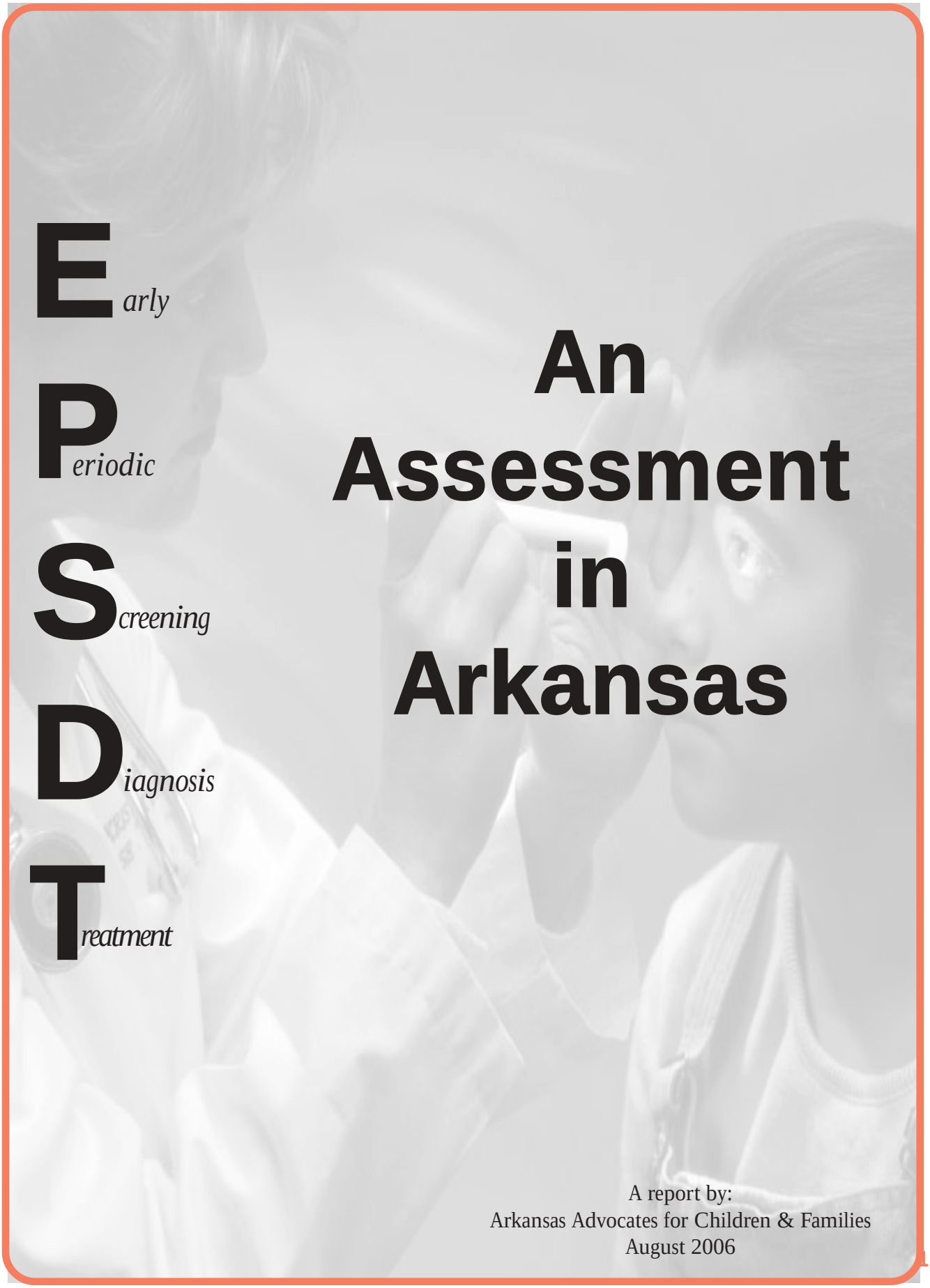

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An Assessment in Arkansas

A report by:
Arkansas Advocates for Children & Families
August 2006

Executive Summary

The Early Periodic Screening Diagnosis and Treatment (EPSDT) program is a federal requirement of the Medicaid program. Its purpose is to provide low-income children with quality well-child screens and guaranteed treatment services to ameliorate the effects of any diagnosed illness. As a nation we have traditionally done a poor job of screening the children eligible for Medicaid (33 percent in 1999 and 39 percent in 2004). According to a recent report by the National Health Law Program, Arkansas has consistently fallen below the national average (21 percent in 1999 and 27 percent in 2004). To provide the best possible opportunities for low-income children, it is imperative that we address the barriers to quality screens.

Arkansas Advocates for Children and Families (AACF) began raising the issue in 2004 after a survey performed in Texarkana as part of the Covering Kids and Families Access Project. A workgroup was established in 2005 to explore issues around the low participation rates. This group identified multiple reasons for the low participation rate, which led to activities focused on increasing the percent of Medicaid eligible children receiving EPSDT screens.

Several issues were identified as possible causes of the low EPSDT participation rate including:

- Doctors do not bill for EPSDTs they are performing because of reimbursement issues and poor billing procedures.
- Physician offices lack staff and resources to track and monitor children who need a screen.
- Screening opportunities are often missed at the physician's office due to scheduling and reimbursement issues.
- Many parents are not aware of the EPSDT program and the benefits it includes.
- Parents only take their children to the doctor if they are ill. It is difficult for many low-income parents to take off work when their children are ill much less when their children are seemingly healthy.
- In 1998 Arkansas made a positive change in the Medicaid program for children by establishing a medical home model and giving the responsibility for the EPSDT screen to the primary care physician. However, some children who received screens at a local health unit or at school have

written by:
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not established a link with their primary care physician for receiving screens. This is most evident in the school age population where screening rates dropped after the new policy was implemented and have not recovered.

Since the work group began in 2005, several initiatives have been impelmeted to address the possible causes including:

- A pilot project was implemented by the Arkansas Foundation for Medical Care (AFMC) to provide intensive technical assistance to nine physician offices to help with scheduling procedures, tracking and monitoring, and outreach to their clients concerning EPSDT screens. The results from this project should lead to a list of best practices for physician offices

- Medicaid instituted a new policy on May 1, 2006 that will allow a physician to bill for an EPSDT screen at the same time as a sick visit.

- A Medicaid Benefits Manual was developed in 2005 and was made available to Medicaid recipients. Improvements were also made to the AFMC website and the Connect Care website to provide information to families about EPSDT.

- Arkansas is expanding Coordinated School Health in ten school districts in the state. It is expected schools will use this opportunity to experiment with ways to build partnerships to increase EPSDT screens. These experiments will lead to best practices that can be modeled by other communities.

The EPSDT work group formed by AACF will continue to monitor and evaluate the status of EPSDT in Arkansas. There are many facets to the problem and many possible solutions. This is an evolving process that will take a multi-pronged approach to reach the goal of screening and treating all children in the state of Arkansas.

Introduction

Arkansas has consistently fallen below the national average of providing Early Periodic Screening Diagnosis and Treatment (EPSDT) screens to low-income children. The national average in 2004 was 39 percent and Arkansas' rate was 27 percent. These screens can provide early detection and treatment for many childhood diseases. Arkansas Advocates for Children and Families (AACF) partnered with the Our Children First Coalition in Texarkana in 2004 to survey families in southwest Arkansas to determine why they did not utilize the EPSDT program. With the results of the project, AACF convened a workgroup to determine ways to improve the utilization of EPSDT in Arkansas. The workgroup consisted of representatives from the Arkansas Foundation for Medical Care, Connect Care, AACF, and the Division of Early Childhood Services and the Division of Medical Services at the Department of Health and Human Services. This report details the results from the workgroup that include: data on the low utilization rate of EPSDT screens, the barriers that prevent families from receiving EPSDT screens, current activities, and recommendations on ways to increase the number of children receiving screens.

What is EPSDT?

Low-income children are at risk of exposure to several factors that may produce poor health outcomes including: poor nutrition, inadequate housing, lack of access to health care, increased exposure to environmental hazards, and fewer educational opportunities. Children in poverty, especially children of color, are more likely to suffer from poor health outcomes such as asthma, dental caries, behavior problems, poor vision and speech or hearing problems.

Identifying and treating chronic and acute health problems early can avoid or minimize the effects of many childhood diseases. The EPSDT program was added to Medicaid in 1967 to address these very issues. With nearly 300,000 Arkansas children on traditional Medicaid, the EPSDT program has the potential to reach nearly half the children in the state and provide early detection and treatment for many childhood diseases. Arkansas, like the rest of the nation, has not achieved the goals set for the EPSDT program.

Policymakers recognize the importance of healthy children to our nation. They have set clear guidelines for the EPSDT program within the Medicaid program. Federal law prohibits the application of any co-payments to children under 18 and requires states to cover services that are determined to be a medical necessity to treat a diagnosed illness. The actual language of the EPSDT regulation requires *states to ascertain eligible children's "physical or mental defect and to provide health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered."* The burden is clearly on states to ensure families know about EPSDT, that

EPSDT Services

The EPSDT program includes the following benefits and services:

Periodic and "As Needed" screening services which include:

- An unclothed physical examination
- Comprehensive health and developmental history including assessment of both physical and mental health evaluation
- Immunizations recommended by the CDC Advisory Committee on immunization practices
- Laboratory tests including blood lead level assessment appropriate for age and risk factors
- Health Education

Vision services which include assessment, diagnosis and treatment including eyeglasses.

Hearing services which include assessment, diagnosis and treatment including hearing aids.

Dental services which include at a minimum:

- Relief of pain and infections
- Restoration of teeth
- Maintenance of dental health

they have access to the screens, and that the services are available for treatment.

Each state that participates in the Medicaid program must offer an EPSDT program that includes:

- Outreach and information
- Screening, diagnosis and treatment services
- Adequate provider participation
- Annual reporting on EPSDT performance.

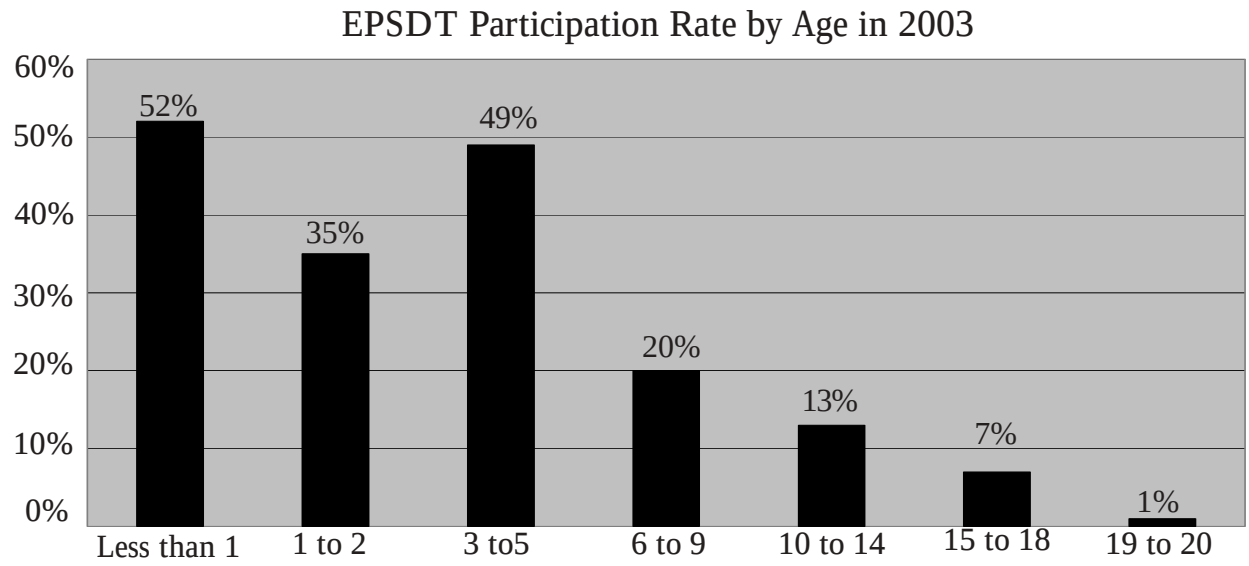
The EPSDT program requires states to engage children and their families about their health care needs. Because of this obligation, it is important to continually monitor and evaluate Arkansas' EPSDT performance, policies and service delivery.

EPSDT Performance Rates

One of the measures of a successful EPSDT program is its participation rate. If children are not receiving periodic preventive health screens, there is greater risk of health problems remaining undetected. In 1990, the Centers for Medicare and Medicaid Services established a screening participation goal of 80 percent to be achieved by 1995. Arkansas falls dramatically short of the goal and short of the national average according to Centers for Medicare and Medicaid Services' reports and to annual HEDIS measures. This is not a new problem as Arkansas has been substantially lower than the national average as far back as 1999 when the national rate was 33 percent and Arkansas' rate was 21 percent.

There are two sources of data concerning Arkansas' EPSDT rates. The Centers for Medicare and Medicaid Services requires states to report their EPSDT activity annually on the CMS-416 form. Many states, including Arkansas, claim this uniform reporting system undercounts the number of children who actually receive screens. Physicians often do not report screening activity that should be included on this report because of the state's Medicaid billing system and managed care procedures. However, data is available for all age groups and can be compared to other states. Participation rate is the unduplicated number of children who recevied one or more medical screens through EPSDT compared to the number of eligible children expected to receive a medical screen, based on the annualized state periodicity schedule and average period of eligibility.

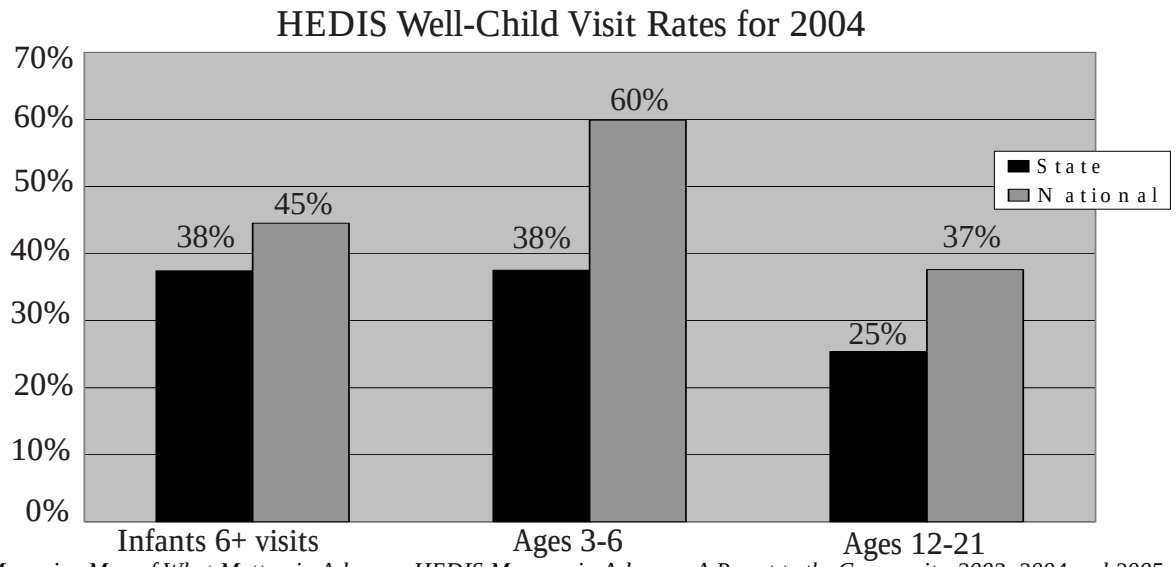
According to this report, Arkansas had an overall EPSDT rate of 27 percent in 2003, the lowest rate in the nation, and well below the national average of 39 percent. As reflected in the table below, Arkansas does a better job screening infants than its school age children. Arkansas' EPSDT rate begins to worsen at age 6 and continues through adolescence.



Data Source: Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment 1999 – 2003, By Jane Perkins, Amy Stinnett, Sarah Somers and Kristi Olson, National Health Law, May 2005

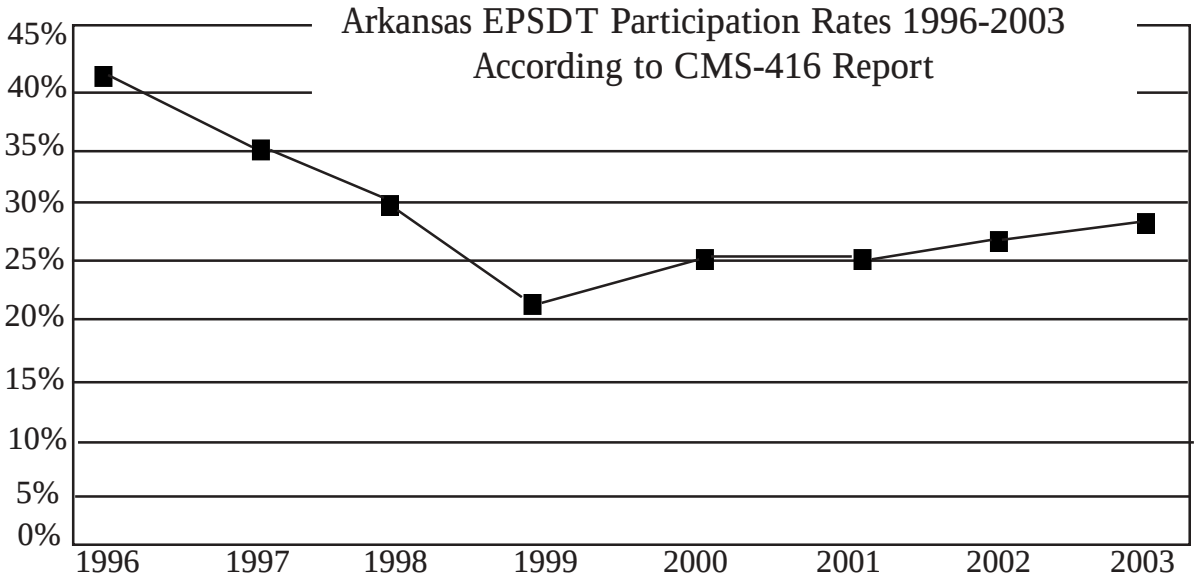
The National Committee for Quality Assurance has developed a set of widely used standards to measure performance in the managed care industry that is used as a second source of data for EPSDT performance. This tool – Health Plan Employer Data and Information Set (HEDIS) - includes well-child visits in its list of indicators. The Arkansas Foundation for Medical Care has utilized the HEDIS tool in Arkansas for the past seven years to measure the performance of the Arkansas Medicaid program. This information is derived from Medicaid claims so any billing and reporting issues are also reflected in the data as with the CMS data. Additionally, HEDIS data is only gathered for specific age groups and excludes children ages 7 to 11. Consequently, an overall EPSDT rate is not available for the state from this data source. HEDIS data, however, can be compared to national data gathered from other states using HEDIS to measure Medicaid performance.

According to the HEDIS data for 2004, Arkansas is substantially below the national percentage for all three age groups. However, it is notable that the adolescent rate jumped from 14.8 percent in 2003 to 25.4 percent in 2004. The national rate did not reflect a similar increase. This increase is credited to provider education concerning the use of sports physicals as screening opportunities and new immunization requirements for older children.

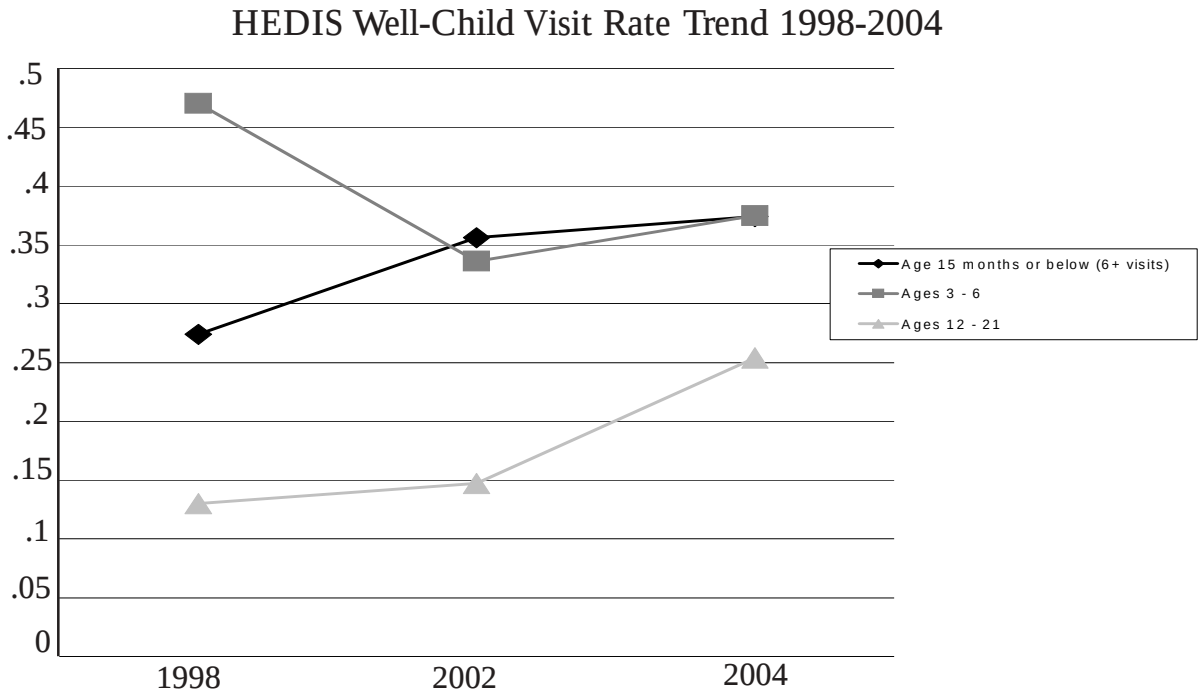


Data Source: Measuring More of What Matters in Arkansas, HEDIS Measures in Arkansas, A Report to the Community, 2003, 2004 and 2005, AFMC

Both reports show a drop in the EPSDT rates around 1998 and a slow upward trend in rates since that time. The next two charts reflect that trend for both reports.



 Data Source: Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment 1999 – 2003, By Jane Perkins, Amy Stinnett, Sarah Somers and Kristi Olson, National Health Law, May 2005



Data Source: Measuring More of What Matters, HEDIS Measures in Arkansas, A Report to the Community, 2003, 2004 and 2005, AFMC

The data reflects improvements in infant and adolescent screenings, but it raises concern over the lack of improvement in preschool and elementary school age children. Many physical and developmental issues that would hamper a child's ability to perform in school are found at school age.

Quality and Completeness of Screening

The EPSDT screen is designed to be more than a traditional well-child visit. Because low-income children are at risk for poor health outcomes the EPSDT screen requires multiple components to address all possible health risks. However, the data shows that just because a physician billed for an EPSDT screen on a child does not mean the screen included all the required components. The current electronic billing system lacks a way to immediately verify the completeness of a screen. The Arkansas Foundation for Medical Care performs random record audits every two years to review immunization records and EPSDT billing records compared to documentation of EPSDT components in medical records. From this they are able to determine the completeness of the EPSDT screens. The most recent data is from 2003 and were gathered from a sample of 500 children, divided evenly among ARKIDS A and ARKIDS B recipients. The sample was divided into three groups: children age 2, children age 6, and children age 12 to 15.

Of these three groups, none of the 2- or 6-year-old children had all screen components documented. The number of children missing 6 or more components of the screen ranged from 38.7 percent (6-yr-olds) to 60.6 percent (12-to 15-yr-olds) Approximately 50 percent of the children reviewed were missing between five and six components of the screen. The most likely

Components of the EPSDT Screen

Growth and Nutrition
Development Assessment
Physical Exam
Neurological Exam
Cardiac Status
Vision Screen
Hearing Screen
Dental Screen
Laboratory Testing
Hematocrit
Urinalysis
Other Laboratory Tests
Immunizations
Health Education and Guidance

components to be missing were the vision and hearing screens and lab tests. Since one of the major goals of the EPSDT program is to educate parents about their children's health needs, it is disturbing to find that the health education and guidance component was not documented from nearly one-third of the screens on the 2 - yr-olds and almost half of the screens on 6- and 12-15-yr olds.

An additional issue pertaining to the quality of EPSDT screens is the lack of referral monitoring and follow-up. Currently a system is not in place to assist families with referrals or to track compliance. In order for EPSDT to be truly effective a child and their family must move along a continum of care from screening to diagnosis to treatment.

Barriers and Current Activities to Screening

Low participation rates coupled with the low rate of completed screens leads to the question, "Why is Arkansas performing so poorly?" Several possible barriers have been offered based on experience and information. These barriers can be divided into three groups: physician barriers, individual barriers and system barriers.

Physician Barrier:

As the state's quality improvement organization for Medicaid and Medicare, the Arkansas Foundation for Medical Care (AFMC) has close working relationships with Medicaid providers in the state. AFMC cites lack of provider education, time, and reimbursement mechanisms as possible barriers. From their one-on-one contacts with physicians, AFMC representatives have found that many providers are performing EPSDT screens, but they are not recording or billing for them when they are done in conjunction with a sick child visit. Many of the physicians who are performing and billing for EPSDT screens are poorly documenting their activities. In addition, screening opportunities are often missed due to scheduling, tracking or reimbursement issues. For instance, if a child is in a physician's office for a sick visit and is one day short of meeting the periodicity requirement, an EPSDT claim reimbursement for that screen will be denied. This Mediciad policy discourages many physicians from taking those opportunities. Physicians want to increase EPSDT screening rates, but tracking and monitoring their case load, adjusting scheduling procedures while balancing Medicaid policy requirements place undue burdens on their clinics and staff.

Current Activities:

Over the past few years AFMC has instituted several efforts aimed at assisting physician offices with increasing their EPSDT rates. Annual profile reports are provided to physicians showing the number of EPSDTs completed and the number they could have performed based on current caseloads. They have also

developed education tools for providers to use in their offices and have included EPSDT issues on the agendas of their regional Medicaid conferences. Over the last six years, AFMC has distributed over 517,000 well-child tools. Education and technical assistance regarding the value and best practices regarding health information technology are offered to aid in tracking and preventive care needs for all patients. Provider representatives from AFMC call on physician offices and provide technical assistance and education to office staff. Additionally, on May 1, 2006 a Medicaid reimbursement policy was changed to allow physicians to bill for a sick child visit and an EPSDT screen at the same time if the doctor performed both activities during the visit. Finally, in 2006 AFMC implemented nine pilot projects in the state targeting the frontline office staff in physician offices. This project is aimed at the entire office team and includes technical assistance with monitoring tools, scheduling techniques, billing processes and patient information. The project will be evaluated for its effectiveness and expanded statewide accordingly.

Providers are a critical link in the provision of EPSDT screenings and services to Arkansas children. As the contracted primary care physician, they have the responsibility to ensure quality and effective health care for children. Acute health care needs often consume the majority of resources in the health care system. Efforts to educate, incentivise and empower preventive efforts will improve the health status of Arkansans.

Individual Barriers:

Physicians do not bear the full responsibility for Arkansas' low EPSDT participation rate. Physicians can only screen children that present themselves for screening. In order to understand more about the barriers families face, a study was done in 2004 by the Our Children First Coalition in Texarkana with Medicaid eligible families. This study revealed that many parents were not aware of the EPSDT program and don't consider taking their children to the doctor unless they are sick. Furthermore , Medicaid families lacked any information concerning their Medicaid benefits. This lack of knowledge and mindset is clearly a barrier to children receiving EPSDT screens.

Current Activities:

The Arkansas Foundation for Medical Care and Connect Care are the two contract organizations that provide outreach, education and quality assurance for Medicaid recipients. They have taken the lead for informing the Medicaid population about the Arkansas Medicaid Program. Since the 2004 study in Texarkana, a Medicaid benefits manual has been developed and is being provided to enrollees at the point of contact during the photo ID process. Additionally, both the Arkansas Foundation for Medical Care and Connect Care have updated their websites so that more information is easily available about EPSDT and well-child visits. In 2006, AFMC created tools to distribute to communities concerning preventive health screenings.

Connect Care, with the Division of Health at DHHS, links Medicaid and ARKids First recipients in the state to their primary care providers. They also inform and educate Medicaid clients about critical health issues like the improtance of preventive health services and disease managment.

Providing education and access to information is key to raising awareness of the importance of early and regular screening of children. Initiatives that include parents and the community will help

to increase the EPSDT participation rates. Providers cannot be the only link families have to learn about the EPSDT program.

System Barriers:

After the implementation of ARKids First in 1997, Arkansas moved to a medical home model of care that included new requirements for the provision of EPSDT screens. Primary care physicians are now required for all children on Medicaid. The primary care physicians, or their designee, is responsible for performing EPSDT screens on their caseload. This was a drastic shift in the policy as previously certified and trained local health unit nurses and school based health clinics were allowed to perform EPSDT screens on children. This policy change has had both positive and negative results. Children on Medicaid now utilize hospital emergency rooms for primary care at a much reduced rate. Many children and their families have built relationships with their physician for the first time and have improved access to preventive health services. However, EPSDT participation rates dropped sharply among school-age children after the policy was enacted in 1998. It was believed that families would adjust to the new delivery system and screening rates would rebound, but this has not occurred.

While the adoption of the medical home model is not at fault for the reduction in EPSDT screening rates, this shift may have inadvertently broken a link in the chain of care that has not since been rebuilt. A major component of the medical home model is the coordination with other providers of care and with the family. An example of the lack of coordination within the system is the disconnect between schools and primary care providers. Schools are mandated to complete several screens which are also part of the EPSDT screening components. These screens include vision and hearing, scolosis, and the body mass index. Since the schools are not considered part of the EPSDT provider system there is no mechanism for providing primary care physicians with screening results or for ensuring referrals and follow-up visits. Improving the links between the family, the medical home and other providers such as schools and childcare centers may be the final missing link in the chain of preventive health services for children.

Current Activities:

Arkansas is expanding its Coordinated School Health initiative, based on the accepted Centers for Disease Control model, in ten school districts in diverse regions around the state. As part of this initiative, schools will be encouraged to provide an environment where organizations can work together to maintain the well-being of young people. The health services component of the model calls for strategies to provide services to appraise, protect, and promote the health of students. This will be done differently at each of the ten schools based upon the needs of the families, educators and local health professionals. The Departments of Education and Health and Human Services have recently filled several key positions that will provide technical support and resources to the coordinated school health project. This project should serve as an incubator to test ideas that will strengthen the delivery of preventive health services for children in Arkansas. The expectation is that schools participating in the project will test a variety of options including: physicians or their staff providing screens on campus during school registration or parent nights; school nurses serving as case managers to help families schedule EPSDT appointments and keep them; and school nurses functioning as an extension of the physician offices to help complete EPSDT screens. This is not a complete list of the possible solutions and each has implementation issues that must be resolved in order to be successful. However, testing them on a small scale basis and addressing implementation problems as they arise should result in some viable options for other communities and schools to model.

Barriers and Current Activities to Increase EPSDT Rates in Arkansas	
Barriers	*Current Activities*
Physician education Physician scheduling Physician documentation	Provider representatives visit with office staff, regional Medicaid meetings, physician newsletters, physician pilot projects to improve EPSDT rates, Electronic Health Records.
Physician reimbursement	On May 1, 2006 new Medicaid policy was implemented to allow physicians to bill for an EPSDT screen along with an acute visit.
Parent education	AFMC and Connect Care improved websites to highlight EPSDT information. AFMC has developed new educational materials to be distributed in local communities.
Parent Awareness of Program and Benefits	Medicaid benefits manual developed and distributed.
Shift in EPSDT delivery system, Lack of coordination of various health screens performed in schools with primary care physicians	Coordinated School Health sites to experiment with local partnerships to enhance delivery system.

Further Recommendations

- Establish an EPSDT advisory group to provide input into the development of initiatives and policies to increase EPSDT rates in Arkansas.
- Provide financial and technical support for the Coordinated School Health model in Arkansas. This model can be used to develop delivery and information systems between schools, physicians and parents for increased use of preventive health services.
- Reimbursements and incentives should be developed to encourage both schools and physicians to partner in performing EPSDT screens.
- Develop a monitoring system for tracking referrals and follow-up visits from EPSDT screens.
- Increase opportunities for parent education and outreach. Current efforts focus on providers and utilizing them as the channel of information to parents. Expanding parent education concerning the EPSDT program by others avenues such as Connect Care and schools will provide a broader base for education.

Summary

It is clear that no single entity is responsible for the success or failure of the EPSDT program in Arkansas. While physicians bear the responsibility of providing a quality screen for identifying treatment needs, families need to be educated on the benefits of early detection and treatment. The system itself should be strengthened in order to provide optimum opportunities for children to receive quality screening and health education. Solutions are as varied as the obstacles and should be tested for effectiveness and outcomes. Other states with good EPSDT screening rates, such as Vermont and Massachuesetts, have developed systems that use organizations and schools outside the provider network to help coordinate access to EPSDT screens. The recent infusion of resources and support into the infrastructure of coordinated school health in Arkansas promises to be a prime opportunity to develop a similar coordinated approach. However, it will take the long-term committment of statewide partners and providers to actually implement systemic changes in Arkansas. AACF is committed to this process and will continue to montior and evaluate activities within the EPSDT program.

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