- Programs put provider lists online and routinely update them, so that families have access to this information.
- Both Medicaid and CHIP programs have periodically solicited information on families' experiences through provider surveys and given that feedback to participating providers.
- Programs have established a patient advisory process as an ongoing way of making system changes.

ACA Provisions that Support Primary Care Practice Transformation

The ACA includes provisions supporting primary care practices focusing more on the family and seeking to engage parents in the delivery and coordination of care for their children.

- While defined as a health home rather than a medical home, the ACA reinforces the importance of this model of comprehensive care, which provides an option for providing health homes for Medicaid beneficiaries with chronic conditions and offers enhanced federal match for eight quarters following approval of the state plan amendment implementing the option. While not specific to children, this would be beneficial to children with qualifying chronic conditions, since it would facilitate access to a multi-disciplinary array of medical and behavioral care and community-based services.
- $5 million was provided in the ACA to continue funding for Family-to-Family Health Information Centers in each state and the District of Columbia. Led and staffed by experienced family members of children with special health care needs, these centers provide outreach, peer support and benefit counseling and serve as a model of effective collaboration between families and the system of care for these children.

Challenges and Strategies

- Encouragement and nurturing is an important component of promoting parents' engagement with their primary care physician. This takes a commitment by staff and requires staff training. A systematic approach, such as that used by Bright Futures, encourages this interaction and provides resources and tools.
- Providers are sometimes unaware of state MCH Title V programs, Part C early intervention programs, Medicaid targeted case management, or other programs for CSHCN, so it is particularly important to educate them about available resources and establish those linkages.
- Providers' office staff are key in the success of educational efforts, yet there is often a significant turnover in support staff, making it difficult to keep well-trained staff that are fully aware of available patient resources or know where to access information. This situation makes it particularly important for programs to maintain contact with primary care practices on a routine basis and have a program liaison available to the provider's office staff.

Support Needed to Maximize Opportunities for Seamless, Quality Health Care

Both EPSDT and CHIP state representatives noted there were areas where additional support from federal agencies, foundations, NASHP, or other national organizations could aid their work toward continuous and

improved coverage for children in the context of health care reform, and made the following recommendations.

- Share best practices, lessons learned, innovations, and care models with state EPSDT and CHIP programs as the ACA is being implemented. Sharing this information in real time is particularly important, so states can use these examples to guide their health care reform decisions. Programs were particularly interested in being informed of examples of care coordination and of involving families in the care of their children.
- Spearhead a national effort to develop principles around promoting consistency and comparability of benefits and quality across Medicaid, CHIP, and the Exchange plans.
- Provide guidance to programs for working with Regional Extension Centers and HIT coordinators to help Medicaid and CHIP programs identify the best ways for maximizing the usefulness of available technical assistance.

Conclusion

CHIP and Medicaid EPSDT programs can provide leadership in ensuring that health care reform works effectively for children and youth by working closely together on common issues and goals, and drawing upon their collective knowledge and experience in providing health care coverage for children. Promoting seamless, quality health coverage and care for children as they move across programs, using HIT to foster improved measurement and delivery of care, as well as helping to transform primary care practices, are key goals. Participants in this leadership forum believed that program collaboration around these goals would position states well for reforming children's health care and providing lessons and models for broader systems transformation.

NOTES

1 Centers for Medicare and Medicaid Services, *Connecting Kids to Coverage: Continuing the Progress.* (Washington, DC: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2011).

2 The calculation of 138 percent of the FPL is the result of the 5 percent income disregard for all eligible individuals that will be added to 133 percent of the FPL.

3 Kaiser Commission on Medicaid and the Uninsured. "Health Coverage of Children: The Role of Medicaid and CHIP." February 2011. Kaiser Family Foundation. Accessed 18 April 2011.

4 Sections 1331 and 10104 of the ACA provide the option for states to establish basic health programs for low-income individuals are between 133 percent and 200 percent of the FPL.

5 American Academy of Pediatrics Ad Hoc Task Force on Definition of the Medical Home, "The Medical Home," *Pediatrics* 90, no. 5 (Nov. 1992): 774.

6 National Academy for State Health Policy. "Medical Home States." 2010. NASHP. Accessed 18 April 2011: http://nashp.org/med-home-map.

7 Gina Robinson. PowerPoint Presentation. "Colorado Medical Home." Presented at the National Academy for State Health Policy Meeting, *EPSDT, CHIP, and Health Reform: a Discussion with State EPSDT and CHIP Leaders*, Baltimore, MD, November 18, 2010.