From Coverage to Care in Medicaid and CHIP:

Getting Out the Preventive Care Message to Pennsylvania's Low-Income Families with Children

Philadelphia Citizens for Children and Youth

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A Report By

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Executive Summary

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"Managed care has made us confront the real challenges in operationalizing the concept of a medical home. It is always much easier to treat the child in front of you than to develop effective outreach for those families who do not seek care."[1] – Jonathan Finkelstein, M.D., M.P.H., Harvard Medical School and Harvard Pilgrim Health Care

This report examines some of the ways a sample of Pennsylvania health care providers participating in Medicaid and CHIP attempt to ensure that the children they serve make use of preventive care. It also identifies how managed care organizations or benefits administrators contracting with the state typically inform families about available benefits, assist them in using services, and interface on these issues with children's primary care providers. The questions below - which often surface in local and statewide discussions of children's access to care - prompted PCCY to survey Medicaid and CHIP primary care providers and managed care organizations about preventive care outreach.

- Once children are enrolled in health insurance, how do their parents learn about preventive care?
- How are children at risk of not receiving preventive care identified?
- What is currently done to reach out to and assist the families of children who do not get regular preventive care?
- What strategies are most effective for prompting families whose children might be missing out to use preventive care services?

PCCY conducted interviews with 40 health care organizations, and found that Pennsylvania's Medicaid and CHIP programs can boast a variety of preventive care outreach efforts. Reminder calls and missed appointment notices, for example, are effective strategies used by most of the providers we surveyed. In addition, a number of providers and managed care organizations are embarked on more ambitious efforts to reach families with information about preventive care. Some of these initiatives, such as welcome calls to all new CHIP members, have been able to reach close to 80 percent of families. Others, such as the EPSDT follow up program in one managed care organization, focus on children who may be missing out on care and provide intensive education and support through home visits and referrals.

The report also examines some outreach strategies that are inconsistently implemented among the organizations we surveyed, and points to some gaps in the ways that information is provided to families. For example, compliance with required follow up to families of children whose EPSDT screens are overdue is often difficult or impossible for many of the primary care providers we interviewed.

Managed care organizations frequently take up this task, but the amount of outreach and the assistance they provide to families varies. Medicaid managed care organizations report difficulty in locating families due to frequent moves, and the procedures a family must follow to change an address seem to exacerbate this problem. Although some outreach materials are translated, a significant amount of material is still produced only in English, including key communications such as missed appointment notices.

Recommendations developed from this research are intended to enhance the accomplishments of the organizations working with children enrolled in Medicaid and CHIP, and to prompt the development of new best practices. We were struck throughout this project by the complexity of designing preventive care outreach strategies to reach families who may have children enrolled in different coverage programs, may lack information about preventive care, and may have difficulty accessing care. As Pennsylvania's CHIP and Medicaid programs continue to reach more children in diverse communities, these challenges will grow. Our recommendations ask state government, primary care providers, and state Medicaid and CHIP contractors to ensure families have input into the design of outreach strategies; that primary care providers have the tools that they need to reach families; and that the initiatives from different parts of the health care system reinforce each other and make sense to families.

The appendix to this report includes an in-depth look at how a primary care provider and two CHIP organizations approach preventive care outreach, and a discussion of the issue of locating families who move frequently.

Introduction

Introduction

More Pennsylvania children than ever before are enrolled in Medicaid or the Children's Health Insurance Program (CHIP). These two programs, supported by federal and state funds, provide free or low-cost health coverage to 844,000 low to moderate-income children, or 28 percent of the state's three million children.[2] Both programs provide a comprehensive benefits package, including primary and preventive care according to recommended schedules for children.[3] Each program also offers enrollment with no waiting lists to any children who qualify.

This health coverage is invaluable to children in Pennsylvania. Study after study has shown that uninsured children often can't get the care they need, either to stay healthy or to get early treatment for sickness, before it becomes serious or even life threatening. Health coverage opens doors that are often closed to uninsured children: a Medicaid or CHIP card is the key not only to a doctor's office, but also to dental and vision care, prescription drugs, mental health care, and a range of other services.[4]

To be fully effective, however, health coverage programs for children must design these services so that families will find them friendly and easy to use. Programs then need to inform parents and caretakers about the services, encouraging them to take advantage of all the health care that their children need. Because some low-income children have missed out on care in the past, and some may lose eligibility for coverage when their family income increases, it is especially important that they have every opportunity to receive care while they are enrolled in Medicaid and CHIP.

No single characteristic distinguishes health care that meets the needs of low-income families with children, although such factors as culturally competent care, accessible practice hours, transportation and interpreter services, and seamless connections to other health and social services are recognized as important components in a family-friendly system.[5] Outreach – by which we mean informing, encouraging, and assisting parents in using the health care system for their children, particularly primary and preventive care—also plays an important role. In fact, some forms of outreach, such as appointment reminders by telephone, are well documented as successful in prompting some families to get preventive care.[6]

Survey Method

To learn about the strategies used to reach out to families, PCCY conducted a telephone survey of 30 health care providers (some with multiple sites) whose practices included a significant percentage of children enrolled in Medicaid or CHIP. The survey was designed not only to determine what strategies are employed, but also to understand the primary care provider's perspective on this issue. We also conducted telephone and some in-person interviews with insurance companies and administrative entities contracting with Pennsylvania's Medicaid and CHIP programs, a total of 10 different organizations.[7]

The surveys and interviews did not include questions on the adequacy of primary care provider networks, practices offering weekend or evening office hours, availability of consultation after hours, or many other characteristics of family-friendly health care. These tremendously important issues were beyond the scope of our research, but are key to understanding how well Pennsylvania's health care system serves low-income families. Outreach can inform and assist families; ultimately, the health care system must be designed to welcome and serve them.

Survey Participants - Health Care Providers

The 30 participating health care providers are hospital-based pediatric sites, federally qualified health centers, nurse-managed primary care sites and group practices serving a substantial number of children enrolled in Medicaid and/or CHIP. In most cases, we spoke with mid- or upper-level administrative staff, and/or pediatricians and nurse practitioners. The sites were chosen because they were accessible to PCCY staff through our established contacts with provider organizations and others in the health care community. The participating sites serve a wide range of populations, including a variety of racial and ethnic groups, and take various approaches to primary care for children. Nine of the participating organizations operate multiple sites, so that information from 56 sites is included in the report. A table displaying the sites by location is included in the appendix.

Survey Participants - Managed Care and Administrative Organizations

Six managed care organizations contract with the Commonwealth of Pennsylvania to provide care to people enrolled in Medicaid; six also contract with the Commonwealth to provide care to children enrolled in CHIP. Three of the CHIP contractors are also Medicaid contractors. In two regions of the state, participation in managed care is mandatory for people enrolled in Medicaid; a third region, the Lehigh/Capital area will require managed care for Medicaid enrollees as of April 2002 (enrollment for the mandatory program begins in October 2001). Most children in CHIP are enrolled in managed care, which includes a preferred provider organization in four counties in Central Pennsylvania. The Caring Foundation of Northeastern Pennsylvania provides dental and vision coverage to CHIP enrollees through an indemnity product; all other benefits are provided through managed care.

For this report, we interviewed five of the six managed care organizations with Medicaid contracts; one managed care organization with both Medicaid and CHIP contracts declined to participate. We also interviewed the state's Medicaid primary care case management contractor; three CHIP administrative organizations and two managed care organizations with CHIP contracts.

Getting Out the Preventive Care Message through Primary Care Providers

Getting Out the Preventive Care Message through Primary Care Providers

In recent years, the term "medical home" is increasingly used to describe the ideal of personalized pediatric care. Endorsed by the American Academy of Pediatrics, the medical home concept suggests that children should have access to medical care that is "accessible, continuous, comprehensive, family-centered, coordinated and compassionate."[8] Pennsylvania's Medicaid and CHIP systems are designed so that a parent can select a medical home from a list provided by the managed care company. For children on Medicaid in rural areas of the state, the Family Care Network, a primary care case management system, is responsible for assisting the parent with selection of a medical home.[9] When a parent does not select a medical home for the child, one is assigned, based if possible on current provider relationships and other needs such as language and access to transportation (to the extent that these needs are known.)[10]

The primary care providers we spoke with for this report are considered the medical home for the Medicaid and CHIP- enrolled children in their care. As such, they take on a variety of preventive care outreach responsibilities, some of which are explicitly required through agreements with the state. Although CHIP does not specifically require outreach activities of primary care providers, many of those participating in CHIP do conduct these activities. Pennsylvania's contracts with Medicaid managed care organizations require the health plans to engage the primary care providers for children in a variety of preventive care outreach activities. Primary care providers participating in Medicaid are required to:

- Contact members who are overdue for EPSDT screenings and immunizations in order to arrange appointments;

- Identify to the managed care organization members who continue to be overdue for screening or immunization one month following notification by the managed care organization;

- Document reasons for non-compliance and efforts to bring the members into compliance

- Contact families of children who miss appointments. Three attempts are required, including two notices in writing and a telephone call. [11]

All of the primary care practices we spoke with are interested in the issue of outreach for preventive care and believe that at least some of these functions are appropriate for them in their role as the medical home for children. All are also engaged in these activities; some are unable to do as much as they think is necessary or as Medicaid requires. For this report, we asked primary care providers about their strategies to encourage parents to keep well child appointments; protocols for follow up on missed appointments and overdue EPSDT screens; and their ability to get in touch with families who just recently became a part of their panel.[12] The appendix displays the range of strategies reported by the sites.

Reaching Out with Reminders and Missed Appointment Notices

Most providers were concerned about no-show rates for well-child visits. Estimated no-show rates ranged from five to 60 percent; the average estimated no-show rate was 31 percent. Seventy percent of the providers – 22 out of the 30— contact families to remind them of an upcoming well child appointment. This strategy seems for work well for the practices that use it. As one practice explained, "The reminder call is one of our critical processes—our no-show rate is much better when we do it. We see a visible impact. For instance, if a doctor is out and we decide not to do the calls, our volume will go down." Providers that were not able to make reminder calls generally had estimated no-show rates higher than the average for the sample.[13] Most of these providers said that they knew reminder calls would be helpful, but told us they couldn't take on this task. One community health center director expressed a common opinion for this group: "we'd like to be able to remind people, but we have staffing and system constraints."

Across the board, the primary care providers we surveyed contacted patients either by phone or with a note when a child missed an appointment. Some used more than one method of contact, including home visits. The most common method of contact was telephone (only four out of the 30 providers surveyed used written contact exclusively) and more than half of our sample (16 providers) routinely use both telephone and written contacts to reach out to families who have missed appointments for their children.[14] Four sites reported getting a social worker involved after three no-show appointments; another provider noted that the nurse practitioners responsible for the child generally know the families and make a determination on a case by case basis about whether to send an outreach worker to the home after a missed appointment.

Some providers noted, however, that improvements in their systems were needed, particularly in terms of language accessibility. For example, only six of the 18 providers with some non-English speaking patients send missed appointment notices in languages other than English. All but one of these 18 sites reported that one or more staff members speak other languages, but we were not able to assess the degree to which these sites can free these bilingual staff members to follow up with families who have missed appointments.

Three of the 30 providers reported engaging managed care organizations or the Family Care Network (through the state's contractor) in working with families whose children had missed appointments. One provider told us that a managed care plan had offered to assist with this issue, but the provider had turned down the offer, believing that the personal touch that their site could offer would be more effective. As this provider put it, "One plan offered to help with appointments, but we declined the offer. We know more about the community than they do. The community trusts us more often." Most providers we spoke with expressed some form of this sentiment, indicating that they felt they should work closely with families who miss appointments. Providers were concerned, however, about their ability to target families who have never been seen in their practice, or those whose children are overdue for EPSDT screens. These issues are addressed later in this report.

In general, providers expressed frustration with missed appointments, but we were told about some effective, if time-consuming, approaches. One provider, for instance, described a process in which doctors reviewed the charts of patients with missed appointments at the end of each day to determine whether there was a serious problem. If a child missed only one visit and was generally healthy, this provider might just send a note. But if the patient were more at-risk, or if there were a pattern of no-shows developing, the provider would get a staff social worker involved.

Reaching Out When Children's Screens Are Overdue

We asked primary care providers participating in managed care whether they were able to contact families of children who were overdue for an EPSDT screen and encourage them to make preventive care appointments. Several sites reported that they had developed ways of doing this. For example, a provider in Western Pennsylvania told us that a staff person devotes 12-14 hours weekly to determine which children are overdue, using the monthly reports from managed care organizations and internal records. When a child is overdue, the staff person reaches out by mail or phone. This site described the process as labor-intensive, but noted only minor difficulties, including variation in the usefulness of information provided by the managed care plans.

However, most providers reported this area as one of their biggest outreach frustrations. Although they receive information on children who are overdue for an EPSDT screen on a monthly basis from the Medicaid managed care organizations, most providers told us that it was difficult or impossible to follow up with families. The reasons included lack of time and resources, incorrect addresses or phone numbers and a lag time between completion of a screen and the recording of this information (resulting in some children being reported as overdue when they really were not).

Because plans do not share patient encounter data with each other, providers observed that children who change plans are sometimes recorded as overdue when they actually are up-to-date, but with a prior provider. Some providers also said that they couldn't follow up because the children's contact information was not provided on the lists or that it was difficult to follow up because they didn't feel the information was reliable or presented in a useful format. Currently five of the plans that PCCY interviewed provide addresses and phone numbers for overdue patients; two plans do not provide contact information. Three of the plans only inform providers when a screen is due in the current month; the others plans we interviewed provide more extensive information, such as due; overdue; and overdue by more than six months. A breakdown of information provided by the plans to the primary care providers is included in the appendix.

Some of the providers we interviewed seemed confused about what was available and what was not, as reflected in the comments below. It was not clear whether these providers had simply not been able to take the time to work with the information more closely, or whether the different types of information provided (and the lack of contact information from some plans) contributed to their confusion. Comments that reflect this confusion included:

"Right now we don't have lists of who's due [for a screen]. The plans don't seem to keep track. We asked for help with this from them, but we didn't get much help, so now we're setting up a data base on our own."
- A provider in Southeastern Pennsylvania

"It's hard to know where the breakdown is, but with both our MA plans there are discrepancies between our information and what's on the lists."
- A provider in Southwestern Pennsylvania

Primary care providers are responsible for attempting to reach children whose EPSDT screens are overdue, and for documenting their efforts to contact the families. Our interviews revealed that most found this task overwhelming. While some employ social work or outreach staff to work with families whose children are missing out on care, it appears that a significant amount of the follow up on these children is falling to the managed care organizations or the primary care case management contractor. Their efforts are described later in this report.

Reaching Out to New Patients

New patients are either children who are enrolled in Medicaid or CHIP for the first time; enrolled again after a period without coverage; or children who have been enrolled in one of the coverage programs, but are new to a particular managed care plan or primary care provider. We asked primary care providers how the families of new patients learn about CHIP and Medicaid benefits, and the importance of preventive care, and learned that most providers are not engaged in this type of outreach.

Managed care organizations and the state's primary care case management contractor are providing the majority of the outreach to new families. Each of the Medicaid managed care organizations we interviewed sends informational material on EPSDT and well child care when a new child is enrolled; some also provide additional educational materials to targeted families. Each CHIP managed care organization also reaches out to new enrollees, providing a variety of informational pamphlets on well-child care. Several of the CHIP contractors take on more, and have developed specific projects and programs on this issue. The findings from our interviews with managed care organizations and other state contractors provide more information on this issue.

Some primary care providers were also interested in this role. In contrast to the widespread opinion that reaching out to overdue patients was too difficult to take on, some providers felt that connecting with new patients could be a reasonable undertaking for them and a few have developed ways of doing this work. Providers were interested in this role because of the personal connection they believe they should have with new families. Six had taken on this function at the time of our interview; the remaining 24, or 80 percent of our sample, did not, and for the most part said they could not, reach out to new families. One provider was just starting this outreach as a new function at the time of our interview, having hired an outreach worker in part to reach out to every new family with children on Medicaid.

Some providers in our sample said that they couldn't reach out to new patients because they don't get addresses and phone numbers for new families on the panel lists from the managed care organizations. PCCY confirmed that although one of the health plans contracting with Medicaid provides this information, others currently do not.[15] On the CHIP side, the situation is slightly different: providers noted that outreach of this sort to new CHIP families is not possible because often the CHIP identification cards and panel lists are the same as those for the commercial patients in a given insurance company. It is important to note that the lack of obvious distinction between CHIP and private insurance is often seen as an advantage from a family's perspective.

More information on families, while it would be helpful, is clearly not the entire solution. Many providers say that even if they had contact information, they are too overwhelmed to conduct outreach to new families. Below are some comments from providers on this issue.

Some Providers Need More Information in Order to Reach Out

"We'd love to be able to send a welcome packet and would do that if we had lists of new families with their addresses. We get panel lists every month but it would take too much time to go through them manually to figure out who was added and dropped. Also we don't have addresses for them."
- A provider in Central Pennsylvania

"We don't even know when they're new…we have to rely on the parent to call for an appointment..." - A provider in Western Pennsylvania

Some Providers Don't Have Resources to Reach Out

"We don't contact new patients at all…until they contact us, they are not our patient. We concentrate our efforts on those who have already accessed the system. There are two reasons we don't do this: it would take an enormous amount of time and manpower and we are at capacity . . . we don't need to get new patients." - A provider in Southeastern Pennsylvania

"We don't have the resources to reach out before they're seen here. We're scrambling just to provide care, and can't do the outreach we'd like to even once we've seen them. It would help if we had complete and accurate lists of new patients, in alphabetical order with names, addresses, and phone numbers, from all of the plans."

- A provider in Central Pennsylvania

Outreach by Overcoming Barriers: Transportation Assistance

Although transportation assistance is not, strictly speaking, a form of outreach, families cannot act on outreach messages if care is inaccessible. We did not attempt to study the degree to which transportation problems pose a barrier for families in various parts of the state, but in keeping with the purpose of this report, focused instead on whether children's health care providers were able to integrate information about transportation resources into their outreach messages.

We asked providers whether they were aware of any transportation assistance available to any of their patients, and learned that half of our sample (14 providers) could tell us that families on Medicaid are eligible for transportation assistance. Twelve of the sites that seemed unaware of this program mentioned that they were located near public transportation (although families sometimes cannot afford the fares); four of the sites seemed unaware of transportation assistance and were not located near public transportation.

Although we did not ask specifically about providers' experiences with the state's Medical Assistance Transportation Program (MATP), we heard some positive, but mostly negative comments about the program. Providers with positive comments noted recent improvements in the program, for example "now they can get a ride the same day, which helps." Negative comments focused on accessibility. One provider's comment was fairly typical: "The MA transportation program is hard to get through to, and people don't want to rely on it because they've been stuck waiting for it, or heard it is unreliable." Another said: "the system exists, but no one can figure out how to use it. There are huge barriers, especially for non-English speaking families."

Outreach to Non-English Speaking Families

Two-thirds (18) of the providers we surveyed reported that they serve some non-English speaking patients. Of these sites:

- Almost all (16) employ one or more staff fluent in a language other than English; one provider also employs a part-time interpreter. We did not assess the roles of the staff speaking languages other than English, an important issue in overall language accessibility.

- Five providers indicated that they use telephone interpreter services; two providers said that they use other organizations to assist with translation.

- Six providers send missed appointment notices in at least one language other than English.

- Almost all (16) have educational brochures available in languages other than English (this includes brochures obtained from the Centers for Disease Control and other institutions).

Some providers have taken many steps to ensure language access, and have included outreach in this endeavor. One provider, for instance, serving a patient population that is 50 percent Latino, told us that they employ a bilingual outreach worker, medical assistant, and receptionist as well as a bilingual legal advocate. Although this survey was not designed to assess overall language access, it appears that most providers still need to take steps to translate missed appointment notices and possibly to ensure that other outreach activities are conducted in the appropriate languages. Providing information about transportation assistance in languages other than English would also be important in some sites.

Getting Out the Preventive Care Message through Managed Care Contractors

Getting Out the Preventive Care Message Through Managed Care and Other Contractors

Although primary care providers generally can establish closer relationships with families, Medicaid and CHIP managed care and contracting organizations have tremendous potential for conducting preventive care outreach. Guidelines developed by the American Academy of Pediatrics suggest that parents should be educated about getting health services for their children when they enroll in a health plan;[16] Pennsylvania's Medicaid and CHIP plans have specific responsibility for this function, as well as additional roles in moving children from coverage to care.

In order to understand the role of state contractors as distinct from primary care providers, PCCY interviewed several CHIP administrative entities responsible for enrollment and some member education functions, Medicaid and CHIP managed care companies and the state's primary care case management contractor. Each organization we surveyed generally maintains information on children's enrollment status, and has some responsibility for preventive care outreach.[17]

CHIP contractors are required to provide newly enrolled families information about covered benefits and how to access them, in language that is readable and easily understood.[18] Medicaid managed care organizations and primacy care providers are required to:

- Inform families about covered benefits and how to access them
- Schedule an EPSDT screen for newly enrolled members within 45 days of enrollment, unless the child is already under the care of a primary care provider and is current with screens and immunizations
- Provide transportation for EPSDT screening visits, if requested.
- Have protocols for conducting outreach with non-compliant members, including home visits if appropriate
- Establish a process for outreach and follow up with special needs children, including homeless children and children in the foster care system[19]

Written Materials

All Medicaid and CHIP contractors send handbooks to parents about their children's benefits and how to access them. This information comes to families shortly after enrollment. Most contractors also send periodic mailings throughout the year in a variety of formats –general brochures, letters, newsletters, and pamphlets on key health care issues. PCCY asked each contractor's member services staff whether they provide new member materials in languages other than English, and found that:

- Five of the seven Medicaid contractors interviewed can provide new member handbooks in Spanish. One of the contractors with only an English version indicated that a family with translation needs would be advised to call the contractor's language line, and the relevant information would first be translated over the phone and then mailed to the family.

- Two of the six CHIP contractors interviewed provide their member handbook in Spanish. One contractor said that the handbook could be made available in any language on request.

Telephone Calls

Each of the Medicaid contractors we interviewed attempts to call new families to inform them about EPSDT benefits and to schedule an appointment if appropriate. Contractors generally make three attempts at different times of day, usually including one in the evening, and usually contact about 50 percent of families. One contractor, for instance, explained that the success rate with telephone calls to families of new child members is about 30 percent; then, after the contractor sends a letter to the families who were not reached, another 10 to 20 percent call back. These attempts and results appear to be fairly typical. However, there is considerable variation reported by plans and the primary care case management contractor in terms of follow up on families who can't be reached, or for assisting families whose children's EPSDT screens are overdue. These issues are discussed in "Taking the Next Step."

Although CHIP contractors are not required to reach families within a specified time period, some contractors are conducting outreach similar to Medicaid's new patient outreach. Three CHIP contractors try both approaches, sending letters or postcards on the importance of making a preventive care appointment and also making attempts to reach families by phone. Two do not make telephone calls, but send letters. One CHIP contractor told us that although letter and phone outreach to new families had been a regular practice, it was no longer possible given recent staff reductions.

Information on the effectiveness of these welcome calls or the role they play in health education for parents is scarce. Although contractors told us that some families are pleased and surprised to get a call, there does not appear to be system-wide analysis of the content or impact of this outreach. Information is generally collected on the number of outreach attempts and the number of families contacted. One exception: the state's primary care case management contractor does collect and analyze information on the number of calls scheduled as a result of a three-way call between the provider, the contractor and the family, providing one close-up look at the impact of this type of outreach.

Of the approximately 13,000 EPSDT screening appointments scheduled in the Family Care Network in a recent month, approximately 40 percent were scheduled with some assistance from the contractor. Assistance includes direct assistance via a three-way telephone call with the provider and the family, or any of a number of other attempts by phone or mail to encourage a visit. Approximately 60 percent of the overall appointments scheduled are kept; PCCY was not able to obtain data on whether appointments made as a result of outreach are kept more or less frequently than other appointments.

Managed care organizations maintain data on the number of Medicaid families reached by their telephone or mail efforts, but did not appear to have information on how many appointments were made or kept as a result of this outreach. Qualitative information that might be helpful in refining these efforts was also not available. We do not know, for instance, how many families are asking questions during the calls, or whether the information presented is new to families.

Assisting Families: Taking the Next Step

How do Pennsylvania's Medicaid and CHIP programs assist families whose children have a record of missed appointments or no record of a recent preventive care visit or ESPDT screening? Although primary care providers are required to contact members who are due or overdue for EPSDT screens and arrange for appointments, most reported that they couldn't follow up systematically. Responsibility for this work most often ends up with the Medicaid contractor. CHIP primary care providers generally cannot distinguish CHIP enrollees from other children on their panel, and CHIP contractors do not usually become engaged in identifying individual children who may be behind on preventive care.

Medicaid contractors said that they are aware of a minority of children who were hard to reach and likely to be missing out on care. Contractors pointed out that most children enrolled in Medicaid, particularly young children, are getting some primary care, and data collected by the Southeastern Pennsylvania Medicaid managed care contractors for the state confirm this. Children may not, however, be getting all of the comprehensive ESPDT screening and treatment that they need, and it appears that some children are missing out on preventive care.[20]

Medicaid contractors told us that children miss out on preventive care for reasons that are well documented: problems with transportation in rural, urban and suburban communities, including difficulty paying for public transit; lack of child care for siblings; and a lack of understanding about the importance of well child health care. Most agreed that the effective interventions included providing specific help with barriers, as well as educating parents about the importance of preventive care.

The degree of specific help and education, however, varied from contractor to contractor. Although every Medicaid contractor interviewed provided telephone and mail follow up to encourage parents to bring in children with overdue screens, procedures to assist families beyond this varied as follows:

Transportation: Six out of seven contractors told us that they would provide assistance with transportation, if the contractor was aware a problem existed, but it was not clear how a family would know about or qualify for this assistance. Our impression from discussions with the contractors was that this help was not available by request, but was provided at the discretion of the contractor. For example, one contractor noted "if a family can't manage to schedule a ride with MATP (the state's Medical Assistance transportation service), we'll coordinate it from here. And in special circumstances, we might help with a cab voucher." Another said "we might make tokens available and in the most severe cases, cab vouchers – for a follow up visit, but not a screen."

Child Care: None of the contractors we interviewed offer child care assistance as a means of supporting well child visits. Several noted that child care problems were a major issue for families whose children miss out on care.

Language Barriers: All of the Medicaid contractors provide tag lines on screening reminder materials, indicating a phone number that families can call for assistance in their own languages. The number of tag lines varies from one in just Spanish to up to five languages on screening reminders sent by one managed care organization.

Home Visits: One Medicaid contractor routinely sends outreach workers to visit families with children who can't be reached by telephone and haven't responded to letters or postcards. One contractor was designing this type of initiative at the time of our interview, and planned to begin this work in October 2001. Another contractor indicated that home visits could be triggered by exceptional needs. Four contractors did not include home visits in their outreach strategies.

We asked the contractor engaged in home visiting about the protocol and outcomes of home visits. We were told that the visits were a crucial component in an overall focus on EPSDT, and contributed to a significant increase in the company's screening rate, which is currently 71 percent of all eligible children. An outreach supervisor who conducts and supervises visits provided us with specific details about the visits, including impressions of the needs of families receiving these visits.

After three attempts to reach the family by phone fail, the outreach workers visit the family's home. The outreach workers approach the family by introducing themselves and the company, explaining that they are visiting the neighborhood to provide information about children's health, and asking if they can visit with the family. Outreach workers report that most families are comfortable with this approach, and that they are then invited in to discuss the issues. Only after they are invited to visit the family do the workers bring up a specific child's record, and ask the parent or caretaker if the child has had a recent health screening.

Most of the time, according to the outreach supervisor, "there is a real lack of knowledge." Although the parent may have a general awareness that, for instance, children need immunizations, the need for regular, preventive care for their child is not well understood. Younger parents in particular need information. "They really don't know what can happen. . . as long as their kids look fine, they are not worried."

Whenever possible, after educating the parent about the child's health care needs (and often the needs of siblings as well), the outreach worker makes a call with the parent to set up an appointment for the child. A tracking system permits the outreach staff to find out if this appointment was kept and to work with the family if the appointment is broken or missed. Not infrequently, the outreach workers also assist families with barriers to care and issues resulting from poverty: "sometimes we are there for 45 minutes working on resource and referral."

Seven outreach workers and two supervisors are employed specifically for this function. Languages spoken by outreach workers include Spanish, Russian, Vietnamese and two dialects of Chinese. Approximately 800 attempts to reach families at home are made each month; about 40 to 45 percent of these are successful, resulting in a home visit. When a family cannot be found at the home address, the outreach unit makes an attempt at a different time (staff conduct visits in the late afternoon or evenings and on Saturdays) or checks with the primary care provider to see if there might be a more current address than the official state listing.

Conclusion

Conclusion

No single entity in Pennsylvania "owns" preventive care outreach to children enrolled in Medicaid and CHIP; this important work is, and should be, the job of everyone in the health care system. For this job to be done well, it is necessary to strike a difficult balance between individualized strategies and a coordinated effort that ensures that multiple messages and supports are reinforcing each other. Both of these approaches are necessary, particularly for children whose families are likely to confront barriers to getting preventive care. The providers and contractors we interviewed have taken the task of communicating preventive care messages to families very seriously; some have also developed ways of actively assisting families whose children are missing out on care. Many of these efforts seem to be paying off, as most children enrolled in Medicaid and CHIP are accessing some preventive care.[21]

Improvements are needed in the linkages among the different parts of the health care system engaged in this work, and in outreach that focuses on families with multiple barriers, including language, lack of knowledge and problems getting to care. Many of the primary care providers we interviewed are unable to assist the families with multiple missed appointments or overdue screens, and most indicated that they are not working in concert with the health plans to ensure that families get the prompting or assistance that they need. Assistance provided by health plans to families varies; families are likely to get more or less information and help accessing care depending on the health plan in which they are enrolled.

Language accessibility also varies: some Medicaid and CHIP handbooks are produced in languages other than English, but some are not. Similarly, some families are likely to receive information from their primary care provider in their own language, whereas others probably will not.

The appendix to this report includes an in-depth look at how a primary care provider and two CHIP organizations approach preventive care outreach, and a discussion of the issue of locating families who move frequently. Recommendations developed from this work take note of the strengths and accomplishments we found in current preventive care outreach efforts, as well as the need to reach more families with multiple barriers in more coordinated ways.

Recommendations

Recommendations

1. Find Out What Families Have to Say.

No one knows more about how preventive care outreach and assistance are perceived and used than families with children enrolled in CHIP and Medicaid.

Possible Action Steps:

- Integrate questions about preventive care outreach and assistance strategies into routine consumer satisfaction surveys for both Medicaid and CHIP

- Conduct focus groups with consumers to assess specific outreach strategies, including phone calls, letters, and home visits. The issue of culturally appropriate interventions should be addressed in these groups.

- Seek consumer input for changes in the preventive care outreach practices of Medicaid and CHIP contractors and providers through the Medical Assistance Advisory Committee and other forums.

2. Build on the Strengths of Pennsylvania's Medicaid and CHIP Programs.

Pennsylvania's Medicaid and CHIP programs guarantee each child a medical home, and many Medicaid and CHIP providers and managed care organizations are conducting preventive care outreach programs.

Action Steps:

- Continue the guarantee of a medical home, and continue to publicize to families the importance of continuity of care.

- Solicit the input of primary care providers and contractors deeply engaged in preventive care outreach regarding best practices and system changes.

- Develop methods of identifying children who are missing out on preventive care as well as the families with children who receive some, but not all the necessary care.

3. Provide Primary Care Providers with Additional Tools to Conduct Preventive Care Outreach.

Primary care providers participating in Medicaid and CHIP are not sufficiently able to engage families in preventive care outreach.

Possible Action Steps:

- Offer providers standard materials (such as missed appointment notices) in languages appropriate for their patient populations.

- Provide additional compensation for outreach activities, either in the form of enhanced capitation fees or payment for specific activities.

- Improve the consistency and quality of panel lists: lists of new patients and those overdue for EPSDT screens should be standardized and include addresses and phone numbers.

- Transfer encounter data when a child changes plans, so that providers and plans do not conduct outreach on overdue screens to children who are already up-to-date.

Primary care providers are not adequately informed about transportation assistance available to families on Medicaid.

Possible Action Steps:

- Develop a process for county Medical Assistance Transportation Program (MATP) contractors to visit primary care sites, promote the program, and provide information for the use of providers and families.

- Provide information about transportation assistance in all of the standard outreach materials (such as missed appointment notices) used by providers. This information should be available in the major languages used by families in Pennsylvania.

4. Continue the Preventive Care Outreach Conducted by CHIP Contractors, and Strengthen Requirements so that all CHIP Enrollees are Provided With a Consistent Level of Preventive Care Outreach and Assistance.

Some CHIP contractors have designed and conducted innovative preventive care outreach programs, but approaches are not standardized.

Possible Action Steps:

- Require preventive care outreach activities for CHIP comparable to those required for Medicaid.

- Collect data on CHIP preventive care outreach efforts comparable to data collected by Medicaid contractors and providers.

5. Ensure that all Families with Children Enrolled in Medicaid are Provided a Consistent Level of Preventive Care Outreach and Assistance.

The amount and quality of preventive care outreach assistance currently provided to a family may depend on the plan in which the family is enrolled.

Possible Action Steps:

- Develop and implement standard outreach protocols, based on family input and data concerning the most successful practices.

- Provide support for families who need child care or transportation assistance in order to get preventive care.

- Redesign activities that require coordination with the primary care provider (such as outreach on overdue EPSDT screens) so that roles are clear and tasks can be accomplished.

- Ensure that information provided by plans to primary care providers is up-to-date and accessible, and include includes screening information from any past Medicaid or CHIP provider.

6. Improve change of address procedures.

Many families lose out on preventive care information and, even more seriously, lose Medicaid benefits, both because of the inadequate coordination between the managed care and Medicaid systems and because of Medicaid's procedures regarding returned mail.

Possible Action Steps:

- Authorize managed care organizations and Benova, the state's enrollment broker, to obtain consent from families to transfer information about their new addresses to the County Assistance Offices.

- Redesign procedures regarding returned mail in Medicaid to mirror the CHIP procedures, which emphasize outreach to the family before termination.

- Alert managed care organizations when benefits are due for renewal, and encourage plans to assist families on their panel with Medicaid renewal forms.

7. Assess the effectiveness of outreach efforts.

Identifying the most effective efforts will benefit families, providers and managed care organizations.

Possible Action Steps:

- Conduct studies on preventive care outreach, including an assessment of the effectiveness of telephone and written outreach for overdue EPSDT or CHIP preventive care appointments; an analysis of family attitudes toward these activities; and an examination of the content of home visits and their potential for increasing receipt of preventive care.

Appendix

Successful Strategies and Ongoing Concerns: The Community Check Up Center of South Harrisburg

The Community Check Up Center of South Harrisburg is located within Harrisburg's largest public housing community. Two-thirds of the patients – and many of the Center's staff and board members – are residents of nearby public housing. The Center serves about 300 children per month; about half come from Latino families. More than 95 percent of the children are enrolled in Medicaid; most are enrolled in managed care.

The Center reports that most of the children it serves are up-to-date with EPSDT screening and receive regular preventive care. Staff consider several strategies key to their success, including ongoing education by doctors and nurses about the importance of well child care; scheduling well child appointments with the parent or caregiver in advance; providing a reminder card about the next appointment when the family leaves the office; and calling the family the day before or the morning of the appointment. Early morning has proven to be the best time to remind families.

Still, many of the staff at the Center are concerned about the minority (the Center's estimate is 20 percent) of children on their panel lists who are never brought in for preventive care. "There are people who don't know it's important to bring their kids in before they're really sick," said one front-line staff person. The Center's executive director explained that they would like to send each new parent a welcome letter and an incentive to make an appointment, but that this is not possible given resource limitations and the difficulty of working with the data provided on patients. The same limitations hamper the Center's ability to target families whose children's EPSDT screens are overdue: this strategy would require checking every file for the last screen actually performed, as the Center feels it cannot rely on screening information provided by managed care plans.

According to the Center, trust is as important as outreach activities in engaging families in the health care system. The Center is trusted, says its Executive Director, because it hires people from the community it serves, including several bilingual staff, and staff spend time talking to families and attending neighborhood functions. The Center also makes sure that patients are treated respectfully, so that it can be regarded as a "safe harbor" in the community. Cultivating an inviting atmosphere is also important: books and used clothing are available in the Center's waiting room; once a week, the Center offers an after-school story hour; and classes in health education (including a Healthy Image class for pre-teens) as well as music and arts workshops are common at the Center.

Welcome to CHIP: Two Examples of Preventive Care Outreach

Welcome to CHIP: Two Examples of Preventive Care Outreach

"Welcome to CHIP" is the message two CHIP contractors in Southeastern Pennsylvania decided to communicate in personal calls to the families of new enrollees – along with information about benefits, the importance of immunizations and well child care, and assistance with any special health care needs. Aetna U.S. Healthcare's program, Smart Start, began in 1998 with funding from the Aetna Foundation; Healthy Futures, a program of the Independence Blue Cross and Pennsylvania Blue Shield Caring Foundation for Children, was initiated in 1999 with support from charitable funds raised by the Foundation. Although the two efforts were designed somewhat differently, both were launched with the personal phone call as the cornerstone.

The assumptions behind the two programs were also similar. PCCY interviewed staff responsible for the design of each program, and learned that Healthy Futures was "rooted in the conviction that while it is vitally important to make coverage available to children in need, it is equally important to make sure the coverage is utilized." Smart Start was also begun with the purpose of making sure that enrolled children accessed care, and sprang from the concern that children enrolling in CHIP may have missed out on care in the past, a concern that some research confirms. [22]

Both programs have observed that many parents are happy for the personal connection with CHIP, and that it is possible – often with multiple contacts—to reach the majority of enrollees. When Smart Start began, an average of five to eight calls were made in order to reach each family, most of the time during dinnertime or Saturday morning; later in the program, "three good efforts" were made. Overall, 79 percent of families were reached by phone. Healthy Futures has reached 83 percent of parents of enrolled children by making three attempts to reach each family. Healthy Futures has found that its proactive effort can be credited for over 250 referrals to its case management programs.

Neither program, however, has been able to document whether the personal phone calls lead to more preventive care visits for children, in part because other outreach initiatives (postcards, health education materials, etc.) make it difficult to isolate the impact of the calls. Healthy Futures has been able to collect data on some of its eight other program initiatives, such as the Health Risk Assessment Forms mailed out to all new enrollees (50 percent of these are returned and used in determining future interventions with the family), but currently cannot assess the impact of the initial phone outreach. Smart Start points out that the program was not designed with the aim of identifying whether this type of outreach works, but was rather developed to offer a service and assistance with a new health care system. To identify the relationship between the personal phone calls and use of preventive care would require a special study, and Smart Start is without the resources for such an undertaking at this time.

Smart Start was reshaped in 2000, and now consists of automated mailings of preventive health information. In lieu of phone calls, two mailings are now sent to the families of newly-enrolled children.

One contains the child's identification card and a member handbook, and a second mailing, sent in the month of enrollment, encourages parents to make well child appointments, to access dental care and to make sure their child is up-to-date on immunizations. Healthy Futures is continuing with the personal phone calls, as well as member mailings and other communication tools.

Both initiatives reflect a commitment to moving children from coverage to accessing health care, and both provide some evidence that the extra effort matters. But the experience of both programs also suggests that it may be time to investigate more empirically which interventions are most likely to prompt action from parents. Right now, it is not possible to say whether a personal phone call from a CHIP contractor can increase use of preventive care, or whether some families respond better than others to this type of outreach. There is also no information to indicate whether reaching out to families just after enrollment might be more or less effective than targeted outreach later on, when a children who may be higher risk than others could be identified. Healthy Futures and Smart Start provide rich experiences on which to draw as preventive care outreach becomes an increasingly important component of Medicaid and CHIP.

Locating CHIP and Medicaid Families: Different Challenges in Different Systems

Locating CHIP and Medicaid Families: Different Challenges in Different Systems

Mail returned by the post office; expired forwarding addresses; disconnected telephones or no phone numbers at all . . . Almost every contractor and primary care provider we spoke with encountered these problems, but Medicaid contractors, particularly in the Philadelphia area, reported unreliable mailing addresses or phone numbers as a major frustration in conducting outreach on preventive care issues.

The lack of affordable housing in this region, coupled with a decrease in the real income of Philadelphia's lowest income families, has led to enormous housing instability among the poorest families. Indicators of this instability: between 70 and 75 percent of low-income families in Philadelphia face housing costs in excess of 30 percent of their income, housing that is deteriorated, or both.[23] Although the problem of outdated contact information was identified more often in interviews with groups working in Philadelphia, contractors elsewhere in the state also pointed to outreach difficulties resulting from the frequent moves of low-income families.

Locating families was described as an "overwhelming challenge" by most Medicaid health plans, and some reported that this issue surfaces more frequently with children who may be behind on care. Some primary care providers also told us that the majority of children on their panel list who were not seen for preventive care were from families whose contact information was inaccurate. One Medicaid plan explained that "trying to make phone contact with members is one of the most difficult, labor-intensive things we do." Another contractor observed that "an inordinate amount of mail comes back." Several contractors and providers offered estimates of their bad contact information. For example, one Medicaid contractor reported that of 9,723 children they had recently attempted to reach, only about 5,300, or slightly more than half, had actually been contacted. This contractor considered a member "contacted" if the family was reached by phone; a message was left on an answering machine and someone called back; or a letter was sent and someone called the contractor in response.

An Easier Task for CHIP

CHIP contractors report neither an overwhelming volume of returned mail nor tremendous difficulty in reaching out to families. As one contractor put it, "if we don't have a correct address or phone number, we'll try to find them. But it's not a huge percentage; it comes and goes." Several CHIP contractors reported that with multiple phone calls, they were successful in reaching the vast majority of families of their new patients.

CHIP contractors are not, however, routinely trying to reach the families of children who have been enrolled for some time and not seen for preventive care, whereas Medicaid contractors are contractually obligated to do so. CHIP contractors efforts have focused primarily on children who have just enrolled in the program, and these children may be easier to reach.[24]

The size of the CHIP program – about one-seventh the size of the children's Medicaid program in Pennsylvania—also probably contributes to the lower volume of returned mail or outdated contract information. Families with children enrolled in CHIP are also likely to have higher incomes than families with children enrolled in Medicaid, and therefore more likely to have stable housing.

Returned Mail: Contrasting Approaches

CHIP and Medicaid contractors treat returned mail differently. CHIP contractors are instructed in the state's Procedures Manual that "mail returned to the insurer by the U.S. Postal Services that is marked 'address unknown' may provide cause for disenrollment," but are encouraged to "when practical . . . make an attempt to contact the parent or guardian by telephone or other means to establish that the family is no longer at the address previously provided." [25]

CHIP contractors reported that they are sometimes successful in doing this, and some said that it is helpful to use a work number to contact a family with a missing address. Some contractors also noted that if the post office indicates there is a new forwarding address, the contractor makes the change for the family. Termination of benefits appears to be the last resort. One CHIP contractor explained to us that if mail has been returned and it is impossible to contact the family by phone, the contractor will "go into a member comment screen to indicate that mail is returned as undeliverable and [instruct staff] to verify the address and phone number if the customer calls in."

In contrast, Medicaid managed care contractors send returned mail to the welfare department, as they are capitated for delivery of medical benefits, and are not responsible for enrollment in the Medicaid program. Medicaid benefits do not continue unless the family contacts the relevant office. Although most Medicaid contractors are just as eager as CHIP contractors to locate families and update their addresses, the information they obtain for the purpose of preventive care outreach cannot be used to maintain the child's eligibility.

Finding and Losing Families

Several managed care organizations we spoke with were engaged in multi-departmental efforts to improve the quality of their contact information on patients. One described their initiative as an attempt by marketing, customer relations, provider relations, and utilization management to "identify all potential times we might touch a member, to reduce 'unable to contact' rates." This contractor added "if mail is returned and we have no alternative address, we often work with the primary care provider to get more updated information. We'll be more aggressive depending on the situation, for example, a two-year old with no recorded visits." While this work might pay off in terms of educating a member about preventive care, it cannot impact on Medicaid's officially recorded address for the family. The Medicaid contractor may contact the welfare department to relay the information about the move, but this contact in itself will not result in a change of address.

As a result, some plans find themselves updating addresses in their own system, then receiving monthly downloads from the welfare department with outdated information on families they have contacted successfully. Some keep their own lists – distinct from the official welfare department lists — indicating the locations where they can find families. Others are unable to maintain an internal system that is different from the official information. In both cases, some plans say opportunities for reaching out to families can be lost. Moreover, when families do make address changes with their caseworkers, or renew their eligibility after a period without benefits, the plan can lose critical outreach time waiting for the monthly update of enrollees.

The Bottom Line: The Family's Perspective

It is important to preserve a family's right to convey personal information to the welfare department. It is likely, however, that many families are not aware of the contractual relationships between managed care organizations and the state, or of the structural and legal differences between CHIP and Medicaid. Telling a state contractor about an address change in CHIP has a different impact than giving a Medicaid contractor the same information. As one family in Pennsylvania may have children in each program, and as some families move frequently, it is not surprising that preventive care outreach programs have trouble locating families and that families are confused by the procedures they are supposed to follow.

Some families are likely to have difficulty with address changes as long as the basic functions and procedures of CHIP and Medicaid systems remain multi-layered and confusing. Managed care organizations are also likely to continue to face obstacles, as the task of locating families whose children may be missing out on care is difficult to begin with, given the serious issues in the lives of many low-income families. Some short-term, immediate steps could, however, make it easier for families to communicate with the various levels of the health care system and for contractors to provide the assistance that many parents need. Developing procedures for managed care organizations and primary care providers to obtain permission from families to transmit a change of address to the welfare department would be one such step. A state contract with managed care organizations to complete renewal forms with families whose benefits have expired would be another. These steps are outlined in the recommendations at the end of this report.

Endnotes

[1] Johnathan A. Finkelstein, "Commentary 2: Defining the Challenge and Opportunities for Children in Managed Health Care / A Pediatrician's Perspective," The Future of Children 8.2 (1998): 139.
[2] As of August 31, 2001, 729,403 children were enrolled in Medicaid; as of September 1, 2001, 114, 197 children were enrolled in CHIP. Sources: Pennsylvania Department of Public Welfare ARM572 Report; Pennsylvania Department of Insurance, CHIP Enrollment, September 28, 2001<http://www.ins.state.pa.us.>
[3] The CHIP program currently uses the American Academy of Pediatrics (AAP) periodicity schedule; the Medicaid program uses a modified version of the AAP schedule, but is expected to use the AAP schedule as of January 1, 2002.
[4] Federal law requires that all states implement the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of the Medicaid program. The EPSDT program mandates provision of screening examinations and all medically necessary treatment services. Children must receive preventive health services as well as treatment for chronic and acute childhood illnesses and conditions. There are no co-pays, deductibles or premiums. CHIP provides comprehensive preventive services and treatment with no co-pays but some limits and uncovered services.
[5] Roberta Riportella-Muller, et al., "Barriers to Use of Preventive Health Care Services for Children," Public Health Reports, 111 (Jan/Feb 1996): 71-77. Also Glenn Flores et al., "Access Barriers to Health Care for Latino Children," Archives of Pediatric and Adolescent Medicine 152 (Nov. 1998): 1119-25.
[6] A large number of studies document the effectiveness of reminder calls for various populations. Lance E. Rodewald, et al., "A Randomized Study of Tracking with Outreach and Provider Prompting to Improve Immunization Coverage and Primary Care," Pediatrics 103 (Jan, 1999): 31-38.
[7] One insurance company contracting with both Medicaid and CHIP did not participate in the project.
[8] Dickens, M.D. et al, "The medical home: Ad hoc task force of definition of the medical home." Pediatrics (1992) 90, 5:774.
[9] In a primary care case management system such as the Family Care Network, the state contracts with primary care providers for a monthly care coordination fee plus fee for service for the services the provider delivers.
[10] Pennsylvania Department of Public Welfare, Health Choices Southeast Physical Health Agreement, 30, August 2000, 8/27/01<http:www.dpw.state.pa.us>
[10] Pennsylvania Department of Public Welfare, HealthChoices Southeast Physical Health Agreement, 30, August 2000, 8/27/01<http:www.dpw.state.pa.us>
[12] Some providers provided additional information on other strategies as well, such as expanded hours, reduced waiting times, and gift incentives. We did not tabulate the frequency of use of these strategies.
[13] Six of these practices were above the average of 31 percent no-shows for the sample; two were close to the average, with no-show rates of 30 percent; one was significantly under the average with a no-show rate of 10 percent.
[14] For children enrolled in Medicaid, the state mandates three attempts to contact families after a missed appointment,including two notices in writing and a phone call. Pennsylvania Department of Public Welfare HealthChoices Southeast Physical Health Agreement, August 30, 2000, 8/27/01
<http: www.dpw.state.pa.us> p.90.
[16] Committee on Child Health Financing. "Guiding Principles for managed care arrangements for the health care of infants, children, adolescents and young adults," Pediatrics 95 (1995): 613-615.
[17] The relationships between CHIP managed care plans (responsible for the delivery of medical care) and CHIP administrative organizations (generally responsible for enrollment, renewal and member education) are each structured differently, and some CHIP contractors have combined the functions. In contrast, Medicaid managed care organizations are not responsible for enrollment in coverage (which occurs in local County Assistance Offices), nor is the state's administrative contractor for the Family Care Network, the primary care case management system in rural counties.
[18] CHIP standard contract; Appendix g, p.11.
[19] Pennsylvania Department of Public Welfare, HealthChoices Southeast Physical Health Agreement, 30, August 2000, 8/27/01 <http://www.dpw.state.pa.us> p.j-3.

[20] Medicaid HEDIS data for Southeastern Pennsylvania indicate that when children are continuously enrolled in Medicaid, they have a good chance of getting some preventive care. The Health Employer Information Data Set (HEDIS) is a standard measuring tool used by employers and health plans to gauge the adequacy of care provided by managed care organizations. HEDIS data indicate that 85 percent of 15 month old children enrolled continuously in Medicaid in Southeastern Pennsylvania went to a primary care provi der three or more times since they were one month old. The same set of data show that almost all one year olds (children from 12 to 24 months) got to care at least once: 93 percent of these children are recorded as having at least one primary care visit. It is not possible from this data to determine which children are missing out on preventive care.

[21] The HEDIS information in note 21 confirms that most children are accessing some preventive care.

[22] Several studies have shown that a large proportion of children entering Medicaid or CHIP have experienced some unmet need or delayed care. See, e.g, Lave, Judy R; Keane, Christopher R; Lin, Chyongchiou J.; Ricci, Edmund M.; Amersbach, G.; LaValle, Charles P.; "Impact of a Children's Health Insurance Program on Newly-Enrolled Children." JAMA. 1998, 279: 1820-1845. Also see Holl, Jane L.; Szilagyi, Peter G.; Rodewald, Lance E.; Shone, Laura Pollard; Zwanziger, Jack; Mukamel, Dana B.; Trafton, Sarah; Sick, Andrew W.; Barth, Richard; Raubertas, Richard F. "Evaluation of New York State's Child Health Plus: Access, Utilization, Quality of Health Care and Health Status." Pediatrics. 2000; 105: 711-718.

[23] Philadelphia Office of Housing and Community Development, Year 26 Consolidated Plan, p. 15.

[24] CHIP programs do attempt to identify children with high needs, and several CHIP contractors report special medical case management programs for children who are identified as needing this assistance. This is distinct from systematic outreach to families who appear not to be getting well child care for their children.

[25] Pennsylvania Children's Health Insurance Program Procedures Manual, Section II, 12.4.

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Philadelphia Citizens for Children and Youth

Founded in 1980, PCCY serves as the region's leading child advocacy organization, working to improve the lives and life chances of the region's children. Through thoughtful and informed advocacy, community education, targeted service projects and budget and policy analysis, PCCY seeks to watch out and speak out for children in the region.

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