

**Examples of Collaboration between MCH and Medicaid programs in
Improving Early Prevention, Screening, Detection, and Treatment (EPSDT)
Rates**

KAY JOHNSON: Thanks, Jamie. I'm actually going to start talking while I load my slides because we had a problem with the memory stick. Most of you should have a handout that starts on the first page. It has a narrative text with a summary of what some other states found. I just want to also say that, thanks to Stephanie Birch, you don't have the handouts. They went around. If you don't have them now, I may have a few more up here that I can do at the end. They just--I'm--we'll have to manage that when I come back. The--thanks to Stephanie Birch, we actually did talk about this last year at the partnership meeting, and we talked about it from the point of view of having a larger Medicaid session with Sarah Rosenbaum and Charlie Bruner and some of the early childhood development issues. And so, we--and those states--and yet another state that's presented at the partnership meeting, but not in this session today. We also have willing volunteers from Wyoming, Colorado to talk about some of their experience, and I'm going to take it forward from there.

What I want to try do is to give you a little bit of an overview of the project, and what HRSA has asked us to do, Jamie has said why. I'm going to tell you a little more about the what, and then Judith and Gretchen are going to tell you a little bit about the how we did this. This is actually our project goal. This is what's

written into the contract that we have with the Maternal and Child Health Bureau. This is a kind of technical assistance. We've contracted each year to do five states, and Jamie has given you a list of the states we've visited over the years. And these workshops are intended to foster successful coordination between Title V, Medicaid, and their partner agencies, aiming at that child health target and looking through the lens of EPSDT as our most powerful set of rules, regulations and guidelines. I want to just say at this point, so I don't forget, that there was a very important message missing from the stage at the luncheon, and that is that because EPSDT is grounded in the American Academy of Pediatrics' guidelines. If Bright Futures changes and there becomes one consolidated set of guidelines, those in effect become the guidelines that ground EPSDT by law in every single state. Now, I know that Judy Shaw doesn't think about that because she thinks about what the clinicians are due, and other people are thinking about Medicaid, and Joe Hagan is thinking about how this all came together across professions, but to me, the most important legal policy handle is that they are going to issue a new set of guidelines that change the ground rules for EPSDT in every state in effect, so something to be thinking about.

Jamie is our project officer. I do this work with the help of many others. I just wanted to acknowledge that there is a project team. And this is the Web site that Jamie mentioned that we developed, that actually embodies some of what I'm going to talk about today and has some more in-depth examples about the way that these rules all play out.

Why do we care about EPSDT? Well, because the percentage of children enrolled in Medicaid is high, and in the darkest states here, it's over 30 percent. As we know, in most states, Medicaid finances more than 40 percent of births, and those children who have their births financed by Medicaid continue to be eligible through their first year of life, virtually all of them have enrollment mandated for the first year of life. And then, in most states, over a third of the preschool-aged children, the 1 year old up to age 6, are eligible for Medicaid or by a CHP Medicaid program. And then, overall, on average in the nation, it's more than a quarter of all children up through ages 18 would be eligible. So, this is a program that is the single most important payer and guider of our child health services.

It was created in 1967, during the Johnson administration, and President Johnson himself was very committed to this legislation. He was very concerned about what he had seen with poor kids in Texas, that they didn't have good healthcare, that they were ending up with unnecessary disabilities, and there was, at that time, and we're going to talk more about this, from the very beginning, a link to Title V that at the same time while Johnson himself was committed based on what he'd seen when he was out campaigning in rural Texas. The Congress was not quite as committed to the war on poverty at that point in 1967 into doing all of this and to opening up an amending Medicaid, which was a big deal because Medicaid was a brand new program, only 2 years

old at that time. But Congress was persuaded by the fact that such a high number of young men at that time were being rejected by the draft in the Vietnam War. And they were being rejected because their health was not sufficient to induct them into the military. And Congress passed this not because it was concerned about poor children in rural Texas, but because it was concerned that they weren't producing enough young people who are ready to serve in the military. So, you never know how the politics of these things flow. It became a sweeping guarantee for comprehensive health that's never been fully realized for all of the kids in our country. EPSDT is, in effect, the children's health benefit of Medicaid. A lot of people think about EPSDT as the S as the screening part. Some families are very concerned about the T, the treatment part, but it's the S, the D, and the T together. Anything that your state finances in Medicaid for children, it finances under the EPSDT Law. It's the umbrella under which the whole benefit is structured. And so, we have these periodic screening services or well-child visits, comprehensive well-child exams is what they are intended to be, and they are intended to be guided by professional standards, like the AAP Guidelines. Vision, hearing and dental care is necessary, whether or not your state covers it for adults. All medically necessary diagnosis and treatment services that are needed, and a prevention focus standard of medical necessity. So, that in most private insurance is really focused on can you treat an injury or an illness, and EPSDT is focused on prevention. It also has a set of what people used to call affirmative responsibilities, which are a set of really administrative

services about informing families, covering transportation, scheduling, and other assistance linking to other agencies in doing certain kinds of reporting.

This program has a dual nature. This is actually--the first part of this slide is the quote from the Centers for Medicaid and Medicare Service, and it has two mutually supportive operational components. One is about assuring the availability and accessibility, and that's the financing part, and the other is helping the Medicaid recipient and their parents or guardians use the resources effectively, and that's the scheduling and transportation.

Fulfilling each of those continues to be a challenge in many states. It has been largely a challenge on the informing and outreach because those aren't the jobs that Medicaid agencies are traditionally is good at doing. They're good at paying the bills. They are less good at reaching into communities and informing, and that's where the role for public health and Title V comes in.

I'm not going to talk a lot today about the Deficit Reduction Act. We did a session on this last year only to say that it permits states to change eligibility for the first time-charge families' premiums and cost sharing for child health coverage to adopt a benchmark coverage package. But even if they adopt the benchmark coverage package, the EPSDT requirement remains, so you still have to figure out how to wrap around that benchmark, Blue Cross Blue Shield

type of plan, and cover the full range of EPSDT in case management and targeted case management.

I am going to talk a little bit more about that later, and just to say that we are going to be doing a special session at AMCHP talking about the legal and practical implications under the Deficit Reduction Act provisions around the case management and targeted case management because it has the potential to change the way you finance a whole series of things, like care coordination for children with special healthcare needs, home visiting, Part C service coordination, a whole series of things you may be now funding in part with a Medicaid dollar.

The other reason to talk about all of these and to bother to go out and work with states in particular is that we have not achieved our goals. It's hard to show this for all the ages. This is one I've picked for the children. This is really the toddlers from their first birthday to their third birthday. We have had, since 1990, a national benchmark with an expectation that states would achieve an 80 percent participation ratio. And what you can see is that only six states have actually achieved that by 2005. So, only six states have achieved the 1990 objective. And then there's another bunch that are not quite so dark in color that are at the 75 to 79 percent, and you want to give them credit.

Then the other thing to think about this slide is what is the participation ratio if you go to your state and look for your numbers. What a participation ratio is the percentage of children in that age group who had at least one EPSDT screen. Now, the fact is that for 1 and 2-year-olds, we have an expectation in most states, that they would have more than one screen, but they might have two or three well-child visits in that year, and yet this is just whether or not the child got in once. So, this is sort of our best-case scenario, in a way, and were not quite fulfilling. I'm not going to spend a long time, but just to give you a sense, in the states where we did these 2006 workshops, they were--they had a range of screening ratios, they had a range of participation ratios, and they had a range of utilization of Medicaid managed care. So, they weren't all alike. And we were trying to meet them where they were and talk about the opportunities for collaboration to do this work better.

Jamie mentioned, and I mentioned, that since 1967, these programs have been linked. In 1967, Medicaid was amended to add the coverage of this preventive care for all kids and to extend benefits, even if they weren't extended for adults, and now--there are plenty of seats, come on in. And Title V was amended also to assure that state Title V agencies would seek out, screen and treat children, and it was also written into the law that there would be an expectation that Medicaid would pay for services, well, what were then known as crippled children, are children with special healthcare needs. So, all the way back to '67, these programs were married in purpose and in law.

Today, the Medicaid rules for Title V say that Medicaid must establish in agreement with Title V agencies and that they must reimburse Title V providers even if services are provided free of charge to other low-income, uninsured families. The Title V rules for linking to Medicaid and EPSDT are similarly to establish coordination agreements, to assist with the coordination of EPSDT, to use your toll free numbers for helping families who are looking for a health provider, to provide outreach and facilitate enrollment linked to EPSDT, to share data collection responsibilities to be defined by you, and to provide and finance services for Children with Special Health Care Needs that are not covered by Medicaid. These things are all in law that I've shown you in the last two slides.

And another way to look at it is to think about this sort of joint management option. And there are a number of states that have really thought about this and have gone pretty far with it that Medicaid can delegate its outreach duties, its informing duties, transportation assistance, case management, care coordination. They also have a link over to the direct services in terms of relationships where they're actually paying local health departments for services or for Children with Special Health Care Needs, wraparounds. Excuse me. Yet, another familiar way for you to look at this is to think about it along the pyramid. And at each level--so, at the direct healthcare level, we're talking about--Title V might actually be the provider of the EPSDT's well-child visit, the screening visit. At the enabling services level, Title V might be providing or assisting or assuring

around the outreach information translation, care coordination, case management, and linking to the medical home. Around the population-based services, linking children identified with health needs or who are uninsured, linking up for purposes of enrollment or linking through programs such as newborn screening or immunization.

And then, at the infrastructure level, states are taking--State Title V agencies have been taking a role and setting standards or helping to guide the quality initiative, thinking about how Medicaid managed care contract provisions relate, and thinking about how information systems can dually support the two. It's one of the things we talked a lot about two weeks ago in Wyoming.

So, what did we do in 2006? Our learning objectives were to help people improve their skills for managing and meeting these kinds of obligations, and the second, to increase the knowledge of the available tools and strategies that were out there, to cross-fertilize information from other states. Who attends these? Our primary audience when we go out is--and we actually say, "You need to bring together a core planning group that includes Medicaid, that includes your Title V MCH, and Children with Special Health Care Needs leaders, and to the extent that it's relevant, your State Children's Health Insurance Program. And as Jamie mentioned, people bring a variety of others to the table: Part C, Child Welfare, Mental Health. In Colorado, the whole workshop was focused around early childhood mental health. They narrowed--really weigh in on a topic.

We've had state legislators. We've had peoples from the governor's office working on health, or from children's cabinets. We've had commissioners of Health and Human Services. I'm going to use Wyoming again as an example because it's fresh in my mind, but a similar thing happened in Alaska, where in Wyoming, it was the umbrella commissioner who's offered both Medicaid and public health. And in Alaska, it was the Medicaid director and the Health commissioner, and where they came in to do the welcome, and we hooked them, and they stayed all day. And in fact, in Wyoming, the commissioners--the director sent his deputy the next day to be sure that he would be represented there, and in Alaska, we thought, "Okay. They stayed all day. They'll never come back the next day," because the second half-day was just about child development, just about early childhood services, and how they could do collaboration around that. Well, you know, here came the Medicaid director. And there went the senior staff person for the Health Department. The next thing I knew, the Health commissioner was back. So, we had to hook them for the second day around Early Childhood Services, and I have no doubt that if we hadn't somehow hooked them in the second day--the first day, they'd have never come to a meeting just about collaboration around early childhood.

We've also had local public health and human services agencies represented, as well as an array of partners in virtually every meeting, parents and their

advocates, people who are academics, people who are working in health plans, and obviously, the providers themselves.

One of the factors that I feel obligated to tell you, that some things we did made a difference and some things didn't, what we've seen is the factors that were associated with the most successful workshops. Obviously, we're asking people to volunteer to do this. And the second was having a catalyzer, having somebody who just really had the passion for what we were doing and how to get it done in the state, and that's been people in a variety of different roles. We've structured this because we have very limited money from the bureau to have a planning committee that meets four to six times to actually develop the agenda, the work materials, make sure that we know what's gonna be in--what the substance of the meeting is really gonna be, and very carefully pick the invitees. And when the planning committee reflected the core constituencies, and we had senior leaders on the phone with us, we ended up having more successful workshops. These are about finding common ground. They're not about starting a new project, so that's not what you're going to hear from the states they're talking. When we had executive--senior executive branch officials, it kind of raised the level of conversation and people felt like they had permission to go farther.

The general topics that came out of the workshops, we were focused on early childhood development, mental health or early childhood mental health, children

with special healthcare needs, infants and toddlers, and Part C early intervention on adolescent health and on oral health. Probably, not a surprising list to you of special concerns where people wanted to deal with particular issues. But the other things that came up were really about operational issues, about the periodic visit schedules, about whether or not family outreach and informing was effective, whether the referral and treatment process was really working, and in most states, the data show that it isn't really working, that the managed care, and other kinds of provider, a care or contract arrangements, were working for kids not just to save the state money, and implementation of the medical home concept through the notion of EPSDT, and we talked about the Deficit Reduction Act.

And finally, there were a set of administrative or coordination issues linked to provider participation, parent education and family support as distinct from parent informing the legal obligation. This was really about how do we educate parents around prevention and provide support to those who have children with special needs. Care coordination case management: How to do quality improvement? How do you link up what's going on in EPSDT with providers who might be in a pediatric quality initiative? The Child Health Data and Information Systems, there are a couple of states who come back to the recommendation being about somehow putting--linking up what's going on in Medicaid with their efforts to build an integrated child health database, and then thinking about how their Title V Medicaid administrative arrangements were or were not working for them. We

are continually surprised to go to states and have some people not know that there actually is an agreement that maybe was written some time ago and hasn't been updated.

We had good evaluations. I won't bore you with the details of all this. But since MCHB paid for it and I feel like it was fair to show you, actually, that eight out of nine people rated us as good or excellent, and it's not a commercial, but we had really high positive arrangements. I think because we're trying to help people figure out how to go from where they are now to where they want to go. I guess the last thing I would say in terms of thinking about the MCHB investment in this, where we hope to go next year is to build some tools out of this that states can use themselves that don't require that Jamie and I or others are in the room to facilitate this process, that there are things that you could do yourselves. I'm gonna stop there. Gretchen?