



## ANNEX C: EPSDT Outcomes Mapping Report

Prepared for the Colorado Department of Health Care Policy and Financing  
as part of the Healthy Communities Evaluation Project

May, 2015

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## I. Introduction

The Colorado Department of Health Care Policy and Financing (HCPF) manages a program called “Healthy Communities” across the state to ensure that children and pregnant women on Medicaid or Child Health Plan Plus (CHP+) receive the the health care they need. This care includes preventive care, immunizations, and screening.

Each year the state must submit a report (CMS-416) to the federal government on how many children on Medicaid have received the recommended screenings and well-child visits. Colorado’s performance in recent years on the indicators reported via the CMS 416 has been less than satisfactory. HCPF is currently seeking to better understand the data story behind the report, as one component of a broader evaluation of the Healthy Communities program that is being conducted from April to June of 2015.

The purpose of the present report is to map out the data from the CMS 416 report visually, identify any apparent trends across counties, and highlight counties that are performing well and those that are performing poorly. Based on those findings we we also make recommendations that can help guide other steps in the evaluation process.

## II. EPSDT Data Collection and Reporting

### EPSDT Background

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The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

The state of Colorado is required to provide comprehensive EPSDT services to all eligible children on Medicaid. These services include:

- Screening (health, developmental, immunizations, lead toxicity, health education)
- Vision (diagnosis and treatment for vision defects, including eyeglasses)
- Dental (pain relief, infection treatment, emergency, and preventive care)
- Hearing (diagnosis and treatment for hearing defects, including hearing aids)
- Diagnostic (if a screening reveals need for further evaluation, referrals should be made swiftly and ensure diagnostic evaluation is completed)
- Treatment (all physical and mental illnesses or conditions discovered by screening or diagnosis must be treated)

The state of Colorado is also required by the federal government to:

- Inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age-appropriate immunizations
- Provide or arrange for the provision of screening services for all children
- Arrange (directly or through referral) for corrective treatment as determined by child health screenings
- Report EPSDT performance information annually via Form CMS-416

### Form CMS-416

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The CMS-416 form is used by all of the states to report on EPSDT outcomes to the federal Centers for Medicare and Medicaid Services (CMS). The report includes a number of indicators including:

- Total individuals eligible for EPSDT
- Total months of eligibility
- Total number of screenings per eligible individual
- Expected number of screenings
- **Screening ratio** (total screens received over expected number of screenings)
- **Participant ratio** (how many eligible children participated in screening)

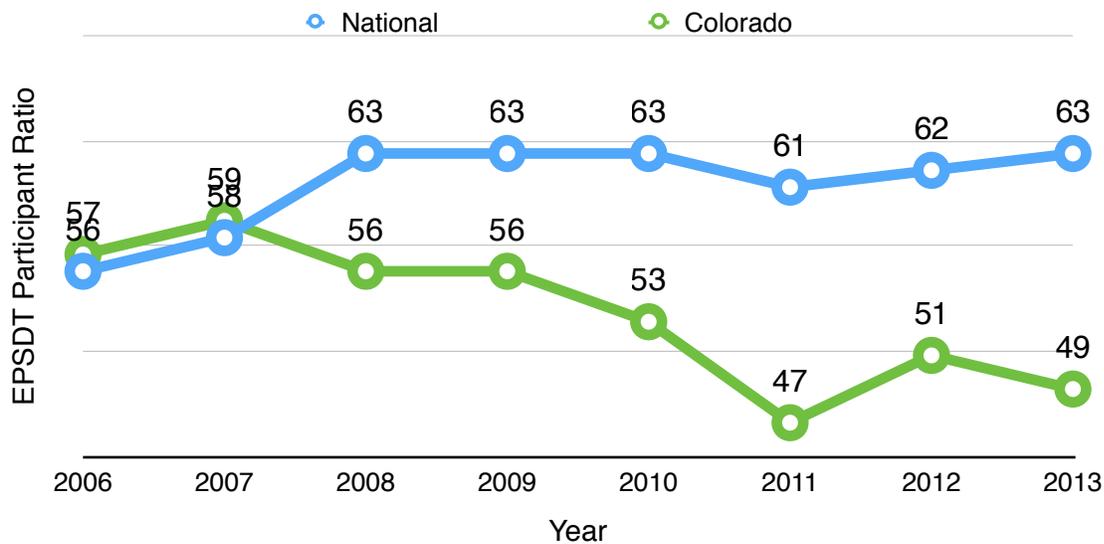
This data is drawn from actual Medicaid claims during the given year, as reported to the Medicaid Management Information System (MMIS) or Medicaid claims database. Data is compiled by staff from the Colorado Department of Health Care Policy and Financing (HCPF) and presented by age group, screening category, and county. The report offers an excellent snapshot and is used to compare states' performance in providing EPSDT benefits to their Medicaid populations.

The federal government expects all states to have an **80% screening ratio** or higher. Colorado's screening ratio in 2013 was only 64%, while the national average was 86%. We recommend also examining the **participant ratio** as it offers a more accurate view of how many children are receiving the necessary well-child visits.

### Colorado EPSDT Results

Since 2007, Colorado's EPSDT results (summarized below by the overall participant ratio) have been steadily dropping while the national average for EPSDT coverage has been rising. By 2013, the national average of state annual participant ratios was at **63%** while Colorado's annual screening ratio had dropped to **49%**. This means that less than 50% of Colorado children on Medicaid receive the number of screenings they should be receiving. Staff at HCPF were alarmed to see how much Colorado's EPSDT outcomes had dropped, particularly in contrast to the national trend. This report seeks to better understand what may account for the poor performance in this arena and identify how to quickly improve results.

**A. Colorado EPSDT Results vs. National Average**



## III. The Healthy Communities Program

“Healthy Communities” is a comprehensive community-based outreach program, financed by the Colorado Department of Health Care Policy and Financing, designed to help families, children and pregnant women receive the appropriate health care services. Through this program, Family Health Coordinators connect families with resources to obtain immunizations, preventive care, and treatment for medical, dental, vision, mental health and developmental problems. All families eligible for Medicaid or CHP+ are encouraged to use these services.

Healthy Communities focuses on the life cycle of a client, which includes all of the activities that must happen for the client to obtain coverage and access to health care services in an appropriate setting. An important part of the Healthy Communities program is to provide education, orientation and follow-up to families to help increase EPSDT outcomes.

While many players contribute to EPSDT outcomes in Colorado (health care providers, Regional Care Collaborative Organizations, other agencies within HCPF), Healthy Communities is the program that has been most directly tasked with boosting EPSDT outcomes among Medicaid and CHP+ clients.

In recent years funding for Healthy Communities has remained stagnant, while caseloads have skyrocketed due to health care reform and a strong push to enroll families in health care programs. With the increased caseload, the Healthy Communities teams are playing a number of additional roles in their communities, which in many cases has made it difficult to maintain their focus on EPSDT outcomes. The program evaluation seeks to better understand and refocus the Healthy Communities program on those activities that are most likely to boost EPSDT outcomes.

### Data Mapping Questions

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In addition to other program improvements, HCPF is exploring the option to implement a pay-for-performance or incentive package to help reward Healthy Communities teams who increase EPSDT results in their counties.

To ensure that the new compensation model takes local challenges into consideration and does not unfairly reward or penalize frontier, rural or urban counties, we are mapping EPSDT and other factors across each county to help identify trends that may be favoring some counties and adversely affecting others. The factors we will be looking at include:

- Type of county (based on population density)
- Ratio of Medicaid primary care providers to eligible Healthy Communities clients
- Distribution of Healthy Communities contractors
- Regional Care Collaborative Organizations
- Screening ratio
- Participant ratio
- Any county outliers (both under-performing and high performing)

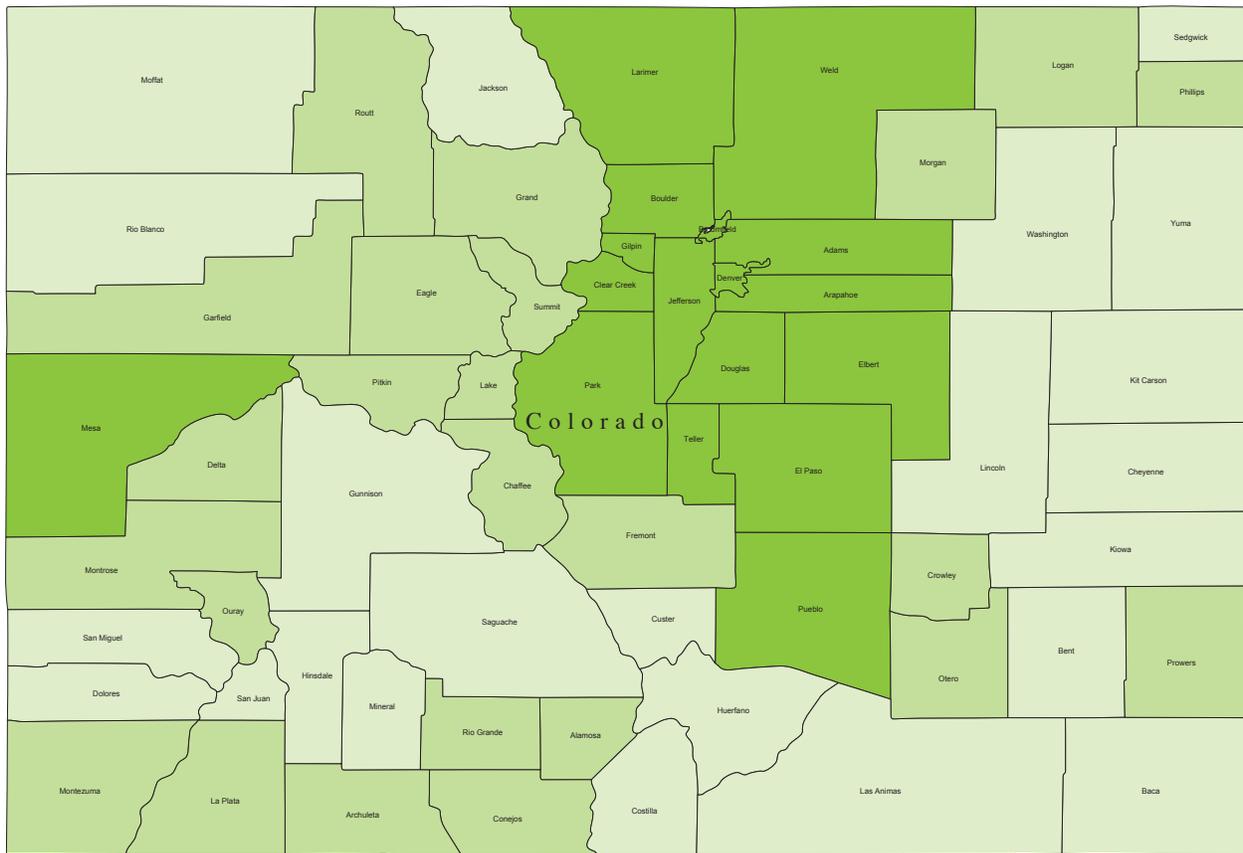
## IV. Mapping Results

All EPSDT data mentioned in this report is FY2013 data (the most recent data available in April 2015). We also found minor discrepancies in data between the report submitted to the federal government and the detailed data spreadsheet given to Upleaf for analysis. The discrepancies were small enough however that they would not significantly change the results presented here.

### Population Distribution

Colorado is a very rural state: 73% of Colorado's 64 counties are rural and only 17 of Colorado's are urban. Among the 47 rural counties 23 are considered "frontier" meaning that they have less than 6 inhabitants per square mile.

#### B. Population Density by County



Population Density by County	Key
Urban	
Rural	
Frontier (less than 6 inhabitants per square mile)	

The rural nature of the state has implications for access to health care, and EPSDT outcomes. Residents in rural counties may have fewer health care options and spend more time in transit to see a provider. For example:

- 13 counties in Colorado do not have a hospital<sup>1</sup>
- 2 counties do not have a hospital, a Rural Health Clinic or a Federally Qualified Health Center.
- 6 counties do not have a licensed dentist or dental hygienist.
- 1 county does not have a licensed physician
- 1 does not have an advanced practicing nurse or a physician assistant
- 12 counties do not have a licensed psychologist or a licensed clinical social worker

There is also an income gap between rural and urban counties; the median household income in rural counties is 26.5% less than the median household income in urban (\$45,307 compared to \$61,642).<sup>2</sup>

## Screening Ratio

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The EPSDT screening ratio is a ratio of the total screenings actually received by Medicaid clients over expected number of screenings among Medicaid clients. Map C below shows the average screening ratio by county, aggregating anticipated and actual screenings across all age groups.

In many cases screening rates among young children (under 3) are very high and reach nearly 100%, while screening rates among older children (10 and up) are very low. Despite these differences between age groups, the screening ratio provides insight into overall county performance and is used nationally as a key performance indicator for EPSDT.

The highest performing counties when measured by the screening ratio are:

- Mesa (100%)
- Gunnison (77%)
- Summit (75%)
- Denver (70%)

The lowest performing counties have screening ratios of:

- Dolores (8%)
- Mineral (9%)
- Hinsdale (14%)
- Ouray (15%)
- Montrose (19%)
- San Juan (26%)

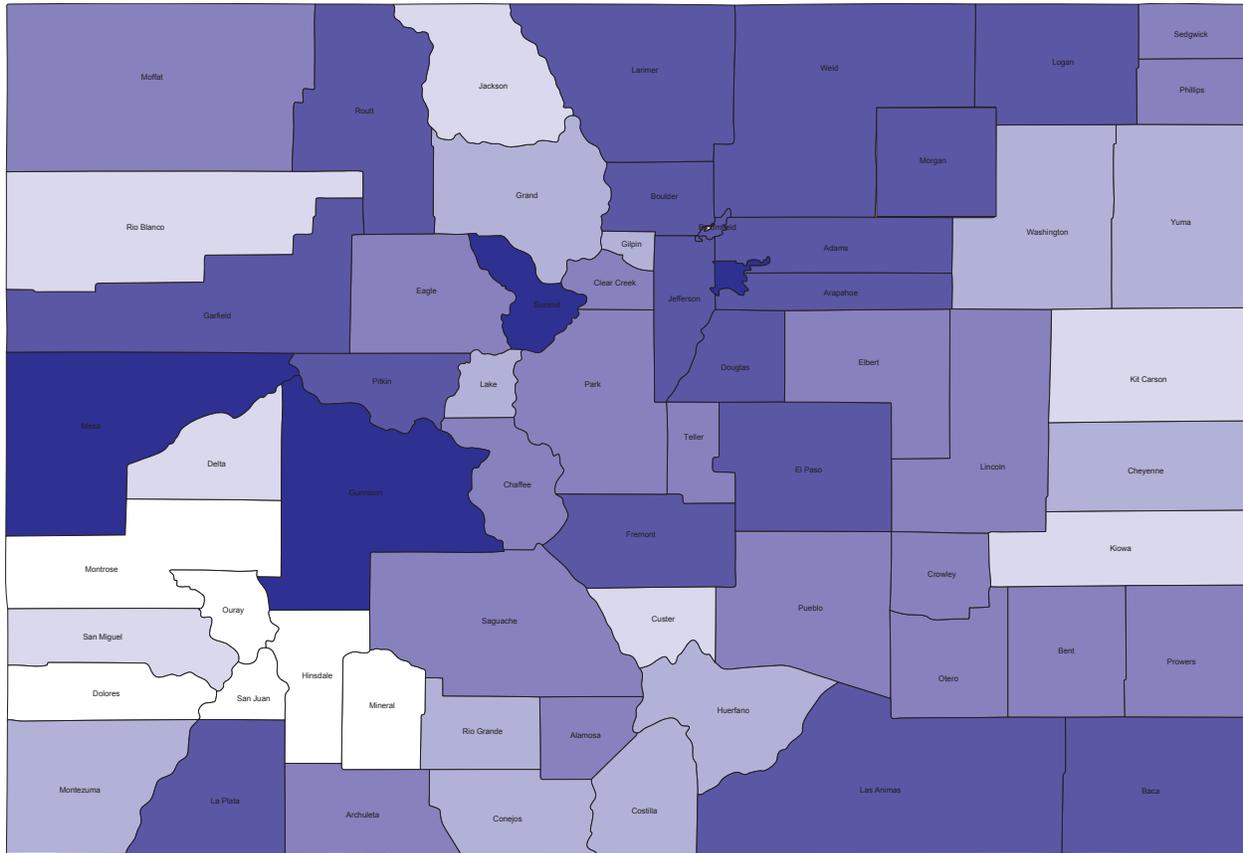
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<sup>1</sup> Colorado Rural Health Center: Snapshot of Rural Health in Colorado 2014 Edition.

<sup>2</sup> Colorado Rural Health Center: Snapshot of Rural Health in Colorado 2014 Edition.

It is important to note that each of the low performing counties have eligible populations of less than 350 people (with the exception of Montrose County which has 5,500 eligible). The overall effect of the poor performance of most of these counties on the statewide screening ratio is insignificant. The screening rates in the higher population density counties are in fact largely responsible for the state's overall numbers.

### C. Screening Ratio by County

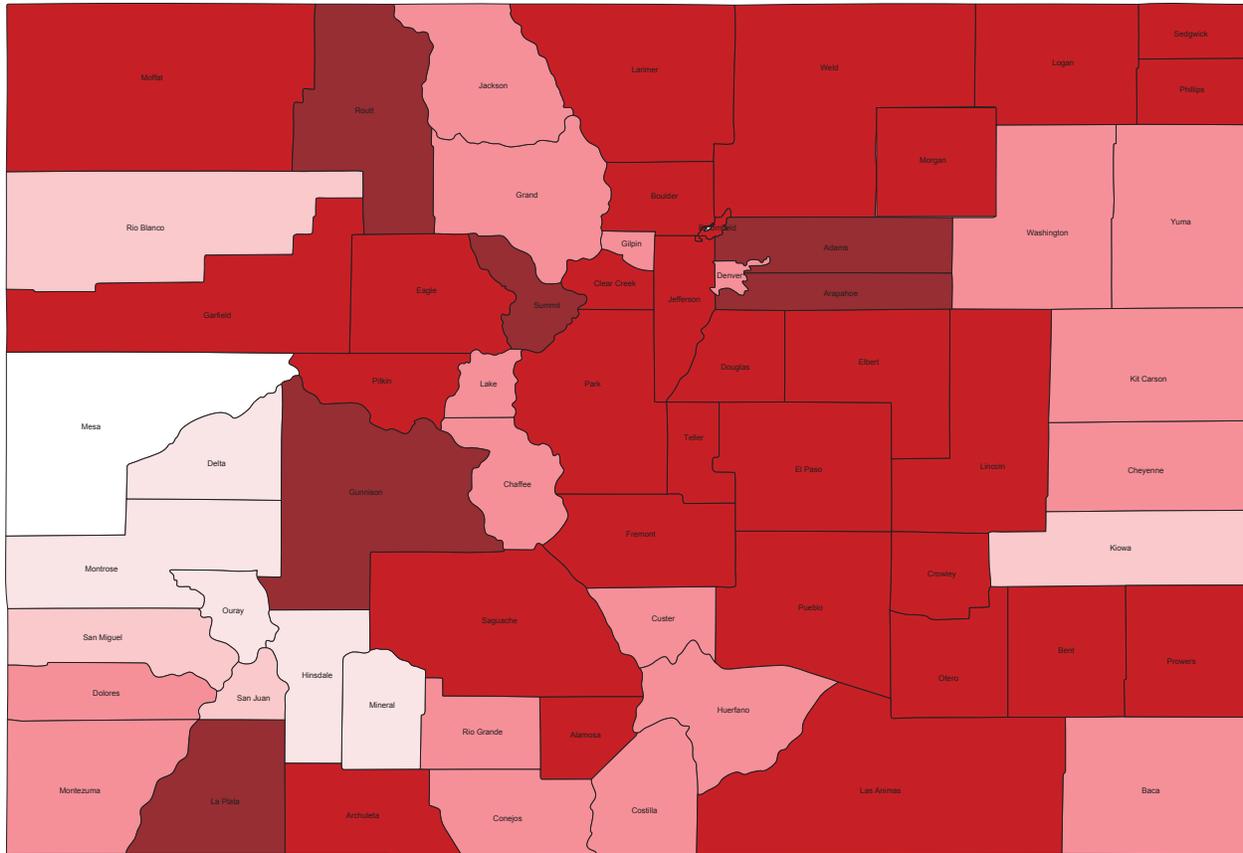


Screening Ratio	Key
1% - 29%	[Lightest Purple]
30 - 39%	[Light Purple]
40 - 49%	[Medium-Light Purple]
50 - 59%	[Medium Purple]
60 - 69%	[Dark Purple]
70%+	[Darkest Blue]

## Participant Ratio

The EPSDT participant ratio is a more accurate reflection of preventive health within the population of children on Medicaid, because the participant ratio looks at how many individual children actually received the recommended screenings. The participant ratio reflects the number of children who have met expectations for their EPSDT screening visits.

### D. Participant Ratio by County



The participant ratio tends to be lower than the screening ratio - across the board - presumably because some families who take their children to all of their well-child visits and screenings exceed the number of expected visits (set at 80%), which effectively skews the screening ratio higher. When looking at results child by child, this effect disappears.

The map of participant ratios by county offers a very different picture of EPSDT performance.

Participant Ratio	Key
1 - 10%	
11 - 19%	
20 - 29%	
30 - 39%	
40 - 49%	
50 - 59%	

Some counties that were high-performing for the screening ratio have now dropped to a lower performance category when examining the participant ratio, notably Mesa County and Denver County. Other counties are consistent high performers including both Gunnison and Summit Counties.

Similarly, other high performing counties have risen to the top of the list, including Adams, Arapahoe, Routt and La Plata Counties which also have high screening ratios.

**We recommend always considering the participant ratio alongside the screening ratio, because it is a more accurate measure of how many children on Medicaid are receiving the recommended well-child checks and screenings.**

## Distribution of Children on Medicaid

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For the State of Colorado to move the needle on EPSDT outcomes, it should focus on geographic areas with the highest concentration of eligible clients.

The total number of eligible children in FY2013 for EPSDT was 518, 128. By May of 2015 it was 570,104. Improving the screening ratio in a county with 60,000 eligible children from 55% to 65% can therefore have a significant impact on Colorado's overall screening ratio, whereas improving screening in a county with 300 eligible children from 15% to 65% will have a negligible impact on the total state screening ratio.

To help identify the counties with the highest concentration of eligible clients, we have organized them into 5 groups based on FY2013 numbers of children on Medicaid from the CMS-416 report.

It is notable that:

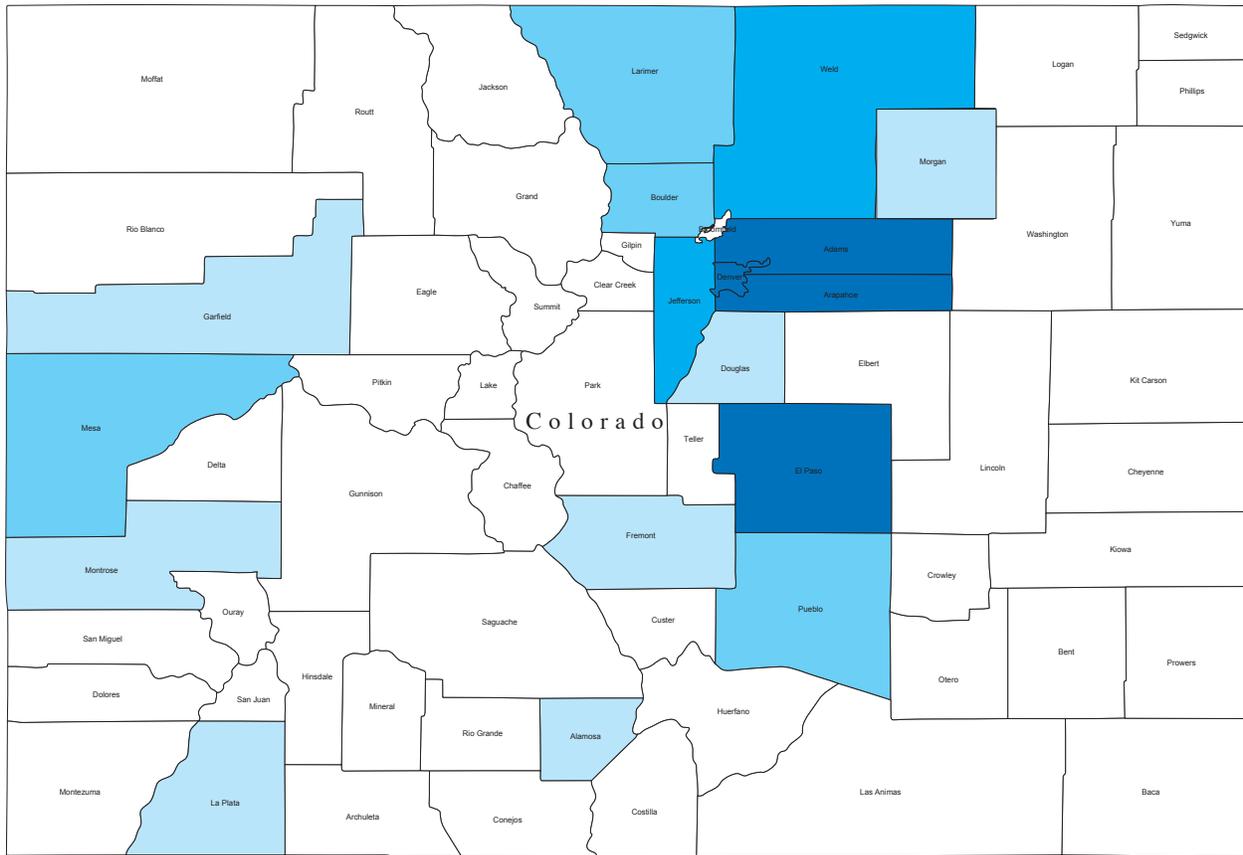
- 4 counties have an eligible population that each represents at least 10% of the total eligible in the state
- 2 counties have an eligible population representing 5% to 9.9% of total eligible
- 4 counties have eligible populations between 2% and 4.9% of total eligible
- 6 counties have populations representing .5% to 1.9% of eligible children
- The remaining 48 counties have eligible populations that represent less than .49% of all eligible children

Later in the report we will take this analysis one step further, and weight each county's influence on overall EPSDT outcomes by both its eligible population of children on Medicaid and the most recent participant ratio. This weighted figure will tell us not only which counties have the highest concentrations of eligible children, but also which have the most influence to sway overall EPSDT outcomes in Colorado if they increase their participant ratios.

This prioritization could help HCPF focus limited resources where they will have the most impact.

The map of eligible children below highlights the counties with the highest concentration of children eligible for Medicaid.

## E. Eligible Population of Children on Medicaid - FY2013



Population of Eligible Children on Medicaid	Key
Less than 3,899 children (less than 0.5% of total eligible)	
Between 3,900 and 10,399 children (0.5% to 1.9%)	
Between 10,400 and 25,999 (2% to 4% of total eligible)	
Between 26,000 and 51,999 (5% to 9% of total eligible)	
More than 52,000 eligible children (10% or more of eligible)	

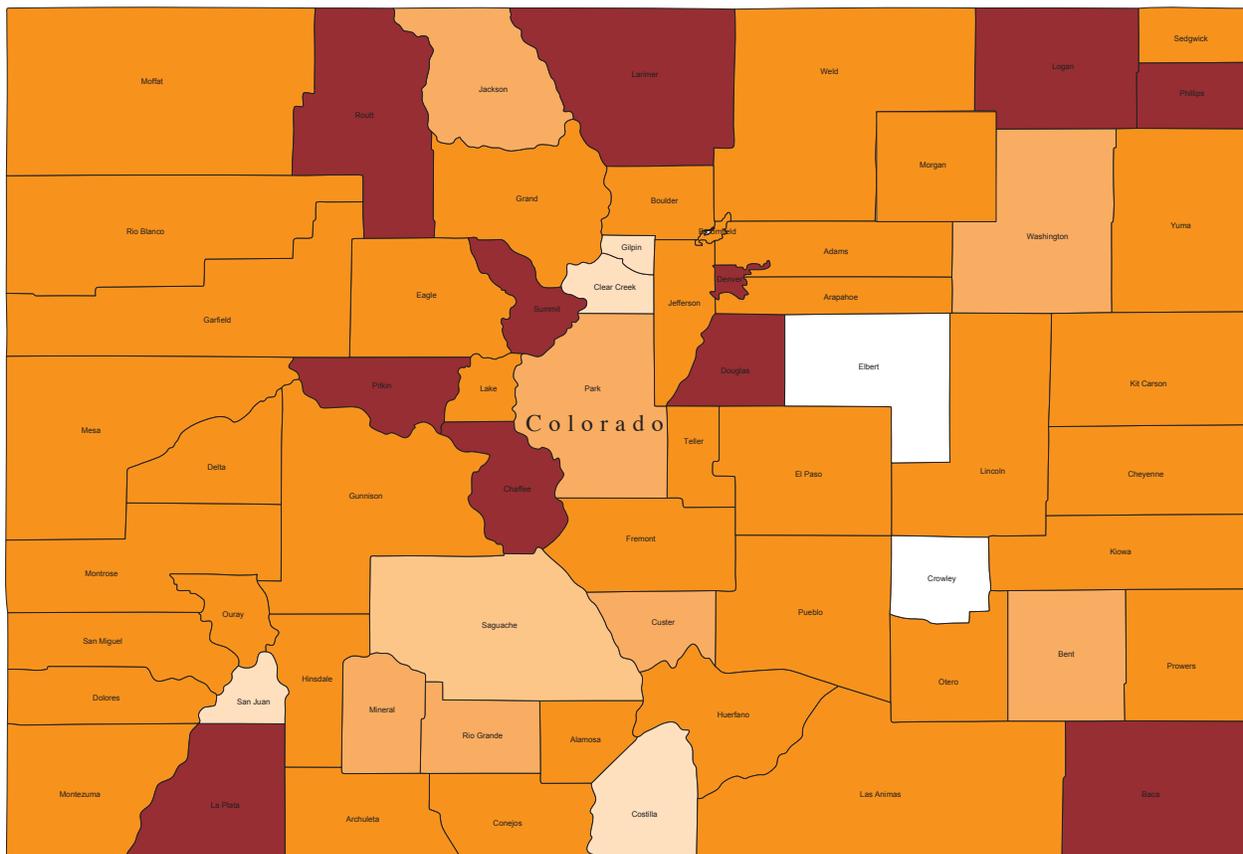
### Distribution of Primary Care Providers

Access to a primary care provider can make a significant difference in EPSDT outcomes. Some counties have many providers but few who accept Medicaid, while in other counties almost all providers accept Medicaid. To get a sense of which counties have easier access and which have more restricted access to primary care for the population in question, we created a **very rough approximation of provider ratio**. The provider ratio equation

reflected in the map below is the number of eligible children on Medicaid in a county (based on CMS 416 data for FY2013) divided by the number of primary care providers that accept Medicaid (pulled from the Healthy Communities CRM database in May of 2015).

**Please note that this is not an official provider ratio because we were unable to factor in provider hours serving Medicaid clients due to lack of availability of that information.**

### F. Eligible Children on Medicaid per Primary Care Provider



Eligible Children per PC Medicaid Provider	Key
More than 200 eligible children per PCMP	[Dark Red]
100 to 199 eligible children per PCMP	[Orange]
76 to 99 eligible children per PCMP	[Light Orange]
51 to 75 eligible children per PCMP	[Light Yellow]
21 to 50 eligible children per PCMP	[White]
Less than 20 eligible children per PCMP	[White]

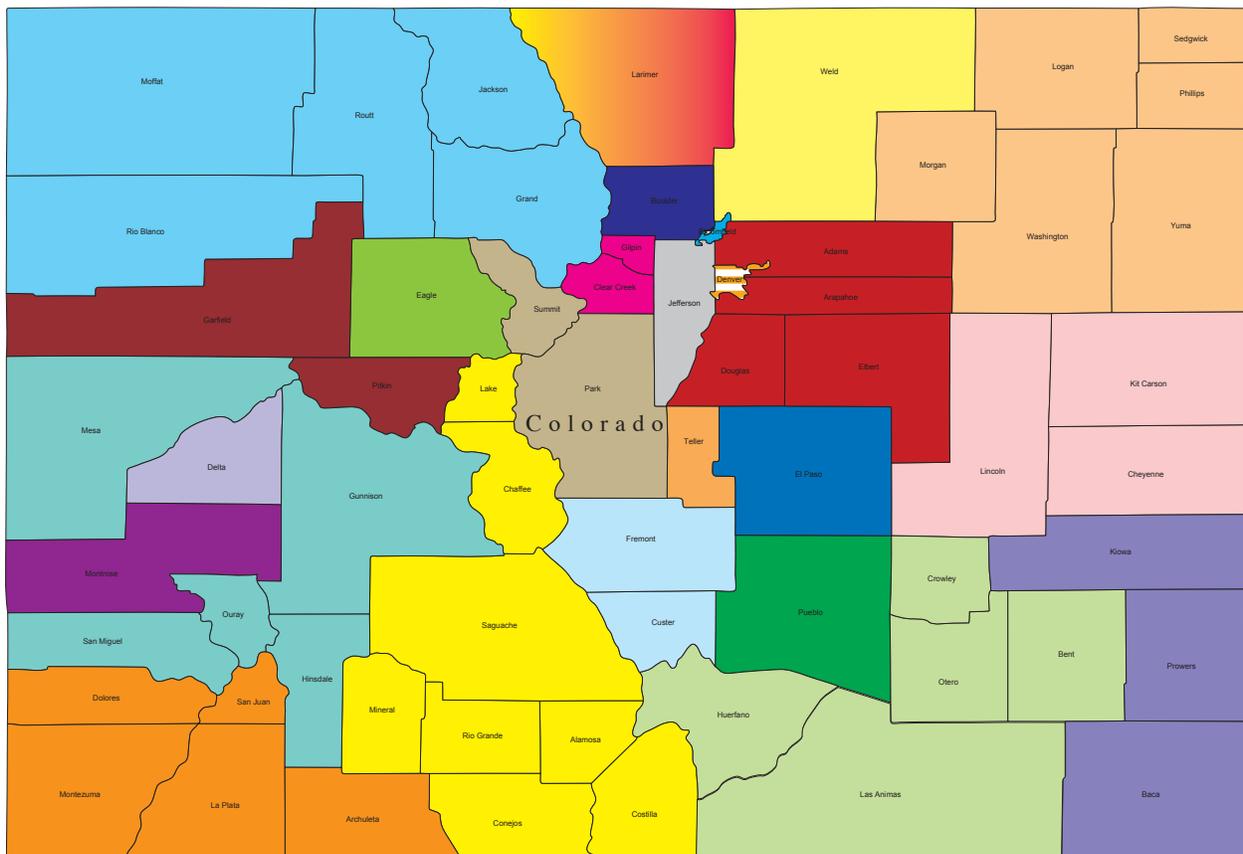
The dark red counties have a large number of primary care providers per eligible children, while the white or light orange counties have much fewer providers per eligible children.

From this very rough and inexact estimate, the vast majority of counties seem to have a sufficient number of primary care providers to serve the number of Medicaid eligible children in their county. A few exceptions are Elbert, Crowley, Clear Creek, Gilpin, Costilla and San Juan Counties. Yet these counties are not necessarily the counties with the lowest screening or participant ratios. It is possible that some of the population centers in these counties are being served by providers in neighboring counties, as we do not see a direct correlation between this map and the participant or screening ratio maps.

## Healthy Communities Program Management

The 64 Colorado counties are covered by a total of 25 Healthy Communities (HC) contractors.

### G. Healthy Communities Contractor Distribution



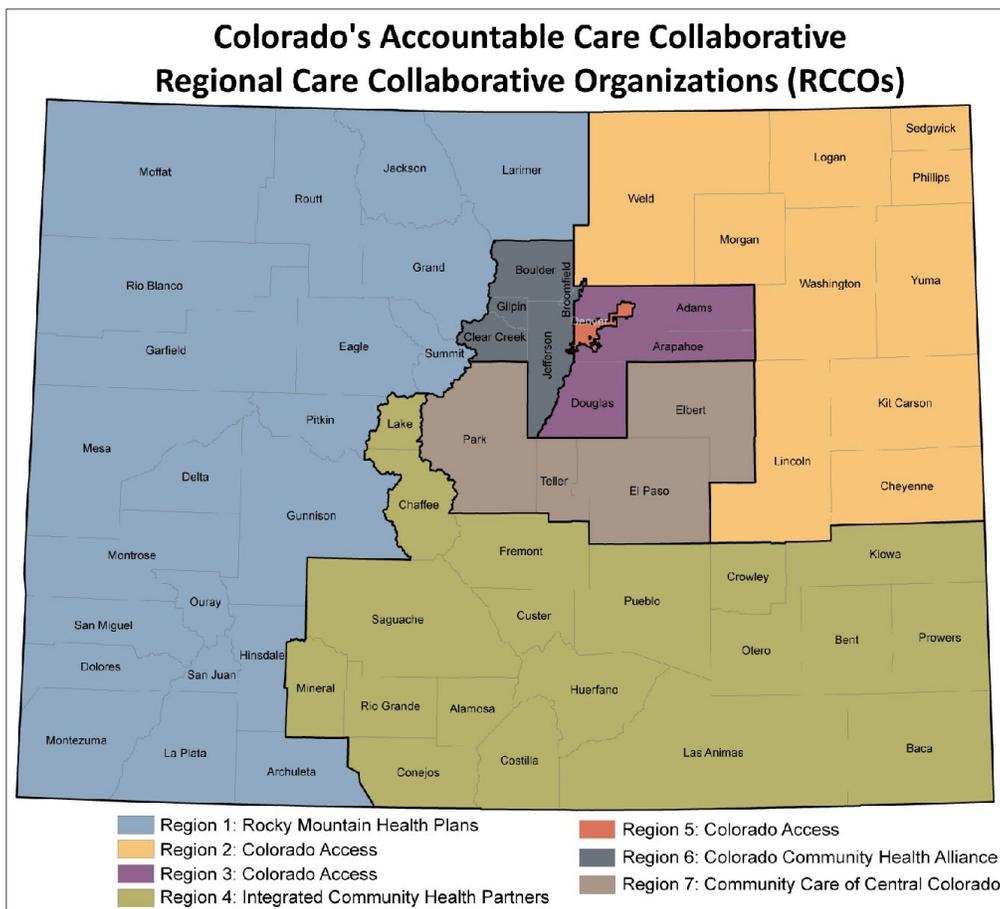
In some administrative regions HCPF has contracted with Family Health Coordinators at the county level, so there are multiple offices within one region. For example the South Central Counties contractor has additional offices in Alamosa, Chaffee, Saguache, Conejos, Costilla, and Lake Counties. Otero County has contracted with staff in Bent County and Las Animas - Huerfano Counties.

Most Healthy Communities contractors who cover multiple counties have varied results from one county to another. There are a few that stand out for their better-than-average results. Otero County is responsible for five counties (two rural and three frontier) which are all performing above the average screening and participant ratios for rural and frontier counties. Tri-County Healthy Department has three of its four counties (Adams, Arapahoe, Douglas) also performing at rates higher than average for urban counties.

## RCCO Distribution

One final factor we wanted to examine is whether any RCCO region is associated with higher or lower screening rates. Region 1 (Rocky Mountain Health Plans) covers many counties with low screening rates, while Region 3 (Colorado Access) covers three urban counties with higher than average screening rates. While there may be some correlation in these two regions, it is difficult to infer any causality with the limited information available.

### H. Regional Care Collaborative Organization Distribution



## V. Trends and Outliers

There are some important trends in performance by type of county, as evidenced in the table below.

### I. Average Results By Type of County

County Characteristics	Avg # Eligibles	Avg Screening Ratio	Avg Participant Ratio	Total Counties
Urban Counties	26133	0.62	0.43	17
Rural Counties	2594	0.53	0.39	24
Frontier Counties	659	0.42	0.34	23

The average number of eligibles in urban counties is ten times greater than the average number of eligibles in rural counties. In turn, the number of eligibles in frontier counties is on average only 25% that of rural counties. Average screening ratios and participant ratios decrease substantially with a decrease in population density.

#### Urban Areas

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The urban counties in Colorado tend to demonstrate better performance on both screening and participant ratios. They also tend to have higher ratios of primary care providers accepting Medicaid per eligible children. A few counties are exceptions however:

- Elbert County has fewer primary care providers per eligible child than the other urban counties, as do Clear Creek and Gilpin Counties
- Denver and Gilpin Counties have lower participant ratios than the rest of the urban counties
- Mesa County has the lowest participant ratio in the state, despite being classified as an urban county
- Screening ratios in urban counties vary from high ratios in Mesa and Denver Counties to lower ratios in Gilpin, Elbert, Park, Prowers and Pueblo Counties

#### Rural and Frontier Areas

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The rural counties in Colorado show very mixed results. Participant and screening ratios vary widely, as does the availability of primary care providers who accept Medicaid. Routt and Summit Counties both have high participant and screening ratios, and stand out among the rural counties. Montrose is of particular concern among the rural counties, with very low participant and screening ratios despite apparent availability of primary care providers.

We see more consistency across the frontier counties, who tend to have more limited access to providers and lower screening and participant ratios. Notable exceptions are:

- Gunnison County - in the top performing category for both screening and participant ratios
- Las Animas and Baca Counties have higher screening ratios than the rest of the frontier areas

The group of frontier counties in the Southwest (San Miguel, Dolores, San Juan, Hinsdale, Mineral) all have low screening and participant ratios, an indication that they may need additional attention.

## Low Screening Rates Among Older Children

One of the factors driving overall screening rates downward in Colorado is the 6 to 20-yr-old age group. While screening rates among 0 to 5 years old are generally high, they drop in the 6 to 9 yr-old group and older.

**The 6 - 20 age group makes up 64% of the eligible population in Colorado** so their screening rates affect Colorado's overall rate quite significantly.

### J. Participant Ratio by Age Group

	Total	Age <1	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20
Eligible Population	518128	29898	62198	96325	117820	119981	72208	19698
Percentage of Total	100%	6%	12%	19%	23%	23%	14%	4%
Participant Ratio	49%	93%	77%	60%	38%	40%	31%	19%
Weighted Average		0.40%	2.76%	7.44%	14.10%	13.89%	9.62%	3.08%

To most quickly boost screening rates in Colorado, we recommend focusing on the 6-9 , 10-14, and 15-18 age groups, all of which have both large populations and low participation rates. Dental care has much room for improvement in these age groups, as does total eligibles receiving at least one initial or periodic screen.

Mental health screening among children aged 10 to 20 is of great importance, particularly in rural regions of Colorado. The regions of the state with a suicide rate significantly higher than the state average are the northwest and the central mountain regions (Health Statistics Regions 11, 17 and 13), as well as the urban HSA 17 (Mesa County).<sup>3</sup> Mental health screening for adolescents in these regions should be prioritized.

Gunnison and Cheyenne are the two counties who do seem to be doing a good job of screening among these age groups, and we recommend exploring their approaches to see if they can also be applied to other counties.

<sup>3</sup> Colorado Rural Health Center: Snapshot of Rural Health in Colorado 2014 Edition.

## VI. Recommendations

This mapping exercise was useful in helping to identify some broad trends across counties, however there is no one factor that seems to consistently impact screening or participant ratios in the state.

HCPF's challenge is to quickly boost EPSDT outcomes, as evidenced in the screening and participant ratios reported to the Federal Government. Based on our analysis of the 2013 CMS-416 data, we recommend the following:

1. **Focus on Older Children.** By increasing screening among children ages 6 and up, the Healthy Communities teams can have a significant impact on the state's overall participant ratio. We recommend exploring strategies to address barriers to screening among these age groups, and helping the Healthy Communities teams reach out to parents of older children about the need for well-child visits and screening.
2. **20/80 Rule.** According to the Pareto Principle, 80% of the effects generally come from 20% of the causes. Identify the 20% of counties that can make the biggest difference in moving the needle, and focus intensely on those. This rule holds true for screening, as evidenced below. There are many frontier counties with such small eligible populations that even a large increase in the participant ratio in those counties would not change Colorado's overall screening ratio.
3. **Best Practices from High Performers.** There are some counties whose performance stands out above the rest with similar characteristics. We recommend exploring and documenting the best practices of those counties that are performing well, to share with other counties.
4. **Review of Issues with Low Performers.** There is a block of counties managed by different contractors that all have very low screening and participant ratios. We recommend reviewing the issues that may be affecting performance in these counties. Are there unique factors in that region of the state affecting outcomes? Are there activities that they aren't implementing? Do they have sufficient staff? Are there management issues that could be addressed?

### Twelve Priority Counties

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To identify the 20% of counties with the greatest potential to move the needle on EPSDT outcomes in the next year, we examined the number of eligible children in each county as of **May 2015** (source: Healthy Communities Salesforce CRM).

The total number of eligibles in Colorado in May 2015 was 570,104 children. Of the 64 total Colorado counties, only 16 have eligible populations that even represent 0.5% or more of the children on Medicaid. **The top 12 counties have 85% of the total number of children on Medicaid in 2015 in Colorado (488,363).**

On average these 12 counties had a screening ratio of 60% and a participant ratio of 41% in 2013. There are however a few counties with very low participant ratios and significant number of eligibles, so to identify those counties that could most impact Colorado’s screening ratio, we created a weighted average based on the 2013 participant ratio per county and share of the 2015 eligible population. The weighted average was used to sort the counties, then the aggregate share determined how many counties could be targeted to reach 85%.

The list of priority counties is displayed below, based on the weighted average.

### I. Twelve Priority Counties for Greatest EPSDT Impact

County	2015 Eligible Population	Share of Eligibles	Weighted Avg.	Aggregate Share
Denver	86,550	15.18%	10.17%	15.18%
Adams	76,815	13.47%	6.60%	28.66%
El Paso	70,641	12.39%	6.57%	41.05%
Arapahoe	67,906	11.91%	5.84%	52.96%
Jefferson	40,424	7.09%	3.62%	60.05%
Weld	35,229	6.18%	3.21%	66.23%
Mesa	18,102	3.18%	2.89%	69.40%
Larimer	26,562	4.66%	2.47%	74.06%
Pueblo	25,234	4.43%	2.43%	78.49%
Boulder	21,552	3.78%	1.97%	82.27%
Douglas	11,598	2.03%	1.06%	84.30%
Montrose	6,047	1.06%	0.93%	85.36%

Due to Montrose County’s very low screening rates, its weighted average was higher than Garfield County and therefore it replaced Garfield County as number twelve on this list, despite Garfield having a larger eligible population.

Most of these 12 priority counties have participant ratios in the 41% to 48% range. Two counties have already surpassed 50% participant ratios (Adams and Arapahoe). The national average is currently at 63%.

There are a few counties that will need extra support and attention due to exceptionally low participant ratios: **Mesa County (9%), Montrose County (12%) and Denver County (33%).**

These twelve counties are currently covered by nine Healthy Communities contractors, with Tri-County Health Department covering Adams, Arapahoe and Douglas Counties. We recommend that these nine contractors receive additional support from HCPF in the coming year to help them meet their EPSDT goals.

## Best Practices from High Performers

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There are a few counties that stand out for their high screening and participant ratios, who are performing much better than other counties with similar characteristics. We recommend interviewing those counties to understand what they may be doing differently, and documenting their best practices to share with other counties or inviting them to help develop training / reference materials for other counties.

The counties we recommend looking to for best practices are:

- **Gunnison County** (77% screening ratio / 50% participant ratio)
- **Summit County** (75% screening ratio / 56% participant ratio)
- **La Plata County** (67% screening ratio / 52% participant ratio)
- **Arapahoe County** (66% screening ratio / 51% participant ratio)

## Poorly Performing Counties

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There are a few counties with very poor performance in both participant and screening ratios, all of which are concentrated in one geographic region in the Southwest. We recommend conducting a review with these counties to understand what unique factors might be adversely affecting their screening rates, and identifying solutions that can be extended to all of the contractors that cover these counties.

The five counties are managed by four different Healthy Communities contractors. The poorly performing counties are:

- **Mineral County** (9% screening ratio / 11% participant ratio)
- **Hinsdale County** (14% screening ratio / 13% participant ratio)
- **Ouray County** (15% screening ratio / 10% participant ratio)
- **Montrose County** (19% screening ratio / 12% participant ratio)
- **San Juan County** (26% screening ratio / 21% participant ratio)

## VII. Conclusion

This mapping exercise has helped us visualize ESPDT results across Colorado, and identify some broad trends that may play a role in preventive health care among children on Medicaid. It has also allowed us to rule out some initial hypotheses and identify both high and low performing counties to learn from. We identified 12 priority counties (based on eligible populations and 2013 participant ratio) that can quickly help boost Colorado's overall screening ratio. We also identified the age groups that if targeted, can also quickly move the needle for the EPSDT report. If HCPF concentrates additional resources and support in these 12 counties, in addition to helping counties reach children ages 6-20, the FY 2016 CMS-416 report will likely show considerable improvements in Colorado.