



# Developmental Screenings for Young Children in Medicaid and the Children's Health Insurance Program

by Elisabeth Wright Burak and Mike Odeh

## Key Findings

- Early identification and treatment of developmental delays can help children access the services and supports they need to reach their full potential. All children should receive developmental screens at pediatrician-recommended intervals to ensure their healthy development.
- States may voluntarily report a developmental screening measure in Medicaid and/or the Children's Health Insurance Program (CHIP). *Of the 26 states reporting in 2016, developmental screening rates for children under age 3 in Medicaid and/or CHIP ranged from 1.6 percent in Alaska to 77.5 percent in Massachusetts, with a median of 36 percent.* Reporting on the full Core Set of Child Health Care Quality Measures, including the developmental screening measure, will be mandatory for all states beginning in 2024.
- Across all health coverage types, a separate 50-state parent survey found that *27.1 percent of all children under age 5 received a developmental screen in 2016. State rates ranged from 11 percent in Mississippi to 48.9 percent in Oregon.*
- Wide variation in reported developmental screening rates among states suggests much room for improvement to assess whether children are being universally screened according to pediatrician-recommended standards. Data availability and voluntary reporting in Medicaid/CHIP make accessing data for all 50 states more difficult. Even more work remains to adequately capture and assess what happens to children following a developmental screen to ensure they get the care they need.

## Introduction

As our nation reaches historic levels of health coverage for children, there is increased interest in further ensuring access to the care needed for children to reach their full potential. Years of research have confirmed the critical importance of the earliest years of a child's development.<sup>1</sup> The first months and years of a child's life are marked by rapid growth and early brain development that pave the way for school readiness and overall physical and social emotional health impacting them well into adulthood. Early identification and treatment of developmental delays can help children access the services and supports they need. Routine screening for all children is an important gateway to ensure those identified with certain delays or needs receive early intervention or other appropriate services that can help them meet developmental milestones and enter school ready to learn.

As many as one in four children under age 6 may be at moderate or high risk for developmental, behavioral, or social delays.<sup>2</sup> Larger shares of young children of color are at risk for delays compared with their white peers.<sup>3</sup> Young children living in poverty (100 percent of the federal poverty line, or FPL) are more than twice as likely to be at high risk of developmental delay than those in families with incomes more than double the poverty line (above 200 percent FPL).<sup>4</sup>



Routine, universal developmental screenings, as recommended by pediatric and child development experts, work to identify children with or at risk of such delays. A screen is the first step in a process to uncover an issue that warrants a closer, more detailed evaluation. That evaluation may, in turn, determine whether a child and their family should be referred to early intervention services or other supports. Yet more consequential than a screen itself is what happens once a child is identified as needing referrals and additional services. Children with developmental delays wait, on average, nine months after a parent's stated concern to receive follow-up

assessments and supports.<sup>5</sup> This wait could have serious implications: The sooner children get to early intervention and treatment, the sooner their delays can be successfully addressed. Ensuring children receive developmental screenings, specifically, marks one step toward identifying and addressing their needs. For example, a child with speech challenges that go unchecked could enter preschool or kindergarten behind. A screening could detect hearing challenges, a speech disorder, or other delays. Early identification and treatment can mitigate negative impacts on a child's development and improve their ability to thrive in school.

## What are developmental screenings?

Use of the term “developmental screening” can denote different things to different people in different sectors. A child's growth and development should be regularly measured to identify any delays or problems that require further monitoring or intervention. Developmental screening differs from the broader monitoring or “surveillance” that should occur during every regular checkup, where a healthcare, community, or school-based professional observes the child and asks parents about their physical and cognitive progress.<sup>6</sup> As defined and recommended by the American Academy of Pediatrics (AAP), developmental screening entails using a validated, standardized tool during well-child visits at regular intervals to determine if a child is meeting developmental milestones at various ages and stages.

Developmental screening tools focus on issues such as motor, communications, problem-solving and social development.<sup>7</sup> These tools usually consist of an evidence-based parent questionnaire or series of questions answered by parents or caregivers, as the most frequent observer of their child's developmental progress.<sup>8</sup> Research has shown that using a validated screening tool, beyond surveillance alone, to ask parents about their child's development can more accurately identify a child's risk of a developmental delay or disability.<sup>9</sup> This means that rather than asking typical questions, the professional uses a validated tool that has been tested by research in health care practices and other community settings and has shown consistent results, compared to surveillance. Screening results that signal concerns prompt further follow-up, which could include a

range of actions, from gathering additional child and family history, asking follow-up questions, close monitoring, referrals to specialists for diagnosis and treatment, or others.

AAP's *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*,<sup>10</sup> provides medical providers with an evidence-based template for preventive care screenings and well-child visits. Bright Futures recommends as a best practice that a developmental screening occur at pediatric well-child visits when a child is 9 months, 18 months and 30 months old.<sup>11</sup>

Pediatricians also use well-child visits as opportunities to screen and address the broader social, economic, educational, environmental, and related needs of the children and families they serve. *The Bright Futures Guidelines* recommend a full host of child health screenings that are important for child development, including check-ups for vision, hearing, social/emotional health, and autism. The 2017 update of the guidelines also recommends that pediatricians screen for social determinants of health, such as poverty and food insecurity, as well as for parent or caregiver depression or mental health, which can also greatly affect a child's development.<sup>12</sup> This broader range of physical, developmental and social-emotional screens offers the most thorough look at a child's overall development. This brief, however, refers to the narrower AAP definition of developmental screenings, which excludes autism screenings. This specific definition is also reflected in the available state-level survey data detailed below and in the appendices.





## Developmental Screenings and Medicaid

As the country’s largest health coverage source for children, Medicaid can be a leader in improved healthcare quality, particularly for our nation’s most vulnerable children. Improvements in health care quality in Medicaid can lead to broader system change and better outcomes for children.<sup>14</sup> Key to any quality improvement efforts for children in Medicaid is reliably measuring and actively working to improve developmental screenings and resulting follow-up referrals and treatment.

While children are the largest group of Medicaid beneficiaries, they are also the least expensive compared to other groups<sup>15</sup>—thus, quality improvement efforts often overlook children in favor of strategies to improve services and contain spending on costlier populations of disabled or elderly beneficiaries. The large number of low-income children served by Medicaid and CHIP provides an opportunity to make major gains, offering potential for longer-term savings within and outside the health

system—in education, public assistance, and earnings, to name a few.<sup>16</sup>

As part of Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, states are required to provide a schedule of recommended preventive screens, follow up with any relevant diagnoses and, in turn, any resulting “medically necessary” services children require to treat or ameliorate the condition.<sup>17</sup> As described above, AAP’s Bright Futures includes a periodicity schedule that outlines a number of health screenings that cover many aspects of child development. But states can determine their own schedules for checkups in Medicaid. While most Medicaid programs generally follow the latest Bright Futures schedule, details and reimbursement structures vary considerably.<sup>18</sup> Much opportunity remains for states to fulfill the promise of EPSDT that all children receive the recommended screens, as well as the follow-up services and supports they need.

## Measuring Developmental Screenings

A clear sense of available data and what it captures is critical to accurately assessing developmental screenings in states. Two national data sources allow for a closer look at state-level developmental screenings as outlined above: (1) the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP; and (2) the National Survey of Children’s Health. States also report some

Medicaid EPSDT data to the federal Centers for Medicare & Medicaid Services (CMS) on form CMS-416. However, CMS-416 data is not standardized across states and does not distinguish the types of screenings children receive. Table 1 below summarizes available state-level data sources for screenings with additional detail in the box on pages 5 and 6.

**Table 1: State-level Child Health Screening Data Sources**

Screening Data Source	Latest Year Available	States Available	Ages	Developmental screening captured?*	Method/Data Source	Health Coverage Type
Child Core Set	2016	26	Under 3 years	Yes	State choice to use claims data, chart review or combination	Medicaid and/or CHIP, states may report separately or in combination
National Survey of Children’s Health	2016	50	Under 5 years	Yes	Survey – Parent report	All (public, private subgroups available with less reliability)
EPSDT CMS-416 Data	2016	50	Under 21 (under age 1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)	No	State reports to CMS and some Medicaid claims data	Medicaid, including CHIP-funded Medicaid expansions

\* Reflects Bright Futures definition as use of validated screening tool.



## More Detail on State-level Health Screening Data Sources

### Core Set of Children’s Health Care Quality Measures (Child Core Set)

In 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) launched new quality initiatives, including the development of new child quality indicators, called the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP. A developmental screenings indicator was included in the federally recommended set, which states report voluntarily.<sup>19</sup> The measure—“developmental screenings in the first three years of life”—reflects the AAP’s Bright Futures recommendation, reporting the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.<sup>20</sup> The measure was informed by state pilot experiences as part of the National Academy of State Health Policy’s multi-state Assuring Better Child Health and Development (ABCD) project.<sup>21</sup> It was developed in conjunction with national quality experts and initially endorsed by the National Quality Forum (NQF), an external validator of quality measures in health care. In August 2017 the measure was included in the nine pediatric quality measures recommended for all public and private health payers by the Core Quality Measures Collaborative.<sup>22</sup> States may report the measure for Medicaid, CHIP, or the two programs in combination using administrative claims data, chart reviews, or a combination of the data collection methods.<sup>23</sup>

The federal Centers for Medicaid and Medicare Services (CMS) does not publicly report state-level rates on a single Core Set measure until at least 25 states provide data. In 2016, for the first time in the program’s history, 26 states reported the developmental screening measure for either Medicaid, CHIP or both. Appendix Table 1 shows rates in Medicaid or CHIP for all states reporting the measure in 2016, along with their data collection methodology (also see Figure 1). Starting in 2024, states will be required to report on all measures of the Core Set.

One methodology limitation is that all states reporting the measure use administrative, or Medicaid billing, data to report developmental screenings. Each state sets up Medicaid reimbursement systems differently. Provider billing codes do not necessarily reflect whether or not a developmental screening occurred; rather, they reflect the extent to which medical providers follow the billing guidelines correctly and/or seek reimbursement for the specific service. Further, some states do not have or promote a billing code specifically assigned to developmental screening—one code (e.g., 96110 in most states) could denote developmental as well as domain-specific (e.g., autism) screens. Therefore it’s possible that even if a developmental screen is occurring, it is not reflected in the available claims data either because it’s administratively burdensome for providers to bill or the system does not reflect the developmental screening itself. In addition, changing or clarifying billing codes and systems or relying solely on medical records review could mean added costs, which may deter a state from reporting the measure in the first place.



## National Survey of Children's Health (NSCH)

The National Survey of Children's Health (NSCH), a parent-reported survey collected by the federally supported Data Resource Center for Child and Adolescent Health, provides the only full 50-state estimates of developmental screenings in health care settings regardless of health coverage type. The developmental screening measure, titled "The percent of children, age 10-71 months, who received a developmental screening using a parent-completed screening tool" captures the percentage of young children who had a health care visit during which parents reported completing a standardized developmental screening tool in the past 12 months.<sup>24</sup>

While a similar version of the measure was reported in the 2007 and 2012 NSCH data sets, the Maternal and Child Health Bureau notes that recent changes in the survey's data collection and item wording make it erroneous to compare 2016 estimates to prior years. The redesigned NSCH will support trend analyses beginning with data from 2016.

Importantly, HHS designated the NSCH developmental screening measure as one of 15 National Performance Measures for state Title V Maternal and Child Health Services Block Grants. Typically run by state health departments, the Title V block grant, seeks to promote and improve the "health and well-being of the nation's mothers, children, including children with special needs, and their families."<sup>25</sup> As shown in Appendix 2, 36 states and D.C. use the NSCH developmental screenings national performance measure in their Title V programs.<sup>26</sup>

## Medicaid EPSDT Data

Sometimes policymakers or stakeholders refer to EPSDT screens to mean *any* well-child screens necessary to adequately monitor a child's progress or needs for additional services. States report EPSDT screening data annually to the federal Centers for Medicare & Medicaid Services (CMS), which collects information in aggregate on progress related to preventive screens based on the state's adopted periodicity schedule. Unlike the Core Set developmental screening measure, state-reported EPSDT data are not specific to developmental screenings. As reported, EPSDT data only show whether children are receiving any screens, capturing how many children received at least one age-appropriate screen during the year (i.e., participant ratio), and how many screens were received according to the state's periodicity schedule (i.e., screening ratio). In 2016, the U.S. Medicaid participant ratio was 58 percent and the screening ratio was 76 percent. While EPSDT screening data reported to CMS, called CMS-416 data, can help track whether children are receiving preventive screens in general, it is by no means a proxy for developmental screenings specifically and cannot be used to make comparisons among states.



## Conclusion

---

While the U.S. has made historic gains in coverage for children, reaching nearly 96 percent of all children in 2016, we know far less about the extent to which children receive the care they need.<sup>27</sup> Young children's developmental screenings offer one important indicator of progress. Yet barely half the states report data on developmental screenings in Medicaid and CHIP, and among those states the reported rate of young children receive developmental screens varies widely. Much more work is needed to ensure that delays and disabilities are successfully measured, identified, and addressed. Medicaid guarantees that children receive all of the screens, evaluations, and medical services they need,

yet it is not clear that this standard is being fulfilled. Data limitations further challenge effective assessment of whether children are getting adequate care. While developmental screening is one early step on a child's journey through the health system, better understanding its prevalence can provide initial clues on areas that need improvement or require better data. Filling information gaps can help leaders identify policy and program opportunities to improve the quality and accessibility of health care that coverage promises for young children. Developing and building on baseline children's developmental screening rates is an important first step.

---

### Additional Information: Healthy Child Development Resource Center

The Healthy Child Development Resource Center, administered by the National Academy for State Health Policy (NASHP), maps Medicaid policies and funding reimbursement for developmental screenings by state. This web site also links to profiles, tools and other resources of NASHP's Assuring Better Child Health and Development (ABCD) project, which assisted states in improving the delivery of early child development services for low-income children and their families by strengthening primary health care services and systems that support the healthy development of young children ages 0-3. Between 2000 and 2011, 32 states, most of them supported by ABCD, had implemented policies to improve developmental screening, which informed development of the Child Core Set developmental screening measure. For more information, visit <https://healthychild.nashp.org/resource-center/>.



## Appendix Table 1. Percentage of Medicaid and/or CHIP Enrollees Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool

*Developmental Screening in the First Three Years of Life (DEV-CH), Child Core Set 2016*

State	Program Population	Data Collection Method	State Rate
Alabama	CHIP only	Administrative	32.2
Alaska	Medicaid & CHIP	Administrative	1.6
Colorado	Medicaid & CHIP	Administrative	41.8
Connecticut	Medicaid & CHIP	Administrative	38.7
Delaware	Medicaid & CHIP	Hybrid	50.1
Florida	Medicaid & CHIP	Hybrid	10.7
Georgia	Medicaid & CHIP	Hybrid	50.5
Illinois	Medicaid & CHIP	Administrative	55.1
Indiana	Medicaid & CHIP	Administrative	12.2
Iowa	Medicaid only	Administrative	12.4
Iowa	CHIP only	Administrative	13.3
Louisiana	Medicaid & CHIP	Hybrid	14.6
Maine	Medicaid & CHIP	Administrative	25.4
Massachusetts	Medicaid & CHIP	Administrative	77.5
Michigan	Medicaid only	Administrative	25.9
Minnesota	Medicaid & CHIP	Administrative	45.6
New Hampshire	Medicaid only	Administrative & Hybrid	27.5
Oklahoma	Medicaid & CHIP	Administrative	15.7
Oregon	Medicaid & CHIP	Administrative	54.7
Pennsylvania	Medicaid & CHIP	Administrative	50.7
Rhode Island	Medicaid & CHIP	Administrative & Hybrid	50.6
South Carolina	Medicaid & CHIP	Administrative	33.3
Texas	Medicaid only	Administrative	45.2
Texas	CHIP only	Administrative	45.6
Vermont	Medicaid & CHIP	Administrative	75.2
Virginia	Medicaid & CHIP	Administrative	31.0
West Virginia	CHIP only	Administrative	39.9
West Virginia	Medicaid only	Administrative	49.1
Wyoming	CHIP only	Administrative	2.3

Note: Table reflects total number of states reporting.

Source: Child Core Set FFY2016, Mathematica analysis of MACPro reports for the FFY 2016 reporting cycle. Retrieved from <https://data.medicare.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy>.

States may report the measure for Medicaid, CHIP, or the two programs in combination using administrative claims data, chart reviews, or a combination of the data collection methods. As detailed above, 19 states reported on Medicaid/CHIP program together, three (Iowa, Texas, and West Virginia) reported Medicaid and CHIP programs separately, two states (Michigan and New Hampshire) provided data only for Medicaid populations, while two others (Alabama and Wyoming) reported only on their CHIP program.

To report the measure, states may use Medicaid and/or CHIP payment claims data, medical chart reviews, or a combination of the data collection methods. As shown above, six of the 26 states used a combination of these approaches (indicated as “hybrid in the table above). No state used medical chart reviews as a sole data collection source.



**Appendix Table 2. Percentage of Children 10 Months - 5 Years Receiving a Developmental Screening Based on Parent Report, All Coverage Types, 2016\***

State	Developmental Screening Rate	State Uses NSCH Developmental Screening Measure for Title V Maternal and Child Health Services Block Grant
United States	27.1	
Alabama	16.4	Yes
Alaska	38.1	Yes
Arizona	26.4	Yes
Arkansas	13.7	No
California	20.9	Yes
Colorado	43.4	Yes
Connecticut	28.1	Yes
Delaware	23.2	Yes
District of Columbia	23.9	Yes
Florida	15.7	No
Georgia	27.8	Yes
Hawaii	29.7	Yes
Idaho	23.0	No
Illinois	38.8	Yes
Indiana	23.9	No
Iowa	34.0	Yes
Kansas	30.3	Yes
Kentucky	24.9	No
Louisiana	16.7	Yes
Maine	35.2	Yes
Maryland	34.5	Yes
Massachusetts	41.0	No
Michigan	25.2	Yes
Minnesota	43.4	Yes
Mississippi	11.0	Yes
Missouri	21.1	Yes
Montana	39.8	No
Nebraska	29.7	No
Nevada	21.5	Yes
New Hampshire	30.6	Yes
New Jersey	18.7	Yes
New Mexico	32.8	Yes
New York	15.1	Yes
North Carolina	47.6	Yes
North Dakota	26.8	No
Ohio	32.9	Yes
Oklahoma	25.8	No
Oregon	48.9	No
Pennsylvania	23.2	No
Rhode Island	31.9	No
South Carolina	24.9	Yes
South Dakota	27.6	Yes
Tennessee	28.6	Yes
Texas	33.9	Yes
Utah	28.9	Yes
Vermont	35.9	Yes
Virginia	22.1	Yes
Washington	26.9	Yes
West Virginia	29.0	No
Wisconsin	26.9	Yes
Wyoming	20.7	Yes

\* 2016 Survey was redesigned, making changes to wording and sampling methodology for this measure, making it inaccurate to compare 2016 estimates to prior years.

Sources: Child and Adolescent Health Measurement Initiative (CAHMI), [www.cahmi.org](http://www.cahmi.org); Data Resource Center for Child and Adolescent Health, 2016 National Survey of Children's Health (NSCH) data query, retrieved from [www.childhealthdata.org](http://www.childhealthdata.org); and HRSA Maternal & Child Health, "Population Domains: Child Health National Performance Measures," U.S. Department of Health and Human Services, available at <https://mchb.tvisdata.hrsa.gov/PopulationDomain/Detail/ChildHealth>.



## Endnotes

- <sup>1</sup> See for example, Institute of Medicine, “From Neurons to Neighborhoods: The Science of Early Childhood Development” (The National Academies Press, 2000), available at <https://doi.org/10.17226/9824> or Center on the Developing Child at Harvard University (2016), “From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families.” Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).
- <sup>2</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, “The Health and Well-Being of Children: A Portrait of States and the Nation 2011-2012.” (U.S. Department of Health and Human Services, 2014), available at <http://mchb.hrsa.gov/nsch/2011-12/health/child/childs-health-status/risk-developmental-delay.html>.
- <sup>3</sup> Ibid (2).
- <sup>4</sup> Child Trends: Data Bank, “Screening and Risk for Developmental Delay: Indicators of Child and Youth Well-Being,” (Child Trends, July 2013), available at <https://www.childtrends.org/indicators/screening-and-risk-for-developmental-delay/>.
- <sup>5</sup> G. Kenney and J. Pelletier, “Improving the Lives of Young Children: The Role of Developmental Screenings in Medicaid and CHIP,” (Urban Institute, December 2010), available at <https://www.urban.org/sites/default/files/publication/29436/412275-Improving-the-Lives-of-Young-Children-.PDF>.
- <sup>6</sup> “Developmental Monitoring and Screening,” Centers for Disease Control and Prevention, available at <http://www.cdc.gov/ncbddd/childdevelopment/screening.html>.
- <sup>7</sup> Examples of commonly used standardized tools include the Ages and Stages Questionnaires (ASQ), the Parents’ Evaluation of Developmental Status (PEDStest), and the Survey of Well-being of Young Children (SWYC). A full list is available at US Department of Health and Human Services, “Birth to 5: Watch Me Thrive! A Compendium of Screening Measures for Young Children,” (U.S. Department of Health and Human Services, March 2014), available at [https://www.acf.hhs.gov/sites/default/files/ecd/screening\\_compendium\\_march2014.pdf](https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf).
- <sup>8</sup> U.S. Department of Health and Human Services, “Birth to 5: Watch Me Thrive! A Compendium of Screening Measures for Young Children,” (U.S. Department of Health and Human Services, March 2014), available at [https://www.acf.hhs.gov/sites/default/files/ecd/screening\\_compendium\\_march2014.pdf](https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf).
- <sup>9</sup> C. Bethell, et al., “Rates of Parent-centered Developmental Screening: Disparities and Links to Services Access,” *Pediatrics* (2011): 146-155. Also see Guevara, J., et al., “Effectiveness of Developmental Screening in an Urban Setting,” *Pediatrics*, (2013): 30-37, available at <http://pediatrics.aappublications.org/content/131/1/30>.
- <sup>10</sup> Hagan JF, Shaw JS, Duncan PM, eds., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th ed., American Academy of Pediatrics, 2017. Periodicity schedule available at [https://www.aap.org/en-us/documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/documents/periodicity_schedule.pdf).
- <sup>11</sup> American Academy of Pediatrics, “Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening,” *Pediatrics*, (2006): 405-420.
- <sup>12</sup> See for example: American Academy of Pediatrics, “Poverty and Child Health in the United States,” (American Academy of Pediatrics, 2016), available at <http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf>.
- <sup>13</sup> Op cit (10).
- <sup>14</sup> T. Brooks, “Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders,” (Georgetown University Center for Children and Families, March 2016), available at <https://ccf.georgetown.edu/2016/03/16/measuring-improving-health-care-quality-children-medicare-chip-primer-child-health-stakeholders/>.
- <sup>15</sup> A. Chester and E. Wright Burak. “Fact Sheet: Medicaid’s Role for Children,” (Georgetown University Center for Children and Families, June 2016), available at [https://ccf.georgetown.edu/2016/06/14/medicaid\\_role\\_children/](https://ccf.georgetown.edu/2016/06/14/medicaid_role_children/).
- <sup>16</sup> K. Wagnerman, A. Chester, and J. Alker, “Medicaid Is A Smart Investment in Children,” (Georgetown University Center for Children and Families, March 2017), available at <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.
- <sup>17</sup> K. Whitener, “EPSDT: A Primer on Medicaid’s Pediatric Benefit,” (Georgetown University Center for Children and Families, March 2017), available at <http://ccf.georgetown.edu/wp-content/uploads/2016/03/EPSDT-fact-sheet.pdf>.
- <sup>18</sup> American Academy of Pediatrics, “2015 Medicaid Reimbursement Reports,” (American Academy of Pediatrics, 2015), available at [https://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/medicaid\\_reports\\_national\\_all.pdf](https://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/medicaid_reports_national_all.pdf).
- <sup>19</sup> “The Children’s Health Insurance Program,” (Georgetown University Center for Children and Families, February 2017), available at <https://ccf.georgetown.edu/2017/02/06/about-chip/>, and <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf>.
- <sup>20</sup> Centers for Medicare & Medicaid Services, Centers for Medicaid and CHIP Services, “Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP: Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,” (Centers for Medicare & Medicaid Services, Centers for Medicaid and CHIP Services, May 2017), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>.
- <sup>21</sup> National Academy of State Health Policy, “ABCD: 12 years of promoting healthy child development,” (NASHP, October 2012), available at <https://nashp.org/abcd-12-years-promoting-healthy-child-development/>.
- <sup>22</sup> T. Brooks, “New Pediatric Quality Core Measure Set Released by Collaborative of Public and Private Payers,” (Georgetown University Center for Children and Families, August 2017), available at <https://ccf.georgetown.edu/2017/08/02/new-pediatric-quality-core-measure-set-released-by-collaborative-of-public-and-private-payers/>.
- <sup>23</sup> See pages 71-75 of the “Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specification and Resource Manual for the Federal Fiscal Year 2017 Reporting” (May 2017), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>. Also see CMS June 2013 webinar “Developmental Screening in the First Three Years of Life: Understanding How to Collect and Use the Child Core Set Measure,” available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/developmentalscreeningwebinar.pdf>.
- <sup>24</sup> National Survey of Children’s Health 2016 “Guide to Topics & Questions Asked,” Child and Adolescent Health Measurement Initiative (2017), available at [http://childhealthdata.org/learn/NSCH/topics\\_questions/2016-nsch-guide-to-topics-and-questions](http://childhealthdata.org/learn/NSCH/topics_questions/2016-nsch-guide-to-topics-and-questions).
- <sup>25</sup> “Title V Maternal and Child Health Services Block Grant Program,” US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health, available at <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>.
- <sup>26</sup> “Population Domains,” US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health, available at <https://mchb.tvisdata.hrsa.gov/PopulationDomain/Detail/ChildHealth>.
- <sup>27</sup> J. Alker and O. Pham, “Nation’s Uninsured Rate for Children Drops to Another Historic Low in 2016,” (Georgetown University Center for Children and Families, September 2017), available at <https://ccf.georgetown.edu/wp-content/uploads/2017/09/Uninsured-rate-for-kids-10-17.pdf>.



This brief was written by Elisabeth Wright Burak of Georgetown Center for Children and Families and Mike Odeh of Children Now. The authors would like to thank the following individuals for their reviews and contributions to this report: Tricia Brooks, Phyllis Jordan, Dulce Gonzalez and Kyrstin Racine of Georgetown CCF; Anne Edwards of the American Academy of Pediatrics; and Carrie Hanlon of the National Academy of State Health Policy. Views reflected in this brief do not necessary reflect those of reviewers. Design and layout provided by Nancy Magill.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based in the McCourt School of Public Policy's Health Policy Institute.

Children Now is California's leading nonpartisan umbrella research, policy development and advocacy organization dedicated to promoting children's health, education and well-being. Children Now also leads The Children's Movement of California, a grassroots network of more than 2,200 business, education, parent, civil rights, faith, community-based and multiethnic organizations, as well as thousands of individuals, working together to make children a top priority in public policy. Learn more at [www.childrennow.org](http://www.childrennow.org).

Georgetown University  
Center for Children and Families  
McCourt School of Public Policy  
Box 571444  
3300 Whitehaven Street, NW, Suite 5000  
Washington, DC 20057-1485  
Phone: (202) 687-0880  
Email: [childhealth@georgetown.edu](mailto:childhealth@georgetown.edu)



[ccf.georgetown.edu/blog/](http://ccf.georgetown.edu/blog/)



[facebook.com/georgetownccf](https://facebook.com/georgetownccf)



[twitter.com/georgetownccf](https://twitter.com/georgetownccf)