State of Colorado

Department of Health Care Policy & Financing

Colorado 2004–2005 Focused Study Evaluation of EPSDT Services

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HSAG
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1. Executive Summary

Introduction

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a specific health care program within Medicaid for persons from birth through 20 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and before their treatment becomes more costly.

The Centers for Medicare & Medicaid Services (CMS) has set an EPSDT participation goal of 80 percent for every state. The ratio of EPSDT-eligible children across the United States who received at least one initial or periodic screening service in 1998 was 67 percent. In Colorado, the EPSDT participation rate for fiscal year 1999 was 44 percent, and for fiscal year 2002 was 50 percent.

The purpose of this study, conducted by Health Service Advisory Group, Inc. (HSAG) for the Department of Health Care Policy and Financing (the Department), was to identify potential barriers that could contribute to low EPSDT visit rates among Colorado Medicaid recipients younger than 21 years of age, as well as identify efforts to improve EPSDT services delivered to Medicaid beneficiaries. In addition, blood lead testing and immunizations, two benefits covered under EPSDT, were examined for factors contributing to low rates in Colorado.

Methodology

The health plans included in this study were the three Colorado Medicaid managed care organizations (MCOs)—Colorado Access (CO Access), Denver Health Medicaid Choice (DHMC), and Rocky Mountain Health Plans (RMHP)—as well as the EPSDT administrators at the Department who support these services for the Primary Care Physician Program (PCPP) and the fee-for-service (FFS) populations. Several methods were employed to gather the necessary information, including:

- A provider survey (mail and fax).
- Evidence from the MCOs and the Department regarding efforts employed to increase the percentage of members who receive EPSDT services.
- A face-to-face questionnaire for MCO and Department EPSDT administrators.

The provider survey was designed by a team of survey experts from HSAG, in conjunction with the Department and the three MCOs. The survey was field-tested prior to implementation to ensure the questions would be appropriate and responses would provide meaningful results. Based on this assessment, recommendations were made to modify several of the survey items. The PCPP and FFS programs have different contractual expectations related to the delivery of EPSDT services. The questionnaire was modified to exclude PCPP and FFS providers from certain survey questions because of these differences.

Responses to most items in the survey were made on a 4-point Likert-like scale (1 = strongly disagree to 4 = strongly agree), with two additional response categories for "not sure" and "not applicable." The survey was designed to address the following issues:

- The ease with which providers could obtain their current EPSDT visit rates and lists of Medicaid members in need of EPSDT visits from the MCOs.
- The degree to which providers desired to receive additional information about their EPSDT visit rates from the MCOs.
- Receipt of information from MCOs about Medicaid members eligible for EPSDT visits.
- Provider beliefs and knowledge concerning lead poisoning and blood lead testing.
- Methods used by providers to increase EPSDT visits.
- Obstacles to improving immunization rates.
- Provider knowledge of benefits covered for Colorado Medicaid members younger than 21 years of age.

The MCOs identified providers who had members younger than 21 years of age. Only primary care practitioners (PCPs), defined as general practice (GP), family practice (FP), internal medicine (IM), and pediatrics (PED), were considered for this survey. Surveys were mailed to all identified providers contracted with the three MCOs, and to a random sample of providers from the FFS and PCP program between February 2, 2005, and March 18, 2005. A follow-up phone call and fax were used in an effort to increase response rates.

The final sample sizes and return rates are provided in Table 1-1. The original sample size consisted of 1,754 provider surveys. However, 91 providers indicated that they did not provide EPSDT services to Medicaid members. These 91 provider surveys were considered invalid and excluded from the results. A total of 415 surveys out of 1,663 were returned with sufficient information to be analyzed, for a return rate of 25.0 percent. While the number of surveys returned for Colorado Medicaid overall or in aggregate was determined to be sufficient, the number of surveys returned that represent individual delivery systems was limited and comparisons between delivery systems should be interpreted with caution.

Table 1-1—Final Survey Sample Sizes

Health Plan/Program	Original Sample Size	Invalid Surveys	Final Sample Size	Number of Surveys Returned	Return Rate (%)
CO Access	468	16	452	132	29.2
DHMC	80	4	76	27	35.5
RMHP	127	7	120	43	35.8
PCPP	569	14	555	174	31.4
FFS	510	50	460	39	8.5
Total	**1,754**	**91**	**1,663**	**415**	**25.0**

MCO and Department Questionnaire

In addition to the provider survey, HSAG sent a questionnaire to each MCO and the Department EPSDT administrators by e-mail. These were completed electronically and returned to HSAG. Responses to the questionnaires were used to guide on-site follow-up interviews conducted by HSAG staff with each of the MCOs and the Department EPSDT coordinators. The on-site follow-up review consisted of an examination of the Department's and MCOs' existing EPSDT tracking processes, and efforts to increase the percentage of members who receive EPSDT services. The time frame for the questionnaires and on-site reviews was March 8, 2005, to April 27, 2005.

Limitations

The focus of this study was an EPSDT provider survey. The findings from this report are based on the responses from the providers and, as such, several limitations should be noted. The limitations identified in this study include:

- The PCP providers for this study were identified based on the MCO and State databases. Incorrect provider addresses and phone numbers may have resulted in lower provider survey response rates.
- The survey results should be viewed with caution since the response rates were low. This is especially true for the FFS population, since only 8.5 percent of the Medicaid FFS providers responded.
- The provider survey used a Likert-like scale to collect provider's beliefs and opinions rather than medical record review and claims data analysis to determine what services providers actually performed. It is quite possible providers routinely performed services they did not consider to be part of an EPSDT visit, although the service actually is an EPSDT component.
- DHMC was just beginning as a Medicaid MCO in 2004, and therefore did not have all of its policies and procedures fully operational at the time of this study.

Summary of Findings

Barriers to EPSDT Services

The providers believed that the MCOs did not give EPSDT information to providers on a regular basis. Table 1-2 presents provider rates of agreement with various statements concerning the ease and regularity with which they could access information about their office's EPSDT rates, Medicaid members in need of EPSDT visits, and their desire to obtain additional information about EPSDT program requirements. Based on these provider responses, it appeared that fewer than half of the providers felt they received information on EPSDT requirements from their contracted MCOs, while only about half of the providers actually wanted the information.

Table 1-2—Provider Reported Receipt and Access to EPSDT Information

Category	CO Access	DHMC	RMHP
Easy Access to EPSDT Visit Rates	30.4	25.9	69.8
Easy Access to EPSDT Visit Needed Information	18.2	18.5	53.5
Regularly Receive EPSDT Visit Information	17.5	14.8	41.9
Regularly Receive EPSDT Requirements	38.7	48.1	46.5
Would Like to Receive EPSDT Visit Rates	45.5	40.7	48.9
Would Like to Receive EPSDT Visit Needed Information	56.9	44.4	86.0
Would Like to Receive Additional Requirements Information	46.2	37.0	76.7

Note: Table 1-2 does not include PCPP and FFS providers.

The majority of Medicaid providers surveyed were not fully aware of the benefits covered under EPSDT. Only one-fourth of the providers surveyed correctly identified all 16 covered benefits listed on the survey as EPSDT-covered benefits. The average provider identified 12 of the EPSDT covered benefits.

Fewer than one-third, or 31.8 percent, of providers or their office staff attempted to make contact with Medicaid members to schedule an EPSDT visit (see Table 1-3). More than half, or 51.3 percent, indicated they did not initiate contact. Among providers who attempted to increase their EPSDT visit rates, the most common methods used were the delivery of EPSDT services during other types of visits, phone calls, and reminder postcards.

Table 1-3—Provider Response to Provision of EPSDT Services and Methods to Increase Rates

Category	CO Access	DHMC	RMHP	FFS	PCPP
EPSDT Services Are Important	88.7	77.7	88.4	74.3	85.7
Routinely Provides EPSDT Services During Other Visits	66.6	81.5	48.8	43.6	51.7
Office Routinely Contacts Medicaid Members	40.1	11.1	30.2	20.5	31.6
Method of Contact:					
Phone	32.6	11.1	32.6	23.1	25.9
Postcard	27.3	11.1	32.6	15.4	20.7

Lead Poisoning and Blood Lead Testing

The majority of providers believed that only children in high-risk areas should be tested for lead poisoning (see Table 1-4). CMS considers all Medicaid children at-risk for lead poisoning, and CMS policy requires a blood lead test for all Medicaid children at 12 and 24 months of age. Most providers (72.5 percent) believed lead poisoning is a small problem, while 12.5 percent did not believe it was a problem at all. Blood lead testing is a component of the EPSDT exam at 12 and 24 months or 36 to 72 months, if not previously tested.

Providers were more likely to perform a lead poisoning risk assessment than actually order a blood lead test. The findings in Table 1-4 suggest providers considered lead poisoning a small problem and generally conducted a risk assessment to determine if additional testing should be conducted for lead poisoning.

Table 1-4—Providers Beliefs About Lead Poisoning and Blood Lead Testing

Category	CO Access	DHMC	RMHP	FFS	PCPP
Lead Poisoning Is a Small Problem	75.0	81.5	69.8	61.5	72.5
Routinely Conduct Lead Poisoning Risk Assessment	62.9	62.9	46.6	43.6	52.3
Routinely Order Blood Lead Tests	53.0	74.1	34.9	38.5	42.5
Blood Lead Testing Should Only Be Performed for High Risk Cases	54.5	18.5	53.5	48.7	66.6

Immunizations

Most providers reported that they routinely provided immunizations during EPSDT visits (see Figure 4-7 on page 4-16). Overall, 81.2 percent responded that immunizations were given during EPSDT visits. However, 11.1 percent of the providers responded that they would not give immunizations during an EPSDT visit. Immunizations are a basic component of EPSDT preventive services and should be provided during EPSDT visits, when appropriate.

Providers identified different barriers to improving immunization rates based on their practice (see Table 4-11 on page 4-17). Providers who routinely performed immunizations during EPSDT visits were more inclined to view parents' noncompliance with immunization schedules and the lack of availability of immunization records as the primary barriers to increasing immunization rates. Providers who did not routinely perform immunizations during EPSDT visits were more inclined to view the fact that immunizations can be obtained from local health departments or schools and low reimbursement rates as the primary barriers to increasing immunization rates. A need for an immunization tracking system was also identified.

MCO and Department EPSDT Coordinators Questionnaire and On-Site Review

The on-site interviews consistently identified the challenges imposed by incorrect enrollment status and incorrect or missing addresses/contact information for patients. Incorrect or missing contact information makes it difficult to conduct member outreach and/or education on the importance of EPSDT visits. Other barriers related to members, along with interventions, included the following:

- The problem of members not showing for visits and not canceling appointments was reported consistently across all organizations. As an intervention, CO Access indicated it verifies and corrects member contact information during each customer service call.
- Transportation for EPSDT visits was an issue for members. Transportation problems were addressed by DHMC by specific inquiries during welcome visits, and by locating major clinics on public bus routes. CO Access provided the list of transportation resources to members.
- Members found it difficult to understand the importance of immunizations, complex screening guidelines, and EPSDT terminology. The MCOs had implemented age-appropriate reminder mailings, cards and calls to improve immunization rates. CO Access sent age-appropriate EPSDT information to members before their birthdays. RMHP provided an incentive for children who completed immunizations by age two, and coordinated efforts with county health departments to increase access to EPSDT services. The MCOs and the Department also sent letters and EPDST brochures to newly enrolled members.

The MCOs and the Department had implemented a variety of methods to educate providers about EPSDT. The MCOs produced provider newsletters and manuals, e-mails and fax communications, meetings, in-services, and orientation programs to discuss EPSDT. The Department provides on-going education, reaching 50 percent of providers every year. Every two years, all providers receive education on EPSDT benefits and wrap-around services. The Department's EPSDT outreach offers missed appointment and appointment assistance to all providers, as federally required.

Finally, the Department and the MCOs reported that immunizations were under-reported and not easily tracked, and requested a State registry. (During the 2004-2005 Colorado legislative session, the Senate approved the development and implementation of an immunization tracking system and the House approved the funding of the system.) All also identified the need for more EPSDT providers, and for current providers to increase the number of new patients accepted, as well as the need for dental providers in most areas of the state.

Recommendations to Reduce Barriers and Increase EPSDT, Blood Lead Testing and Immunization Rates

MCO Recommendations

- Providers should be given information on federal and State requirements regarding blood lead testing for children enrolled in Medicaid.
- Partner with the Department's EPSDT provider outreach education to begin or continue to increase provider awareness of covered benefits under EPSDT.
- Providers should be encouraged to perform EPSDT preventive services, such as immunizations, during office visits other than EPSDT visits.
- MCOs should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information to providers on a regular basis (e.g., monthly or quarterly).

Department Recommendations

- The Department should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information to PCPP providers on a regular basis (e.g., quarterly).
- The Department should investigate ways of obtaining reliable member enrollment and contact information, and updating this information on a timely basis. The Department should examine the enrollment process, particularly as it relates to newborns, to determine whether it can be made more efficient and timely.
- The Department should continue and expand provider outreach education and training programs that present the full range of EPSDT services and benefits that are available to Medicaid members, including dental, well, and sick care.
- Providers should be encouraged to perform EPSDT preventive services during visits other than EPSDT visits.

Department and MCO Recommendations

- Review and validate the process for data calculation using the CMS-416.
- Support the continued development and implementation of the Immunization Tracking System, including outreach and education.

2. Background

The EPSDT Program

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a voluntary health care program within Medicaid for persons from birth through 20 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and before their treatment becomes more costly.

The Centers for Medicare & Medicaid Services (CMS) has set an EPSDT participation goal of 80 percent for every state. The rate of EPSDT-eligible children across the United States who received at least one initial or periodic screening service in 1998 was 67 percent. The Colorado EPSDT participation rate was 44 percent for fiscal year 1999 and 50 percent for fiscal year 2002.

Changes in the Colorado Medicaid program, funding, and database have impacted the provision, coordination, performance tracking, and monitoring of EPSDT services in Colorado. The EPSDT outreach function shifted from the Department of Public Health and Environment to the Department of Health Care Policy & Financing in 2003.

The new Colorado combined benefits/enrollment database has been challenged to maintain accurate and current eligibility and demographic data. Colorado has the lowest reimbursement for immunization administration in the United States; and the newly funded immunization tracking system may impact the current under-reporting of immunization.

Two important benefits covered by the EPSDT program are the provision of recommended immunizations and testing for lead poisoning. HSAG, with the Department of Public Health and the Department of Health Care Policy & Financing, prepared fact sheets, refrigerator magnets and posters as interventions to help improve lead testing in 2001. Immunization rates are measured each year through annual Health Plan Employer Data and Information Set (HEDIS®) audits.

To improve the provision of EPSDT services, some states have developed collaborative initiatives, collaborative performance improvement projects, and targeted interventions. For example, at Michigan State University, the Institute for Health Care Studies established a collaborative maternal child work group to research, collaborate on, and improve EPSDT services for Medicaid beneficiaries. They conducted focus groups and telephone surveys of parents/guardians and clinician telephone surveys. Reports and a clinician toolkit developed by the work group were available on the Web sites. Based on the results of the clinician survey, the work group report recommended two interventions: (1) reminders to parents and (2) a tickler file. The clinician survey report identified two barriers to EPSDT services: (1) transportation and (2) difficulties with parents scheduling appointments.

Immunizations

Highly effective immunizations are used routinely in childhood to prevent measles, mumps, rubella, varicella (chicken pox), diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, and invasive Hib disease (Haemophilus influenzae type B). Immunizations for these diseases have reduced reported cases to record-low levels. Polio has been eliminated in the United States, and reported cases of diphtheria are near zero. The 2003 National Healthcare Quality Report indicated that a minimum investment in immunizations can have a high impact. This report cited health care cost savings up to $24 for every dollar spent.

The current recommendations of the Centers for Disease Control and Prevention (CDC) and others for childhood vaccination is the "4:3:1:3:3:1" series for children 19–35 months of age (four or more doses of DTaP [diphtheria, tetanus, and pertussis vaccines], three or more doses of poliovirus vaccine, one or more doses of measles-mumps-rubella vaccine, three or more doses of Hib vaccine, three or more doses of Hepatitis B vaccine, and one or more doses of varicella vaccine). Maintenance of high vaccination coverage levels in early childhood prevents the spread of vaccine-preventable diseases (VPDs) in childhood and provides the foundation for controlling VPDs among adults.

There are subgroups or pockets of undervaccinated persons who make the population vulnerable to major outbreaks of VPDs. Monitoring of coverage at smaller geographic levels within the United States helps ensure that these potential pockets of children are identified to target interventions and reduce the risk of future disease outbreaks. The poorest children are less likely to be fully immunized. According to the 2003 National Healthcare Disparities Report, children who are poor (32 percent), near poor (29 percent), and middle income (25 percent), compared with children from high-income families (21 percent), do not receive all recommended immunizations.

Healthy People 2010 has set goals for children in the 19–35 month age range of 90 percent for each of these individual immunizations and 80 percent for receiving the complete series. According to the 2003 National Immunization Survey, the U.S. national rate for the complete 4:3:1:3:3:1 series was 72.5 percent. Colorado ranked 45th in the nation with an immunization rate of 63.0 percent for children 19-35 months of age.

Most providers (public and private) overestimate the immunization coverage they are achieving with their clients. Assessment of practice-based coverage levels and feedback of those data to the providers have provided an effective strategy for increasing immunization rates of children served by a given practice. Practice-based assessment has also been recommended by the Advisory Committee on Immunization Practices, the National Vaccine Advisory Committee, the American Academy of Pediatrics, and the American Academy of Family Physicians, as well as the Task Force for Community Preventive Services.

Population-based immunization registries have been shown to provide an effective way to improve immunization rates for children. Healthy People 2010 established a target goal of having 95 percent of children under age 6 (baseline was 32 percent in 1999) enrolled in a population-based immunization registry by 2010. A fully operational population-based registry includes capabilities to:

- Protect confidential information.
- Enroll all children at the state or community level automatically at birth.
- Give providers access to complete vaccination history.
- Recommend needed vaccinations.
- Notify caregivers of children who are due and overdue for vaccinations.
- Assess practice- and geographic-level coverage.
- Produce authorized immunization records.

The Colorado Immunization Information System (CIIS) went online in April 2004. The Web-enabled database lets doctors, nurses, and health departments review a child's immunization history at each visit and quickly determine which immunizations are due. Providers are also able to use CIIS for printing and sending out reminder cards to parents about immunizations coming due. The current CIIS plan is for 95 percent of Colorado children 6 years and younger to be included in the CIIS registry by 2006. As of mid-April 2004, data from 33 percent of Colorado children in that age group had been entered in CIIS. The 2005 legislative session approved the continued development and funding of this tracking system.

Lead Poisoning and Blood Lead Testing

Blood lead toxicity from blood lead levels (i.e., ≥ 70 µg/dL) can cause serious health effects, including seizures, coma, and death. Blood lead levels (BLLs) as low as 10 µg/dL have been associated with adverse effects on cognitive development, growth, and behavior among children ages 1–5. The threshold for lead's harmful effects on childhood learning and behavior has not been determined. Most commonly, children are exposed through chronic ingestion of lead—contaminated dust from a home with lead-based paint. Since the virtual elimination of lead from gasoline and other consumer products in the United States, lead-based paint in homes remains the major source of lead exposure among U.S. children.

During 1999–2000, the CDC estimated that 434,000 children (2.2 percent) ages 1–5 had elevated BLLs (≥ 10 µg/dL), based on data from the National Health and Nutrition Examination Survey (NHANES) III. Children from low-income families have been determined to be at risk for elevated BLLs. Previous reports showed that Medicaid-eligible children represented 60 percent of children with BLLs > 10 µg/dL and 83 percent of those with BLLs ≥ 20 µg/dL. A national goal of eliminating blood lead levels >25 g/dL in children ages 6 months to 5 years by the year 2000 was not met.

The CDC called on state health departments to develop plans to ensure testing of all children at high risk for exposure. Lead testing involves a blood test via a finger stick. The CDC also recommended various strategies for increasing blood lead testing for high-risk children, including those enrolled in Medicaid.

According to the CDC's September 12, 2003, *Morbidity and Mortality Weekly Report* (MMWR), national surveys and state and local surveillance data show that childhood lead exposure has decreased in the United States. However, the national goal of eliminating blood levels > 25 µg/dL in children ages 6 months to 5 years by the year 2000 was not met, and tens of thousands of children remain exposed to lead. During 1999–2000, the CDC estimated that 434,000 children (2.2 percent) ages 1–5 had elevated BLLs (≥ 10 µg/dL), based on data from the National Health and Nutrition Examination Survey (NHANES) III. Children from low-income families have been determined to be at risk for elevated BLLs. Previous reports showed that Medicaid-eligible children represented 60 percent of children with BLLs > 10 µg/dL and 83 percent of those with BLLs ≥ 20 µg/dL. Despite their high risk for elevated BLLs, only 19 percent of Medicaid-eligible children had been tested for lead.

Children with elevated BLLs in the 10–25 µg/dL range do not develop clinical symptoms, but are still at risk for adverse effects from ongoing exposure. Testing is necessary to identify children who need further environmental or medical intervention to reduce their BLLs. Blood lead testing is currently a required component of an EPSDT screen for children at 12 and 24 months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a blood lead test if there is no record of a previous test. Additional diagnostic and/or treatment services are required for children with elevated blood lead levels.

Healthy People 2010 set a national target of 0 percent for elevated blood lead levels in children. According to the Colorado Department of Public Health and Environment, a total of 51,878 children had new lead tests in the state during the period 1996–2003 (2.2 percent of all Colorado children were tested in 2003). Of these children, 1,255 (2.4 percent) had lead levels ≥ 10 µg/dL.

Study Objective

Because of the importance of increasing the provision of EPSDT services in Colorado, the Department—in conjunction with CO Access, RMHP, DHMC, and HSAG—chose to conduct a focused study on EPSDT. This focused study was a collaborative effort among the MCOs and the Department to identify the current practices and providers' opinions related to the delivery of EPSDT services, immunization, and blood lead testing for children in the Colorado Medicaid program.

The purpose of this study conducted by HSAG for the Department was to identify potential barriers that could contribute to low EPSDT visit rates among Colorado Medicaid recipients younger than 21 years of age, as well as identify efforts that have been employed in an attempt to improve EPSDT services delivered to Medicaid beneficiaries. In addition, blood lead testing and immunizations, two benefits covered under EPSDT, were examined for factors contributing to low rates in Colorado.

Methodology

The health plans included in this study were the three Colorado Medicaid MCOs (CO Access, DHMC, and RMHP), PCPP, and FFS populations. Several methods were employed to gather the necessary information, including:

- A provider survey (mail and fax).
- Evidence from the MCOs and the Department regarding efforts employed to increase the percentage of members who receive EPSDT services.
- A face-to-face questionnaire for MCOs and the Department EPSDT administrators.

MCOs identified providers who had members younger than 21 years of age, while HSAG identified similar providers from PCPP and FFS. From this population, providers were selected by HSAG, and surveys were mailed to the provider offices. Approximately two weeks after the initial mailing, a reminder postcard was sent to all providers who had not returned their surveys to HSAG. Approximately two weeks after the reminder postcards were mailed out, a second copy of the survey was sent by fax to providers who had not returned their surveys to HSAG. Surveys were collected from February 2, 2005, through March 18, 2005.

Sampling

Only primary care practitioners who were active with the MCO as of December 31, 2004, and had members younger than 21 years of age were included. Primary care providers (PCPs) who were considered for this survey were defined as general practice (GP), family practice (FP), internal medicine (IM), and pediatrics (PED). Although obstetricians/gynecologists (OB/GYNs) can sometimes be considered PCPs, these provider types were not included since EPSDT services would not be considered part of routine services delivered by these OB/GYNs.

HSAG mailed surveys to all providers contracted with CO Access, DHMC, and RMHP. Random samples of providers in the PCPP and FFS categories were surveyed. The final sample sizes and return rates are provided in Table 3-1 on page 3-2. The original sample size consisted of 1,754 provider surveys. However, 91 providers indicated that they did not provide EPSDT services to Medicaid members. These 91 provider surveys were considered invalid and excluded from the results. A total of 415 surveys out of the remaining 1,663 were returned with sufficient information to be analyzed, for a return rate of 25.0 percent.

Table 3-1—Final Survey Sample Sizes

Health Plan/Program	Original Sample Size	Invalid Surveys	Final Sample Size	Number of Surveys Returned	Return Rate (%)
CO Access	468	16	452	132	29.2
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FFS	510	50	460	39	8.5
Total	**1,754**	**91**	**1,663**	**415**	**25.0**

The Survey

The provider survey (Appendix B) was designed by a team of survey experts from HSAG in conjunction with the Department and the MCOs. The survey was field tested prior to implementation to ensure the questions would be appropriate and responses would provide meaningful results. Based on the field test, recommendations were made to modify several of the survey items. For example, it was determined that not all of the questions in the survey pertained to the PCPP and FFS populations. The PCPP and FFS programs have different contractual expectations related to the delivery of EPSDT services. The questionnaire was modified to exclude PCPP and FFS providers from certain survey questions because of these contractual differences. Similarly, the analytical sections for those questions do not include PCPP and FFS comparisons.

Responses to most items in the survey were made on a 4-point Likert-like scale (1 = strongly disagree to 4 = strongly agree), with two additional response categories for "not sure" and "not applicable." The survey was designed to address the following issues:

- The ease with which providers could obtain their current EPSDT visit rates and lists of Medicaid members in need of EPSDT visits from the MCO.
- The degree to which providers desired to receive additional information about their EPSDT visit rates from the MCO.
- Receipt of information from MCOs about Medicaid members eligible for EPSDT visits.
- Provider beliefs and knowledge concerning lead poisoning and blood lead testing.
- Methods used by providers to increase EPSDT visits.
- Obstacles to improving immunization rates.
- Provider knowledge of benefits covered for Colorado Medicaid members younger than 21 years of age.

MCO and Department Questionnaire

In addition to the provider survey, HSAG also sent a questionnaire to each MCO and the EPSDT contract administrator at the Department. The questionnaire was sent by e-mail, filled in electronically, and returned to HSAG by e-mail. Responses to the questionnaire were used to guide on-site follow-up interviews conducted by HSAG staff. The time frame for implementation of the questionnaire and the interview was March 8, 2005, through April 27, 2005. The completed questionnaires can be found in Appendix C. The on-site follow-up review consisted of:

- Examination of EPSDT policies and procedures.
- Examination of EPSDT monthly tracking reports.
- Examination of provider lists of members who needed EPSDT visits.
- Review of any postcard reminders.
- Efforts the Department and MCOs were using to increase the percentage of members who received EPSDT services.
- A discussion of barriers to improving rates, covering topics such as:
  - Access to care.
  - Parental refusal and education.
  - Provider compliance and provider monitoring.

Limitations

The focus of this study was an EPSDT provider survey. The findings from this report are based on the responses from the providers and, as such, several limitations should be noted. The limitations identified in this study include:

- The PCP providers for this study were identified based on the MCO and State databases. Incorrect provider addresses and phone numbers may have resulted in lower provider survey response rates.
- The survey results should be viewed with caution since the response rates were low. This is especially true for the FFS population, since only 8.5 percent of the Medicaid FFS providers responded.
- The provider survey used a Likert-like scale to collect provider's beliefs and opinions rather than medical record review and claims data analysis to determine what services providers actually performed. It is quite possible providers routinely performed services they did not consider to be part of an EPSDT visit, although the service actually is an EPSDT component.
- DHMC was just beginning as a Medicaid MCO in 2004, and therefore did not have all of its policies and procedures fully operational at the time of this study.

Introduction

This section presents the main findings for the provider survey. For the purpose of statistical testing, rating categories of "strongly agree" and "agree" are collapsed into a single "agree" category, and "strongly disagree" and "disagree" are collapsed into a single "disagree" category. Rates of agreement (agree versus disagree) were compared for each pair of provider groups using chi-squared (χ^2) statistical tests.

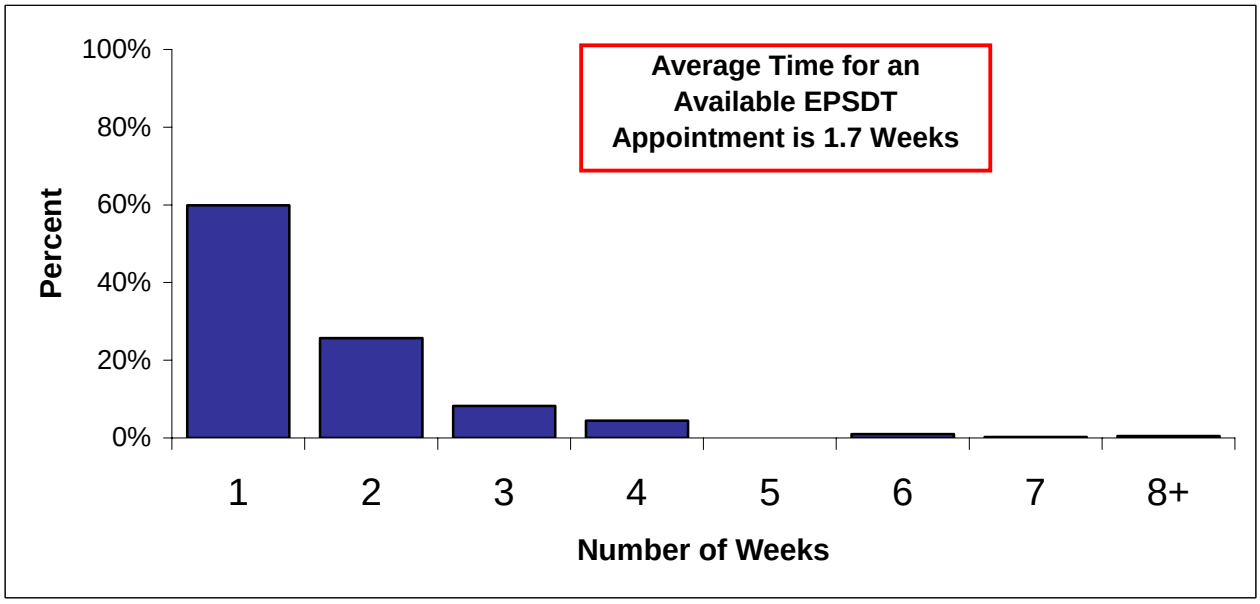
Barriers to EPSDT Services

Access and Availability

One barrier to receiving an EPSDT visit may be the availability of the provider and his or her office staff members. Members have to wait longer for appointments when providers have no open appointments or are not available (e.g., due to illness, vacations), which may increase the risk of not scheduling an appointment or canceling the appointment. Questions 2 through 4 in the provider survey dealt with access and availability of providers and their office staff members.

As shown in Figure 4-1 the average time to receive an appointment for an EPSDT visit is 1.7 weeks. More than 80 percent of the survey responses across the health plans indicated an appointment was available within one or two weeks. The survey indicates the number of office staff members and providers practicing at a location were sufficient and did not have a negative impact on the waiting times for EPSDT appointments.

Figure 4-1—Available EPSDT Appointment Times



Monitoring EPSDT Visits

Providers in MCO practices were asked to indicate how easy it was to obtain information on their EPSDT visit rates, and how easy it was to obtain information on Medicaid members in need of an EPSDT visit from the MCO. Table 4-1 and Table 4-2 present the distribution of responses to these two questions for providers contracted with CO Access, DHMC, and RMHP. The FFS and PCPP providers were not included for this portion of the survey. Differences in rates of agreement are statistically significant (p-value < 0.05), for all comparisons except CO Access versus DHMC for ease of obtaining information about EPSDT visit rates.

Overall, 38.1 percent of providers from the three MCOs indicated it was easy to obtain current EPSDT visit rates for members under their care, while 13.9 percent disagreed. An additional 36.1 percent were not sure how easy it was to obtain EPSDT visit rates, indicating the provider does not currently receive this information and most likely has not tried to obtain this data.

Table 4-1—Provider Response to "Easy to Obtain Current EPSDT Visit Rates"

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		Colorado Medicaid Managed Care Organizations (N = 202)	
Response	n	%	n	%	n	%	N	%
Agree	40	30.3	7	25.9	30	69.8	77	38.1
Disagree	18	13.6	8	29.6	2	4.7	28	13.9
Not Sure	54	40.9	11	40.7	8	18.6	73	36.1
Not Applicable	10	7.6	0	0.0	1	2.3	11	5.4
No Response	10	7.6	1	3.7	2	4.7	13	6.4

Note: Table 4-1 does not include PCPP and FFS providers.

Responses by MCO varied significantly, with 69.8 percent of providers contracting with RMHP stating that it is easy to obtain information about their EPSDT visit rates. Only 30.3 percent of providers contracting with CO Access and 25.9 percent of providers contracting with DHMC believed it was easy to obtain information about their EPSDT visit rates. More than 40 percent of providers contracting with CO Access and DHMC were not sure how easy it was to obtain information about their EPSDT visit rates.

Although EPSDT visit rates were easily available for some providers, knowing which members needed an EPSDT visit was much more difficult for them, as shown in Table 4-2. Overall, 25.7 percent of the providers responded that it was easy to obtain information on members in need of an EPSDT visit, while 24.3 percent disagreed and 38.1 percent were not sure.

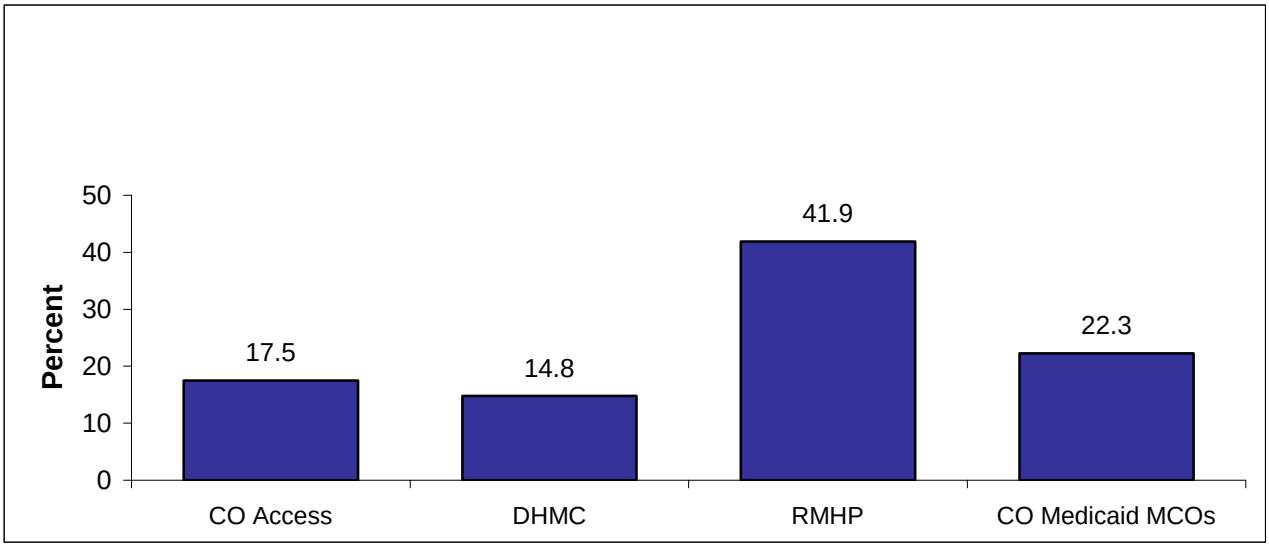
Table 4-2—Provider Response to "Easy to Obtain Information on Medicaid Members" in Need of an EPSDT Visit

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		Colorado Medicaid Managed Care Organizations (N = 202)	
Response	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Agree	24	18.2	5	18.5	23	53.5	52	25.7
Disagree	34	25.8	8	29.6	7	16.3	49	24.3
Not Sure	54	40.9	13	48.2	10	23.3	77	38.1
Not Applicable	10	7.6	0	0	1	2.3	11	5.4
No Response	10	7.6	1	3.7	2	4.7	13	6.4

Note: Table 4-2 does not include PCPP and FFS providers.

Figure 4-2 shows the percentage of providers from CO Access, DHMC, and RMHP who indicated they regularly received information from their contracted health plans about members who were due for an EPSDT visit.

Figure 4-2—Percentage of Providers Who Strongly Agreed or Agreed They Regularly Receive Medicaid Member EPSDT Visit Information



Note: Figure 4-2 does not include PCPP and FFS providers.

RMHP providers were more than twice as likely to receive information regularly for members who needed an EPSDT visit. This also supports the findings from Table 4-2. Improving EPSDT rates may be difficult for MCOs and providers when member level information is not readily available. Based on these responses, CO Access and DHMC should consider a more aggressive provider profile of EPSDT rates, along with increased member-level EPSDT visit information that can be sent to providers.

The survey also asked providers to indicate the type of additional information they would like to receive from their contracted MCOs. This included information about their EPSDT visit rates, information about Medicaid members in need of an EPSDT visit, and information about EPSDT program requirements.

Table 4-3 shows providers were relatively consistent in their desire to receive additional information regarding their EPSDT visit rates. Overall, 45.5 percent would like to receive additional information on their own EPSDT visit rates. Responses by MCO ranged from 40.7 percent to 48.8 percent.

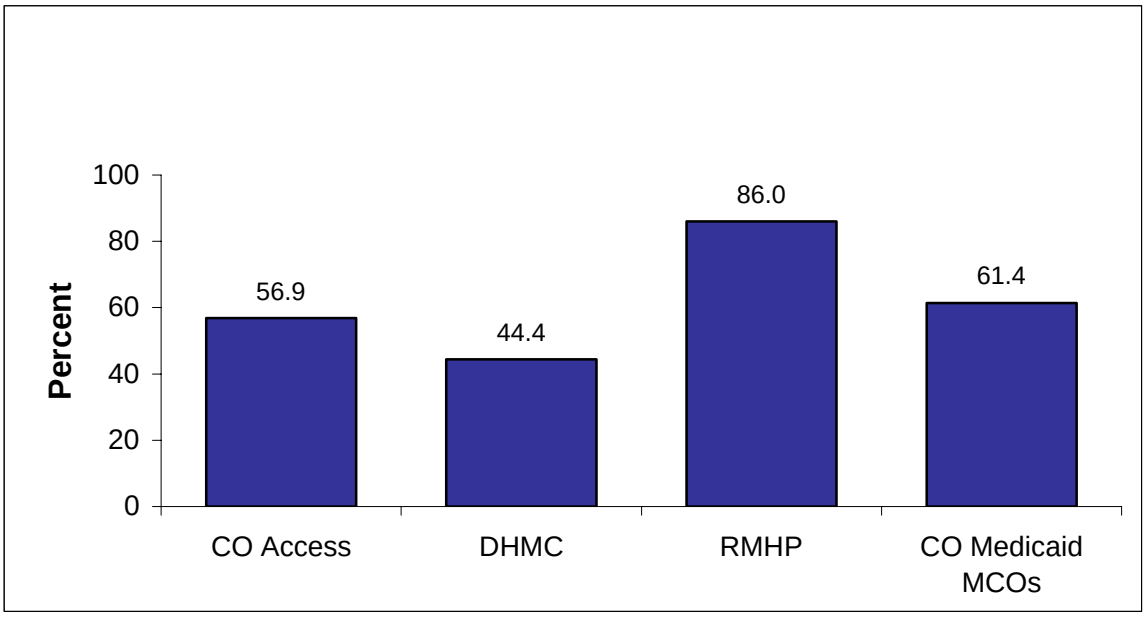
Table 4-3—Provider Response to "Desire to Receive Additional Information on EPSDT Visit Rates"

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		Colorado Medicaid Managed Care Organizations (N = 202)	
Response	n	%	n	%	n	%	N	%
Agree	60	45.5	11	40.7	21	48.8	92	45.5
Disagree	30	22.7	10	37.0	13	30.2	53	26.2
Not Sure	21	15.9	4	14.8	5	11.6	30	14.9
Not Applicable	11	8.3	1	3.7	2	4.7	14	6.9
No Response	10	7.6	1	3.7	2	4.7	13	6.4

Note: Table 4-3 does not include PCPP and FFS providers.

In contrast, 26.2 percent did not want additional EPSDT visit rate information and 14.9 percent were unsure. Reasons for not wanting additional information or being unsure were not asked in the survey. Based on Figure 4-3, it may be that individual provider rates are not as useful as information on individual members who need an EPSDT visit. Overall, 61.4 percent of the providers indicated they would like to receive member-level information. The highest percentage came from RMHP providers, who typically already receive some regular member-level information.

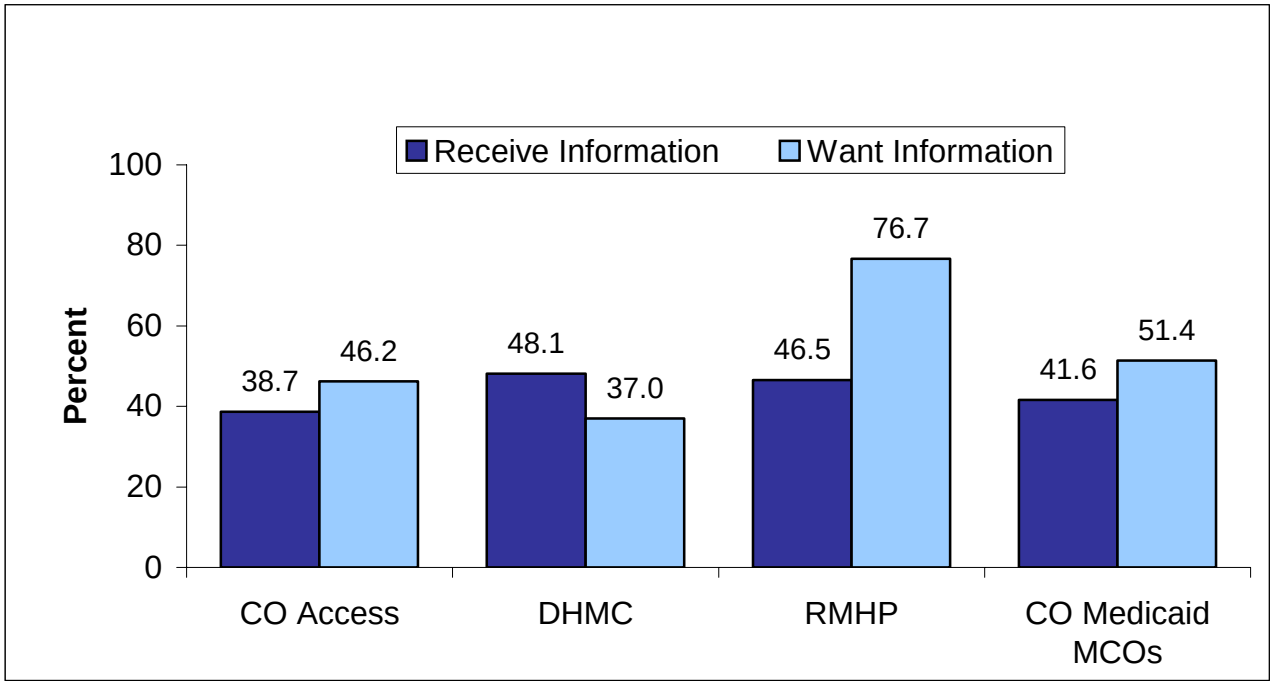
Figure 4-3—Percentage of Providers Who Strongly Agreed or Agreed They Desire to Receive Additional Information on Members in Need of an EPSDT Visit



Note: Figure 4-3 does not include PCPP and FFS providers.

In another area, Figure 4-4 examines the availability of information on EPSDT requirements. Overall, 41.6 percent of the providers from the contracted MCOs indicated they currently receive information on EPSDT requirements. The results did not show statistically significant differences among MCO providers, with rates ranging from 38.7 percent to 48.1 percent.

Figure 4-4—Availability of Information on EPDST Requirements



Note: Figure 4-4 does not include PCPP and FFS providers.

The difference among the proportions of providers who would like to receive additional information on EPSDT requirements from their contracted MCOs was statistically significant. The overall rate was 51.4 percent. The individual MCO rates ranged from 37.0 percent to 76.7 percent. Only DHMC had fewer providers who responded that they did not want more information on EPSDT requirements than those who indicated they already received this information. In January 2005, DHMC began education to providers related to EPSDT services.

Lack of knowledge about EPSDT requirements poses a challenge to improving EPSDT visit rates. Based on these responses, it appeared that fewer than half of the providers felt they received information on EPSDT requirements from their contracted MCOs, while only about half of the providers actually want the information. It also appeared that providers who received the most information from their MCOs about EPSDT visit rates and member-level information also desired to have more information on EPSDT requirements. MCOs should strongly consider increasing provider education on EPSDT requirements.

Methods to Increase EPSDT Visit Rates

Providers were asked to indicate whether their office routinely contacted Medicaid members in an attempt to schedule EPSDT visits, and to indicate what methods they used to contact Medicaid members. The results are presented in Table 4-4 and Table 4-5. Overall, 31.8 percent of providers or their office staff members attempted to make contact with Medicaid members to schedule an EPSDT visit. More than half, 51.3 percent, indicated they did not initiate contact. Providers contracted with CO Access, PCPP and RMHP were more likely than DHMC providers or FFS providers to make routine contacts with Medicaid members (p-value < 0.05).

Table 4-4—Provider-Reported Office Contacts to Increase EPSDT Visit Rates

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		FFS (N = 39)		PCPP (N = 174)		Colorado Medicaid (N = 415)	
Response	n	%	N	%	n	%	n	%	n	%	n	%
Agree	53	40.2	3	11.1	13	30.2	8	20.5	55	31.6	132	31.8
Disagree	60	45.5	20	74.1	24	55.8	19	48.7	90	51.7	213	51.3
Not Sure	13	9.9	4	14.8	4	9.3	6	15.4	19	10.9	46	11.1
No Response	6	4.6	0	0.0	2	4.7	6	15.4	10	5.8	24	5.8

The most common methods used to increase EPSDT visit rates involved phone call reminders and postcard reminders (Table 4-5). Approximately one-third of the providers indicated they did not use any method to increase EPSDT visits.

Table 4-5—Methods Used by Provider Offices to Increase EPSDT Visit Rates

	CO Access (N = 132)	DHMC (N = 27)	RMHP (N = 43)	FFS (N = 39)	PCPP (N = 174)	Colorado Medicaid (N = 415)
Response	%	%	%	%	%	%
Phone call reminder	32.6	11.1	32.6	23.1	25.9	27.5
Reminder postcards	27.3	11.1	32.6	15.4	20.7	22.9
Transportation Assistance	2.3	7.4	4.7	0.0	2.9	2.9
Registry or other tracking system	15.2	0.0	18.6	7.7	15.5	14.0
County Outreach Coordinators	0.8	3.7	0.0	2.6	1.1	1.2
Not Sure	10.6	29.6	14	12.8	8.6	11.6
Other	3.0	3.7	4.7	7.7	3.4	32.3
None	32.6	40.7	27.9	30.8	32.2	3.9

Provider Beliefs and Knowledge

Understanding what services should be provided during an EPSDT visit and which benefits are actually covered may be confusing for providers. As noted earlier, most providers indicated or reported that they did not receive information on EPSDT requirements. Attitudes or beliefs may also influence what services are provided. For example, some providers may feel lead poisoning is not a problem in Colorado, and therefore, the provider may choose not to conduct a blood lead test without the presence of risk factors, such as the member living in a house with lead-based paint. Providers were asked to respond to a series of questions designed to measure their beliefs about, and knowledge of, issues relevant to EPSDT services, immunizations, lead poisoning, and blood lead testing.

Table 4-6 shows that overall, 85.3 percent of providers agreed EPSDT services were an important part of patient care. Nearly 15 percent disagreed, were not sure, or chose not to respond to this question. The FFS providers reported the lowest agreement rate.

Table 4-6—Providers Belief of the Importance of EPSDT Services to Medicaid Members

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		FFS (N = 39)		PCPP (N = 174)		Colorado Medicaid (N = 415)	
Response	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Agree	117	88.6	21	77.8	38	88.4	29	74.4	149	85.6	354	85.3
Disagree	5	3.8	0	0.0	3	7.0	3	7.7	8	4.7	19	4.6
Not Sure	7	5.3	6	22.2	2	4.7	2	5.1	11	6.3	28	6.7
No Response	3	2.3	0	0.0	0	0.0	5	12.8	6	3.5	14	3.4

EPSDT preventive services often may be provided during other types of office visits, such as a "sick child" visit. For example, a child with a follow-up visit for an ear infection may also be given an immunization. Table 4-7 shows that providers conduct routine EPSDT preventive services during other types of visits 57.3 percent of the time.

Table 4-7—EPSDT Services Provided During Other Types of Visits

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		FFS (N = 39)		PCPP (N = 174)		Colorado Medicaid (N = 415)	
Response	n	%	n	%	n	%	n	%	n	%	n	%
Agree	88	66.7	22	81.5	21	48.8	17	43.6	90	51.7	238	57.3
Disagree	38	28.8	3	11.1	19	44.2	14	35.9	80	46.0	154	37.1
No Response	6	4.5	2	7.4	3	7.0	8	20.5	4	2.3	23	5.5

Differences in provider responses between individual health plans varied significantly:

- RMHP's rate of agreement was significantly lower than that of CO Access, DHMC, or PCPP provider groups (p-value < 0.01)
- DHMC's rate of agreement was significantly higher than that of the RMHP, FFS, or PCPP provider groups (p-value < 0.01)

Providers who responded that they did not routinely perform certain EPSDT services, such as blood lead testing, may refer members to other agencies. Table 4-8 shows the percentage of providers who routinely refer various services to other agencies. Four service categories stand out as referral categories:

- Dental services (76 percent for CO Access, 63 percent for DHMC, 84 percent for RMHP, 59 percent for FFS, and 87 percent for PCPP)
- Orthodontic services (71 percent for CO Access, 41 percent for DHMC, 70 percent for RMHP, 54 percent for FFS, and 74 percent for PCPP)
- Community programs (72 percent for CO Access, 59 percent for DHMC, 58 percent for RMHP, 49 percent for FFS, and 72 percent for PCPP)
- Mental health services (67 percent for CO Access, 56 percent for DHMC, 67 percent for RMHP, 44 percent for FFS, and 68 percent for PCPP)

Table 4-8—Benefits Routinely Referred to Other Agencies by Providers

	CO Access (N = 132)	DHMC (N = 27)	RMHP (N = 43)	FFS (N = 39)	PCPP (N = 174)
Response	%	%	%	%	%
Immunizations	8.3	3.7	27.9	10.3	13.8
Hearing assessment	39.4	18.5	48.8	33.3	37.4
Nutritional assessment	15.2	11.1	20.9	2.6	20.1
STD assessment	6.8	0.0	20.9	2.6	13.2
Case management	22.7	14.8	25.6	12.8	24.1
Lead testing	15.9	7.4	25.6	12.8	22.4
Vision assessment	20.5	0.0	16.3	17.9	21.3
Dentist	75.8	63.0	83.7	59.0	86.8
Vaccines for Children Program	5.3	0.0	18.6	12.8	10.3
Orthodontia	70.5	40.7	69.8	53.8	74.1
Community programs	72.0	59.3	58.1	48.7	71.8
Health education	4.5	0.0	7.0	2.6	7.5
Family planning	14.4	0.0	30.2	7.7	23.6
Local health department	20.5	14.8	39.5	17.9	28.7
Mental health	67.4	55.6	67.4	43.6	68.4
Other	0.8	7.4	2.3	10.3	0.6

Providers were asked to indicate which of the benefits listed in Table 4-9 were covered for Colorado Medicaid members under the age of 21 as part of an EPSDT well-care visit. All benefits listed, except "Other," are covered benefits.

- Among providers contracted with CO Access, most providers (63 percent to 93 percent) correctly identified each of the benefits as a covered benefit, with the exception of case management/care coordination. (Only 46 percent of providers correctly identified this as a covered benefit.)
  - Eight of 16 benefits were correctly identified by more than 80 percent of providers.
  - Providers correctly identified an average of 12 covered benefits.
- Among providers contracted with DHMC, most providers (70 percent to 96 percent) correctly identified each of the benefits as a covered benefit, ranging from a low of 59 percent for case management/care coordination to a high of 96 percent for health and developmental history, immunizations, and physical exams.
  - Ten of 16 benefits were correctly identified by more than 80 percent of providers.
  - Providers correctly identified an average of 13 covered benefits.

- Among providers contracted with RMHP, most providers (56 percent to 91 percent) correctly identified each of the benefits as a covered benefit, with the exception of case management/care coordination (40 percent) and family planning (49 percent).
  - Only five of 16 benefits were correctly identified by more than 80 percent of providers.
  - Providers correctly identified an average of 11 covered benefits.
- Most FFS providers (51 percent to 80 percent) correctly identified each of the benefits as a covered benefit, with the exception of case management/care coordination (39 percent), family planning (46 percent), and STD assessment (49 percent).
  - Only one of 16 benefits was correctly identified by 80 percent of providers.
  - Providers correctly identified an average of 10 covered benefits.
- Most PCPP providers (56 percent to 90 percent) correctly identified each of the benefits as a covered benefit, with the exception of case management/care coordination (44 percent) and family planning (47 percent).
  - Only three of 16 benefits were correctly identified by more than 80 percent of providers.
  - Providers correctly identified an average of 11 covered benefits.

Table 4-9—Providers Awareness of Benefits Covered for Colorado Medicaid Members Under 21 Years

	CO Access (N = 132)	DHMC (N = 27)	RMHP (N = 43)	FFS (N = 39)	PCPP (N = 174)
Response	**%**	**%**	**%**	**%**	**%**
Health and developmental history	93.2	96.3	90.7	71.8	90.2
Immunizations	93.2	96.3	88.4	71.8	89.1
Hearing assessment	81.1	85.2	74.4	59.0	70.7
Nutritional assessment	80.3	77.8	74.4	61.5	73.0
Anticipatory guidance	81.8	88.9	72.1	56.4	74.1
STD assessment	71.2	81.5	55.8	48.7	59.2
Referrals to specialists	70.5	70.4	65.1	53.8	69.0
Blood/capillary lead test	77.3	92.6	83.7	64.1	69.0
Physical exam	92.4	96.3	88.4	79.5	90.2
Vision assessment	83.3	88.9	81.4	66.7	74.1
Dental assessment	68.9	77.8	55.8	56.4	56.3
Health education	77.3	85.2	67.4	51.3	72.4
Family planning	62.9	77.8	48.8	46.2	46.6
Lead screen assessment	80.3	81.5	74.4	71.8	71.8
Behavioral health assessment	72.0	77.8	65.1	53.8	62.6
Case management/care coordination	46.2	59.3	39.5	38.5	43.7
Other	1.5	7.4	7.0	5.1	2.3
Average Number Correctly Identified	**12.3**	**13.3**	**11.3**	**9.5**	**11.1**
Percent of Providers who Correctly Identified All 16 Benefits	**26.5**	**37.0**	**15.4**	**25.3**	**20.9**

The most significant finding in Table 4-9 is that overall, only one-fourth of the providers surveyed were able to correctly identify all 16 covered benefits. The rates ranged from 15.4 percent to 37.0 percent. These findings suggest the majority of Medicaid providers lack comprehensive knowledge about the benefits covered under EPSDT. As noted earlier, fewer than half of the providers reported that they received information on EPSDT requirements from their MCO and only about half actually wanted to receive this information. This finding strongly supports the recommendation to increase provider education on EPSDT requirements.

Blood Lead Testing and Immunizations

Although the primary goal of this study was to examine barriers that may impact EPSDT visit rates, two additional factors were a focus of this study: lead testing and immunizations. Both lead testing and immunizations are components of an EPSDT visit and should be performed, if indicated, during an EPSDT visit.

Table 4-10 indicates the degree to which providers believe lead poisoning is a problem in Colorado. Most providers (72.5 percent) believed lead poisoning was a small problem, while 12.5 percent did not believe it was a problem at all. In addition, 12.0 percent believed lead poisoning was either a big problem or were not sure (5.5 and 6.5 percent, respectively).

Table 4-10—Provider Opinions Related to the Degree "Lead Poisoning is a Problem"

	CO Access (N = 132)		DHMC (N = 27)		RMHP (N = 43)		FFS (N = 39)		PCPP (N = 174)		Colorado Medicaid (N = 415)	
Response	n	%	n	%	n	%	n	%	n	%	n	%
A Big Problem	10	7.6	1	3.7	2	4.7	4	10.3	6	3.5	23	5.5
A Small Problem	99	75.0	22	81.5	30	69.8	24	61.5	126	72.4	301	72.5
Not a Problem	14	10.6	2	7.4	7	16.3	4	10.3	25	14.4	52	12.5
Not Sure	6	4.6	2	7.4	3	7.0	4	10.3	12	6.9	27	6.5
No Response	3	2.3	0	0.0	1	2.3	3	7.7	5	2.9	12	2.9

Providers were more likely to perform a lead poisoning risk assessment for children under 6 years of age than actually order a blood lead test. The one exception was for providers contracted with DHMC, who were more likely to order blood lead tests for these children. Moreover, providers contracted with DHMC were significantly more likely than any of the other provider groups to order blood lead tests (p-value < 0.01) routinely for children under age 6.

Figure 4-5—Provider-Reported Lead Risk Assessments and Blood Lead Tests

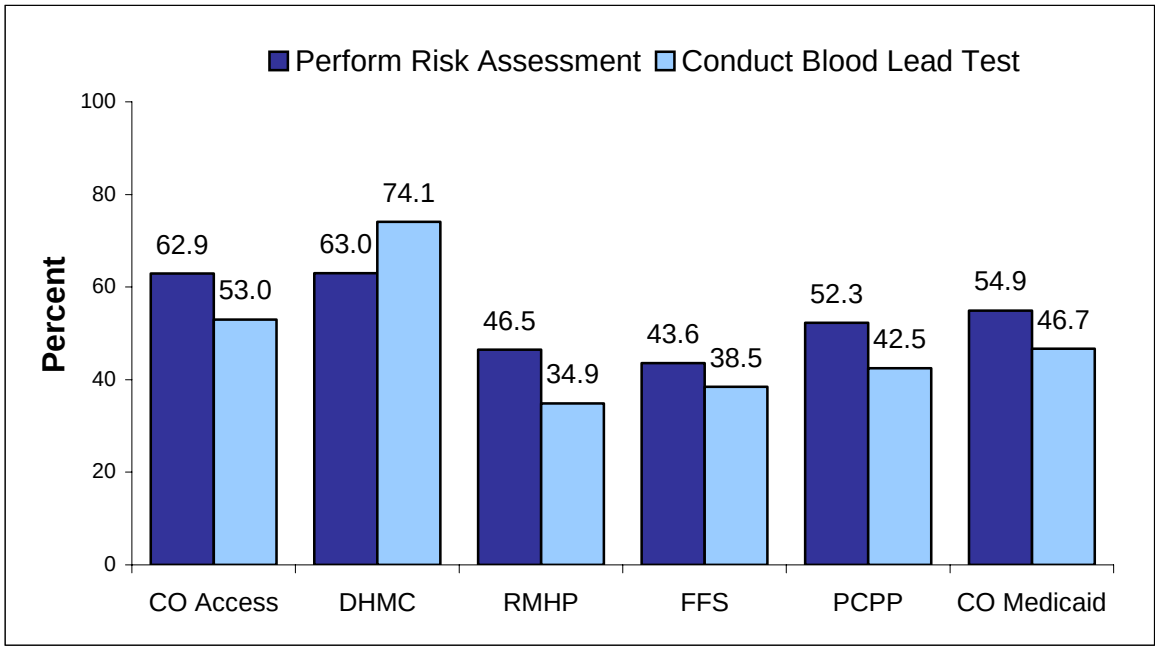


Figure 4-6 shows the percentage of providers who responded that only children in high-risk areas should be tested for lead poisoning. Overall, 56.6 percent of providers agreed with this premise. Rates ranged from 18.5 percent to 66.6 percent. The findings indicate providers considered lead poisoning a small problem and generally conducted a risk assessment to determine if additional testing should be conducted for lead poisoning.

Figure 4-6—Provider Opinion of Blood Lead Testing for High-Risk Children Only

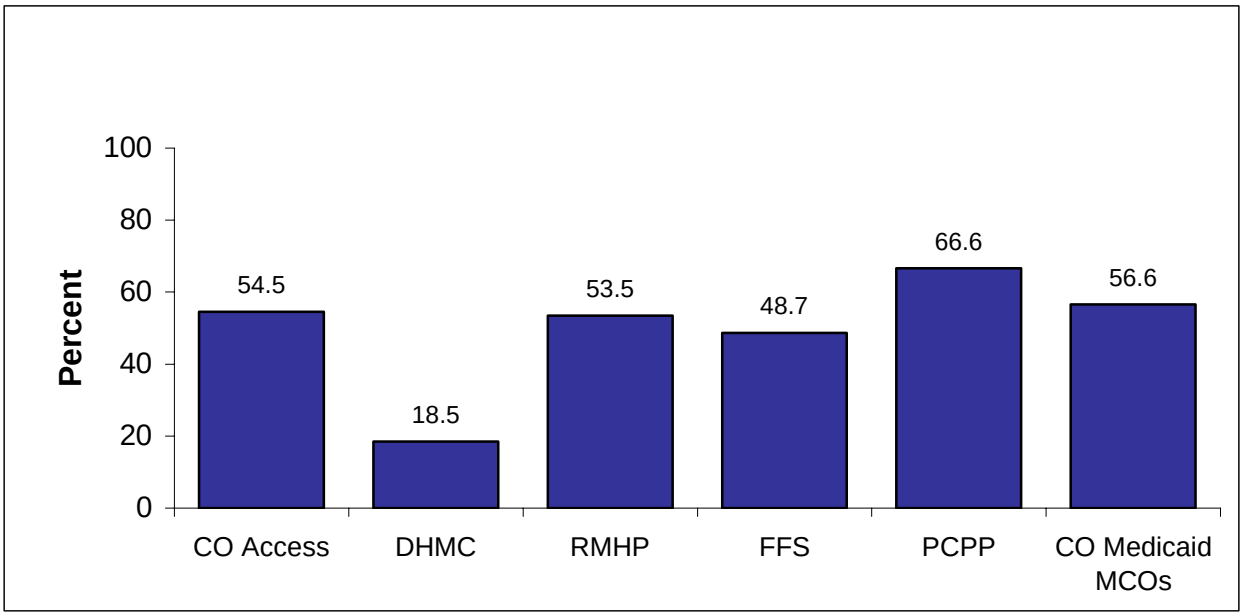


Figure 4-7 shows the percentage of providers who reported they routinely gave immunizations during EPSDT visits. Overall, 81.2 percent responded that immunizations were given during EPSDT visits. However, 11.1 percent of the providers responded they would not give immunizations during an EPSDT visit. Immunizations are a basic component of EPSDT preventive services and should be provided during EPSDT visits, when appropriate.

Figure 4-7—Provider-Reported Immunizations Given During EPSDT Visits

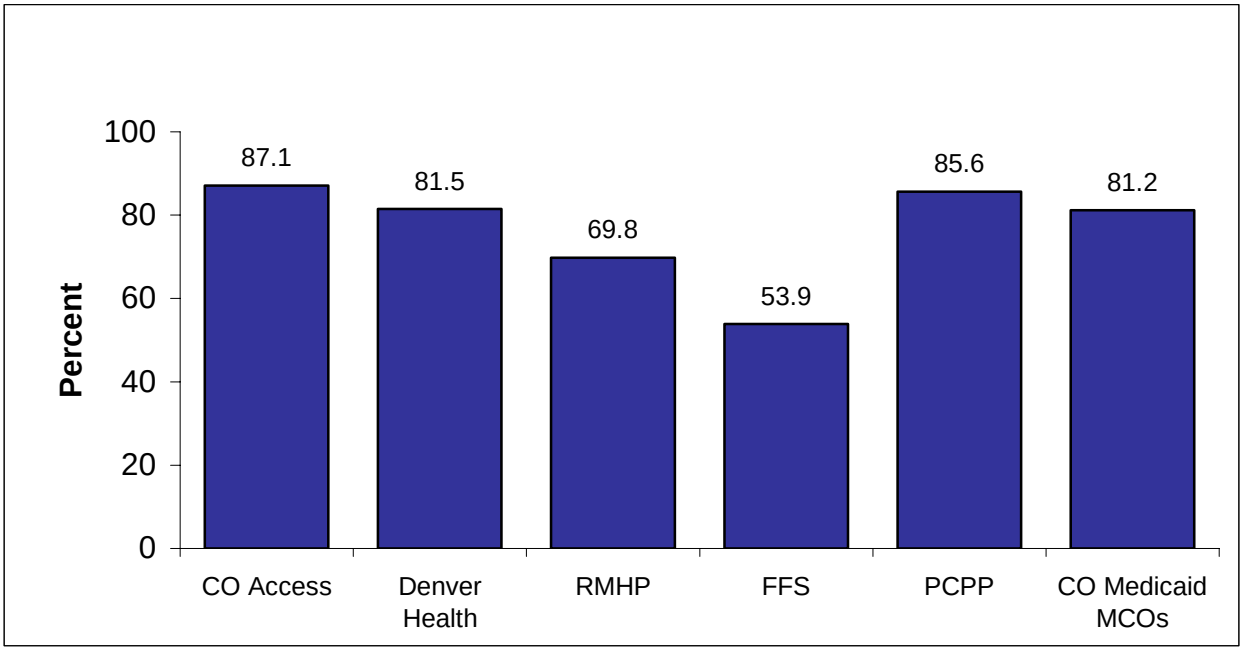


Table 4-11 and Table 4-12 show the potential barriers associated with low immunization rates, and the percentage of providers contracted with each health plan/program who agreed that the barrier contributes to low immunization rates. Providers who routinely performed immunizations during EPSDT visits were more inclined to view parents' noncompliance with immunization schedules and the lack of availability of immunization records as the primary barriers to increasing immunization rates. Providers who did not routinely perform immunizations during EPSDT visits were more inclined to view the fact that immunizations could be obtained from local health departments or schools, along with low reimbursement rates, as the primary barriers to increasing immunization rates.

Table 4-11—Barriers to Improving Immunization Rates for Providers Who Reported They Routinely Gave Immunizations during EPSDT Visits

	CO Access	DHMC	RMHP	FFS	PCPP	Colorado Medicaid
Response	**%**	**%**	**%**	**%**	**%**	**%**
Parents do not comply with schedule	75.7	36.4	50.0	81.0	64.4	66.2
Immunization records not available	60.9	36.4	46.7	42.9	59.1	56.1
Low reimbursement rates	28.7	27.3	40.0	38.1	40.3	35.3
Obtain immunization from health department or school	20.0	0.0	46.7	14.3	24.2	22.6

Table 4-12—Barriers to Improving Immunization Rates for Providers Who Reported They Did Not Routinely Give Immunizations during EPSDT Visits

	CO Access	DHMC	RMHP	FFS	PCPP	Colorado Medicaid
Response	**%**	**%**	**%**	**%**	**%**	**%**
Obtain immunization from health department or school	88.9	0.0	60.0	22.2	75.0	60.9
Low reimbursement rates	44.4	0.0	70.0	22.2	50.0	45.7
Immunization records not available	0.0	50.0	20.0	0.0	12.5	10.9
Parents do not comply with schedule	22.2	0.0	0.0	0.0	6.3	6.5

5. Findings—Health Plan Questionnaire and On-Site Reviews

Introduction

Treatment under EPSDT follows Colorado Regulations 10 CCR 2505-10, Section 8.280, and is applicable to all Medicaid children, regardless of enrollment in a managed care organization or unassigned to fee-for-service. Despite the benefit to health plans to improve EPSDT screening, the rates for EPSDT visits and the provision of EPSDT services in Colorado remains low. The Department, in conjunction with the MCOs and HSAG, selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that impact the provision of EPSDT services. As part of the focused study, HSAG conducted an EPSDT provider survey to determine potential barriers providers recognized that impact the provision of EPSDT services.

In addition to the provider survey, HSAG sent an auditor on-site to the EPSDT contract administrator at the Department and each MCO to conduct interviews, review existing EPSDT screening tracking processes, and examine efforts to increase the percentage of members who receive EPSDT services. Both the Department and the MCOs provided documented evidence, representing the 2003–2004 contract year, to HSAG regarding how EPSDT services were monitored and what efforts had been taken to increase the number of EPSDT services performed. A discussion of barriers to improving rates was also conducted, covering topics such as access to care, parental refusal and education, and provider compliance and monitoring.

The following is a summary of the findings from reviews of the completed questionnaires and the documentation submitted by the MCOs and the Department, and the on-site reviews including interviews with staff. The same HSAG staff members conducted the interviews and document reviews in each organization.

EPSDT Program Oversight

Tracking/Monitoring EPSDT Rates

All three MCOs and the Department had one person responsible for monitoring EPSDT rates. The primary EPSDT tracking processes included the use of the CMS-416 reports. The CMS-416 reports use enrollment data and administrative data (i.e., claims and encounter data) to determine all members enrolled in a managed care plan, regardless of length of enrollment, and to determine how many of those members receive an EPSDT service as defined by specific billing codes. These reports provide general, overall rates and are limited in usefulness for monitoring EPSDT visits. Member-level information or EPSDT rates by provider are not part of the CMS-416 report.

In addition to the CMS-416 reports, efforts to increase and monitor EPSDT rates included the following:

- The MCOs and the Department sent letters and EPSDT brochures to members.
- All MCOs had provider education, manuals, and newsletters or fax communications.
- All MCOs and the Department used HEDIS measures (e.g., well-child visits) to monitor performance.
- CO Access produced quarterly provider trending reports and an annual EPSDT profile report. A member Web site and television information had also been produced.
- DHMC used an immunization tracking and reminder system. DHMC also sent outreach letters and information to members with no encounters or only specialty claims, and conducted outreach to members who used urgent or emergency services.
- RMHP monitored and produced quarterly versions of the annual CMS-416 report. Reminder lists for immunizations were sent to providers of children who turned 15 months of age.
- The Department provided EPSDT outreach and benefits for MCO, FFS, and PCPP provider offices.
- The Department contracts with county health departments to provide FFS and PCPP providers information about members who have not had a well-child exam. In 2004, the Department sent a mailing to providers about children in their practice who had not had a dental exam.

Data Completeness

There is a potential for missing or incomplete data because of the different types of reimbursement submission methods. MCOs that compensate their providers on a fee-for-service basis require a submission of claims for reimbursement. However, providers paid on a capitated or salaried basis do not need to submit a claim to be paid. Instead of a claim, the office provides encounter data indicating the type of visit. Receiving all encounter data from providers can be challenging and may negatively impact EPSDT rates. As part of the review process, HSAG examined claims and encounter data for completeness.

With the exception of DHMC, which reimburses providers on a capitated basis, the MCOs reimburse 97.5 percent to 100 percent of providers on a fee-for-service basis. Average monthly claims volumes at the MCOs ranged from 561 to 2,547[1]. The encounter data for DHMC was comparable to the claims data reported by the other two MCOs and was reasonable compared to their Medicaid population. Additionally, all three MCOs used standard billing forms and required standard and complete coding. Based on these findings, data completeness did not appear to be an issue for the MCOs at this time.

The Department reimbursed EPSDT claims from providers based on a flat fee. The Department processed a monthly average of 1,765 PCPP claims and 8,859 FFS claims. All claims were submitted using standard forms, and only standard codes were used. Most claims were submitted electronically. Both paper and electronic claims were transferred to databases for adjudication and payment. Data completeness for PCPP and FFS did not appear to be an issue for the Department at this time.

[1] Based on data from January through October 2004, provided by the health plans

Barriers Identified by Health Plans

The on-site interviews consistently identified the challenges with incorrect enrollment status and incorrect or missing addresses/contact information for patients. Incorrect or missing contact information makes it difficult to conduct member outreach and/or education on the importance of EPSDT visits. Other barriers related to members, along with interventions, included the following:

- The problem of members not showing for visits and not canceling appointments was reported consistently across all organizations. As an intervention, CO Access indicated it verifies and corrects member contact information during each call to customer service.
- Transportation for EPSDT visits was an issue for members. As an intervention, CO Access provided the list of transportation resources to members. Transportation problems were addressed by DHMC by specific inquiries during welcome calls and all other member service calls as well as through utilization and care management. Members were also assisted with suggestions for clinic locations on public bus routes.
- All three MCOs identified the absence of reliable member contact information as a key barrier to providers performing EPSDT services.
- All three MCOs identified member reading comprehension level and transportation as key barriers to members receiving EPSDT services.
- Members found it difficult to understand the importance of immunizations, complex screening guidelines, and EPSDT terminology. As interventions, the MCOs had implemented age-appropriate reminder mailings, cards, and calls to improve immunization rates. CO Access sent age-appropriate EPSDT information to members before their birthdays. RMHP provided an incentive for children who completed immunizations by age two, and coordinated efforts with county health departments to increase access to EPSDT services. All three MCOs sent letters and EPDST brochures to newly enrolled members.
- All four organizations reported that immunizations were under-reported and not easily tracked, and supported a state immunization tracking system (this system was approved in the 2004-2005 legislative session, after completion of this study).
- All identified a need in most parts of the state for:
  - Additional providers to conduct EPSDT services.
  - Current providers to accept new clients.
  - Additional dental providers.

Interventions Implemented by the Health Plans

The MCOs and the Department have implemented a variety of methods to both create incentives and educate providers about EPSDT. The MCOs have produced provider newsletters and manuals, fax communications, and e-mails, and have held meetings, in-services, and orientation programs to discuss EPSDT. In March 2005, the Department began training programs for all Medicaid plans, by outreach coordinators or Department EPSDT staff, on EPSDT wrap-around benefits and medically necessary services. The EPSDT outreach also offered missed appointments and appointment assistance to all providers (e.g., performing follow-up activities when members miss appointments), and there was a special emphasis for members who did not attempt to make dental appointments and for those without prescribed medications.

Summary of Findings

The three MCOs and the Department consistently reported that organizational and provider outreach efforts were challenged due to inadequate reliable member contact information. Incorrect or missing contact information makes it difficult to conduct member outreach and/or education on the importance of EPSDT visits. Most MCOs instituted efforts to obtain and update member contact information in their organizational databases, and one plan had a system for updating its database at the time of each member contact. The Department is aware of the difficulties associated with the new State eligibility database, and is considering options for enhancement.

Additional interventions included provider and member reminders and outreach efforts. The MCOs and Department submit the CMS-416 annually to report EPSDT participation. The MCOs questioned the accuracy of data calculation and identified a need for a review and/or validation of this process. All MCOs used HEDIS measures (e.g., well-child visits) to monitor performance. One MCO produced provider trending reports and submitted the reports to the providers. One MCO sent a monthly list of members eligible for EPSDT services to providers. All three MCOs had an individual responsible for EPDST monitoring, and each had an oversight committee and/or work group.

All four organizations (CO Access, RMHP, DHMC and the Department) reported that immunizations were underestimated and not easily tracked, and requested a State immunization tracking system (this had not been funded by the State legislature at the time of data collection for this study). Additionally, all four organizations identified the need for more EPSDT providers, and providers who would accept new patients, as well as the need for dental providers in most areas of the state.

6. Conclusions and Recommendations

Conclusions

The purpose of this study, was to identify potential barriers that could contribute to low EPSDT visit rates among Colorado Medicaid recipients through the age 20, as well as identify efforts to improve EPSDT services delivered to Medicaid beneficiaries. In addition, blood lead testing and immunizations, two benefits covered under EPSDT, were examined for factors contributing to low rates in Colorado. The following provides a summary of the key findings of this report.

Provider access or availability did not appear to be a barrier to obtaining an EPSDT visit (Table 6-1). The average time to receive an appointment for an EPSDT visit was 1.7 weeks. More than 80 percent of the survey responses indicated an appointment was available within one or two weeks. The survey indicated the number of office staff members and providers practicing at a location was sufficient and did not have a negative impact on the waiting times for EPSDT appointments.

The majority of Medicaid providers surveyed were not fully aware of the benefits covered under EPSDT. Only one-fourth of the providers surveyed correctly identified all 16 covered benefits listed on the survey as EPSDT-covered benefits. The average provider identified 12 EPSDT-covered benefits.

Providers reported that EPSDT information was not given to providers on a regular basis by the respective health plan. Table 6-1 provides a summary of rates for some of the survey questions, concentrating on availability of EPSDT information. Based on these responses, it appears that fewer than half of the providers felt they received information on EPSDT requirements from their contracted MCOs, while only about half of the providers actually wanted the information. It also appears that providers who received the most information from their MCOs about EPSDT visit rates and member-level information, also desired to have more information on EPSDT requirements.

Table 6-1—Provider-Reported "Receipt and Access to EPSDT Information from Health Plans"

Survey Question	CO Access	DHMC	RMHP
Easy Access to EPSDT Visit Rates	30.3	25.9	69.8
Easy Access to EPSDT Visit Needed Information	18.2	18.5	53.5
Regularly Receive EPSDT Visit Information	17.5	14.8	41.9
Regularly Receive EPSDT Requirements	38.7	48.1	46.5
Would Like to Receive EPSDT Visit Rates	45.5	40.7	48.8
Would Like to Receive EPSDT Visit Needed Information	56.9	44.4	86.0
Would Like to Receive Additional Requirements Information	46.2	37.0	76.7

Fewer than one-third, or 31.8 percent, of providers or their office staff members reported that they attempted to make contact with Medicaid members to schedule an EPSDT visit. More than half, or 51.3 percent, indicated they did not initiate contact. Among providers who attempted to increase their EPSDT visit rates, the most common methods used were the delivery of EPSDT services during other types of visits, along with phone calls and reminder postcards.

The majority of providers believed that only children in high-risk areas should be tested for lead poisoning. Most providers (72.5 percent) believed lead poisoning was a small problem, while 12.5 percent did not believe it was a problem at all.

Providers indicated that they were more likely to perform a lead poisoning risk assessment than actually order a blood lead test. The findings in Table 6-2 suggest providers considered lead poisoning a small problem and generally conducted a risk assessment to determine if additional testing should be conducted for lead poisoning.

Table 6-2—Beliefs About Lead Poisoning and Blood Lead Testing

Category	CO Access	DHMC	RMHP	FFS	PCPP
Lead Poisoning Is a Small Problem	75.0	81.5	69.8	61.5	72.5
Routinely Conduct Lead Poisoning Risk Assessment	62.9	62.9	46.6	43.6	52.3
Routinely Order Blood Lead Tests	53.0	74.1	34.9	38.5	42.5
Blood Lead Testing Should Only Be Performed for High Risk Cases	54.5	18.5	53.5	48.7	66.6

Most providers indicated that they routinely provided immunizations during EPSDT visits. Overall, 81.2 percent responded that immunizations were given during EPSDT visits. However, 11.1 percent responded they would not give immunizations during an EPSDT visit. Immunizations are a basic component of EPSDT preventive services and should be provided during EPSDT visits, when appropriate.

Differences in barriers to improving immunization rates identified by providers appeared to be related to differences in practice approach. Providers who routinely performed immunizations during EPSDT visits were more inclined to view parents' noncompliance with immunization schedules and the limited availability of immunization records as the primary barriers to increasing immunization rates. Providers who did not routinely perform immunizations during EPSDT visits were more inclined to view the fact that immunizations could be obtained from local health departments or schools, along with low reimbursement rates, as the primary barriers to increasing immunization rates.

On-Site Findings

All of the health plans and the Department used the CMS-416 report to track EPSDT services delivered to Medicaid beneficiaries. The health plans used this information to generate reminder letters for beneficiaries, and the information was given to providers on an annual basis. Additionally, two MCOs generated internal quarterly tracking reports for EPSDT visits. The Department offered outreach education to providers and assistance with missed appointments. Most were participating with some type of immunization registry, and all were supportive of the recent legislation for the Colorado immunization tracking system.

All three MCOs identified the absence of reliable member contact information as a key barrier to providers performing EPSDT services. Other barriers included reading comprehension level and transportation, and lack of knowledge about well-child care.

Recommendations

MCO Recommendations

- Partner with the Department's EPSDT provider outreach education to begin or continue to increase provider awareness of covered benefits under EPSDT.
- Providers should be given information on federal and State requirements regarding blood lead testing for children enrolled in Medicaid.
- Providers should be encouraged to perform EPSDT preventive services, such as immunizations, during office visits other than EPSDT visits.
- MCOs should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information to providers on a regular basis (e.g., monthly or quarterly).

Department Recommendations

- The Department should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information to PCPP providers on a regular basis (e.g., quarterly).
- The Department should investigate ways to obtain reliable member enrollment and contact information, and update this information on a timely basis. The Department should examine the enrollment process, particularly as it relates to newborns, to determine whether it can be made more efficient and timely.
- The Department should continue and expand provider outreach education and training programs that present the full range of EPSDT services and benefits that are available to Medicaid members, including dental, well, and sick care.
- Providers should be encouraged to perform EPSDT preventive services during visits other than EPSDT visits.

Department and MCO Recommendations

- Review and validate the process for data calculation using the CMS-416.
- Support the continued development and implementation of the Immunization Tracking System, including outreach and education.

Appendix A. References

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Appendix B. Sample Provider Survey

The survey sent by the Department for providers to complete follows this cover page.

EPSDT Provider Survey

Dear Health Care Provider:

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal program intended to provide comprehensive health care to children and adolescents covered under Medicaid. EPSDT ensures access to routine comprehensive preventive services necessary to maintain healthy growth and development from birth up to age 21. The Colorado Department of Health Care Policy and Financing is working to improve EPSDT services for the Colorado Medicaid Program. Your answers to the following brief survey will help us in this endeavor.

You will notice there is a bar code on this questionnaire. This bar code is solely for the purpose of letting us know that you have returned your questionnaire, so that we will not trouble you with a second request to complete the survey. Your name will not be connected with your responses to this survey in any report of the results. For your convenience, you may fax your completed survey back to us at [fax number]. **If your site receives multiple surveys addressed to multiple providers, it is important that <u>each</u> survey be completed and returned. This will ensure that a representative sample of all Colorado Medicaid health care providers is included in the survey results.**

Please note: Your answers to this survey should reflect your experience with the Colorado Medicaid Program. Questions 5 through 11 are health-plan-specific questions, and your answers to these questions should reflect your experience with any of the health plans listed. If you are not contracted with a health plan, please skip Questions 5 through 11 and proceed to Question 12.

A summary of the survey results will be made available on our Web site at http://www.chcpf.state.co.us. Click on Medical Assistance Programs, then the EPSDT link. If you have any questions about the survey, you may contact Donna Kellow at 303-866-6320. Thank you for your help!

Donna Kellow
Quality Improvement Manager
The Colorado Department of Health Care Policy and Financing

Scheduling **Note:** *The **Office or Practice Manager** may fill out Questions 1 – 4. The **Provider** must complete questions 5-24.*

1. Does the Health Care Provider to whom this survey is addressed provide services to Medicaid members under the age of 21?

   ☐ Yes → Please Go to Question 2

   ☐ No → Please Return this Survey Utilizing the Instructions Provided on Page 6

2. How many administrative staff persons are employed at this location?

   ☐ 1 or 2 ☐ 3 or 4 ☐ 5 to 7 ☐ 7 to 9 ☐ 10 to 19 ☐ 20 or more

Scheduling (continued)

3. How many providers (e.g., physicians, physician assistants, nurse practitioners) practice at this location?

   ☐ 3 or less ☐ 4 to 7 ☐ 7 to 9 ☐ 10 to 19 ☐ 20 or more

4. If someone wanted to schedule an EPSDT appointment for a Medicaid member under 21, when would be the next available date (on average)? Within:

   ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks
   ☐ 5 weeks ☐ 6 weeks ☐ 7 weeks ☐ 8 or more weeks

Monitoring/Tracking

Note: *The **Health Care Provider** to whom this survey is addressed should complete the remainder of the survey.* Questions 5 through 11 are **health-plan-specific**. If you or your group are not contracted with any of the health plans listed below, then please proceed to Question 12. *For each of the statements in Questions 5 through 11, please indicate how strongly you agree with the statement for each contracted **health plan**.*

5. I can easily find out my current EPSDT visit rate for Medicaid members under 21 from the following health plans:

   Colorado Access

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

   Denver Health Medicaid Choice

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

   Rocky Mountain HMO

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

6. I would like to receive additional information about my EPSDT visit rate for Medicaid members under 21 from the following health plans:

   Colorado Access

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

   Denver Health Medicaid Choice

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

   Rocky Mountain HMO

   ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Monitoring/Tracking (continued)

7. I can easily find out which of my Medicaid patients under 21 are in need of an EPSDT visit from the following health plans:

Colorado Access

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Denver Health Medicaid Choice

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Rocky Mountain HMO

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

8. I receive information on a regular or ongoing basis about Medicaid members under 21 who are in need of an EPSDT visit from the following health plans:

Colorado Access

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

Denver Health Medicaid Choice

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

Rocky Mountain HMO

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

9. I would like to receive regular information about members under 21 who need an EPSDT visit from the following health plans:

Colorado Access

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Denver Health Medicaid Choice

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Rocky Mountain HMO

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

10. I receive information about EPSDT requirements from the following health plans:

Colorado Access

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

Denver Health Medicaid Choice

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

Rocky Mountain HMO

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Applicable

Monitoring/Tracking (continued)

11. I would like to receive additional information about EPSDT requirements from the following health plans:

Colorado Access

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Denver Health Medicaid Choice

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

Rocky Mountain HMO

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure ☐ Not Applicable

12. My office routinely contacts Medicaid members under 21 who have not had an EPSDT visit during the past year.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure

13. My office uses the following methods to increase EPSDT visits (check all that apply):

☐ Phone call reminder to schedule appointment
☐ Reminder postcards
☐ Assistance with transportation
☐ Registry or other tracking system
☐ County Outreach Coordinators
☐ Not Sure
☐ None
☐ Other (please describe) _____
_____

Beliefs/Knowledge

14. For Medicaid members under 21, EPSDT services are an important part of patient care.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure

15. In my opinion, lead poisoning in the State of Colorado is:

☐ A Big Problem ☐ A Small Problem ☐ Not a Problem ☐ Not Sure

16. I routinely provide EPSDT preventive services to Medicaid members under 21 during other types of visits (e.g., a sick visit for otitis media).

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

17. I routinely conduct lead poisoning risk assessments for children enrolled in Medicaid who are less than six years of age.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

18. I routinely order blood lead testing for children enrolled in Medicaid who are under six years of age.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

Beliefs/Knowledge (continued)

19. I prefer the following method for blood lead testing (check one):

☐ Venous ☐ Capillary ☐ Risk Assessment ☐ None–Not a problem in Colorado

20. Blood lead testing should be performed only if a child lives in a high-risk area or is found to be at high risk through a screening assessment.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Not Sure

21. My office routinely performs child and adolescent immunizations for Medicaid enrollees during their EPSDT visits.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

22. Obstacles to performing immunizations for Medicaid members under 21include (check all that apply):

☐ Reimbursement rates are low.
☐ Parents can obtain immunizations at the local health department or in the school setting.
☐ Vaccines for children enrolled in Medicaid are not readily available.
☐ Parents fail to comply with the immunization schedule.
☐ Records on immunizations received in the past are not available.
☐ Other (please describe) _____

Benefits and Services

23. Please indicate which **benefits you believe are covered** for Colorado Medicaid members under 21 as part of an EPSDT well-care visit (check all that apply):

☐ Health and developmental history
☐ Immunizations
☐ Hearing assessment
☐ Nutritional assessment
☐ Anticipatory guidance
☐ STD assessment
☐ Referrals to specialists
☐ Blood/capillary lead test
☐ Physical exam
☐ Vision assessment
☐ Dental assessment
☐ Health education
☐ Family planning
☐ Lead screen assessment
☐ Behavioral health assessment
☐ Case management/care coordination
☐ Other _____

Benefits and Services (continued)

24. Please indicate which EPSDT services **you routinely refer to someone outside your office** for Colorado Medicaid members under 21 for (check all that apply):

- ☐ Immunizations
- ☐ Hearing assessment
- ☐ Nutritional assessment
- ☐ STD assessment
- ☐ Case management
- ☐ Lead testing
- ☐ Vision assessment
- ☐ Dentist
- ☐ Vaccines for Children Program
- ☐ Orthodontia
- ☐ Community programs (i.e., WIC, food banks, housing)
- ☐ Health education
- ☐ Family planning
- ☐ Local health department
- ☐ Mental health
- ☐ Other _____

Please fax your questionnaire to: [fax number]

Or, you may mail your questionnaire to [address].

Thank you for your help!

Appendix C. Completed MCO Questionnaires

The questionnaires completed by the MCOs follow this cover page.

Colorado Department of Health Care Policy & Financing
Completed MCO Questionnaires
Colorado 2004–2005 Focused Study Evaluation of EPSDT Services

The provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services can prevent and/or identify potential health problems in individuals, which, if left untreated, may result in serious health problems among members and substantial costs to the health plans. Despite the benefit to health plans to improve EPSDT screening, the rates for EPSDT visits and the provision of EPSDT services in Colorado remain low. The Department, in conjunction with the health plans and Health Services Advisory Group, Inc. (HSAG), has selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that negatively impact the provision of EPSDT services. As part of the focused study, HSAG will conduct EPSDT surveys with providers and health plans to determine possible barriers providers and health plans recognize that potentially impact the provision of EPSDT services. In addition to the provider and health plan surveys, HSAG requests information from the Department concerning its processes for monitoring/tracking EPSDT visits, and what efforts (ongoing as well as those in the planning stage) have been taken to increase the provision of EPSDT services to Medicaid recipients.

The following baseline questions have been designed to help HSAG identify potential systemic issues.

Baseline Questions

Please provide complete, detailed information. Based on the information provided back to us, additional questions or documentation may be requested.

Department of Health Care Policy & Financing Contact Name: Gina Robinson

1. Does the Department have a person or division responsible for tracking or monitoring EPSDT visit rates?

☒ **Yes** ☐ **No**

Who is that person/division?

Sandy Mortensen/Acute Care Benefits

Baseline Questions

2. Please describe the process for monitoring /tracking EPSDT visits.

HIFA 416 Reporting based on claims data.

3. What type of information on EPSDT services does the Department send to the managed care plans?

EPSDT Outreach and Benefits are included in their contracts as required services.

How often?

Contract year

4. What type of information on EPSDT services does the Department send to FFS providers?

Information regarding EPSDT Outreach and Benefits is included in Department issued provider bulletins.

How often?

At least twice a year.

5. What type of information on EPSDT services does the Department send to PCPP providers?

Information on EPSDT Benefits and Outreach is included in provider bulletins and the PCPP newsletter.

How often?

At least twice a year.

Baseline Questions

6. What type of information on EPSDT services does the Department send to Medicaid recipients?

Introductory letter listing basic services such as physicals, dental, vision, and immunizations, along with local Outreach offices for more information or assistance.

How often?

Yearly.

7. What information and/or data does the Department receive about EPSDT services?

Conference call hosted by Centers for Medicare & Medicaid (CMS).

How often?

Quarterly.

8. Please describe how the Department reimburses providers for EPSDT visits.

Flat rate based on CPT coding.

9. Please provide a flow diagram and describe the EPSDT claims or encounter submission process. Note: Submit flow diagram with desk review documentation.

Baseline Questions

10. Are EPSDT claims/encounters submitted on standard CMS 1500 forms, non-standard EPSDT forms, or both?

1500. UB92 or new 837 forms are required

Please provide an example copy of each type of Non-Standard form used. (Submit with desk review documentation.)

11. Does the Department accept only standard ICD-9-CM and CPT-4 codes, or can EPSDT visits be submitted with non-standard codes or State codes?

12. Please provide the volume of claims/encounters and the volume of PCPP EPSDT visits submitted monthly for calendar year 2004.

13. Please provide the volume of claims/encounters and the volume of FFS EPSDT visits submitted monthly for calendar year 2004.

Baseline Questions

14. What issues have been identified with members (e.g., canceling appointments or transportation problems) by the Department that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has the Department conducted analysis that supports these findings?

Anecdotal information from EPSDT Outreach contractors lists no shows as the highest negative impact on services.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

EPSDT Outreach offers missed appointment follow-up to providers who request such services for their patients. EPSDT Outreach has implemented additional outreach calls and client letters to increase recipient knowledge and to train recipients to understand and better utilize the health care system and available services.

Baseline Questions

15. What issues have been identified by the Department with providers or clinics (e.g., they do not submit encounters, complain about reimbursement, or are not sure what EPSDT services are covered) that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has the Department conducted analysis that supports these findings?

Anecdotal information leads us to believe that providers are unaware that medically necessary services are available to children even if the service or item is not included in their contractual responsibilities.

Providers are unhappy with current reimbursement rates.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

At the request of a managed care contracted provider, EPSDT has developed a training for providers and managed care agencies on wrap-around services and how the provider can better assist the recipient to obtain the needed services or items that may not be covered under managed care contracts but which still may be medically necessary for a child. Training of providers, parents and MCOs began on March 9, 2005.

A request was approved to raise the reimbursement rate on code 99213.

Baseline Questions

16. What issues have been identified with managed care plans (e.g., they do not submit encounters, complain about reimbursement, or are not sure what EPSDT services are covered) by the Department that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has the Department conducted analysis that supports these findings?

Anecdotally, providers and managed care contractors are unaware that medically necessary services are available to children even if the service or item is not included in their contractual responsibilities.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

At the request of a managed care contracted provider, EPSDT has developed a training for providers and managed care agencies on wrap-around services and how the provider can better assist the recipient to obtain the needed services or items that may not be covered under managed care contracts but which still may be medically necessary for a child. Training of providers, parents and MCOs began on March 9, 2005.

17. Please add any comments you have regarding potential EPSDT collaborative interventions, Medicaid program improvements (such as reimbursement, eligibility, dissemination of EPSDT requirements), or other pertinent information as it relates to the provision of EPSDT services.

The Department is currently meeting with State and local representatives of Part C and the Health Care Program for Special Needs (HCP) to set standards and make policy recommendations to ensure collaborative, non duplicative efforts at the local level between three programs, which may serve the same client.

The Department is currently presenting EPSDT Benefits and Outreach information at the Colorado Department of Education, Early Childhood Connections training sessions. These sessions include families and service coordinators as well as service providers.

The Department is working with local hospital NICU staff and SSI representatives to ensure that those children born with special health care needs, who may be eligible for services while hospitalized, receive services to which they are entitled after discharge. The process includes

Baseline Questions

training on SSI and EPSDT, as well as Medicaid eligibility.

The Department began utilizing a reporting process to ensure that children born to mothers with Medicaid eligibility (Needy Newborns—NNB) were quickly and accurately determined eligible to ensure timely EPSDT services and physician reimbursement for EPSDT services rendered. This Add A Baby project has processed 2,000 NNB children since October 2004.

Acute Care Benefits has been collaborating with the Department's Managed Care section to better clarify EPSDT requirements contained in the managed care contracts.

The Department attends Colorado Children's Immunization Coalition (CCIC) meetings.

The Department meets monthly with EPSDT Outreach contractors to disseminate EPSDT requirements as well as Department changes that may affect client services.

The Department is collaborating with the CMS Healthy Start program to disseminate growth and development information to every child born to a Medicaid-eligible mother in the state. Thirteen informational booklets are provided to mothers, including booklets that explain the importance of well care, sick care and immunizations. This program will continue through 2006.

Colorado Department of Health Care Policy & Financing
EPSDT Focused Study – Assessment of Current Practices
Health Plan Questionnaire

The Colorado Department of Health Care Policy & Financing (the Department) is working to improve Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for the Colorado Medicaid Program. The Department requires that every member enrolled in the Colorado Access Medicaid program and who is less than 21 years of age receive and EPSDT visit annually. The provision of EPSDT services can prevent and/or identify potential health problems in individuals, which left untreated, may result in serious health-related problems and substantial costs to the health plans.

Despite the benefit to health plans to improve EPSDT screening, the rates for EPSDT visits and the provision of EPSDT services in Colorado remain low. The Department, in conjunction with the health plans and Health Services Advisory Group, Inc. (HSAG), has selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that negatively impact the provision of EPSDT services. As part of the focused study, HSAG will conduct and EPSDT provider survey to determine possible barriers providers recognize that potentially impact the provision of EPSDT services. In addition to the provider survey, the Department would like information from the health plans concerning their processes for monitoring/tracking EPSDT visits, and what efforts (ongoing as well as those in the planning stage) have been taken to increase the provision of EPSDT services to their members.

The following baseline questions have been designed to help the Department identify potential systematic issues.

Baseline Questions and Requested Documentation

Please provide complete, detailed information. Based on the information provided back to us, additional questions or documentation may be requested.

MCO Name: Colorado Access

1. Does your health plan have a person or department responsible for tracking or monitoring EPSDT visit rates?

☒ **Yes** ☐ **No**

Who is that person/department?

During State Fiscal Year 2003–2004, tracking and monitoring EPSDT visits was a responsibility shared by three departments: Clinical Support Services (CSS), Decision Support Services (DSS), and Quality Management. The Health Program Coordinator in the CSS department was responsible for coordinating interventions such as developing member and provider communications, provider training materials, and providing training for

Baseline Questions and Requested Documentation
Colorado Access staff. This person was also responsible for reviewing quarterly EPSDT monitoring reports and providing findings to CSS management. Decision Support Services produced the data, reports, and data analysis for EPSDT tracking and monitoring. Annually, EPSDT results were evaluated and reported by the Quality Management Department in its Quality Management Program Evaluation. During the end of calendar year 2004, Colorado Access evaluated the organizational responsibilities of the various health outcome activities performed throughout the company. Starting in 2005, Colorado Access began transitioning the responsibilities associated with its EPSDT program into a new Health Outcomes Unit. The Health Outcomes Unit will be accountable for, among other things, maintaining and enhancing our current EPSDT program. This will include monitoring and tracking of EPSDT services, developing and coordinating implementation of intervention strategies, and evaluating their effectiveness. Colorado Access believes that by focusing resources and integrating EPSDT program efforts with other initiatives and projects, Colorado Access will ultimately facilitate monitoring activities and further improve health outcomes. This new Health Outcomes Unit will have a Health Outcomes Manager, a dedicated analyst, and a program coordinator.
2. Please describe the process for monitoring/tracking EPSDT visits. Colorado Access tracks and monitors EPSDT visits using the CMS-416 report generated annually, an adapted version of the CMS-416 to produce provider-specific reports, provider-specific preventive care profiles and HEDIS Effectiveness of Care, Access/Availability of Care, and Use of Services measures. To produce the CMS-416 report, data associated with EPSDT visits are collected administratively using the HCFA 1500 and UB 92 claim submission forms. These claims are loaded into Colorado Access' transaction system as can be seen on the claims flow chart referenced in response to question #8 of this survey. The codes that define an EPSDT visit are identified based upon previously-received directions from CMS on completing the 416 form and are used to generate the report. (HCFA 2000 document). Also attached is a crosswalk showing the codes that qualify as EPSDT visits and the codes that qualify as other well child visits for HEDIS (code crosswalk). Data are extracted from the Colorado Access PowerStepp transaction system on a daily basis and are entered into our operational data repository and, on a monthly basis, are entered into our reporting and trending data warehouse. Reporting and tracking of EPSDT visits is accomplished using data from our operational data repository, the Enterprise Database, as well as from our trending data warehouse, Medstat's Advantage Suite. The report is reviewed internally and compared to prior year results and rate trends for specific HEDIS well care and immunization measures as they relate to this population. Colorado Access adapted the CMS-416 to produce provider-specific reports on EPSDT participation and screening (Quarterly provider CMS-416 form). The reports are generated

Baseline Questions and Requested Documentation

quarterly and reviewed internally. At this time, Colorado Access provides this information annually to its providers, and more frequently upon request.

In addition to the CMS-416 report, Colorado Access monitors pediatric visits to primary care providers for both well and sick child visits. Colorado Access recognizes the limitations associated with the CMS-416 report in that this report is based on claims/encounter data only rather than a combination of medical record data and claims/encounters, and the code set includes only well care visits. The population served by Colorado Access includes many children with chronic illness and/or disabilities. In 2004, 4 percent of the members under age 21 were in the AND/AB aid category, indicating they have severe disabilities. In addition, depending on the definition between 5 percent to12 percent of the non-AND/AB members under the age of 21 have a diagnosed chronic condition. Colorado Access has also found that with the increasing number of children with special health care needs in the Colorado Access plan, there are children who are receiving their EPSDT services in the context of a sick visit. Directions used to complete the CMS-416 form do not allow these visits to be counted as an EPSDT encounter unless it is coded with one of the well visit designations. Because this excludes well care that may have been provided (retrievable on through medical record review), it contributes to potential under-reporting and impacts outreach efforts.

For its own internal monitoring, and for reports to its providers, Colorado Access uses both well and sick visits to assess the extent to which members are accessing care. (preventive care profile, sample clinical profile).

Finally, Colorado Access utilizes select HEDIS Effective of Care, Access/Availability of Care, and Use of Services measures to monitor and evaluate the extent to which the Colorado Access Medicaid population accesses preventive services. These include, but may not be limited to Childhood Immunizations; Children's and Adolescent's Access to Primary Care; Well-Child Visits in the First 15 Months of Life; and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life. The population-based measures, produced annually, are analyzed to determine potential barriers to care and interventions are developed based on the findings.

3. What type of information on EPSDT services does your health plan send to members?

Colorado Access informs its members about the EPSDT program and encourages them to visit their primary care provider. Following is a list of materials and mailings sent to members and the frequency of dissemination (links below).

In addition to the direct mailings sent to members, Colorado Access utilizes other member-targeted media to promote well care and EPSDT on an ongoing basis. These include: Colorado Access Web site for the member that contains a schedule of preventive care and the guidelines with links to other health and wellness Web sites and a bilingual Spanish

Baseline Questions and Requested Documentation

and English television show on Denver Community Television, "Salud, Amor and Risa" with scheduled programs addressing well-child check ups, exercise, dental care, swim safety, and exercise.

How often?

- During 2003, Colorado Access mailed an Open Enrollment Letter with age-appropriate well care flyers annually to the member. Consistent with the changes made by HCPF, Colorado Access revised the letter in December 2004. The mailing schedule also was revised to coincide with the members birth month on an annual basis.

  Open Enrollment Letter 11-03 EPSDT 6Mo
  Open Enrollment Letter 11-03 EPSDT 12Mo
  Open Enrollment Letter 11-03 EPSDT 18Mo
  Open Enrollment Letter 11-03 EPSDT 24 Mo
  Open Enrollment Letter 11-03 EPSDT Well visits
  Open Enrollment Letter and Survey 11-03
  Open Enrollment Letter Dec 2004 Flyer 0-2.
  Open Enrollment Letter Dec 2004 Flyer 3-10.
  Open Enrollment Letter Dec 2004 Flyer 11-20.
  Open Enrollment Letter Dec 2004 Flyer 21+.
  Open Enrollment Letter English Dec 2004.
  Open Enrollment Letter Span Dec 2004.
  Open Enrollment Letter for Jan 2005 English.

- 15-month immunization reminder initiated in November 2004—mailed to parents or guardians of children who are 14 months old.

  FINAL 15monthletter11-04

- Member Handbook, an ongoing mailing—mailed as part of new member enrollment packet.

  Member Handbook pp 7,9,11,12

- Annual member mailing instituted at the inception of the health plan—mailed annually to members.

  Annual mailing to AHP 8-30-04
  Annual Member mailing 2004 2 pg

- Flu reminder initiated prior to 2003—annual mailing to high risk members including those with asthma and diabetes; however, the mailing was suspended this past fall secondary to the vaccine shortage.

Baseline Questions and Requested Documentation

Flu reminder
Flu reminder for DM and asthma

- Special Delivery New Mom Newsletter initiated prior to 2003—mailed post delivery to members enrolled in the Colorado Access Prenatal Program.

  Special Delivery New Mom mailing

- Other media used to promote member well care—ongoing.

  Colorado Access Website Home Page
  Colorado Access Website for members - AAP-child-schedule-twopgs-03
  Colorado Access Website for members - pediatric screening guidelines
  Colorado Access Website Health and Wellness
  Salud, Amor & Risa T.V

4. What type of information on EPSDT services does your health plan send to providers?

A variety of mechanisms are used to communicate with, and educate, providers concerning the EPSDT program and well care.

Colorado Access' provider manual, given to all newly contracted providers and available on the Colorado Access Web site, contains detailed information about the EPSDT program, what an EPSDT visit should contain, schedule of screenings, benefits and wrap-around services, reporting, appointment access standards, and how to bill Colorado Access for the services rendered. In addition, Colorado Access provides at least an annual notice/mailing to all primary care providers highlighting the program, reminding providers of its importance, and offering additional support and information to providers who are interested.

Colorado Access adapted the CMS-416 to produce provider-level reports on EPSDT participation and screening (quarterly provider CMS-416 form). At this time, Colorado Access provides this information annually to its providers, and more frequently upon request. As noted previously, Colorado Access provides preventive care profiles to providers on pediatric visits to primary care providers for both well and sick child visits.

The Colorado Access Web site contains information for providers that includes EPSDT screening guidelines, preventive health guidelines, and an EPSDT Provider Guide. EPSDT information is also included in the Access Behavioral Care (ABC) section of the Web site and the ABC provider manual.

Finally, new providers receive training on various topics including information regarding EPSDT services, as well as coding and billing. EPSDT refresher training is offered to offices experiencing staff turnover or when new providers join a practice.

Baseline Questions and Requested Documentation

How often?

- Provider manuals are given to all new providers, and updates and changes are communicated via fax and posted on the Colorado Access Web site.

  AHPCHP Provider Manual AHP Benefits & Services
  AHPCHP Provider Manual Appointment & Service Standards
  AHPCHP Provider Manual EPSDT Billing
  AHPCHP Provider Manual EPSDT Pediatric Guideline
  AHPCHP Provider Manual PHG Childhood Immunization
  AHPCHP Provider Manual Preventive Health Guidelines

- The Access Health Plan and Access Behavioral Care Provider Manuals, as well as the EPSDT screening guidelines, preventive care guidelines, and the EPSDT Provider Guide are available online at: www.coloradoaccess.com.

  AHPCHP Provider Manual AHP Benefits & Services
  AHPCHP Provider Manual Appointment & Service Standards
  AHPCHP Provider Manual EPSDT Billing
  AHPCHP Provider Manual EPSDT Pediatric Guideline
  AHPCHP Provider Manual PHG Childhood Immunization
  AHPCHP Provider Manual Preventive Health Guidelines
  ABC Provider Manual pgs 18,19,26,63,77
  Website EPSDT Provider Guide
  Website Immunization Guidelines

- Annual provider notice/mailing regarding EPSDT.

  Provider Letter for EPSDT 2005
  Provider Letter for EPSDT Fact Sheet 2005

- Provider blast faxes are sent at least quarterly and on an as needed basis.

  Provider Fax Blast for EPSDT focus study fax 1-21-05
  QM Fax Blast with HEDIS Information 11-5-04

- Provider EPSDT profile reports are sent annually.

  Practice Key Indicator Report Preventive
  Practice Key Indicator Report - Sample
  Preventive Care Profile Draft
  Provider EPSDT Report Template for 3rd Q CY04
  Provider Report EPSDT Sample

Baseline Questions and Requested Documentation

- New provider training is provided on an ongoing basis at the provider's office.

  2004 Provider Training Presentation
  EPSDT Provider Guide
  EPSDT Billing

5. What information and/or data does your health plan receive from the Department about EPSDT services?

Colorado Access received a list of dental providers that Customer Service staff use to help members find a Medicaid-contracted dentist. HCPF sent the dental list upon Colorado Access' request for an updated list.

HCPF has EPSDT information for its Medicaid providers on its Provider Services Web site. This includes the July 2004 newsletter sent to PCPP providers, which included information on EPSDT, as well as EPSDT information in Medicaid's Provider Billing Manual. Colorado Access did not receive this information directly from HCPF; however, Colorado Access has accessed this information from HCPF's Web site.

How often? See above

Statewide Dentists
Medicaid Provider Services Newsletter
Medicaid Provider Billing Manual
Medicaid Enrollee Information

6. Please describe how providers are reimbursed (e.g., fee-for-service, capitated) for EPSDT visits.

Providers are reimbursed based on their contracts with Colorado for covered services. EPSDT services are submitted via the HCFA 1500 or the UB 92 using a standard set of codes. Providers with fee-for-service contracts are reimbursed based on the Colorado Medicaid fee schedule. Providers with capitated contracts are paid a monthly fee that covers all care provided to that member.

7. For providers who deliver EPSDT services (FP, GP, IM, and PED), what percentage of providers are capitated versus fee-for-service?

Please see the attached table showing the percentage of primary care providers and specialists with capitated versus fee-for-service contracts (PCP capitation status).

Baseline Questions and Requested Documentation

8. Please provide a flow diagram and describe the EPSDT claims or encounter submission process. Note: Submit flow diagram with desk review documentation.

Please see the attached flow chart detailing the claim submission process (Claims Workflow). Colorado Access requires providers to submit claims, including claims for EPSDT visits on a standard claim form as noted below in question #9. EPSDT visits flow through Colorado Access' standard claim submission and adjudication processes.

9. Are EPSDT claims/encounters submitted on standard CMS 1500 forms, home-grown EPSDT forms, or both?

Colorado Access only accepts the HCFA 1500 and the UB 92 claim submission forms. EPSDT visits must be submitted on one of these forms to be counted in the CMS-416 report.

Please provide an example copy of each type of Non-Standard form used. (Submit with desk review documentation.) Not applicable.

10. Does your health plan use only standard ICD-9-CM and CPT-4 codes, or can EPSDT visits be submitted with home-grown codes or State codes?

EPSDT visits are counted using ICD-9 CM and CPT-4 codes. Colorado Access complies with the HIPAA standard code requirement and does not accept non-standard codes.

11. Please provide the volume of claims/encounters and the volume of EPSDT visits submitted monthly for calendar year 2004.

Please see attached table showing EPSDT visits by month for 2004.
EPSDT Visits by month for 2004.

12. What issues have been identified with members (e.g., canceling appointments or transportation problems) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings?

Analyzing data and researching the literature, Colorado Access has determined that common barriers that impact member access to EPSDT services include:

Member comprehension of complex EPSDT terminology and lack of knowledge about its importance
Members do not understand the term EPSDT, nor do they connect the term to preventive

Baseline Questions and Requested Documentation

care services. This misunderstanding, combined with the common barrier of potential lack of knowledge surrounding the importance of preventive screenings and immunizations, presents an opportunity to educate the member and to encourage utilization of services.

Member's ability to track and lack of knowledge regarding screening guidelines for immunizations and well care

Members are unable to track the required schedule of well-child visits and immunizations or they lack knowledge surrounding the screening guidelines. As discussed previously, HEDIS is used to monitor and measure the extent to which EPSDT services are utilized. Analysis of the HEDIS Childhood Immunization data revealed that overall completion rates, impacted by the DTP and HIB immunizations, decreased at 15 to 18 months of age.

Lack of reliable member contact information

Barrier analysis and intervention efforts are complicated by the lack of reliable member contact information (telephone numbers or correct addresses). Colorado Access has found, through the care management program, that reliable contact information is not available for at least 30 percent of the membership population. Without contact information, the ability to outreach to these members, either by the plan or the provider is limited. The issue is greater for members who are new to the plan or haven't accessed services.

Transportation

When Medicaid changed its non-emergent transportation benefit, Colorado Access care management staff initially experienced an increase in care coordination needs surrounding transportation as a result of some confusion related to the benefit that may have led to access issues for members. It should be noted that reports of this have subsided.

Systemic Issues

As noted previously in response to question #2, ongoing monitoring that is exclusively based on claims/encounter data, rather than a combination of medical record review and claims, poses unique challenges when providing feedback to providers and conducting outreach activities. While a percentage of members are not receiving preventive services during sick visits (as noted above in the analysis of HEDIS data), many practitioners take the opportunity, especially for children with chronic conditions or children with special health care needs, to provide preventive care during such a visit. Because this is the case and the CMS-416 report only captures or assumes well care is provided during a well visit, the results reflect care coded as such (administrative data only) and may, therefore, be under-reported.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

03-04 Evaluation FINAL for HCPF submission 9-17-04
MQIC Minutes 8/5/03
MQIC Minutes 9/2/03

Baseline Questions and Requested Documentation

MQIC minutes 8/3/04
MQIC Minutes 9/7/04
MQIC Minutes 11/2/04
EPSDT Report 2000 - 2003
Childhood Immunization 2004
EPSDT Research Summary
Cervical Cancer Screening

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

Member comprehension of complex EPSDT terminology and lack of knowledge about its importance

To the extent possible, Colorado Access has tried to simplify its materials so members are not confused by complex terminology. For example, the importance of well-child check-ups and shots are stressed in general terms, avoiding complex language. Colorado Access continues to address member comprehension and knowledge in a number of ways and actively promotes preventive services using various media (see the list of member communications with implementation dates under question #3 of this survey). Prior to 2003, Colorado Access mailed annual cervical cancer screening reminders to members. This intervention was suspended during 2004 to evaluate its impact. Based on the HEDIS Cervical Cancer Screening results, the reminder mailing will be re-instituted beginning March 2005 (PAP test Letter).

Member's ability to track and lack of knowledge regarding screening guidelines for immunizations and well care

Because studies and best practices have demonstrated increased completion rates for immunization when members receive reminders, Colorado Access implemented the 14-month reminder mailing in November 2004. (EPSDT Interventions)

In November 2003, Colorado Access began distributing age-appropriate information to members before their birthday to remind children and teens about care they should receive. (Open Enrollment Letter and Survey 11-03, Open Enrollment Letter and Survey 12-04) See attached flyers that are included in response to question #3 of this survey.

Colorado Access also recently developed two low-literacy, easy-to-comprehend, one-page documents to help members understand the immunizations that children and teens need. (Immunizations for Babies, Children and Teens Vaccine Chart) Future strategies will be determined by the new Health Outcomes unit. Please see the list of member communications with implementation dates under question #3 of this survey for other materials used to assist members.

Baseline Questions and Requested Documentation
Securing member contact information Colorado Access utilizes a number of mechanisms to secure reliable member contact information. These include verifying member demographics as a part of each member call to Customer Service; obtaining information during the assessment of patients for care management or disease management; and accessing information from entities providing care such as primary care and specialty provider offices, county case workers, and inpatient facilities. Transportation Colorado Access has developed a list of resources to ensure transportation access when asked.
13. What issues have been identified with providers or clinics (e.g., they do not submit encounters, complain about reimbursement, or are not sure what EPSDT services are covered) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings? Through data analysis and provider feedback, Colorado Access has identified barriers that potentially impact the provision of EPSDT services by providers. Lack of reliable member contact information When discussing the issue of EPSDT visits with contracted providers (and as discussed previously in response to question #12), the most common barrier to outreach is lack of reliable contact information. While practitioners indicate that if the member accesses services, they receive well care, and the health care centers utilize immunization registries as well as other strategies to engage the member and encourage well care, providers are limited when it comes to outreach to members who are assigned to their practice. This is even more difficult for new members who have not contacted the provider to request care. Additionally, Colorado Access has found through the care management program that reliable contact information is not available for at least 30 percent of the membership population. This makes it very difficult to reach these members. Missed opportunities and provider education Analysis of the zero visits associated with the HEDIS Well-Child Visits in the First 15 Months of Life measure revealed 13 percent of children did not access services through Colorado Access while 74 percent of children accessed services for episodic care and did not receive well care during these visits. Systemic Issues As noted previously, Colorado Access has also found that with the increasing number of children with special health care needs in the Colorado Access plan, there are children who are receiving their EPSDT services in the context of a sick visit. Directions used to complete the CMS-416 form do not allow these visits to be counted as an EPSDT encounter, unless

Baseline Questions and Requested Documentation

they are coded with one of the well visit designations. Because this excludes well care that may have been provided (retrievable on through medical record review), it contributes to potential under-reporting and impacts outreach efforts.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

03-04 Evaluation FINAL for HCPF submission 9-17-04
MQIC Minutes 8/5/03
MQIC Minutes 9/2/03
MQIC minutes 8/3/04
MQIC Minutes 9/7/04
MQIC Minutes 11/2/04
EPSDT Report 2000 - 2003
EPSDT Research Summary
Cervical Cancer Screening

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

Securing member contact information
Colorado Access utilizes a number of mechanisms to secure reliable member contact information. These include verifying member demographics as a part of each member call to Customer Service, obtaining information during the assessment of patients for care management or disease management, and accessing information from entities providing care such as primary care and specialty provider offices, county case workers, and inpatient facilities.

Missed opportunities and provider education
Provider education continues, noted in question #4 of this survey.

In addition to the activities noted in question #4 above, Colorado Access is exploring best practices among providers with a high percentage of HEDIS completion rates to determine if strategies might be adopted and implemented throughout the network.

Systemic Issues

- Colorado Access is interested in working collaboratively with other Medicaid plans and HCPF to determine opportunities to enhance reporting using the CMS-416 report.

Baseline Questions and Requested Documentation

14. Please add any comments you have in regards to potential EPSDT collaborative interventions, Medicaid program improvements (such as reimbursement, eligibility, dissemination of EPSDT requirements), or other pertinent information as it relates to the provision of EPDST services.

Colorado Access would like to participate in an open forum with the state and other health plans to discuss how EPSDT visits are defined administratively, to identify best practice or in other benchmarking projects. Colorado Access is willing to collaborate with the other plans to implement common programs with common messages. The joint data project undertaken to decrease the use of unnecessary antibiotic use throughout all health plans in Colorado has been very successful and could serve as a model for future collaborative projects. We would also like to receive more complete racial and ethnicity data that would allow for more focused interventions and evaluations. The scarcity of this information on the eligibility files does not allow for analysis on disparities in the Colorado Access population that could inform new interventions. Colorado Access would also support a statewide immunization registry, shared information on wrap-around services and a standard mechanism for identifying special needs children so they could be targeted for specific interventions immediately upon enrollment.

Colorado Department of Health Care Policy & Financing
Completed MCO Questionnaires
Colorado 2004–2005 Focused Study Evaluation of EPSDT Services

The Colorado Department of Health Care Policy & Financing (the Department) is working to improve Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for the Colorado Medicaid Program. The Department requires that every member enrolled in the Colorado Medicaid program and who is less than 21 years of age receive an EPSDT visit annually. The provision of EPSDT services can prevent and/or identify potential health problems in individuals, which left untreated, may result in serious health-related problems and substantial costs to the health plans.

Despite the benefit to health plans to improve EPSDT screening, the rates for EPSDT visits and the provision of EPSDT services in Colorado remain low. The Department, in conjunction with the health plans and Health Services Advisory Group, Inc. (HSAG), has selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that negatively impact the provision of EPSDT services. As part of the focused study, HSAG will conduct an EPSDT provider survey to determine possible barriers providers recognize that potentially impact the provision of EPSDT services. In addition to the provider survey, the Department would like information from the health plans concerning their processes for monitoring/tracking EPSDT visits, and what efforts (ongoing as well as those in the planning stage) have been taken to increase the provision of EPSDT services to their members.

The following baseline questions have been designed to help the Department identify potential systemic issues.

Baseline Questions and Requested Documentation
Please provide complete, detailed information. Based on the information provided back to us, additional questions or documentation may be requested.
MCO Name: Denver Health Medicaid Choice

Baseline Questions and Requested Documentation

1. Does your health plan have a person or department responsible for tracking or monitoring EPSDT visit rates?

☒ **Yes** ☐ **No**

Who is that person/department?

Erica Gosselin, Care Management Coordinator and Ivette Villalobos, Data Analyst

There will be an additional staff person in the spring of 2005, who will be dedicated to EPSDT tracking and monitoring.

2. Please describe the process for monitoring /tracking EPSDT visits.

The process is as follows: EPSDT visits are identified through DHMC's claims system. The Managed Care Information Systems Department's Data Analyst pulls data, biannually, identifying Medicaid Choice eligible members with either no encounters since enrollment or only specialty service encounters (e.g., Emergency Room, Urgent Care, Specialists) since enrollment. The report is run against the Aged, Blind and Disabled member database, identifying Medicaid Choice Special Need members, including EPSDT, not accessing services.

Once the data is collected, the Care Management Coordinator records members in a database entitled "No PCP encounters." Members included in the database are sent an educational letter reminding them to visit their Primary Care Provider. EPSDT members are also sent preventive guidelines and an EPSDT brochure issued by the Department of Health Care Policy & Financing.

3. What type of information on EPSDT services does your health plan send to members?

A. EPSDT educational brochures, issued by the EPSDT office at the Department of Health Care Policy & Financing, will be sent to all new members at the time of enrollment.

B. Members identified on the "No PCP Encounter" database currently receive a reminder to visit their Primary Care Provider.

How often?

A. Ongoing

B. Quarterly

Baseline Questions and Requested Documentation

4. What type of information on EPSDT services does your health plan send to providers?

Provider Newsletter

E-mail information

"Draft" Provider Manual

How often?

E-mails sent prior to the sending of the EPSDT survey

Quarterly Provider Newsletters

5. What information and/or data does you health plan receive from the Department about EPSDT services?

A. EPSDT contract language and requirements.

EPSDT informational brochures in both English and Spanish.

How often?

A. The contract is updated annually and other materials are made available upon request.

6. Please describe how providers are reimbursed (e.g., fee-for-service, capitated) for EPSDT visits.

100 percent capitated for primary care providers.

DHMC has a small number of members who receive corrective treatment services outside of Denver Health and would be fee-for-service.

Baseline Questions and Requested Documentation

7. For providers who deliver EPSDT services (FP, GP, IM, and PED), what percentage of providers are capitated versus fee-for-service?

100 percent capitated for primary care providers.

DHMC has a small number of members who receive corrective treatment services outside of Denver Health and would be fee-for-service.

8. Please provide a flow diagram and describe the EPSDT claims or encounter submission process. Note: Submit flow diagram with desk review documentation.

DESCRIPTION OF CLAIMS OR ENCOUNTER SUBMISSION PROCESS:

Claims may be received in paper form or electronically. Paper claims may be sent to a post office box from which a courier retrieves the claims every business day. Paper claims are delivered by the courier to the HMO Clerk, who opens the mail, date stamps the paper claim as to day of receipt, and batches the claim into batches of 50 or less. Large dollar claims are photocopied and brought to the attention of the Claims Manager, and, at her discretion, the Manager, HMO Finance. Batch totals are entered by the HMO Clerk into an Excel spreadsheet that shows the day received, the number of claims in the batch, and the total billed charges in the batch. Claims are entered by claims staff. When a batch is completed, the HMO Clerk enters the amount of non-denied billed charges in the batch, and the net amount allowed (paid) on the batch. If a claim could not be keyed (for example, the member has never been in the managed care plan), then it is noted, with the reason. The Claims Manager, and the Manager, HMO Finance, review the log to ensure all batches are accounted for.

Claims may be received electronically, if the provider/vendor contacts the Director of Provider Contracting to set up the process. Test files are received first and reviewed prior to the initiation of production receipt of paper claims.

Weekly, the Claims Manager runs edit reports on the claims ready to be paid. Those edits include:

- Reports of claims with blank company codes.
- Check run edit.
- Listing of claims lines with blank status.
- Due date audit.

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- DHMP or DHMCD denials.
- Claims billed with ICD9 procedures.
- Claims for member over 65.
- Vendors with negative balances.
- Check run edit report.

When the editing process is complete, the Claims Manager notified the Manager, HMO Finance, and the Financial Analyst of the total dollar amount to be paid. The Financial Analyst contacts Denver Health's accounts payable department to get the beginning check number. The Financial Analyst or Manager, HMO Finance, runs the following processes in the claims system:

APUPD: Sets to payable all non-denied non-held claims in the system for the specific line of business designated. A report is printed giving each claim line and the net amount, provider name, and member ID number. A journal entry is shown at the end of the report giving the appropriate expense entry for the claims. This is reviewed by the Financial Analyst and the Manager, HMO Finance, prior to proceeding in the process.

FINAL: Sets as fully adjudicated all non-denied non-held capitated claims in the system for the specific line of business.

CKPRT: Causes the claims system to create an electronic file of checks, using the starting check number supplied by accounts payable and using the check date input. This process creates a payment record for every payable claim processed in the APUPD process, and summarizes all claims by vendor, and creates an electronic remittance advice.

CKREG: A check register is created and printed and agreed to the total of APUPD

CKPST: This "posts" the checks created; if no CKPST is run, the checks can be cancelled and re-run if an error is found after the CKPRT process.

Payment authorization: A Denver Health payment request form is created by the Financial Analyst or Manager, HMO Finance. The APUPD printout and the check register is attached. This is sent to the Denver Health Director of Managed Care for review and signature. It is also sent to the Denver Health Budget staff for review and signature. The payment authorization covers all claims checks to be issued and has the total check run amount on it. When signed, it is returned to the Manager, HMO Finance, or Financial Analyst.

GENRL: A special program is run, specified by check date, that takes the claims systems electronic file of checks, and the general ledger distribution created for those checks, and uploads them into Denver Health's Lawson accounts payable system. The Financial Analyst or

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Manager, HMO Finance, reviews the results in Lawson to ensure the check detail, totals, and expense distribution is correct. When correct, accounts payable is notified that the checks are ready to be created, given the number of checks, the check run total, the check date, the first check number, payee, and amount, and the last check number, payee and amount. Accounts payable staff use this information to ensure the Lawson checks actually produced agree with the detail provided.

Printing and Mailing: The Claims Manager supervises the printing of the remittance advices from the claims system, and has two copies made. One copy is delivered to accounts payable, with a copy of the APUPD printout, and the signed payment request. Accounts payable staff prints the checks and compares the check amount to the total on the remittance advice, and mails the checks with the remittance advices. When checks are issued, the Lawson accounts payable (a/p) system interfaces with the Lawson general ledger to debit the expense accounts, and credit cash on the general ledger.

Reconciling: The Financial Analyst prints a check register from Lawson and agrees to the claims system check register. Monthly, a paid by incurred date report is created and printed from the claims system, which is reconciled to the dollar amount of checks paid that month by the Lawson system. This is also agreed to the Lawson general ledger expense for claims payments. Denver Health Finance receives the bank statements and reconciles the bank statement to the general ledger balance. Old outstanding checks are subject to escheat in accordance with Colorado law.

Monitoring: The Claims Manager, Financial Analyst, and Manager, HMO Finance, review the claims batch log every month end to determine the inventory of claims on hand. In addition, statistics regarding the number of claims processed are maintained. This inventory and statistics are provided to the Director of Managed Care monthly. In addition, the Claims Manager monitors daily inventory, to keep the claims inventory within reasonable limits, and may request overtime for claims personnel, if necessary. Non-capitated payable claims are monitored monthly for timely payment. A report in the GENRL section of the claims system, run monthly, lists all paper claims paid after 45 days of receipt, and all electronic claims paid after 30 days of receipt. This report is reviewed to ensure there were no COB issues on the claim, and that the claim was clean. If clean, then penalty and interest is calculated as set by State law, and a liability accrued. Once the payment amount to any vendor is $5 or greater, a check is issued. The Claims Manager also meets with Denver Health's Assistant General Counsel to review all possible subrogation issues. The Assistant General Counsel directs managed care on release of information requests, and pursuit of recovery, if appropriate. Any subrogation recoveries are credited on the general ledger as a subrogation receipt, which reduces overall claims expense. Denied claims are also monitored by running a weekly report (with each check run) on claims that were denied. This report is reviewed by the Manager, HMO Finance, to ensure no inappropriate denials are evident, and if so, that the appropriate corrective action is taken. In addition, feedback may be provided to the Manager of Contracting so that unclear issues regarding billing specifications may be resolved.

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Reinsurance: The Denver Health Managed Care Medical Management staff notifies the Financial Analyst of any potential high dollar claim, based on length of stay and location of stay, based on criteria provided by the Manager, HMO Finance. A reinsurance notification is done by the Financial Analyst if the claim meets the criteria set forth for notification by the reinsurer. The Claims Manager is notified of any hospitalizations, and has a tickler file of members for whom the claim, when received, must be copied for the Financial Analyst. When the claim is paid, a copy of the check, remittance advice and claim is provided to the reinsurer. When there is a claim due, the Financial Analyst completes a reinsurance claim form, which is reviewed by the Manager, HMO Finance, and submitted to the reinsurer. A journal entry is made recorded a reinsurance recovery and a reinsurance receivable. When the cash is received, the receivable is credited.

IBNR: The Manager, HMO Finance, provides a qualified actuary with the monthly claims paid by incurred date schedule, the reconciliation of the claim lag to the financial statements, and information as needed regarding high dollar claims payments, and expected future high dollar payments for current dates of service. The actuary provides a monthly estimate of IBNR, which is recorded on the general ledger after discussion with Denver Health's Director of Managed Care, Assistant CFO, and CFO.

The following segregation of duties exists:

No claims personnel may enter or change a member, provider, or vendor record. No claims personnel may run APUPD, FINAL, CKPRT, or CKPST. Provider Contracting is responsible for all provider and vendor additions or changes. Neither the Claims staff, the Manager, HMO Finance, or the Financial Analyst can add or change member, vendor or provider records. Neither the Manager, HMO Finance, Financial Analyst, claims staff, or any managed care staff has access to create checks in Lawson, and does not have access to blank check stock, nor do they mail or handle checks at all—this is all done by a/p staff at a remote location off-site. No accounts payable staff has access to the claims system. No managed care staff, or accounts payable staff, has access to the cancelled checks. Bank statements and cancelled checks are received directly by Denver Health Finance.

Coverage of Out-of-Network Service

Claims with emergency room codes are automatically paid without requirement for authorization. Inpatient admits that result from an emergency department visit may be reviewed by Medical Management, if no notification was performed. The emergency inpatient stabilization period for the member will be authorized if there is documented medical necessity. If Medical Management receives notification of the stay, concurrent daily review will be performed. They may elect to deny subsequent stay days, if according to clinical criteria there was no medical necessity. No timely filing limit is imposed on non-contracted providers for emergency claims. Contracted providers are held to the timely filing limit specified in their contract. Providers are notified that they may request an extension to the timely filing requirement, if extenuating circumstances exist. Outpatient Renal dialysis claims require prior

Baseline Questions and Requested Documentation
authorization by Medical Management to pay. The organization would, and does, use the NAIC coordination of benefit rules, as adopted by the Colorado Division of Insurance to ensure that no duplicate payments are made and that the order of payment as primary or secondary is correct. Member handbooks include information about coordination of benefits and the members' responsibility to provide information regarding other coverage upon request. The claims system has the benefit rules set to pay items such as these based on the allowable amount, be it a fee schedule or set dollar amount. The claims system is capable of paying the provider directly, or reimbursing the member, whichever is appropriate.
9. Are EPSDT claims/encounters submitted on standard CMS 1500 forms, home-grown EPSDT forms, or both? Claims and encounters are submitted on CMS 1500 and UB 92's. DHMC does not use any non-standard forms. **Please provide an example copy of each type of <u>Non-Standard</u> form used. (Submit with desk review documentation.)**
10. Does your health plan use only standard ICD-9-CM and CPT-4 codes, or can EPSDT visits be submitted with home-grown codes or State codes? Claims and encounters are submitted on CMS 1500 and UB 92's. DHMC does not use any non-standard forms.

Baseline Questions and Requested Documentation

11. Please provide the volume of claims/encounters and the volume of EPSDT visits submitted monthly for calendar year 2004.

	MAY	JUNE	JULY	AUGUST	SEPTEMBER	TOTALS
VOLUME OF CLAIMS	308	252	372	7032	4773	12737
VOLUME OF EPSDT VISITS	25	11	43	790	271	1140
VOLUME OF LEAD VISITS	6	4	8	75	41	134

12. What issues have been identified with members (e.g., canceling appointments or transportation problems) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings?

DHMC started in May of 2004 with approximately 1,600 members through August of 2004. In August of 2004 the membership grew to a total of approximately 14,000 members. The first EPSDT report submitted was based on five months of data, from May through September 30, 2004.

We have not identified any issues that may negatively impact the provision of EPSDT services. Many of the Denver Health Clinics, namely two of the larger clinics westside and eastside, are on major buslines. During the Welcome Calls made to new members, DHMC staff ask about the transportation needs of the member and have found that taking the bus is the number one need.

The Care Management program is currently identifying members not accessing EPSDT services. As noted above, the Care Management Coordinator records members in a database entitled "No PCP Encounters." Members included in the database are sent an educational letter reminding them to visit their Primary Care Provider. EPSDT members are also sent preventive guidelines and an EPSDT brochure issued by the Department of Health Care Policy & Financing.

Reports are run quarterly and matched to the "No PCP Encounters" database. Members who continue to not access services will be contacted via phone. Reasons preventing members from accessing services will be documented and an analysis will be conducted.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

Baseline Questions and Requested Documentation

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

Letters and brochures were sent to members in January 2005.DHMC will analyze this effort as we run quarterly, no-PCP-visit reports. We will look at ways we can assist providers and have plans to inservice internal staff and providers about EPSDT.

13. What issues have been identified with providers or clinics (e.g., they do not submit encounters, complain about reimbursement, or are not sure what EPSDT services are covered) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings?

Since our Denver Health Providers are capitated and familiar with Medicaid there have not been provider issues brought to our attention. We feel that there may be missed opportunities for patients who only access care through emergency or urgent care.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

The Care Management program is tracking the utilization of the Emergency Department and Urgent Care for children 0–20 years old who qualify for EPSDT services. If members are utilizing these services three or more times per calendar year, they are sent an educational letter informing them about Denver Health services (Nurse Line, PCP clinics, etc.), as well as a reminder to follow-up with their PCP. Members continuing to frequent the Emergency Department and/or Urgent Care will be contacted for follow-up.

Baseline Questions and Requested Documentation

14. Please add any comments you have in regards to potential EPSDT collaborative interventions, Medicaid program improvements (such as reimbursement, eligibility, dissemination of EPSDT requirements), or other pertinent information as it relates to the provision of EPSDT services.

DHMC is CURRENTLY working with Kiera Zapien who is on-site at Denver Health and affiliated with EPSDT through HCPF. * Kiera has resigned effective 2/25/05.

Denver Health Medicaid Choice will be educating staff and providers about EPSDT.

We feel that EPSDT updates through the HMO Association meeting would be helpful.

Colorado Department of Health Care Policy & Financing
Completed MCO Questionnaires
Colorado 2004–2005 Focused Study Evaluation of EPSDT Services

The Colorado Department of Health Care Policy & Financing (the Department) is working to improve Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for the Colorado Medicaid Program. The Department requires that every member enrolled in the Colorado Medicaid program and who is less than 21 years of age receive an EPSDT visit annually. The provision of EPSDT services can prevent and/or identify potential health problems in individuals, which left untreated, may result in serious health-related problems and substantial costs to the health plans.

Despite the benefit to health plans to improve EPSDT screening, the rates for EPSDT visits and the provision of EPSDT services in Colorado remain low. The Department, in conjunction with the health plans and Health Services Advisory Group, Inc. (HSAG), has selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that negatively impact the provision of EPSDT services. As part of the focused study, HSAG will conduct an EPSDT provider survey to determine possible barriers providers recognize that potentially impact the provision of EPSDT services. In addition to the provider survey, the Department would like information from the health plans concerning their processes for monitoring/tracking EPSDT visits, and what efforts (ongoing as well as those in the planning stage) have been taken to increase the provision of EPSDT services to their members.

The following baseline questions have been designed to help the Department identify potential systemic issues.

Baseline Questions and Requested Documentation

Please provide complete, detailed information. Based on the information provided back to us, additional questions or documentation may be requested.

MCO Name: Rocky Mountain Health Plans

1. Does your health plan have a person or department responsible for tracking or monitoring EPSDT visit rates?

☒ **Yes** ☐ **No**

Who is that person/department?

The Government Operations department is responsible for the coordination of EPSDT. They head up a multi-departmental groups that works on EPSDT visit rates.

Baseline Questions and Requested Documentation

2. Please describe the process for monitoring /tracking EPSDT visits.

The EPSDT group monitors the annual HCFA416 report as well as a quarterly run version of this report. The group also reviews the annual HEDIS measures dealing with EPSDT components. The ESPDT group has developed a policy and procedure that outlines the process for this review.

3. What type of information on EPSDT services does your health plan send to members?

The Member Handbook, member newsletter article, new member welcome calls, immunization reminder cards contain information regarding EPSDT services. Information is distributed and collected during the postpartum calls or screenings that are done by the OB coordinators.

How often?

The member handbook and a member newsletter article is sent out annually. Welcome calls are made at the time of enrollment. Immunization reminder cards are sent at 12 and 18 months of life. Information is given, distributed and collected during the postpartum calls or screenings that are done by the OB coordinators following delivery.

4. What type of information on EPSDT services does your health plan send to providers?

EPSDT information is included in the Provider Manual, provider workshops, and provider newsletter. Reminders on children turning 15 months are sent to reminder providers to get immunizations up to date.

How often?

Provider Manual is sent out annually, workshops are done every one to three years, a provider newsletters article is done annually, and immunization reminders are sent quarterly.

Baseline Questions and Requested Documentation
5. What information and/or data does you health plan receive from the Department about EPSDT services? Workshops are done for RMHMC staff. No data has ever been sent to RMHP by State Medicaid. How often? Every two to three years.
6. Please describe how providers are reimbursed (e.g., fee-for-service, capitated) for EPSDT visits. All are fee-for-service at the same rate of reimbursement as for commercial members.
7. For providers who deliver EPSDT services (FP, GP, IM, and PED), what percentage of providers are capitated versus fee-for-service? 100 percent are fee-for-service.

Baseline Questions and Requested Documentation
8. Please provide a flow diagram and describe the EPSDT claims or encounter submission process. Note: Submit flow diagram with desk review documentation.
9. Are EPSDT claims/encounters submitted on standard CMS 1500 forms, home-grown EPSDT forms, or both? Only submitted on a CMS 1500 form. **Please provide an example copy of each type of <u>Non-Standard</u> form used. (Submit with desk review documentation.)**
10. Does your health plan use only standard ICD-9-CM and CPT-4 codes, or can EPSDT visits be submitted with home-grown codes or State codes? RMHP is HIPAA-compliant, no homegrown codes are utilized.
11. Please provide the volume of claims/encounters and the volume of EPSDT visits submitted monthly for calendar year 2004. RMHP does not calculate volume of claims for EPSDT visits monthly. There were 6,735 visits over a 12-month period, with an average of 561 visits per month.

Baseline Questions and Requested Documentation

12. What issues have been identified with members (e.g., canceling appointments or transportation problems) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings?

RMHP EPSDT group is looking at the HEDIS measures to see what visits are being missed in the first 15 months of life. We feel that we are not capturing data for the first visit after birth and up to the 2 months of life. RMHP works with the Mesa, Montrose, and Delta county health departments to coordinate EPSDT services for our members. This results in great coordination of care and increased use of services. RMHP educates new mothers during the postpartum follow up call on the importance of getting the newborn exam and starting immunizations. Well care guidelines and immunization schedules are published annually in the provider newsletter, are available on the Web site,. and are included in the Provider Manual. We monitor member concerns and complaints but, to date, we have had no complaints regarding access to services.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

RMHP send members reminder cards to get immunizations completed. We have an incentive program to get immunizations completed by the age of two years. Welcome calls identify new members who need assistance, case management or who have special needs. RMHP Customer Service assist members in finding the right provider to meet their needs.

Baseline Questions and Requested Documentation

13. What issues have been identified with providers or clinics (e.g., they do not submit encounters, complain about reimbursement, or are not sure what EPSDT services are covered) in your health plan that may negatively impact the provision of EPSDT services? Are these issues anecdotal, or has your health plan conducted analysis that supports these findings?

Patients have problems getting on Medicaid and getting their Medicaid cards. Providers have problems verifying eligibility. This is especially true for newborns; it can take up to 90 days to get them onto Medicaid. There are no provider complaints about reimbursements as RMHP reimburses at the same rate for Medicaid services as for commercial members. One issue is that diabetes education by a non-physician (CDE or RD) is not a covered benefit for Medicaid members, which leaves a gap in their care.

Please provide any reports or documentation that support these findings. (Note: Submit with desk review documentation.)

What efforts have been taken, based on these findings, to increase the provision of EPSDT services? When were these efforts implemented? Are additional interventions planned, and, if so, what are they and when will they be implemented?

Sending immunization reminders; publishing articles in provider newsletters.

14. Please add any comments you have in regards to potential EPSDT collaborative interventions, Medicaid program improvements (such as reimbursement, eligibility, dissemination of EPSDT requirements), or other pertinent information as it relates to the provision of EPSDT services.

Get members on faster; get newborns on right after birth. All RMHP providers in Medicaid areas that are accepting new patients take RMHP Medicaid members as well as commercial members.

Appendix D. File Layout

The Colorado Department of Health Care Policy & Financing (the Department) is working to improve Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for the Colorado Medicaid Program. The Department, in conjunction with the health plans and Health Services Advisory Group, Inc. (HSAG), has selected EPSDT as a topic for a collaborative focused study this year in order to identify common barriers that negatively impact the provision of EPSDT services. As part of the focused study, HSAG will conduct an EPSDT provider survey to determine possible barriers providers recognize that potentially impact the provision of EPSDT services. In order to conduct the EPSDT provider survey, HSAG will need the following information submitted by December 31, 2004.

Field Name	Type	Description
planname	String	Health Plan Name
clinic	String	Name of Clinic (if applicable)
group	String	Group Practice = Yes of No (if able to identify)
plast	String	Last Name of Provider
pfirst	String	First Name of Provider
provid	String	Unique Provider ID
type	String	Provider Type (FP, GP, IM or PED)
Address1	String	Location of Clinic or Provider
Address2	String	Location of Clinic or Provider
City	String	City
State	String	State
Zip	String	Zip Code of Clinic or Provider
Phone	String	Phone Number of Clinic or Provider
Fax	String	Fax Number of Clinic or Provider
Volume	Numeric	Number of members under (or less than) 21 years of age assigned to Provider

Note: The provider type should be either Family Practice (FP), General Practice (GP), Internal Medicine (IM), or Pediatrics (PED). The location should reflect the practice location (where the medical records are likely to be), rather than the billing address.

The last data element, Volume, is the number of members who are under (or less than) 21 years of age and are assigned to the provider and/or clinic at your health plan as of October 31, 2004.

The information supplied will be used to select samples for a provider survey based on the volume of members assigned to the providers; therefore, it is important to have current provider contact information. For providers with multiple office locations, please provide information for all of their office locations.

The following file layout should be used for this focused study. This file can be in ASCII or dBase IV. If you need to submit using another file format, contact Tom Miller at 602.745.6263, or e-mail: tmiller@hsag.com.