

As a follow up to the Medicaid Work Group meeting of January 24, 2008, continued research has been focused on expressed areas of interest by the Work Group members.

Early Intervention Services (Part C of the Individuals with Disabilities Education Act) or “First Steps” as it is known in Missouri

DESE reports that in October 2007, 39.7% of children with IFSP’s were Medicaid eligible and the rate in November 2007 was 39.2%. Assuming the program regularly averages 39% Medicaid eligibility, one would expect significant federal Medicaid revenue. However, Medicaid revenue for direct services of \$2 million was projected for FY 2007, as compared to \$14.2 million of General Revenue and federal IDEA funds of \$7.6 million. (Federal law provides that prior to using IDEA funds, all other sources of revenue, including Medicaid are to be used.) If the children are being appropriately identified as Medicaid eligible, problems with billing and/or collection of the Medicaid revenue might explain low levels of Medicaid receipts. This seems to point to a problem with the current system, and not necessarily with the need for a Medicaid waiver to increase federal funds. However, there may be other reasons that the state may want to pursue a waiver, increase eligibility for existing programs, or pursue new opportunities to expand eligibility under the Deficit Reduction Act to enhance federal Medicaid revenue for children served by the First Steps program in Missouri.

Two states that have specifically targeted waivers to children under 3 years of age are Pennsylvania and Nebraska. These waivers have served to enhance Medicaid revenue for children served in Early Intervention programs.

1. Pennsylvania, through the Office of Child Development and Early Learning, operates the Infants, Toddlers, and Families Waiver, providing services to children from birth to age three who are in need of Early Intervention services and would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Mental Retardation or Other Related Conditions (ICF/MR-ORC). Children must be eligible for medical assistance to qualify for the waiver, although the parent’s income is disregarded. The child must also be age 0 to 3; need early intervention services; and require an ICF/MR-ORC level of care. Eligible children must have a higher level of delay than Part C eligible children (50% in one area of growth or development or 33% in 2 or more areas as compared with Part C eligibles who only need a 25% delay in one area.) The only covered service is Habilitation, which is a bundled service that consists of the “assistance and acquisition, retention or improvement of skills related to activities of daily living, such as feeding and dressing, communication with caregivers; orientation and mobility, and social development needed by the child.” It does include therapies. The service is provided directly to a child while the family/caregiver is present and participating or it can be provided as instruction to a family member of caregiver. Service providers include registered nurses, licensed practical nurses, physical and occupational therapists, licensed teachers of the hearing impaired, licensed psychologists, and licensed clinical social workers. Other services to meet the child’s needs are provided through EPSDT or Part C. This waiver funds some of the Early Intervention services mandated by Part C of the Individuals with Disabilities Education Act. Currently, there are almost 5,000 children served by the waiver and there is no wait list. According to the state official contacted, consideration is being given to adding service coordination to the waiver.

(Source: Renewal of Pennsylvania's Home and Community-Based Services Waiver for Infants, Toddlers and Families for the period July 1, 2001 - June 30, 2006; CMS Control #0324.90 and conversations with Cathi Berkey 717-346-1119)

2. Nebraska has an Early Intervention Medicaid Waiver that provides respite services and service coordination. Eligibility is based on the child's income, regardless of family income. It is available to children under 3 who are not served under any other HCBS waiver, live at home, are eligible for special education and related services, participate in Early Intervention Services Coordination, have care needs which meet a level of care typically provided in a nursing facility, and are Medicaid eligible. If eligible, the family is allowed up to \$100 per month per child for respite care. The family decides on a provider and negotiates the rate of pay. The family is given a waiver respite provider enrollment contract to be completed by the provider of the family's choice. The provider signs and returns the contract, which is checked against the Department's child and abuse/neglect registries.

Expanded Eligibility (Expand Eligibility; Close Benefit Gaps, Cover more Services)

Eligibility Options To better understand how eligibility might be increased, which also may present an opportunity to decrease the General Revenue required for the First Steps program, it is necessary to review how children are eligible for services in Missouri and where gaps in coverage exist.

While Medicaid is designed to make health care services available to low income persons, it only covers those who fit within defined categories of eligibility. As a result, many people who live in poverty are not eligible.

SSI Children become eligible for Medicaid through different avenues. One is through Supplemental Security Income, SSI, which provides a monthly payment to persons with a qualifying disability who meet certain income and resource limits. Children under 19 who are SSI recipients qualify for Medicaid. In Missouri, these children must make application; it is not automatic as it is in most states. SSI eligibility is dependent on the severity of the disability and the family income and resources in the case of a child. A portion of the family income is deemed, or considered available to, a child. This deemed amount is compared to a Federal Benefit Rate and if the deemed income is less than the FBR, the child is SSI eligible. For an adult, defined as more than 18 years of age, the income of the individual determines eligibility.

SCHIP The State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, provides Medicaid coverage to low-income children under age 19 who are uninsured and not otherwise Medicaid eligible due to family income. The SCHIP program was authorized as a part of the Balanced Budget Act of 1997. Missouri used this opportunity to expand Medicaid coverage to uninsured children from families with incomes too high for them to qualify for regular Medicaid. SCHIP eligible children are eligible for the same straight Medicaid benefit package, with the exception of non-emergency transportation, but they are not eligible for waiver services. Children must be uninsured for at least 6 months to qualify and families above certain income levels must pay a premium for coverage. In state fiscal year 2007, more than 60,000 children were covered in Missouri through SCHIP alone. (Source: Medicaid Expenditures for Large Eligibility Groups, DSS – dss.mo.gov/mis/pdfs/expmtx07.pdf)

States had the option to implement separate SCHIP programs rather than expanding on the existing state Medicaid program, or a combination of the two. By implementing a separate SCHIP program, the entire Medicaid benefit package need not be offered to eligible children. Limits on services or the amount of services may be imposed. By combining expanded Medicaid coverage and a separate SCHIP program, some children are eligible for the full Medicaid benefit package and others receive a more limited package of benefits. The federal government caps the amount that it will contribute to the cost of the SCHIP program, but contributes a higher match rate for services. In Missouri, the federal match rate for SCHIP is 73% as opposed to 62% in the Medicaid program. Consequently, the state cost of covering the additional children is relatively small as compared to expanding Medicaid eligibility.

TEFRA If a child is not eligible for Medicaid or SCHIP based on household income, it is still possible to qualify a child with severe disabilities for Medicaid under an optional eligibility program that allows for disregard of family income. However, Missouri, like most other states, did not elect to cover this optional group of eligibles. This option, created by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), allows states to disregard parental income in determining eligibility. Eligible children must have a disability, be under 21 years of age, and require the level of care provided in an institution. TEFRA creates an entitlement for those who qualify. For states that do not elect the TEFRA option, many of these same children may be covered through a home and community-based services waiver. The advantage to the state of a waiver is that it can limit the number of enrollees and impose additional eligibility restrictions, thereby better controlling costs. The waiver also offers the advantage of more generous benefits.

Expanded Eligibility Options There are a number of ways in which coverage may be expanded, including expansion of eligibility for SCHIP; adoption of the TEFRA State Plan Option for Severely Disabled Children; expansion of the existing waivers; or Medicaid buy-in.

One way to expand eligibility is to increase State Children's Health Insurance Program eligibility for children. As previously stated, states have an incentive to do so because the federal contribution is higher than it is to the Medicaid program; although the federal cap on overall spending will impact program growth. Connecticut has proposed an expansion of its SCHIP program to 400% of the federal poverty level with automatic enrollment of all uninsured newborns into the program. Families with income above 400% of the federal poverty level may buy-in to the program at full cost. Maryland expanded its SCHIP program to children under age 19 in families with incomes below 400% of the poverty guidelines. Those with incomes between 200 and 400% of poverty would pay premiums to participate.

Pennsylvania operates a separate child health program. The state has extended coverage to all uninsured children and teens up to age 19 who are not eligible for Medical Assistance. There is no income limit, although there are premiums and co-pays for some services. In addition, Pennsylvania disregards family income for all children who meet SSI disability criteria, qualifying large numbers of children for Medicaid benefits. (See www.chipcoverspakids.com) Source: National Conference of State Legislatures Increase Coverage Access 2006 & 7

Medicaid Buy-In Another option for expanding eligibility for children is with a buy-in program for children with special health care needs. Buy-in programs make Medicaid benefits available to persons who would otherwise not qualify due to excess income. This option has been available for

years, and some operate buy-in programs for children with disabilities. With passage of the Deficit Reduction Act, the Family Opportunity Act also presents states with the opportunity to establish Medicaid buy-in programs for children with disabilities if family income is less than 300% of the federal poverty, with coverage phase in based on the child's age. States may also use a buy-in program to expand services. A buy-in program creates an incentive for families to keep private insurance coverage if premiums to buy into Medicaid are kept at reasonable levels. (A concern with SCHIP is that it creates an incentive for families to drop private insurance coverage, even with penalty for doing so, because it is limited to children who are uninsured.) This option provides children with special needs access to needed services through Medicaid that are frequently excluded or limited in a private insurance plan, including such things as durable medical equipment and supplies, prescription drugs, personal care and extended therapies. Children do not have to meet the institutional level of care requirement, which makes it easier to qualify for Medicaid than it would be under the MRDD waivers currently available to children in Missouri. Pennsylvania, Vermont, Minnesota and Massachusetts offer some variation of a Medicaid buy-in program for children with special health care needs. Massachusetts and Vermont do so pursuant to Section 1115 waiver authority.

DRA The Family Opportunity Act, a part of the Deficit Reduction Act of 2005, gives state the option to cover children with severe disabilities with family income under 300% of the federal poverty level. As one health analyst points out, it is a common misperception that children and youth with special health care needs are covered but having child with a disability is a financial hardship that may lead to bankruptcy, family stress, missed employment opportunities. She argues that the reasons to cover these children are better access can result in improved health status, there is no institutional level of care requirement, it improves family employment opportunities, it may incentivize families to keep private coverage and it allows for expanded coverage with federal match dollars. Source: Meg Comeau, MHA, of The Catalyst Center "Improving Financing of Care for Children and Youth with Special Health Care Needs" presented at the NASHP Annual State Health Policy Conference in October 2007)

Expanded EPSDT Early Periodic Screening, Diagnosis and Treatment is an important provision of federal Medicaid law as it offers opportunities to states to utilize Medicaid funds to provide a wide array of services to children. As an existing delivery structure, it offers advantages over options for system reform. It is defined as 1) screening services; 2) vision services; 3) dental services; 4) hearing services; and 5) such other necessary health care, diagnosis services, treatment, and other measures . . . [listed in 42 USC Section 1396d(a)] . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. Section 1396d(a), which defines the extensive list of services considered to be "medical assistance", includes "other diagnostic, screening, preventive and rehabilitative services for the maximum reduction of physical or mental disabilities and restoration to the best possible functional level." If the service comes within the scope of services listed in Section 1396d(a) and it is necessary to correct or ameliorate defects, illnesses and conditions, arguably federal law requires states to cover the service. Federal regulations do allow states to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures [42 CFR 440.230(b)], but the courts have a history of requiring coverage of needed services for children if the service is determined necessary to correct or ameliorate a condition. Courts have held that it is not necessary that the service be specifically named in Section 1396d(a) so long as it can fit into the description. For example, incontinence supplies are not specifically enumerated, but courts have held that they may be covered as home health, durable medical

equipment or preventive services. It is also important to note that the state's responsibility cannot be avoided by contracting for the provision of these services with managed care companies or other agencies.

EPSDT requirements were the basis for a challenge to the Medicaid program in the state of Massachusetts. *Health Care for All v. Romney*, No. 00-10833-RWZ, 2005 WL 1660677 (D. Mass. July 13, 2005) The court "held that Massachusetts' low Medicaid payment rates for dentists significantly contributed to a lack of available providers for children. This provider shortage, in large part, led the court to find the State in violation of the Medicaid Act requirements for prompt provision of EPSDT services." The parties entered into a Joint Remedial Program that resulted in changes in the state's Medicaid program and court oversight of the changes and their impact on the program. . (Source: "Medicaid Early and Periodic Screening, Diagnosis and Treatment: Recent Case Developments" Jane Perkins, National Health Law Program, 2004)

EPSDT requirements were also used as the basis to challenge the lack of community-based services for children with serious emotional disturbances in Massachusetts. *Rosie D. v. Romney*, No. 01-30199MAP, 2007 WL 51340 (D. Mass. July 16, 2007). In *Rosie*, the court found that children with serious emotional disturbances (SED) were not "receiving appropriate mental health screenings, service coordination, and home-based treatment services." The court ruled that Medicaid eligibles under 21 years of age screened and diagnosed with behavioral, emotional or psychological disabilities must receive preventive and rehabilitative treatment. Providers must perform EPSDT screens during well-child visits using a standardized behavioral health screening instrument and refer children in need of treatment. The assessment must be connected to a treatment plan and services must be provided. Existing mobile crisis intervention and stabilization services were enhanced and new services were created, including: In-home behavioral services (behavior management therapy and behavior management monitoring); In-home therapy services (therapeutic clinical intervention and therapeutic training and support); and Mentor services (to improve child's skills). The system is to be integrated across multiple agencies with a single point of entry. One potential challenge that has been identified is the shortage of qualified providers. Another is the projected cost, which is more than twice the amount currently being spent on behavioral health for Medicaid eligible children. (Source: "Implementing the *Rosie D.* Remedy: The Opportunities and Challenges of Restructuring a System of Care for Children's Mental Health in Massachusetts" Holly A. Kenny, Massachusetts Medicaid Policy Institute, September 2007)

Iowa's 1st Five Healthy Mental Development Initiative

The Commonwealth Fund launched an initiative in January 2004 to help states promote the healthy mental development of low-income children under age 5, referred to as the Assuring Better Child Health and Development initiative, or ABCD II, which included the state of Iowa. At the conclusion of the initiative, the state of Iowa assumed responsibility for continuation of the project to identify children at risk of developmental or behavioral delay in primary care settings and refer to appropriate specialists; refer parents at risk of depression to mental health professionals; design Medicaid policies to promote standardized screening and referral for follow-up services; and train health care professionals to provide higher quality preventive care to young children. Initially, the focus was on Medicaid eligible children from birth to 3 years of age. The state sought to enhance well child exams and convened a panel of state experts who designed the "Child Health Development Record (CHDR)". This is considered to be a "surveillance" form that helps identify

risk factors and developmental “red flags” that signal the need for further assessment and evaluation. (There are actually a set for age-appropriate CHDR forms.) All children were assessed using this form, which could be used in its entirety or in part by providers. From this initial surveillance, there were two additional levels of screening based on “red flags” that were noted from the initial CHDR. The project was piloted in two medical practices, one pediatric practice and one family practice. (In Iowa, family practice is more prevalent in the rural areas than pediatric practices.) The identification of issues and the services provided as a result of the screenings supported the need to continue and enhance the project, which became the basis for a request to the legislature for funding.

From this initiative, Iowa developed a statewide initiative called the *1st Five* Healthy Mental Development Initiative. The focus is on children 0 – 5 years. It has been operational for approximately 1 ½ years. Private providers work with public health partners on referrals and care coordination. Private providers are not required to participate, but support has been good. Currently they are operating from four sites covering 10 counties and three other areas have community planning grants. State staff indicate that it is critical that the public health system work with the private providers. They report that on average, there are 3 – 5 referrals from an encounter with a child/family. The forms that providers use are not dictated, but there are minimum standards for screening that suggest tools that may be used. From these forms certain information is extracted. Some providers have a memorandum of understanding with the local public health agency that they work with but there is no formal contractual arrangement. There is no additional reimbursement to the provider for participation. If the child is Medicaid eligible, developmental screenings are billable to Medicaid.

In focus groups with providers, they found that the screening process takes on average only 3 additional minutes. The reasons being that having a standardized tool helps to streamline the questions, and a referral source is available for follow-up. Most communication between the provider and the public health entity is done by fax. The public health entity is supposed to provide feedback to the provider within 24 -48 hours, which may simply be an acknowledgment that they have received the referral and not been able to reach the family, but some communication to let the provider know that follow up is underway.

Providers bill Medicaid (for Medicaid eligible children) for a developmental screening. They use Medicaid developmental screening codes that pay varying amounts based on the level of screening performed. Consideration is being given to increasing the reimbursement for these codes. Education of providers was necessary to generate billings for the developmental screening codes.

Providers use forms developed for the 0 -5 age group. Some responses generate automatic referrals for public health intervention. There are some questions specific to autism on the form. Work is underway to develop a tool for older children.

Problems identified by staff: 1) Provider capacity is limited, particularly in the rural areas, to address identified mental health needs; 2) there are limited resources available for those children determined to be at risk but who do not qualify for Part C because of their restrictive eligibility; and 3) lack of a quality mental health system statewide.

The Part C program is housed in the Department of Education and they do have a dedicated public health liaison. Staff acknowledged that having the support of the Part C administrators was critical because of the increase in referrals generated by this initiative.

A considerable amount of work has been done to garner the support of various associations throughout the state. Work is now underway to get the medical schools to begin teaching use of the screening tools so that new physicians will be on board from day one and the need for ongoing provider education will be minimized.

No Medicaid waiver was required to implement this initiative. Although it was piloted in certain areas, the billing codes were available to any provider throughout the state who provided the service to an eligible patient.

The Medicaid program in Iowa did a file match of those receiving home and community-based services and Part C children and found that 86% of home and community-based service recipients were on Part C.

With regard to the proposed new definition of case management, the Medicaid staff person did report that they plan to send a letter to families advising them that they will need to choose one case manager. Currently consumers have a Part C case manager and they may have either a DHS service worker or a county TCM worker.

Sources: Sonni Vierling, State Coordinator, 1st Five Healthy Mental Development Initiative, IDPH, 515-281-3108 svierlin@idph.state.ia.us and Sally Nadolsky, Medicaid, 515-725-1142, snadols.dhs.state.ia.us

An excellent study was done by the National Academy for State Health Policy related to social and emotional impairments of young children. The study suggests that there are policies and practices that can be implemented to enhance Medicaid coverage for early childhood mental health development services even in times of tight budgets. The report also concludes that early intervention strategies reduce the incidence and high cost of severe emotional and behavioral conditions. The coordination of primary care health professionals, mental health professionals, education professionals, families and community-based entities that provide support services is critical. The report recommends a number of actions that a state might take, including:

- Adoption of Medicaid policy that specifically defines covered services and qualified providers for early childhood mental health services with development of age appropriate screenings and diagnostic tools and inclusion of family in therapy;
- Coverage of mental health services to your children who show early signs of risk with new diagnostic and billing codes for very young children by providers of early mental health services;
- Interagency planning because of the difficulties in distinguishing between developmental, emotional and physical conditions and to access funds from different sources;
- Modification of Medicaid managed care contract to clearly specify the responsibilities of the managed care contractors;

- Legislative approval to use state child care, foster care, public health, maternal and child health, early intervention, mental health, or social services dollars as Medicaid matching funds.

Indiana, Ohio and San Francisco are identified as having programs worthy of review. A separate research document prepared by The Commonwealth Fund identifies similar strategies and points to examples of programs in Florida and Vermont.

How to use EPSDT to extend Medicaid benefits to young children in need of mental health services http://www.commonwealthfund.org/usr_doc/johnson_medicaidmentalhealth_705.pdf?section=4039 “Using Medicaid to Support Young Children’s Healthy Mental Development” Kay Johnson and Neva Kaye, Sept 2003, Revised Jan 2004 National Academy for State Health Policy The Commonwealth Fund

Georgetown University Center for Child and Human Development developed a workbook for states and communities to assist with financing of early childhood mental health services and supports. A matrix was designed to assist with an inventory of existing services and resources, identification of gaps, and duplication. Included is a description of an extensive list of financing resources, both governmental and non-governmental.

http://gucchd.georgetown.edu/topics/mental_health/object_view.html?objectID=2561

Serious Emotional Disturbances

Massachusetts Mental Health Service Program for Youth (MHSPY) is a capitated program for children 3 – 19 with serious emotional disturbance at risk of residential placement. The program blends funds from different state agencies. An HMO provides physical health care, mental health and substance abuse treatment, care coordination and wrap-around services. Michigan operates a waiver for children with serious emotional disturbance on a fee-for-service basis. Community mental health centers provide the state match. Services include wrap-around services, respite, community living services and therapeutic foster care. Texas also has a fee-for-service program that is a collaboration of families, state agencies and community groups. Texas Integrated Funding Initiative – services are provided through county-based mental health organizations. Arkansas uses social services block grant funds to purchase services for children with mental health diagnoses at the county level. Three state agencies operate the program

Managed Care

Children with special health care needs by definition incur higher than average health care costs. Because capitated systems create incentives to minimize services, the use of managed care for children with complex needs may be a concern. For this reason, methods to develop risk-adjusted rates were developed. Some states use the Chronic Illness and Disability Payment System (CDPS); others use the Ambulatory Care Groups (ACGs) to develop risk-adjusted capitation rates. Reinsurance is another tool to reduce risk to incentivize plans to offer services. Some states have

specialized programs within their managed care contracts for children with special health care needs, with a corresponding increase in the capitated rate.

** Michigan has “the Special Health Plan”, available to children with special needs who are Medicaid eligible. Capitated networks designed to meet their needs have developed.

** NC uses The Children with Special Health Care Needs Screener©, which consists of 5 questions, to identify children with special health care needs as a part of its Medicaid and SCHIP application. If there are 2 or more “yes” answers, the child is considered to have special health care needs. This designation becomes a part of the child’s eligibility file and is made available to the health care provider when the child enrolls in a plan or network. It is a parent response tool that can be administered by telephone or in person. There are other tools available. Catalyst Center State at a Glance Chartbook Source

George Washington University has developed Medicaid managed care contracting purchasing specifications for use by states.

<http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/cshcn/part1.cfm>