IMPROVING ACCESS TO CARE IN ARKANSAS THROUGH SCREENINGS:

GETTING CHILDREN THE EARLY CARE THEY NEED

DECEMBER 2017

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

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by Marquita Little, AACF Health Policy Director
December 2017

Health coverage is one of the most important resources that children need to thrive and grow into healthy adults. Medicaid and the Children's Health Insurance Program (CHIP) ensure that nearly half of Arkansas children — over 400,000 — have access to health care coverage.[1] The important investments made in children's coverage, at both the federal and state levels, have made this possible. The Medicaid program has been a cornerstone of the children's health care system for over 50 years. Building on the foundation of Medicaid, CHIP helps working families who are unable to afford health care to obtain a comprehensive, consistent source of coverage for their children. These coverage programs are designed with kids in mind – with an eye toward preventive care and treatment.

One of the most important factors about children's Medicaid is that it provides for regular, comprehensive screenings that are designed to catch health conditions and get them treated early. These benefits allow children to have important access to early childhood screenings and follow-up treatment. This is what's best for kids, but it's also the best way to operate a quality and efficient health care system.

By screening children regularly, health conditions can be identified early and treated. Because early screenings are so important, the Medicaid program requires them as covered benefits for all children. Even when a child is screened in another setting, like an early education center or pre-K program, they may require follow-up treatment through the Medicaid program.

These early investments in the health and well-being of young children are especially important because most brain development occurs within the early years. Research shows that children perform better in school and are more economically stable as adults when they have a healthy start. In addition, children have better health outcomes, and it is more cost-effective to detect and treat illnesses early.

This report describes recent work to expand access to childhood screenings in Arkansas and our state's early childhood intervention system. It examines important barriers that we need to fix, as well as opportunities in the Medicaid program to improve access to screenings, detection, and treatment services.

ACCESS TO CARE IN ARKANSAS

The health care system in Arkansas has improved dramatically over the past 20 years. Today, 95 percent of children have health coverage. Also, the state has made strides in recent years to improve access to care by offering doctor's incentives for providing high-quality preventive care through the patient-centered medical home initiative. Yet, children in Arkansas lag behind because many kids still lack *access* to the treatment they need. Simply having coverage isn't enough; children must get the screenings and preventive care necessary to stay healthy. We're not doing as well as most other states in that regard, and it shows in our state's overall child well-being. According to the annual Kids Count report released by the Annie E. Casey Foundation, Arkansas ranks 46th in child health. Also, 18 percent of children are not in "excellent or very good health," which is slightly higher than the national figure — 16 percent — and several neighboring states including Mississippi, Louisiana, and Tennessee.

To improve health and educational outcomes for children in Arkansas, the state must have an effective early intervention system that promotes the importance of young children's early development, screens all children, makes appropriate referrals, and assures that children receive the services they need to thrive. Developmental screenings are an effective way to ensure children are hitting important milestones in their growth and development. The most important period in a child's life is the first three years, due to the rapid brain development that occurs. This early rapid brain development creates the foundation for more complex brain function later, like language, memory, and visual skills. It's also the best time to influence children's long-term health and well-being. If developmental delays can be identified early, children can receive services to help them catch up. The state of Arkansas, like other states, has a special early intervention system for young children who have a special health care need.

OPPORTUNITIES AND BARRIERS IN ARKANSAS

In July 2016, stakeholders from multiple sectors convened to discuss strategies to improve access to and delivery of early childhood screenings, referrals, and services. National and state experts presented research on child development, promising practices for building comprehensive screening and referral systems, and successful models being implemented nationally and locally. Stakeholders then collaborated to examine state-level data and discuss barriers and opportunities to improve services in Arkansas. Key findings related to each step in this comprehensive system, as well as new and developing opportunities on which to build, are presented in the following pages.

CHILDHOOD SCREENINGS

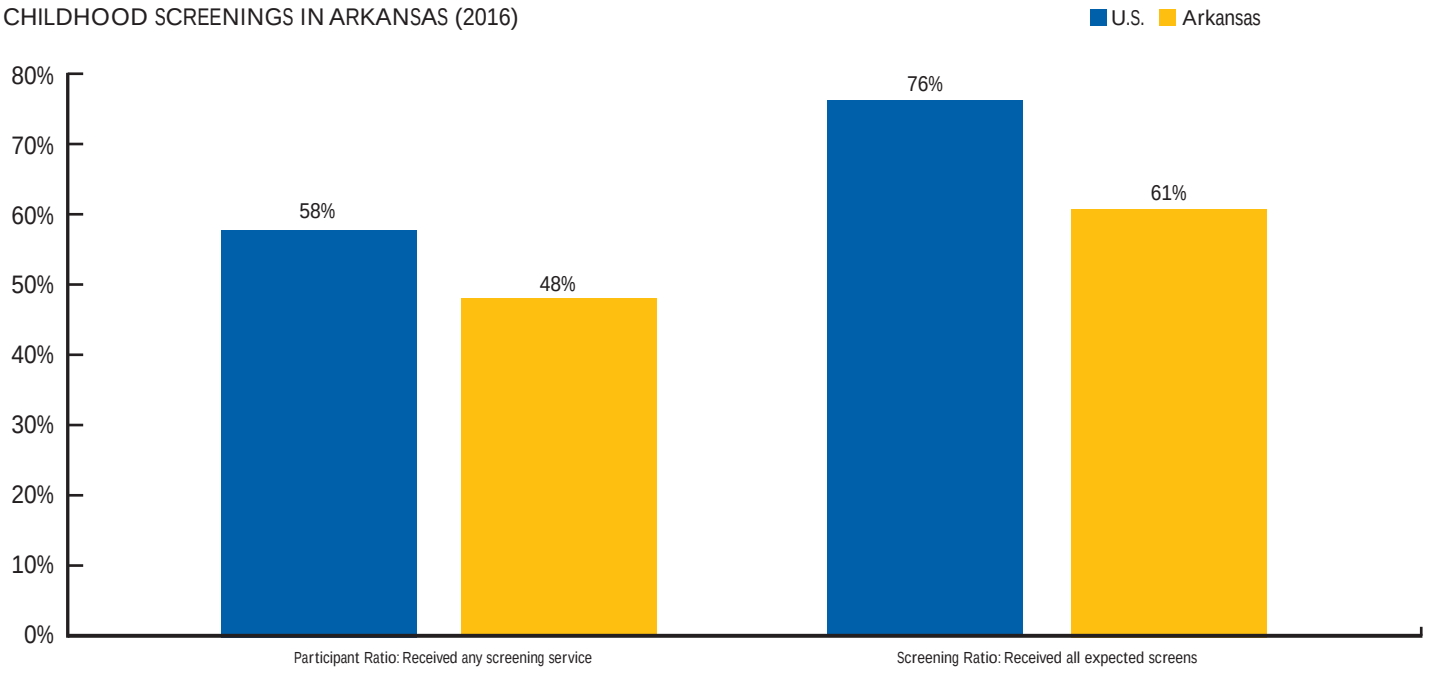
Meeting participants considered two types of screenings: physical/developmental and social-emotional. The American Academy of Pediatrics defines a developmental screening as the administration of a brief tool to identify possible development delays.[2] Developmental screenings, usually conducted during pediatric well-child visits, are an effective way to ensure children are hitting important milestones in their growth and development, showing their progress and allowing problems to be recognized early and addressed. However, less than half (45 percent) of children enrolled in Arkansas Medicaid receive a well-child visit, compared to a national average of 58 percent.

One way to monitor whether kids are getting the assessments and follow-up they need is by examining program reports for early periodic screening, diagnosis, and treatment (EPSDT), an essential benefit for children. Every state Medicaid program reports EPSDT screening data to the federal Centers for Medicare and Medicaid Services (CMS) to determine whether children enrolled in Medicaid are receiving required health screening services and being referred for treatment.[3] Because of the differences in children's needs, the specific screen or treatment services are not defined by federal or state law, and EPSDT is broadly defined. The treating physician decides what each child needs.

The data on the next page show the number of Medicaid-enrolled children in Arkansas who receive EPSDT screens and whether they receive all that are recommended for their age group (also known as the periodicity schedule). While these data help paint a picture of the extent to which developmental screenings may be occurring, EPSDT metrics are not a proxy for the specific frequency of developmental screenings with a standardized screening tool, as recommended by AAP. States have the option to report Medicaid developmental screening data through CMS's child core set, which includes a metric for *Developmental Screening in the First Three Years of Life*.[4] To date, Arkansas has not elected to report developmental screening data, but doing so would provide a more accurate picture.

The charts on the next page show two measures that are reported to assess the state's EPSDT screening performance for all required screens, including developmental and physical screens. The participation ratio indicates the number of children in Medicaid that received any initial or periodic screening services during the year. In Arkansas, less than half (48 percent) of children receive any screenings services in a year. The

CHILDHOOD SCREENINGS IN ARKANSAS (2016)



Source: Annual EPSDT Participation Report, 2016 National and State data. Centers for Medicare and Medicaid Services.

screening ratio shows the proportion of the recommended screenings children received. In Arkansas, less than two-thirds (61 percent) of children receive all recommended screens. Both measures fall below the national screening figures. These data suggest that even when children in Arkansas are screened during the year, most are not likely to receive all screenings recommended for their age group. Arkansas also falls below the national average on both EPSDT performance measures.

Arkansas data also show that the percentage of children receiving any recommended screen during a year decreases with age. Therefore, if a delay is not identified in the first year of life, the chances of it being identified in future years goes down. Additionally, enrollment data follow a similar trend with the uninsured rates increasing as children get older. This underscores the importance of children having access to a consistent source of comprehensive coverage throughout childhood, like the coverage provided through Medicaid. It provides access to services for children in low-income households that is comparable to other coverage sources. According to data from the Kaiser Family Foundation, 85 percent of children enrolled in Medicaid and other public coverage have a well-child visit, which is similar to rates of children enrolled in their parent's employer-sponsored coverage – 86 percent.[5] In comparison, only 53 percent of uninsured children have these visits.

National research shows that, historically, 70 percent of health care professionals have relied solely on their clinical judgment rather than using formal, evidence-based developmental screening tools.[6] Efforts have been made to improve this issue over time, particularly through training child care and health providers on certain tools. But Arkansas still lacks policies that require and provide incentives for the use of standardized screening tools across the system. As a result, doctors may be missing delays that would be detected by such tools. Developmental screenings also occur in other settings: child care centers, Head Start, home visiting, pre-K programs, and by the organizations that provide services to children who have delays. However, there are often no formal mechanisms for communicating the results of these screens to a child's primary care physician (PCP) and little records to determine if appropriate referrals and services are provided if delays are identified.

Social-emotional screenings are not required as part of EPSDT; however, there is evidence that the need is great. Children's development of social and emotional capacities contributes significantly to their health and learning.[7] In a study of 1,448 children enrolled in Arkansas Head Start and Arkansas Better Chance pre-K programs, 16 percent of children had clinically elevated behavioral

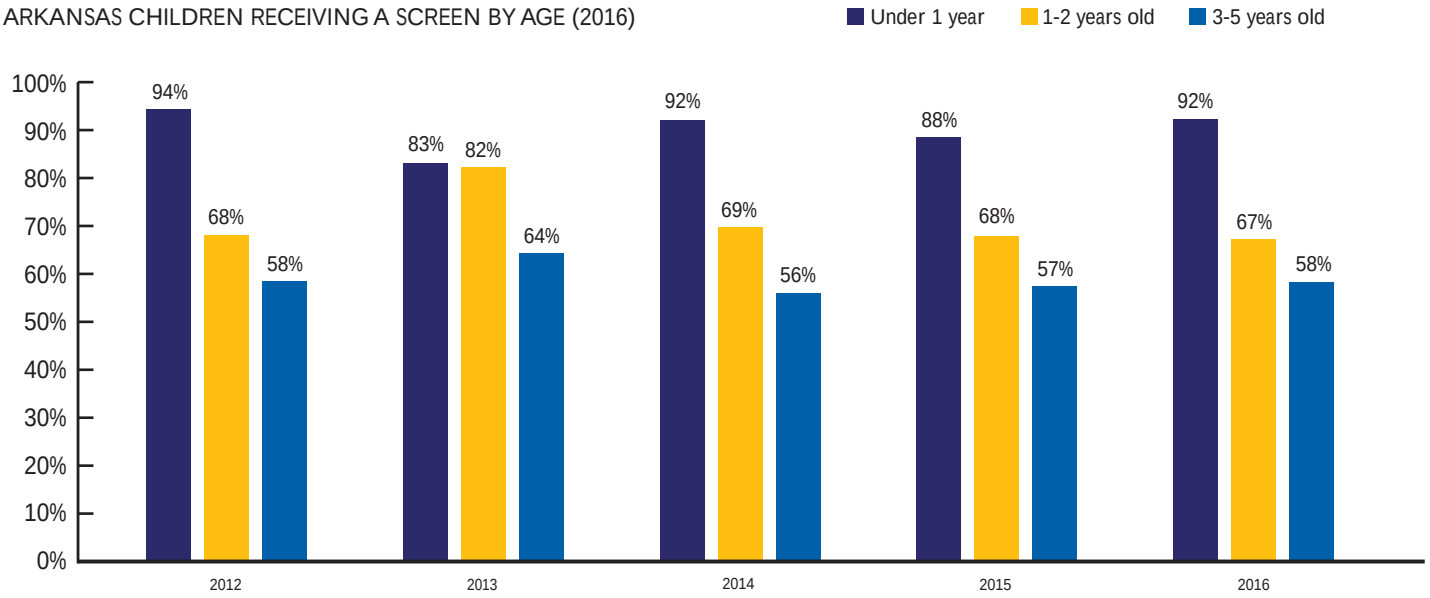
screening results.[8] Recognizing the under-identification of children's mental health issues and the limited capacity of most doctors to screen and make referrals, the American Academy of Pediatrics has provided guidance and potential screenings tools.[9] However, given the lack of behavioral health services specifically for young children in Medicaid, it is unlikely that these tools are being used widely. Additionally, providers would have a greater incentive to provide social-emotional screening services if there were billable codes in the Medicaid system for those screens.

According to local experts and stakeholders, some additional factors in Arkansas that may be contributing to low developmental and social-emotional screening rates include the following:

- Some families do not understand the importance of well-child visits and visit the doctor (or an emergency room) only when their child is sick or their school/child care provider requires immunizations or other documentation.
- Families may also face difficulty finding transportation to the doctor or taking time off from work for a well-child visit, especially if the clinic's hours are the same as their work day.
- Many children see a family physician instead of a pediatrician. Family physicians see patients of all ages and may not have the depth of knowledge necessary to conduct developmental screens.
- Many pediatricians and family physicians do not feel equipped to conduct behavioral health/social-emotional screenings.
- Since parents are more likely to bring their children to see the doctor when they're sick, some pediatricians may conduct a screen during a sick child visit. Even so, they have run into challenges billing for EPSDT during such a visit, which means there is usually no record of the screen in claims data for Medicaid or the insurance provider.

While statewide screening rates are relatively low, there is anecdotal evidence that in some parts of the state, particularly in rural areas, larger numbers of children have been screened and found to have higher rates of delays. In some cases, these screenings are conducted by the same entities that provide the services to the children, which raises some concern that children may be identified for unnecessary treatment and supportive services if providers can "self-refer" for their services.

ARKANSAS CHILDREN RECEIVING A SCREEN BY AGE (2016)



Source: Annual EPSDT Participation Report, 2016 National and State data. Centers for Medicare and Medicaid Services.

REFERRALS AND LINKAGES TO PROVIDERS

Once a developmental or social-emotional screen is completed and a potential delay has been identified, the doctor or provider conducting the screen often refers the child's family to another entity for further evaluation and/or provision of services.

The Medicaid Early Intervention Part C program is a key next step for many children identified with significant delays. Early Intervention Part C, called First Connections in Arkansas, is a federally funded program that helps infants and toddlers with serious delays and disabilities. Two overarching goals of First Connections are to build the capacity of the families to facilitate their children's development and to provide services in natural settings. First Connections works with families to conduct additional assessments and evaluations, if necessary; helps families understand their rights and the array of potential services available to them; develops an Individualized Family Service Plan with the family; and connects the families to those services.

The Part B program provides similar services for preschool children ages 3 to 5. In Arkansas, Part B services are overseen by the Arkansas Department of Education, through educational service cooperatives and individual school districts.

The doctor or organization conducting the initial screen may also refer a family directly to a provider of services such as a developmental day treatment center (DDTC) or another private provider. These organizations may also provide screenings and refer families to their own services. Additionally, much of the treatment provided to eligible children is reimbursed by Medicaid.

The following challenges have been identified with the ways that referrals occur, especially for children with low-to-moderate developmental needs:

- Pediatricians and family doctors are often unaware of the array of appropriate service options in their communities. In rural areas, options may be limited. Even in urban communities, a doctor may make a referral to a particular provider, because that is what he has always done or because he has a social relationship with the person.
- If a doctor identifies a social-emotional issue, they currently have limited referral options because

Arkansas has not had the necessary services in place in Medicaid for young children. The limited Medicaid-reimbursable services are often inadequate or inappropriate for young children.

- Early childhood education providers such as Head Start, child care centers, and pre-K programs have similar challenges in making referrals for both developmental and social-emotional services.
- Without support and guidance from their physicians or early childhood education providers, families have difficulty learning about and navigating through the service options available to them.
- The ability of DDTCs and other private providers to self-refer may be leading to over-provision of services, or provision of the wrong kinds of services, for some children.
- There are multiple ways that children can be referred for services, and there is no statewide system for tracking those referrals and whether families access the services.

TREATMENT SERVICES FOR CHILDREN

In Arkansas, DDTCs are key providers of services for young children with developmental delays. Core services include 1) diagnosis and evaluation, and 2) habilitation, which is instruction in areas of self-help, socialization, communication, etc. Services are primarily provided in clinical or early childhood education facilities and should be provided to both the child and the parent. DDTCs also offer occupational, physical, and speech therapy.[10] DDTCs often offer child care or pre-K classes in addition to the core services and therapies, which make them convenient for and attractive to working parents.

First Connections works with families of children from birth to 36 months to connect them to service providers, which include DDTCs and other private providers. To be eligible for services, a child must have a delay of 25 percent of chronological age or greater in one or more areas of development or a documented medical diagnosis that is likely to result in a developmental delay.

Once a child reaches age 3, he or she must access services through the Part B program, which is offered through educational service cooperatives and some school districts. To be eligible for services, a child must have a condition that falls into one of the following categories: autism spectrum disorder, deafness, blindness, hearing impairment, multiple disabilities, orthopedic impairment, other health impairment, speech or language impairment, traumatic brain injury, or visual impairment.[11]

For preschool-age children, services can be provided at public school pre-K programs or at other pre-K programs or child care centers.

The following challenges have been identified with the way services are provided in Arkansas:

- Some children are prescribed the full allowable amount of a particular service, even when they don't need it.
- At the same time, many children do not receive services they need.
- Children with mild and moderate issues often fall through the cracks.
- PCPs that make referrals often do not receive follow-up information from the providers about the provision of services and outcomes achieved.
- When the referral is made by an entity other than the PCP, the physician often does not receive information about the screening results, referral, or the provision of services and outcomes.
- The capacity of First Connections staff varies across the state, resulting in uneven provision of services to families.
- First Connections has limited funding, all of which comes from federal dollars. Unlike other states, Arkansas provides no funding to support the service.
- Services are primarily provided in clinical or early childhood education facilities, which is different from the prevailing trend across the country to provide services in more natural and inclusive settings.
- Mental health services for infants and toddlers and their families are almost nonexistent in Arkansas, since Arkansas Medicaid has not reimbursed for them in most cases. This has forced many behavioral health providers and doctors to provide what limited services they can under the current system.

CHILDREN'S ACCESS AND THE FEDERAL HEALTH CARE THREAT

As debate continues at the federal level to change the health care system, proposed cuts to Medicaid funding pose the greatest threat to the gains made in Arkansas on children's health care coverage and access to care, including early screenings, detection, and treatment. Recently, several bills have been introduced by members of Congress that would result in significant cuts to funding that covers children, seniors, and individuals with disabilities enrolled in the Medicaid program. As an example, the Graham-Cassidy bill would have resulted in Arkansas losing over $1 billion annually in federal health care funding by 2026.[12] This proposal would have made some of its deep cuts by implementing a new funding model for Medicaid that creates a gap between the federal funding the state receives and the amount needed to sustain the program at the current levels.

While these proposals have been defeated, there is an ongoing threat to children who rely on Medicaid as the health reform debate continues.

Not only could these proposals limit access to children's coverage, they could also result in changes to important benefits that children need to grow and develop. Cutting federal Medicaid dollars and shifting these costs to the states would likely cause states to cover fewer children and benefits. A recent report from the Georgetown Center for Children and Families sheds light on the concern that parents with incomes below the poverty line are more likely to report that their children are in poor health and at greater risk of a developmental, behavioral, or social delay.[13] Additionally, these families are the most likely to lack the income to afford treatment if EPSDT services were no longer a required Medicaid benefit. If benefits are reduced, states may cope with the reduced funding by reducing eligibility to only the very lowest income households. Also, access may be even worse for the millions of children with special health care needs enrolled in the Medicaid program, since most qualify for coverage based on family income and not disability.

As Congress continues to consider the future of the health care system, children's coverage must remain a priority. The historical investments in children's health through Medicaid have ensured that children have access to the care they need. These investments improve their health outcomes, as well as their educational and economic future, which allows every child the opportunity to become a healthy, successful adult.

PROGRESS TO BUILD ON IN ARKANSAS

Arkansas has made a lot of progress in recent years to improve access to care for children. Much of this progress has been through innovations in the Medicaid program, opportunities to use state and federal health care dollars in innovative ways, and initiatives that use health care funding to promote high-quality, evidence-based care. These recent efforts provide opportunities to build on and improve child health promotion, screenings, referrals, and treatment services.

- **Patient-Centered Medical Homes.** Because of the state's patient-centered medical home (PCMH) initiative and the ability to reward health professionals for innovative practices, care coordination has improved significantly. The PCMH is a primary care model that focuses on providing comprehensive, team-based, coordinated, and high-quality care.[14] Health care providers have several specific activities that they engage in to improve care coordination, including identifying a care coordination lead, implementing specific care coordination strategies, and addressing care coordination barriers. For example, more health professionals provide parent education and tools like text reminders for appointments and follow-up. Many clinics also try to make care convenient with flexible clinic hours. The PCMH model was developed as part of the state's larger Payment Improvement Model, which includes a focus on using Medicaid dollars to provide incentives for high-quality care.[15]

- **Home Visiting Program.** The Arkansas Home Visiting Network (AHVN), which administers developmental screens for children in the families it serves, is developing a partnership with First Connections. AHVN includes several different home visiting program models: Following Baby Back Home, Healthy Families America, HIPPY Arkansas, Parents as Teachers, and Nurse-Family Partnership. All programs use the Ages and Stages Questionnaire, and most use the Ages and Stages Questionnaire: Social Emotional, which screens for mental health. AHVN will link families identified by the screeners as needing follow-up to First Connections. According to the national Health

Resources Administration, federally funded home visitors reached 160,000 parents and children in 2016.[16] This funding, like funding for several other health care programs, must be reauthorized by Congress periodically to continue.[17]

- **Behavioral Health Transformation.** Current efforts to transform the state's behavioral health system will create a service array in Medicaid for children from birth to age 3. These new services will include treatment that allows the mother or caregiver to receive services as well. After over a decade of work to transform the children's behavioral health system in the state, this proposal received legislative approval in 2016, and implementation will begin by the end of this year. These services will be reimbursed for children enrolled in the Medicaid program.

In addition to these efforts, there are several projects focused on improving access to early childhood screenings and treatment by establishing a connection between the health and education sectors. The Project Play program, through the University of Arkansas for Medical Sciences, works in early childhood settings to promote social and emotional health in children, which includes supporting families with screenings, behavior management plans, and referrals. Solutions focused on the early childhood setting present a great opportunity to reach young children and their families.

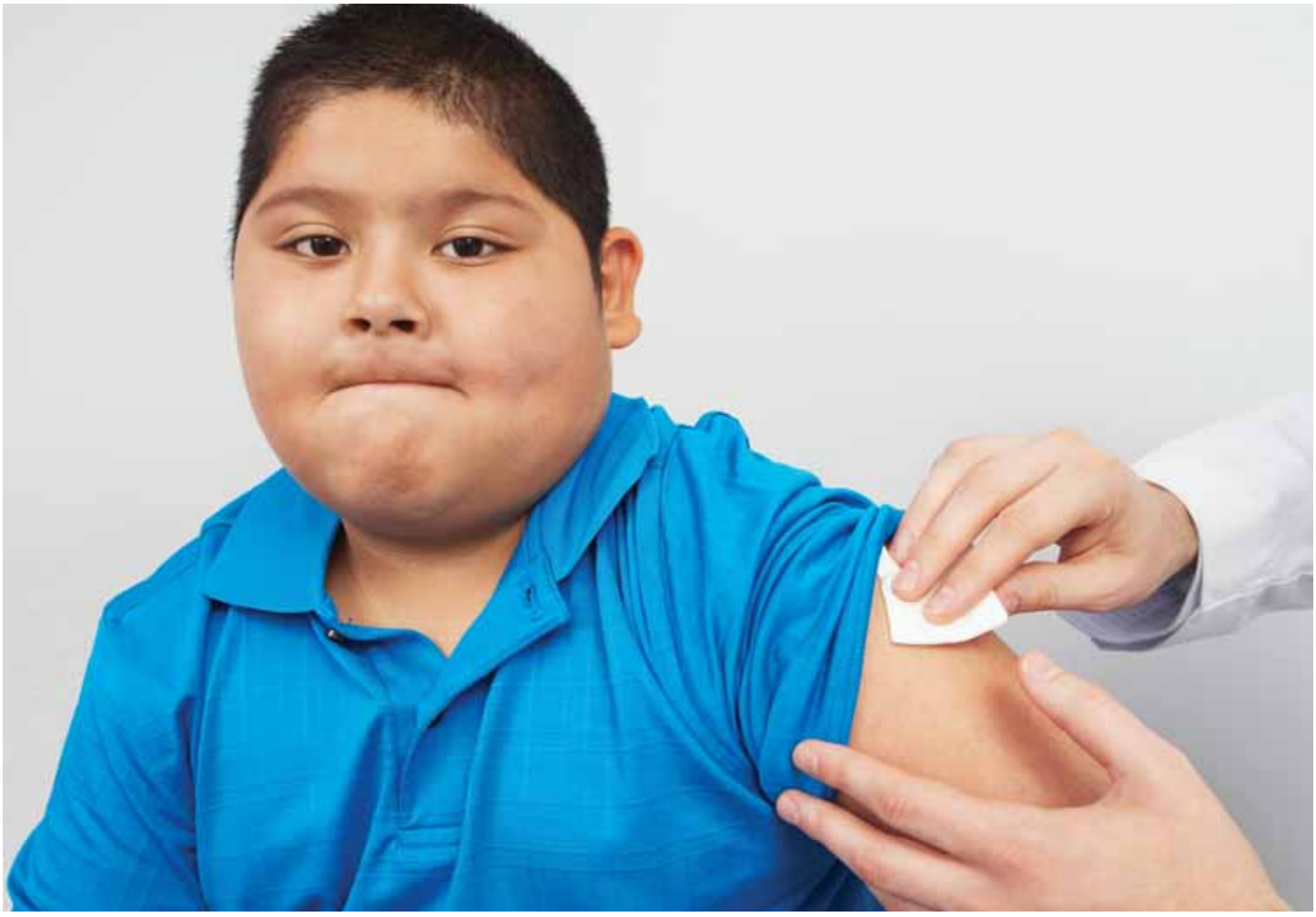
MOVING FORWARD: IMPROVING ACCESS TO CARE FOR CHILDREN

To improve health care for children in Arkansas, a key next step must be addressing barriers *across the system* to increase access to screenings, referrals, and follow-up treatment. Recently, the state has made investments in improving care coordination through the PCMH program. Despite this progress, services focused on early intervention and children with disabilities remain difficult to navigate and are fragmented across the health and education sectors. However, several important policies have been passed to improve services for children with special health care needs by implementing an organized care model for the highest-need Medicaid enrollees. A major effort is underway to begin to allow Medicaid to cover behavioral health services for younger children.

As these models are implemented, strengthening the following areas will improve supports for young children:

- Providing incentives for screenings, early identification, and prevention services through Medicaid;
- Using standardized screening tools for all children regardless of whether they are screened in a doctor's office, education facility, or other child-serving program;
- Providing care coordination, which includes engaging families and assisting them with navigating the system; and
- Creating a continuum of high-quality care with treatment options designed to meet the specific needs of children.[18]

Most importantly, children must have access to coverage for any of these strategies to be effective. That coverage must be consistent, and it must cover the types of services that children need, like screenings and treatment services for any health concerns that are identified. These important investments in young children are vital to ensuring every child in Arkansas has the resources he or she needs to be ready for school and become healthy, productive adults.



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