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Research Review for Characteristics of Presumptive Eligibility Promoting Early Intervention Access

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Fevola, A., Bagnato, S.J., Matesa, M., & Lehman, C. (2006). Research review for characteristics of presumptive eligibility promoting early intervention access. Pittsburgh, PA: TRACE Center for Excellence in Early Childhood Assessment, Early Childhood Partnerships, Children's Hospital/University of Pittsburgh; US Department of Education, Office of Special Education Programs, and Orelena Hawks Puckett Institute.

Abstract

The practice and effect of presumptive eligibility (PE) to provide expedited entry into early intervention services (Part C) for children birth to five is the focus of this research analysis and synthesis. PE is characterized by flexible regulations and procedures allowed and used by states and agencies to enable quick access of children and families into coordinated community-based human services through the use of pre-identified and pre-existing risk factors to circumvent the traditional eligibility determination process.

The research synthesis included 33 studies which directly or indirectly examined the features and outcomes associated with this PE. The reviewed literature suggests that PE practices are associated with improved access to care, reliance on multiple sources and types of information (e.g., risk factors, functional and diagnostic information) and timely enrollment into a more coordinated range of services and supports, especially within the healthcare system. Meager literature refers to the use of PE for eligibility determination in early intervention. Implications and usefulness of PE practice for child finding and early identification in early intervention are described as well as fundamental changes required in the system of care in the U.S. to align with presumptive eligibility principles and practices.

Research Review for Characteristics of Presumptive Eligibility

Promoting Early Intervention Access

Purpose

The purpose of this practice-based research synthesis is to identify the distinguishing characteristics and to systematically examine the effectiveness of a practice known as *presumptive eligibility (PE)* for improving states' Part C eligibility determination practice as regulated under the Individuals with Disabilities Education Act and Early Intervention Program for Infants and Toddlers (IDEA, 1997; IDEIA, 2004). Presumptive Eligibility (PE) is a relatively novel, underutilized and un-researched practice when applied to early intervention and/or special education. Since the inception of PE as an administrative practice, 11 states have adopted PE wholly or in part in health and mental health services. PE is part of the larger Medicaid, SCHIP, WIC and CHIP expansion strategies to simplify the enrollment process and to ensure appropriate and timely entry of eligible populations into the health care system, presumably including early intervention services and/or special education for children with established risk factors (Shackelford 2005; ; Klein, 2003, Ross and Cox, 2000; Schwamm, 1996;) An at-risk infant or toddler is defined under Part C as "an individual under 3 years of age who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual" (20 U.S.C. §1432(1). However, the degree or level of severity of the delay and the list of PE risk factors that each state allows as eligibility markers is highly heterogeneous, arbitrary, and unsupported by research.

The presumptive eligibility (PE) practice is characterized by the use of pre-determined and pre-existing "risk markers" such as child, family, and environmental characteristics which

place a child and family high risk for future problems in the absence of early intervention services. The quality and impact of PE requires coordination among qualified community-based service entities; these entities are intended to function as outreach resources, make presumptive eligibility decisions, and expedite the enrollment process (Shonkoff & Miesels, 1991; Ross-Cohen, 1998; Perry et al. 2000; Simeonsson 1991). The practice is also associated with other measures (e.g., express-line eligibility, continuous eligibility and adjunctive eligibility) and in some states cross-linked to gather information from other public and social programs (Andrulis et al. 1999). The practice is intended to streamline and facilitate eligibility determination decisions and reduce, if not eliminate, burdensome procedures and paperwork.

PE was selected as the focus of this research practice synthesis because of the implications and promise it holds as part of the larger child-finding, referral and early identification strategies to permit a timely entry of high risk children and families into early intervention Part C services and as they transition from Part C to Part B. We therefore decided to systematically examine the utilization and characteristics of the practices, and any of its impacts, as currently available and retrievable from the literature. This research synthesis applies the characteristics and consequences framework suggested by Dunst et al., (2002) in that it focuses on the identification of the PE practices characteristics which were most often encountered or described in the literature as influencing best practice outcomes.

Background

. PE practice was originally conceived and applied to eligibility decisions pertaining to accessing Medicaid services and SCHIP programs (Klein 2003). This practice was first defined in the Balanced Budget Act of 1986 and then expanded through Title XXI of the Social Security Act in 1997. PE underpins and authorizes Medicaid's extension of benefits to low-income, pregnant women, families and children to receive temporary health care coverage for themselves and/or their children up to 60-90 days or in some cases until a "regular" eligibility determination is made (Kronebusch & Elbel, 2004; Klein 2003; Ross-Cohen, 1998). Leading up to the concept's "formal introduction" in 1986, there was a growing concern about states' improper denial of medical services to as many as 52,000 children and a too complex application process that deterred enrollment of needy children and families to prevent problems. This conception is aligned with the missions of early intervention in that PE would encourage more regular perinatal and prenatal care among low-income women between the ages of 14-44 who had significant risk factors (Swann, 2003). Presumptive eligibility has since become a part of a wide range of strategies offered to states to improve enrollment practices and thereby extend health care coverage and deliver healthcare services to eligible children, mothers and families (Future of Children Fast Facts; BIPA, 2000; Klein, 2003, Ross-Cohen and Cox, 2000).

Description of the Practice

Despite the heterogeneity of PE, it is still possible to arrive at a definition of PE practices by extracting and synthesizing distinguished attributes from the reviewed literature. The general policy used by states refers to PE as an "option" through which states can authorize immediate access to medical care or health services and delay completion of paperwork until later (Klein, 2003). Others have referred to PE as a screen-and-enroll process *completed by a qualified entity* (usually a community outreach staff member who completed state mandated PE training) (Federal Register/Vol. 67, No. 191;Kronebush & Elbel, 2004).

Under Part C IDEA/IDEIA, presumptive eligibility can enable early intervention lead agencies to provide required and necessary services to children who have *conditions of established risk*. A condition of established risk is defined as a "diagnosed physical or mental condition which has a high probability of resulting in developmental delay. (20 U.S.C. §1432(5)(A)(ii). Each state differs in the adoption of risk factors as a category for eligibility and of these not all include the same risk factors when considering or determining eligibility for services (Spiker, 2000). There is a general consensus however that these differences in eligibility requirements can be surmounted when providers use *a combination of categorical and functional classification* as supposed to the more traditional categorical diagnostic condition approach (Shonkoff & Miesels,1991; and 2000). Klein, (2000) describes presumptive eligibility as a *bridge between outreach and enrollment* and as an effective method to improve children's access and enrollment into health coverage programs (Klein, 2000; Families USA 2000). Others have suggested that PE is a way to directly ensure the child a more timely professional evaluation (Mott & Dunst, 2004). Other instances as in the case of the States of Wisconsin & Tennessee, PE practice is described as a *preventive outreach practice* for expectant mothers with

risk conditions or indicators. Using these and other sources, it was possible to compile a working definition of PE as encompassing the following four attributes and practice characteristics: (1) **Pre-determined and/or established risk factors** as a guide to reach consensus for eligibility determination (e.g., low birth weight--<1500 grams, Down Syndrome, early alcohol and drug exposure, poverty); parallel inclusion of more functional terminology in the classification of children's limitations and needs (e.g., "developmental delay" , "pre-school delay", "pre-school special needs" and "preprimary impaired"; at-risk indexes for behavior problems based on cut-off scores; functional profiles on the *International Classification of Functioning-ICF*); (2) **Expedited eligibility processes and decisions**; reduction of paperwork; increased time and effort to define service needs and appropriate health and/or early intervention programs and supports; (3) **Community outreach supports** by qualified health and/or early intervention practitioners as sources for initial eligibility decisions; (4) **Administrative links** among different health and human service programs.

The general consensus derived from the policy and research literature frames PE as an administrative procedure used by a "qualified entity" to facilitate enrollment of applicants into medical and/or health care-related programs and services, without the need of supporting documentation on the part of the families/applicants. There is also a general assumption that PE as a practice "improved access to timely health care, simplified the application process for families, and reimbursed providers for services to otherwise uninsured children" (GAO, 2000). These descriptions or characteristics were in turn used as indicated below in refining our search strategies to identify relevant literature. As further described in the selection criteria below, this synthesis attempted as much as possible, to identify studies which related the use of one or more of these practice characteristics with the diverse needs of families and children. Our search

examined the few studies which analyzed successful access to timely health and human services, including early intervention and/or special education services and who received a more appropriate identification of delays as applicable to Part C. It became apparent, however, that research on the effects and outcomes of PE related directly to Part C early intervention and early childhood special education is meager and will require more planned and intensive study.

Search Strategy

Search Terms

The search process for relevant studies used a variation on phrases in conjunction with PE (e.g., p*resumptive eligibility*; PE or *eligibility* and *early intervention PE and/or, early identification and eligibility; early childhood and presumptive eligibility; educational diagnosis and PE or eligibility; Health and early intervention and PE or eligibility; learning disabilities and PE or eligibility; eligibility determination and infants; evaluation and PE or eligibility) as* base- key-searching-terms. Definitions and descriptors for the search were derived as papers and articles were identified and cross-referenced, as the reference list of these studies were also examined. In addition, we used compiled PE characteristics to guide further searches. The majority of the literature referred to PE as a part of the Medicaid//SCHIP expansions and very few focused on studying the independent impact of PE as relating to early childhood intervention and/or special education.

In conducting the computer-based key-word search we accessed various on-line library databases including: Psychological Abstract (PsychInfo), Social Sciences Citation Index, Education Resource Information Center, OVID MEDLINE, CINAHL CIRRIE, Elsevier Science Direct, Ingenta, JSTOR, ISI Web of Knowledge, EBESCO, Cochrane Library and Pub Med. Additional searches were also conducted using Google Scholar search engine. We also reviewed policy papers and studies concerned with early intervention covering the birth to five years and

birth to 18 year age ranges; as we identified additional terms and/or conditions, these were added to our search.

Selection Criteria

Studies were included in the review when they: (1) directly used presumptive eligibility in the title or anywhere within the article; (2) indirectly related to presumptive eligibility by addressing expansions in the eligibility requirements of infants and toddlers as related to IDEIA Part C; and (3) showed some association, some implication for Part C (i.e., early detection and identification of handicapping conditions; early access to care, continuity of care etc.). Child age was initially a precursor for inclusion/exclusion criteria from this synthesis, but we had to lift this constraint and expand the search to children 0 to 9 years and later from 0 to 18 years of age in order to capture any relevant information that could inform the use of PE and/or more generally the impact of the expansion of eligibility rules which included PE. Another criterion that was lifted was stringent research design as searches conducted using this criteria yielded scant results. Hence, we included position papers and other qualitative articles whenever these were considered relevant to state and federal policy directives, guidelines in regard to eligibility and/or referred in any ways to presumptive eligibility. We excluded most of the articles related to general eligibility decisions since this aspect of practice has been already addressed by Dunst, Bagnato, Gorman & and Trivette, (2004).

From the literature review, it emerged that not much is currently known about the effectiveness of PE practices especially in how it has influenced or improved Part C early-identification, referrals and child-find procedures. It also became apparent that the majority of the literature referencing PE or eligibility rules for children is grounded in participation in health care insurance, health services needs and enrollment into primary health and medical care. This

does not take away but actually adds even more relevance to PE practices as an important link between psychological, social and medical health as it might be a natural conduit (albeit not tested) to accelerate and improve coordination between health and Part C early childhood intervention and child-finding activities. This synthesis summarizes the research findings about the current best available evidence on the use and effect of PE practices.

Search Results

A consensus approach was used to sort the outcomes of the searches and to select articles to include or exclude from this synthesis. This process resulted in a group of 44 articles from the field of health, health care financing, special education, and early intervention which were most relevant. Policy papers were identified, that directly or indirectly covered presumptive eligibility or eligibility as relating to early identification and intervention for Part C & Part B of IDEA. Of these, 33 articles were finally selected which met one or all of the inclusion criteria we used for this research synthesis. Table 1 reports the final selection of the studies which have direct or indirect implications regarding the use and effect of presumptive eligibility.

Participants

Overall for the 33 articles reviewed, 51% or 17 studies analyzed data on 144,412 participants. Of these, 88,507 (23%; n=10 studies) included families with eligible children, and/or mothers/pregnant women or participants who had eligible children. Another 12 studies (36%) included 55,905 infants, toddlers and/or preschool children. A total of 12% (n=4) of studies did not include participants. Age was provided in about 36% (n=12) of the studies for the children and in two studies for other participants. The average age of the participant children was nearly 5 years of age (4.7) and ranged from birth to 18 years of age. For other participants,

age ranged between 14 and 44 years of age. Gender was reported in 7 of the 33 studies (21.1%) and on average males comprised 47% of the total sampled populations of children.

Presumptive Eligibility

Table 1 profiles the frequency of the PE practice characteristics as these were addressed, discussed or referred to in the selected article/studies. This table also classifies the setting or the focus-area of the study (e.g., Health, Administration or Social). There seems to be a wealth of information and research done in regard to health coverage expansions. Hence, we were selective and included only a representative sample based on the contents of the articles as well as how often the article/study had been cited. We reduced the defining characteristics of PE practice to four major elements (previously identified) based on the frequency of their occurrences:

(a) Pre-determined and/or established risk factors (frequency of occurrence of 17.3%),

(b) Expedited eligibility processes and decisions (frequency of occurrence of 24.7%),

(c) Community outreach supports (frequency of occurrence of 30.1%), and

(d) Administrative interagency links (frequency of occurrence of 28.4%)

Study Findings or Outcomes

The most cited outcomes or indicators associated with PE practice were “expedited enrollment and/or access to care/services” and administrative linkage. PE is intended as a tool for accelerating enrollment. Within the context of Part C eligibility, it is interpreted as having two additional potential roles. The first function is enabling qualified professionals to reach eligibility determination decisions based upon functional developmental indicators and researched risk factors, instead of categorical diagnoses. The second function of PE practices, is an important aspect of outreach-support strategies through which families can be engaged into the

care/services, while at the same time being supported informed and guided through the enrollment (or also eligibility re-determination) processes. The reviewed literature is informative on the intended impact that PE and other practices have had on increasing enrollment, improving preventive care, and expediting contact with health care and producing better health outcomes for children or mothers. How well these practices are being implemented remains to be determined. In Table 2 we have included the descriptive characteristics within each study and provide a synthesis summary of the salient finding as it has implications for this PE practices synthesis.

Research Designs

The last table (Table 3) summarizes the description of the studies on the basis of the research design and statistical procedure used. This table also includes sample information as available. The studies were divided in four major categories or strands. The first strand includes 15 studies (45%) and were coded as surveys (mail, telephone, interviews) studies. These were mostly qualitative descriptive articles (67%) and about 20% (n=2) were coded as correlational only and another 20% (n=3) as including also multivariate regression analyses. The second group of studies (n=5 or 15% of the total) were classified as ‘discussion/position/policy papers. In all cases (100%) this work was qualitative and used mostly literature or content analysis as their main method of investigation. The third strand of study design (n=8, 24%) were coded as “secondary data analysis”. Of these studies, the majority (n=7, 88%) used multivariate, regressions statistical methodologies and the remaining 2 (25%) used correlational analyses. The last or forth strand was labeled as “pre-post comparisons” studies since in the majority of the cases the sample was not randomized and did not have a control group that could have qualified

as quasi-experimental research. Of these studies 80% (n=4) used multivariate, regression techniques to analyze the data and one used descriptive-correlation statistics.

Secondary data analysis and survey research designs were the most frequent research methodologies used when analyzing administrative or structural factors within PE practices. The secondary data were obtained from a variety of sources including national databanks such as the National Maternal and Infant Health Survey, Current Population Survey, National Health Interview Surveys, and the National Early Intervention Longitudinal Study (NEILS). Additional sources included local data records such as for instance, the Colorado Child Welfare (CWEST) and records from Part C Lead Agency. Diverse types of local and state information data sources provided information about referral, intake/medical records, demographic and socio-economic characteristics, as well as a range of health and services utilization.

Synthesis Findings

Presumptive eligibility holds some promise as a useful strategy to capture children and their families who are eligible but not enrolled in health and/or developmental programs. PE is construed as an administrative pre-determined process to speed up the decision-making process regarding eligibility. PE, when first introduced, was to assist pregnant low income women to overcome barriers that prevented their seeking and applying for health care services. Simply, PE was intended to encourage preventive health care behaviors and anticipate (i.e., “early-entry”) the provision of appropriate prenatal and perinatal care for pregnant women with risk factors (Perry, 2000; Swann, 2003, Klein, 2003). Hence, it is not surprising that the large bulk of the literature concerning PE practices is found mostly in the administration and health related fields, and that evidence and applicability of PE within the early childhood, and/or special educational is limited.

PE research shows increased enrollment, and a timely access to needed healthcare services for vulnerable children and families. Wolfe et al. (2004) for instance found PE to be associated with lower probability of not having coverage. This was especially the case in the early years of the Medicaid/SCHIP implementation which indicated PE to be the biggest program factor for 1998 in reducing the probability that children will be without coverage by at least 5 percentage points (Wolfe et al. 2004). The study also indicates that best results in terms of children's enrollment were obtained in states which had a separate SCHIP program. Yet, using presumptive eligibility was consistently associated with a higher probability of participation. Similar outcome results are presented by Szilagyi and colleagues (2004), which measured the impact of the New York State SCHIP on children's access, utilization and quality of health services. Using a pre-post test design with a sample of 2,644 children, this study concludes that SCHIP expansion and simplification strategies (of which PE is a part of) beside increasing enrollment had also significantly contributed to increased visits, thereby strengthening the continuity of care (pre 47% vs. post 89%) and the quality of care. The greatest impact was observed on children with the lowest baseline health indicators at pre-test (Szilagyi et al. 2004). Other studies also confirm these findings. Swann (2003) using a hazard rate analysis, finds that the ability to self-declare income, presumptive eligibility and adjunctive eligibility for pregnant AFDC and Medicaid recipients, significantly increased the probability of participation in health care ($p= 0.05$). An evaluation conducted by the Office of Inspector General (OIG, 200) examines the impact of various SCHIP models and expansion strategies including PE. The evaluation finds that together with out-stationing, applications processing times, outreach activities and type of SCHIP model implemented to be a significant predictor of enrollment outcomes. Accordingly, it was observed that the use of outreach activities was 2.5 times more

likely to enroll children; “outstationing” support workers were 2.4 times more likely to facilitate enrollment and; that the centers that used PE were 1.7 times more likely to increase enrollment of children (OIG, 2000). Timing of the eligibility decision also affected enrollment with the center that had lower turnaround time (one month or less) with higher rates of enrollments (OIG, 2000). PE has also been suggested as an advantageous administrative strategy for shortening lead-time between application and enrollment, and as part of promising inter-programs coordination efforts to link health to other types of services and programs (O'Brien et al. 2003).

However, these and other studies also provide evidences that suggest that PE effects on measured outcomes are more likely to be observed when combined with other outreach and/or expansion variables. OIG (2000) regression analyses indicated in fact, that when PE was factored in with other elements (e.g., training plus outstationing) the result showed significant interaction effects, but when factored alone its contribution was marginally significant. It is has also been observed that states which had more aggressive outreach/support activities and less stringent eligibility policies were also those that reported lower probability that the child was without coverage (Rosenbach et al. 2003; Gold et al. 1993; Kronebush & Elbel, 2004; Epistein & Newhouse 1998; Racine, 2001).

Kronebush & Elbel, (2004) using logit-regression models did find that simplifying enrollment and relaxing eligibility rules, among which the adoption of presumptive eligibility, did have a relatively large and significant effect on the likelihood of children being enrolled in health programs by an average of 6.4% points. The study also provides evidence that PE worked best when accompanied by direct personal administrative contact in facilitating application process and finding solutions for the potential recipients (Kronebush & Elbel, 2004). Indeed, PE

effectiveness would seem dependent on the presence (or better yet, the absence) of many other structural variables.

Presumptive Eligibility Utilization

There seem to be a number of factors that might explain the underutilization, perceived usefulness, and the adoption of PE practices across the states. In exploring issues and satisfaction relating to the process by which families entered early intervention Bailey et al. (2004) found eligibility category to influence the quality of family experiences with EI. Families identified as having a child with developmental delay and/or in at risk categories do seem to have differing experience when compared to families of children with established diagnostic conditions which suggest that the type of eligibility category and rules a state adopts is a very important variant in the implementation, success and practice of PE. As Shackelford (2006) indicates, under Part C states must provide services for children who are experiencing developmental delays and those who have diagnosed mental or physical conditions that have a high probability in resulting in developmental delay. In addition, States are given the option to adopt a third eligible category known as "at risk of experiencing substantial developmental delay" (Shackelford, 2006). However, the application of these and of the optional categories varies greatly across states. For instance, only 10 states have opted to include at-risk children as an eligibility category and this category is not available under Pert B which intrinsically makes these states liable for discontinuity of care and services, despite their more aggressive enrollment practices in Part C (Shackelford, 2006). These and other variability in the categories used by states for granting eligibility becomes even more relevant when considering that 62% cited developmental delay for the reasons provided by families for eligibility to Part C, followed by

diagnosed medical conditions (22%) and associated biomedical and/or environmental factors/conditions (17%).

Additional factors which might help explain the low rate of utilization of PE by locality and states is offered by Mott & Dunst (2005). For instance, Mott & Dunst (2005) showed PE use for only 185 of the children across 4 regions of North Carolina. The study found that the largest majority of children with identified conditions and those with biological or environmental risk factors were not made presumptively eligible. The study suggests that this underutilization might be explained by the poor use of referral information at the time of determination and bureaucratic eligibility determination procedures (Mott & Dunst, 2005). Additional reasons for this low utilization of PE are discussed in Klein (2003). Currently, PE has been adopted in only 9 states. According to Klein, PE has some drawbacks in that it requires some initial investments in training; the fear that services rendered under PE will not be fully reimbursed has perhaps kept states away from PE. Also, in many states that have adopted other types of administrative simplification such as retroactive eligibility, it is felt that PE is an unnecessary process (Klein 2003). Hence, while there is evidence that the use of functional and curriculum based developmental measures can assist to corroborate eligibility decisions, states' policy and implementation inconsistency and variability in acceptance of these measures might be further cause for disqualifying rather then qualifying eligible children (Harbin et al., 1991; Danaher, 2004; Bricker et al. 2003).

Even when PE is perceived to be useful, and states eligibility policy is less restrictive, it does not guarantee an appropriate and effective utilization of this practice. In their nationwide telephone survey of 1,335 low-income parents and six focus groups exploring barriers to enrollment, Perry et al. (2000) found that between 51%-55% of the participating parent groups

reported that the ability to get services and complete forms and application later through PE was the most helpful process (Perry et al. 2000). This survey suggests that part of this underutilization and decreased effectiveness of PE and of simplification strategies in general can be linked partly to the participant characteristics and perceptions. For instance, of the surveyed parents, 72% perceived the enrollment process as being a “hassle”; another 62% reported the process of enrolling as being too complex, to be too difficult and/or too long (52%) and to be inconvenient because of the office hours (44%). Additional perceived barriers included difficulties in getting to the site (39%); lack of knowledge of eligibility guidelines and rules (58%), and/or of where to go (56%) or finding forms confusing and complicated (50%) (Perry et al. 2000). Barriers to enrollment were also addressed in Peterson et al. (2004). This study indicates that being of "color" and with low education was associated with decreased likelihood of participation/enrollment in Part C (Peterson et al. 2004). Some of the obstacles that can suppress the effect of PE are inherent in states welfare policies such as crowding-out reduced income qualification and mandatory period of wait (up to 6 months) even when the applicant is found presumptively eligible (Kronebush & Elbel, 2004; Ross-Cohen & Cox, 2005). Requiring a fee for services from poor parents is also suggested as further impediment in parents’ utilization of Part C and creating delays in access and receipt of services (Grant, 2005). Contrasting polices and more recently the retrenching on the part of some states in their eligibility policy makes it difficult to establish with any degree of confidence the effectiveness of PE practice in accelerating children’s and parents’ access to Part C and/or other social and health care services.

Conclusion

PE practice characteristics identified in this synthesis do seem to be associated with improved access to care, creation of supportive service linkages, and a better coordination of the enrollment process. It also offers a link between other programs as children who are eligible for SCHIP can be presumed eligible for other types of programs. The results, for health-related services, however, show that notwithstanding these positive trends in the use and impact of PE remains an underutilized yet promising practice, whose effectiveness is reversed and/or suppressed by contrasting welfare policies. Moreover, while functional classification and risk factors can be useful in eligibility determination, it may also present a discontinuity when children transition from Part C to Part B. The overall results from this synthesis do seem to indicate that overall PE can be effective for eliminating unnecessary delays and providing a timelier and more appropriate connection with care and services. PE is used more frequently for infants and toddlers than it is for older children. Infants with a health condition or delay can be automatically presumed eligible for Part C services. Hence, it would seem that PE is much needed for children who transition out of Part C as a way to ensure continuity of care. Yet, Part B policies in states often require "pre-determination" or more appropriately "re-confirmation" of degree of developmental delay which defeats the purpose of PE for early entry and continuity of services for maximum benefits.

Implication for Practices

Presumptive eligibility was targeted by this Cornerstone because it holds promise for child-finding, referrals, and for increasing the likelihood that children with developmental conditions or delays can more easily access developmental specialists and physicians. One of the fundamental goals of early intervention is timing and engagement of the child into preventive

or ameliorative care as soon as possible. This is why the application of PE to expectant mothers (especially mothers with risk factors) may be viewed as strengthening and not weakening the link between healthy development and neurodevelopment functioning, before the child is even born. Yet, the use of PE as an effective child-finding strategy needs to be further developed and strengthened. As the identified characteristics of PE suggest, PE requires a connection between four interconnected elements. PE is most effective when attached to community outreach support strategies (i.e., inform & guide). At the administrative level, PE determination must guarantee a timely, obstacle-free access to qualified early childhood professionals and/or intervention (i.e., engagement). Most importantly, PE could be a more effective gateway to early intervention if the practice uses functional and at-risk parameters rather than non-health related, means-tested eligibility determination decisions (e.g., diagnoses, SES, parent work status). Finally, to maximize the effectiveness and relevance for child-finding and referral, PE practice must incorporate a coordinative-follow-up element both in finalizing enrollment but most importantly to enforce and verify needs during and upon transitions (i.e., continuity and feed-back).

While PE for child-finding, and referral remains on unsure grounds it is also worthy to note that in general, PE usefulness is only derived by relative restricted and means-tested access to health care that is in place in the U.S. Moving toward a universal system of early care and education for all children would eliminate the need for eligibility determination for enrollment in a program since such entry would be guaranteed. Then, decision-making could center on the need for and deliver (within the guaranteed program) of support services to maximize individual children's progress and the coping of each family. In the absence of a universal system of care,

presumptive eligibility, like all similar determination strategies and their complicated and ever-changing administrative silos, will leave many vulnerable individuals unsupported.

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Table 1

Characteristics of Presumptive Eligibility

Study	Expedited Timing Continuity of Contact & Receipt of Care	Administrative-Linking Strategy	Functional-Developmental Risk Indicators	Outreach Supportive Function	Study Description
Andrulis et al. (1999)	1	1		1	Strategies to increase enrollment in children's health insurance programs
Bailey et al. (2004)	1		1	1	Families' first experiences with early intervention.
Bricker et al. (2003)			1	1	Use of a curriculum-based measure to corroborate eligibility decisions.
Carlson-Coccodrilli & Scharf (2004)		1		1	Reforming New York city's fragmented child care subsidy system
Danaher 2004)	1		1	1	Eligibility policies and practices for young children under part B of IDEAS
Danaher et al. (2004)			1		Comparison of eligibility policies for infant/toddler programs and preschool special education programs.
Epistein & Newhouse (1998)	1	1		1	Impact of Medicaid expansion on early prenatal care and health outcomes.
Gold et al. (1993)		1	1	1	The Medicaid eligibility expansions for pregnant women
Grant (2005)	1	1		1	State strategies to contain cost in the early intervention program
Harbin et al. (1991)	1		1	1	Defining the eligibility population: Policy issues and challenges
Klein (2003)	1	1		1	Presumptive Eligibility, a description
Kronebush & Elbel (2004)-2	1	1			Simplifying children's Medicaid and SCHIP.
Kronebush & Elbel, (2004)		1		1	Enrolling children in public insurance
La Paro et al. (2002)			1	1	Special education eligibility: Developmental precursors over the first three years of life.
Mott & Dunst, (2004)	1	1	1		Utilization of PE for Part C of the Infant-Toddler program
O'Brien et al. (1996)		1	1		Defining eligibility criteria for preventive EI in a NICU Population.
O'Brien et al. 2003	1	1		1	State experiences with access issues under CHIP expansions.
Office of Inspector General (2000)	1	1		1	Improving SCHIP enrollment and adapting to a managed Care environment.

Perry, et al. (2000)	1			1	Medicaid and children: Overcoming barriers to enrollment, findings from a national survey.
Peterson et al. (2004)	1	1	1	1	Early Head Start: Identifying and serving children with disabilities.
Piper et al. (1994)	1	1			PE effects on prenatal care and perinatal outcomes.
Racine et al. (2001)		1		1	Differential impact of Medicaid expansions by race and ethnicity.
Robinson & Rosenberg, (2004)		1	1		Child welfare referrals to Part C
Rosenbach et al. 2003	1	1		1	Evaluating the implementation of the SCHIP
Ross-Cohen & Hill, (2003)		1		1	Enrolling eligibile children and keeping them enrolled.
Ross-Cohen (1997)	1			1	PE for enrolling unisured children in Medicaid.
Ross-Cohen, & Cox, (2005)	1	1			State choice influence health coverage access for children and families.
Scarborough et al. (2004)			1		A national look at children and families entering early intervention
Shackelford (2006)			1	1	State and jurisdictional eligibility definitions for infants and toddlers with disability under IDEA.
Spiker et al. (2000)		1	1	1	A framework for describing variations in state EI systems.
Swann (2003)	1	1		1	The dynamic of prenatal WIC participation.
Szilagyi et al. 2004	1	1		1	Improved access and quality of care after enrollment in the New York state SCHIP
Wolfe et al. (2004)	1	1			How the characteristics of SCHIP programs affect take-up.
Total Occurrences	20	23	14	24	
% of Total Occurrences	24.7%	28.4%	17.3%	29.6%	0.0%

Table 2

Outcomes and Related Practices

Study	Describing Practice	Findings-Outcomes
Andrulis et al. (1999)	Timely enrolment and expedited receipts of care. Simplification of enrollment strategies Pragmatic administrative linkage	PE is suggested as a strategy to improve access to timely health care, simplify the application process for families and provide a reimbursement plan for the provider serving uninsured children. PE also provides opportunity for linkage to other social programs. Link with adjunctive eligibility is suggested.
Bailey et al. (2004)	Timing of entry in Part C EI programs. Multiple location or source of referral Utilization of categorical eligibility rules.	On average the timing between first concern and entry into EI was 6.6 months. About 86% of families expressed concerns to a doctor or other medical professionals. Children with non-diagnosed conditions had on average a 5.2 to 13 months lead time wait between diagnosis and enrollment in EI.
Bricker et al. (2003)	Application of curriculum-based measures to eligibility. Usefulness of multiple sources of measures.	Specificity analysis indicates on average a rage between 70% to 90% sensitivity of the AEPS measure. Under identification ranged between 0% to 8% and over identification ranged between 5% to 25%. Overall, CBM measures were found to be useful in corroborating eligibility decisions.
Carlson-Coccodrilli & Scharf (2004)	Administrative improvement for enrollment. A linked community-based application process	New York City should institute a uniform system of presumptive eligibility for child care benefits. The result will be in significant benefits to the family, as well as efficiencies to the system.
Danaher 2004)	Linkages for ensure continuity of eligibility Utilization of categorical eligibility rules. Use of multiple experts of professional judgment.	Acceptable non-categorical terms include developmental delay which has been adopted in 35 states. Twenty-eight states have allowed the use of team consensus, professional judgment/informed clinical opinion, diagnosed conditions, and/or locally determined criteria. The improvement in recent legislations has enabled the option on non-categorical eligibility for children of all ages which accordingly should facilitate continuity in eligibility as children live Part C for Part B.
Danaher et al. (2004)	Use of categorical eligibility for preschoolers Use of developmental and other risk information in eligibility determination.	In 60% (30 States) children eligible for part C are likely to be eligible for Part B. Number of risk factors, professional judgment, psychometric inequivalence and use of categorical diagnosis, all affect eligibility and/or eligibility continuity. States on which eligibility continuity are more likely to use more than one source of judgment for determination.
Epistein & Newhouse (1998)	Timely enrolment and expedited receipts of care.	Increases of 3 percentage points in women initiating care in the first trimester, improved utilization and regular source of care were some of the observed results. In summary, provision of insurance coverage appears to have an inconsistent impact on timely access to care and health outcomes.

	Improved utilization of health and services Increased availability of a regular source of care.	
Gold et al. (1993)	Multiple location or source of referral & access	PE associated with the levels of states aggressiveness in expanding eligibility and access to care to low income pregnant women. State who had limited or no PE ranked lowest. But PE alone was not a sufficient element in increasing accessibility and provision of prenatal care. The level of PE provision in 1991-92 in Medicaid included 1,715 sites across 23 states and 950 counties.
	Streamlining of care enrollment processes. Use of qualitative & quantitative criteria in eligibility determination	
Grant (2005)	Timing of entry in Part C EI programs.	States eligibility retrenching according to this article might be due to attempt of state to shift some of the cost back to private insurance to cover basic child health care services. The term used is “medically indicated vs. developmentally indicated although the distinction might be an artificial one and only for cost-containment reasons. Efforts to increase revenue by requiring parent fees are likely to reduce Part C utilization, create delays in service delivery, and also fail to generate enough revenue to offset associated expenses".
	Improved services/care accessibility	
Harbin et al. (1991)	Utilization of categorical eligibility rules.	Of 39 states, 97%included developmental delay as established conditions. Variability in states' definitions of delay/disability are cause for discontinuity in eligibility. The use of percentage delay is incongruent with most of the norm-referenced test used.
	Increased continuity of eligibility decisions Use of developmental and other risk information in eligibility determination.	
Klein (2003)	Pragmatic administrative linkage (financing integrating strategy)	A total of 9 States has adopted PE for SCHIP as of 2002. & 10 State in Medicaid. PE has potential for reducing the number of uninsured children. Most successful PE agencies are those who conduct intensive follow-up with the families. PE offers a link with other eligibility models such as express lane eligibility (ELE) which provides a connection between health and other types of programs.
	Timely enrolment and expedited receipts of care. Outreach-support for enrollment and eligibility Administrative-linkage (Coordinative element) Linkages for ensure continuity of care	
Kronebush & Elbel (2004)-2	Simplification of enrollment (expediting strategy)	Despite the attempt to increase, simplify and expediting enrollment other welfare reforms implementation created barriers at the same time such as requiring that children be uninsured for a given period of time before these could be considered for eligibility.
	Administrative-linkage (connection to public programs)	
Kronebush & Elbel, (2004)	Administrative connection to public programs.	PE together with other expansion & simplification strategies was associated with increased enrollment in Medicaid and/or public funded programs (3.5% and 6.4% combined effect). PE result in significant decline in private insurance coverage with a net negative impact of 2.5 percentage points on the probability of having any insurance. PE provides opportunity to families to receive assistance in navigating administrative hurdles and was associated with more positive result than continuous eligibility rules which eliminated the contact.

La Paro et al. (2002)	Outreach-support for enrollment and eligibility Use of developmental and other risk information in eligibility determination. (i.e.., Environmental, + child+ maternal variables) Use of multiple experts/sources of professional informants.	Medical professionals were better predictor of group membership if child(age- 0-36 months) had health/behavioral problems. Children assessed early (age 1-15 mos.) on standardized measures home environment and SES were better predictors of group membership.
Mott & Dunst, (2004)	Timeliness for completing Part C eligibility.	Utilization of PE practices. Only 18% of the children were made presumptively eligible. In 85% of the children with identified conditions and risk factors, eligibility took about 30 days. In those with less obvious delays it took about 45 days. In 56% of the cases a multidisciplinary evaluation was deemed unnecessary to make PE decisions. Bureaucratic procedures were the cause of delays in eligibility determination.
O'Brien et al. (1996)	Linking evaluation as precursor to eligibility. Inclusion of multiple risk categories in eligibility determination. Utilization of Perinatal, Family & Infant risk categories Utilization of quantitative developmental measures.	Aggregation of perinatal, family and developmental risk achieves the highest predictive power. Of the three risk categories the most effective predictor was family risk. Developmental test scores from the 1st year of life were fond not to be useful indicator of group membership at later age.
O'Brien et al. 2003	Pragmatic administrative linkage & simplification Administrative facilitation to access	PE is suggested as an advantageous administrative strategy to shortening lead-time between application and enrollment and as part of promising inter-program coordination efforts to link health to other types of services and programs.
Office of Inspector General (2000)	Administrative-linkage (connection to public programs) Outreach-support through a point of contact	PE alone did not significantly predict participation. But when factored with other variables such as outstationing and SCHIP training PE was found to have interaction effects.
Perry, et al. (2000)	Simplification of enrollment (expediting strategy) Streamlining & simplified application process. Multiple entry enrollments points (Drs. office, schools, community).	Perceived difficulty in completing the enrollment process: (72%) Lack of knowledge and (58%) association with welfare (50%) were listed by parent as the most cited reason for non-enrollment. Parents ranked mail-in, PE, extended hours, information line & shorter enrollments forms as preferred improvements for facilitating enrollment.
Peterson et al. (2004)	Use of developmental and other risk information in eligibility determination. Timely enrolment and expedited receipts of care. Outreach-support to enhance parent's understanding of eligibility.	Children in poverty report at least 1 disability indicator. Only 66% of the potentially eligible children received Part C services. Parents with high risk conditions were less likely to report child conditions or verify eligibility status.

Piper et al. (1994)	Implement early perinatal eligibility	Enactment of PE in Tennessee significantly improved prenatal behavior of expectant mothers. Post PE group enter care earlier and followed better prenatal care than pre PE group. PE increased enrollment in Medicaid.
	Timely enrolment and expedited receipts of care.	
Racine et al. (2001)	Improved utilization & access to care.	When compared to non-insured children, there was a difference of 37% points between the likelihood of seeing a physician among the insured compared with the uninsured [(0.19)*(0.37) 0.07]. The finding supports that expansions in Medicaid eligibility positively impact the health care and services access and care utilization by poor children.
	Maintenance of a regular source of care.	
Robinson & Rosenberg, (2004)	Use of Developmental conditions + established risk factors as PE precursors to enrollment in Part C EI.	Of 5,473 children enrolled in welfare programs, 12.2% 668) had conditions that made them presumptively eligible for Part C. Of the 5473 children in the Colorado welfare data set, 4.8% (n=262) were actually enrolled in Part C EI. Demographic risk characteristics do not influence or predict Par C enrollment. Overall PE rate in welfare database only predicted 17% of the total children actually in Part C during the time of the study.
	Utilization of developmental delay category for PE	
Rosenbach et al. 2003	Expediting initial coverage.	Nine states are reported to have opted for PE by the date of this report, as a strategy to enroll children. Most of the states that have opted for PE are those who provide both Medicaid-SCHIP and separate programs for children (AKA COMBO). The 4 design elements of the health care expansion include retroactive eligibility and presumptive eligibility to expedite enrollment and cover cost of care and, continuous coverage or eligibility , together with frequency of re-determination to ensure continuity and facilitate retention.
	Administrative linkage - Reducing barriers to enrollment.	
Ross-Cohen & Hill, (2003)	Linking children to services	Expansion strategies among which PE are reported to have increased and facilitate enrollment across health and social programs. In Ohio between 1997 and 2001, the expansion has increased enrollment by about 20% from 761,000 to 912.000 recipients. Qualified entities within the community can enroll children.
	Outreach-support - simplification strategy	
Ross-Cohen (1997)	Health based outreach strategy.	This discussion paper predates the implementation of presumptive eligibility. It offers some guidance on the probable effect and roles of PE in facilitating children's access to health care and services. Used to derive definitional component of PE. Children can receive medical or other care immediately.
	Timely entry/enrollment: Prompt access to needed services.	
Ross-Cohen, & Cox, (2005)	Facilitating utilization and access to care.	About 20 state s had expanded eligibility and enrollment rules, of these 15 implented PE for either children, families, pregnant women or all. Between July 2004 and July 2005 several states had retrenched their expansion and increased the difficulties of enrollment. Indicates that PE strategies which includes allowing community -based providers to make eligibility decision facilitate enrollments and continuation of eligibility.
	Administrative-linkage: Enrollment simplification strategy.	

Scarborough et al. (2004)	Inclusion of environmental-demographic risk characteristics for eligibility determination.	Poor children, African Americans and boys were disproportionately represented among eligible children. Boys (64%) tend to be eligible based on diagnosis of developmental delay. About 4 in 10 children obtained eligibility related to delays in speech & language; followed by pre/perinatal abnormalities with 2 in 10 children and children with motor delay comprising the third large group with 18%. Not all states offered services to children considered at risk as an eligibility category.
	Utilization of developmental indicators, (i.e., speech/language and other child's characteristics.	
	Use of categorical and diagnostic indicators (e.g., Developmental delay, diagnosed condition or at risk for delays) as precursor for eligibility.	
Shackelford (2006)	Moving away from categorical & to functionally-based eligibility.	38% of children entered EI before 12 months of age and most were eligible due to diagnosed medical condition or at-risk conditions, while toddlers tended to have developmental delays as their eligibility indicator. Part C eligibility would appear to presume all children who fit one of the adopted delay or at risk groups to be eligible for EI services. It was also suggested that children who have a physical or health condition are more readily presumed eligible. States that do not use at risk eligibility for infants and toddlers and who are not otherwise eligible have the option of regularly monitoring changes in eligibility status. The use of informed clinical opinion is mandate for Part C in determination of eligibility.
	Outreach-support - utilization of regular monitoring mechanisms.	
	Use of risk factors and conditions of risk.	
	Use of multiple experts/sources of professional informants/judgment	
Spiker et al. (2000)	Single vs. multiple points entry in EI and for eligibility determination	Of the 20 states selected, 7 served or enrolled in services, children identified as at risk. Some states offered service monitoring. Most states use two categories only: diagnosed physical or mental conditions, and developmental delay. Education agencies, health agencies (e.g., department of health, local health &/or social services agencies) and private programs are often the provider and qualified eligibility points of contact. Most often criteria are 1.5 SD < the mean; 2 SD< the mean; 20% delay, 25% delay up to 50% delay in one area or more of development as markers for children to be eligible for services.
	Concurrent utilization of diagnostic + functional criteria in defining eligibility.	
	Enabling informed clinical opinion to determine eligibility, rather than categorical or diagnostic info alone.	
	Inclusion of environmental-demographic risk characteristics for eligibility determination.	
Swann (2003)	Timely enrolment and expedited receipts of care.	Less resttrictive policies (including PE) have significant effect on likelihood of early receipt for services. Early entry was also associated with increased likelihood of neonatal survival rates. Receiving assistance during enrollment in addition to PE resulted in increased likelihood of enrollment/participation.
	Outreach methods for supporting and providing assistance during enrollment and redetermination.	

	Improved accessibility and availability to a usual source of care.	
Szilagyi et al. 2004	Increased accessibility to health care centers and/or professionals	Increased utilization, accessibility, proportion of medical visits, identified source of care, quality of care and reduction in unmet health needs of children were significantly improved at post test for the participating children.
	Improved accessibility and availability to a usual source of care.	
	Facilitating utilization of preventive services.	
	Enabling multiple source of access.	
Wolfe et al. (2004)	A rule that enables expedited receipt of services.	PE reduced the probability that the child would be without coverage by 5 percentage points. Having PE and offering help by phone reduces the probability of being without any coverage by 6 percentage points.
	Outreach-support to enhance parent's understanding of eligibility.	

Table 3

Research Design

			Sample Size				Sample Participants			
Study	Research Design	Type of Data Analysis	Total	N1	N 2	n-	N 1	N 2	n-	Diagnosis or Conditions
Bailey et al. (2004)	Telephone & Mail Survey	Correlational	2,974	2974	NA		Parents or relatives of youngh children with or at risk of disabilities			Developmental delays; Diagnosed physical conditions; Mental retardation
Carlson-Coccodrilli & Scharf (2004)	Survey-Focus Group	Qualitative policy review.	19		NA		Agency & states representatives			NA
Danaher et al. (2004)	Survey: Content analysis	Descriptive qualitative	50				States			
Danaher 2004)	Survey: Content analysis	Descriptive qualitative	50				States			
Perry, et al. (2000)	Telephone & qualitative survey	Descriptive	1335	836	419		Parents of children in Medicaid	Parents of eligible children but uninsured.		
Harbin et al. (1991)	Survey: Content analysis	Descriptive-qualitative	39				States			
Grant (2005)	Survey: Content analysis	Qualitative policy review.	50				States			
O'Brien et al. (1996)	Interview survey+ content analysis	Correlation & Regressions analyses.	70				Children			Physical disabilities; identified syndrome, chronic health conditions and learning disable/delays
O'Brien et al. 2003	Survey evaluation report	Descriptive qualitative	6				States			
Office of Inspector General (2000)	Mail/Internet Survey	Multivariate, Chi-Square, Logit regression models.	405				SCHIP-Medicaid Community Health Center Sites			
Ross-Cohen, & Cox, (2005)	Policy Survey and secondary review of literature.	Descriptive	50				States			
Scarborough et al. (2004)	Telephone & Mail Survey+ records review	Statistical Analysis of Correlated Data (SUDAAN)	3,200	544	1984	704	Families of Part C or infants. (@ Risk)	Families of Part C or informants. (With developmental delays)	Families of Part C or informants. With Diagnosed Condition	Low birth weight; Health Status; Speech & language delays; Motor impairments; Down Syndrome; Global delays; Physical and/or growth abnormalities; Physiological/neurological impairments; sensory system impairments Intellectual/cognitive delays; Social/behavioral impairment .
Shackelford (2006)	Survey: Content analysis	Descriptive qualitative	50				States			
Spiker et al. (2000)	Telephone Survey	Descriptive-qualitative	220				Agencies Part C coordinators.			
Szilagyi et al. 2004	Pre-post telephone interview	Correlational Multivariate and logistic regression models.	2644	2243		400	Parents below poverty lines with children insured and uninsured			16.6% with Special health care need status (mental health; general health care; at risk);
Andrulis et al. (1999)	Discussion paper	Qualitative policy review.								
Klein (2003)	Discussion paper	Qualitative- Policy review & analysis.								

Ross-Cohen (1997)	Discussion paper	Descriptive-Qualitative								
Ross-Cohen & Hill, (2003)	Case study-Discussion paper	Descriptive qualitative								
Rosenbach et al. 2003	Content analysis, evaluation report.	Descriptive-qualitative	50				States			
Notes &			Summary Statistics:				Descriptive Qualitative			
Gray areas indicase NA or not applicable; NR= Not-Reported										
							Frequency	% of Total		
		Total Survey Studies					15	45%	67%	
		Total Discussion/Position Papers					5	15%	100%	

			Sample Size				Sample Participants			
Study	Research Design	Type of Data Analysis	Total	N1	N 2	n-	N 1	N 2	n-	Diagnosis or Conditions
Gold et al. (1993)	Secondary survey data analysis.	Descriptive, qualitative	50		NA			States		At risk pregnant women
Epistein & Newhouse (1998)	Secondary data analysis - Pre-post Comparison Design	Correlation & Regressions analyses.	2,769	923	1,816		Pregnant low income women with new born pre-expansions	Pregnant low income women with new born post-expansions		At risk pregnant women
Kronebush & Elbel (2004)-2	Secondary data analysis.	Logit Regression Analysis	25264					Households below the poverty lines		
Kronebush & Elbel, (2004)	Secondary data analysis.	Logistic Regression & Mutivariatel analyses	25264					Households below the poverty lines		
Mott & Dunst, (2004)	Secondary record review.	Descriptive	180	77	103		Infant & toddlers at risk	Infants & toddlers identified conditions		@ Risk for or with pre- identified conditions including developmental delays
Racine et al. (2001)	Secondary data analysis.	Correlational, Multivariate and logistic regression models.	26215					Children		Poor Uninsured Children. With & without health problems or disabilities/
Robinson & Rosenberg, (2004)	Secondary data analysis.	Logistic regression analyses	5473	4805	668		Children (no-conditions)	Children (PE eligible)		Developmental delays; medical conditions; Drug exposure; Multiple conditions.
Swann (2003)	Secondary data analysis.	Survival Analysis, Corelational	12354					Women during & after pregnancy		
Wolfe et al. (2004)	Secondary data analysis.	Logistic Regression analyses	36684	14,500	8,500		Children who live in families with incomes below 300% FPL	Children who were eligible for either the Medicaid or SCHIP program.		Sociodemographic risk factors
Bricker et al. (2003)	Correlational two groups comparisons	Rasch (IPL) Logistic & Differential Item Function Analyses	861	258	603		Infants with NOS Disabilities	Typical developing infants		Unspecified disabilities

La Paro et al. (2002)	Two group + control comparisons.	Logistic Regression analyses	106	51	55	80	Infants & toddlers medically identified	Infants & toddlers assessment identified	Control	No disability or Special needs
Peterson et al. (2004)	Quasi-experimental random assignment control group.	Multivariate, Chi-Square, Logit regression.	3001	99	2880		Families & children receiving Part C	Families & children potentially eligible for Part C		Part C receipt; Diagnosed conditions; Suspected delays; Biological risks.
Piper et al. (1994)	Pre-post group comparisons	Correlational, regressions analysis	9702	3995	5707		Mothers & neonatal infants in PE	Mothers & neonatal infants before PE		

Summary Statistics:

			Descriptive Qualitative		Correlational Onlly		Multivariate Regressions	
Totals by Studies	Frequency	% of Total	N	%	N	%	N	%
Survey Studies	15	45%	10	67%	2	20%	3	20%
Discussion/Position Papers	5	15%	5	100%	0	0%	0	0%
Secondary data analysis	8	24%	2	25%	0	0%	7	88%
Pre-post &/or Quasi-experimental	5	15%	0	0%	0	0%	4	80%
Totals	33		17		2		14	