MEDICAID/EPSDT FINANCING QUESTIONS FOR CHILD HEALTH SERVICES

AND CMS RESPONSES

Charles Bruner, Child and Family Policy Center, February, 2013

The Child and Family Policy Center submitted a request for clarification to the Center for Medicaid Services (CMS) regarding four specific case examples of programs or program types which serve young children and their families in ways ultimately directed to improving healthy child development. Each serves a large percentage of children who are covered under Medicaid and provide some services which could be considered "medically necessary" and, in some context, eligible for Medicaid reimbursement. At the same time, each generally constitutes a more holistic approach to providing services (both clinical and community) which involve families as well as children in producing better child health outcomes. They may not fit into traditional Medicaid services and billing and documentation procedures. States, and advocates supporting these programs, often face challenges in securing Medicaid reimbursement in ways that are "consistent with efficiency, economy, and quality of care."

For each of the four case examples, CFPC described the program, the current status of Medicaid/EPSDT reimbursement for the program, and questions regarding ways in which the program might secure Medicaid/EPSDT financing. CMS provided a written response to each of the case examples, which is provided at the end of the description.

Case Example One: Dyadic and Group Therapy to Support Children's Healthy Development

Child FIRST is an evidenced-based home visiting program which provides therapeutic services to young children (0-5) and their families in the home, where the child is at risk of developmental disability or mental health concerns. In most instances, a major reason for referral is parental depression or other characteristics of the parents which jeopardize the child's healthy development. In some instances, the child can be diagnosed with a DSM-IV, but in others the child (often an infant) is not yet manifesting any behaviors which would lead to such a diagnosis.

Current situation regarding Medicaid reimbursement. Currently, it requires the practitioner to make a specific diagnosis of the child (a DSM-IV) in order for services provided under Child FIRST to be covered under Medicaid, but Child FIRST finds that, in the professional judgment of the practitioner there are children for whom Child FIRST is a needed service to ensure healthy growth and development and avoid future developmental or behavioral concerns on the part of the child. In many of these instances, the mother has had a positive screen for maternal depression and the practitioner's surveillance of the child indicates that the child will not develop normally unless there is stronger bonding and nurturing provided, but the child is not old enough to be able to provide certainty in diagnosing a specific existing condition. Changes under the ACA also require insurance programs to adopt "evidenced-informed" guidelines for primary health care services for children (Bright Futures), and guidance for the essential health benefits package in the exchange requires coverage of habilitative services. While in the past "rehabilitative services" have been the funding mechanism for programs like Child FIRST, these other

changes to the ACA could broaden the emphasis to cover significant risk factors as well, and would be in keeping with EPSDT's authorizing language.

Questions regarding Medicaid reimbursement. Are there specific ways for the practitioner to document such cases and use professional judgment so that the services provided under Child FIRST are covered by Medicaid as a medically necessary service, even without a specific child diagnosis? Can a positive parental screen for maternal depression or other parental diagnosis serve as a justification for providing Child FIRST as a medically necessary service (given the research which shows that maternal depression has consequences to child health and Child FIRST's own research shows its efficacy in improving child bonding and attachment and development when provided to mothers with depression)?

CMS Response to Questions regarding Medicaid reimbursement.

Your letter described the Child FIRST home visiting program which includes therapeutic services to young children (0-5) and their families where a child is at risk of developmental disability or mental health concerns due to parental depression or other characteristics of the parents which jeopardizes the child's healthy development. You noted that some states require an official diagnosis in order for Child FIRST services to be available to Medicaid eligible children. As you know, states must provide all services that are medically necessary to children eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, medical necessity determinations are the responsibility of the state, along with input from the treating provider. We encourage services to be provided in the most conducive setting for a child and reimbursement may be made for covered services provided in the home for the direct benefit of the eligible child. Please be aware that any EPSDT services must be available to any child under 21 who needs them and cannot be limited to children ages 0-5.

Case Example Two: Practitioner Surveillance and Care Coordination to Improve Healthy Child Development

An increasing number of child health initiatives are adopting a program model similar to Help Me Grow, where the program provides training to pediatric offices to conduct developmental surveillance and/or screening of young children and their families and makes referrals to a care coordinator of families for whom there are concerns, such as signs of parental depression or family stress or signs of developmental concerns on the part of the child. The care coordinator, often through telephone communication with the family, then delves more deeply into the issues that gave rise to the practitioner referral (usually through some form of motivational interviewing) and makes other referrals to both medical and non-medical providers who can help the child or family to promote healthy development and respond to the child's health issues and needs. Conducting these referrals often involves multiple phone calls to different providers in order to set up visits and report back to the pediatric practice. In addition, in order for the care coordinator to have an adequate knowledge base of community services and those services to understand how they can work with the care coordinator, these programs usually employ a community health liaison whose responsibility it is to identify and education community providers, both licensed practitioners of the healing arts and others providing services to young children and their families, about the program and to know their referral protocols and what services and supports they can provide. In a few instances, the community health liaison may

be called by the care coordinator to assist in finding an appropriate referral for a specific family, but in most instances the community health liaison's work is in community education, identification of resources, and networking. In effect, such programs typically include an overall program coordinator (who usually performs the practitioner outreach functions), several care coordinators, and a community health liaison.

Current situation regarding Medicaid reimbursement. When considered altogether, the program costs for providing this care coordination service could be calculated, and generally average about $500 per family referred, although the actual direct contact with a family (in multiple conversations with the care coordinator) averages only about 2 hours, and the ancillary calls to schedule referrals and provide information back to the practitioner average another 3 hours. Programs like this one have multiple options for drawing down Medicaid funding and some of the activities clearly are eligible for Medicaid support (either as claiming as a Medicaid service or as an administrative expense). At the same time, parsing out the allowable costs to Medicaid can be administratively complex and require additional time in documentation solely for billing purposes. Further, not all the children served by such programs are Medicaid-eligible, nor are many of the services to which children and their families referred (even though these services ultimately contribute to better child health). In many instances, despite understanding substantial additional record-keeping and documentation, these programs only recover a small share of their actual costs in providing the services even to those children who are Medicaid-eligible. Programs like these are seeking more administratively manageable ways to draw down Medicaid funding that more fully covers what they do. They also would like to be able to assist some of the programs to which they refer receive Medicaid coverage when those programs are providing medically necessary services.

Questions regarding Medicaid reimbursement. There are several different ways that such a program might be covered under Medicaid or elements of its program covered, consistent with 1902(a)(30), that payments are "consistent with efficiency, economy, and quality of care."

First, if the care coordination itself is to be covered as a Medicaid service, there are issues of what can go into the cost accounting for that care coordination and the unit of service, and how much of the service provided is actually Medicaid-eligible. The administratively simplest way to bill for a service would be to bill for a care coordination bundled unit (e.g. a client receiving care coordination services) over an extended time (e.g. one month or two months), with documentation requiring to show the individual client was Medicaid-eligible and that care coordination involved Medicaid-eligible activities. The payment would be for the unit at something like $500, justified through the overall cost of the entire program. In determining allowable costs, it would also have to be determined whether all the activities undertaken by the whole program (which fit together) need to be studied to determine the extent to which they can or need to be apportioned relative to Medicaid-eligible and non-Medicaid eligible activities.

Second, the program could be considered as an administrative service which would be responsible for serving all Medicaid-eligible children in a service area – receiving a per member per month fee. Again, the total costs of administrating the program (including the physician outreach, care coordination and

referral and scheduling, and community health liaison work) would need to be included in determining the cost-based per member per month payment.

Third, the physician outreach and the community health liaison work could be considered as part of administrative services and covered accordingly. The care coordination could be considered as a service, billed either in terms of a bundled unit or in terms of some amount of time devoted to the care coordination (e.g. in 15 minute or one hour units). In this context, maintaining something that met the "efficiency, economy" provisions would require streamlined documentation requirements to trigger Medicaid payments and developing allowable costs which fairly represented the actual costs of maintaining the care coordinators.

CMS Response to Questions regarding Medicaid reimbursement.

The Help Me Grow program and other similar programs provide training to pediatric offices to conduct developmental surveillance and/or screening of young children and their families and makes referrals to a care coordinator when there are concerns. As we noted, nationally there are many models, both small and large, of care coordination. Smaller models may be specific to behavioral health services while larger models may encompass the larger health care needs of a child. The Centers for Medicare & Medicaid Services (CMS) has recently released guidance on integrated care models. A July 12, 2012 State Medicaid Director letter outlined options states have with respect to designing care delivery models that improve care, improve health and reduce costs to Medicaid programs. You can access the letter using the following link: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf
Section 1905(t)(1) of the Social Security Act provides a unique opportunity, as part of the Medicaid state plan, for states to implement an integrated care model. The requirements of this section are that care managers are responsible for locating, coordinating and monitoring primary care services, but it does not limit care managers to coordination of primary care.

Another option for implementing care coordination was created by section 2703 of the Affordable Care Act (ACA), which allows states to establish Health Homes to coordinate care for Medicaid beneficiaries with chronic conditions. Further guidance is available in a State Medicaid Director letter at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Another option available under the Medicaid state plan is the targeted case management benefit, which is the most holistic of the options. Medicaid funding may be used for coordination of not just medical services, but also to gain access to social, educational and other services. Finally, under the Medical Home benefit, provider qualifications are left up to the states, so a program such as Help Me Grow may fit within this arrangement.

Case Example Three: School-based free standing health-focused services.

Because of high rates of absenteeism in a local school with a predominant population of children receiving free-and-reduced priced meals, the school explored the reasons for these high rates and found that asthma and allergies contributed. A local children's hospital agreed to deploy a pulmonary nurse practitioner at the school to work with parents and children to improve management plans for addressing these conditions, including home inspections to address environmental contaminants. The school purchased several HEPA vacuum cleaners for use by families and a flexible fund was established to be able to purchase special equipment (such as hypoallergenic mattresses and bedding) for children.

The nurse practitioner estimated that three-quarters of the children she served were covered under Medicaid and that three-quarters of her time was spent on such issues, but that she also provided other advice and guidance to parents around other concerns which could affect healthy child development.

Current situation with regarding Medicaid reimbursement. The program currently is not drawing down any Medicaid financing, although many of the services provided are clearly eligible for reimbursement. Moreover, there are signs that, in addition to reducing absenteeism rates, the program also reduces emergency room and hospitalization costs and saves the state money on its Medicaid expenditures that would more than cover its costs. At the same time, there are no actual referrals from physicians to the pulmonary nurse practitioner, although she did make sure to provide information back to primary care practitioners of what she did and she does work under the general supervision of a physician.

Questions regarding Medicaid reimbursement. There are different potential ways to bill this service – on a per client basis and per service basis, on a bundled basis, and even on a project basis under administrative claiming.

On a per client and per service basis, the practitioner would have to determine the child was Medicaid eligible and then bill for their own time in working with the child and family to address the asthma or allergy, based upon allowable costs. It might also be possible to obtain reimbursement for HEPI vacuum rental and some of the special equipment.

Alternatively, the practitioner could bill on a bundled basis for all these services, based upon an average expense in responding to a particular family, based upon allowable costs.

It may make sense, however, particularly for such a locally-developed initiative, to finance the entire operation as a health project under administrative claiming, potentially apportioning the share of the project cost eligible for Medicaid based upon the percentage of children eligible for Medicaid being served. This might be done in conjunction with a public department of health or with the local children's hospital.

Clearly, this approach actually may produce cost-savings to the Medicaid program in reduced emergency room and hospitalizations. Ideally, there would be ways to reinvest such savings in more preventive approaches (see #1 and #2 above) which also could result in cost savings, but over a longer term and with some of those savings coming to systems other than Medicaid. Models like this often develop indigenously in ways that could be further expanded, provided there are resources to do so. These models also could become part of Accountable Care Organizations, but for children they are most likely to start and enlist their champions through other venues.

CMS Response to Questions regarding Medicaid reimbursement.

A third program we discussed deploys a pulmonary nurse practitioner to a school to improve management plans for children with asthma and allergies. As was noted during our conversation, states providing school based health care must have an approved Medicaid state plan describing the services being provided in the schools. There must be a link to the Medicaid benefit package in the state plan. In addition, comparable health services must be available outside of the school and there must also be comparable provider qualifications as well. CMS is willing to further explore the nurse practitioner/hospital example to determine if such an arrangement could be coverable under Medicaid. We would, however, need additional information.

Case Examples Four: Community-Based Health Related Programs

A community action agency has developed a new nutrition and exercise program, conducted by a state-certified nutritionist and an instructor with an undergraduate degree with majors in both child development and fitness, to respond to the dramatic growth in obesity among young children in its Head Start and other community programs. The program is focused upon three and four year-olds who have BMIs showing them as overweight, although any child and family can participate. The program itself involves both parents and their young children in a group setting where there is one-on-one counseling and group activities, drawing upon the expertise of the nutritionist and the development specialist/fitness instructor. A local pediatrician donates her time to oversee the clinical aspects of the program and to come to the initial and concluding program nights to do abbreviated well-child check-ups and weigh-ins. Most of the children and families are from Head Start or referred from WIC, although there are an increasing number referred by physicians who are colleagues of the local pediatrician. Located within a very poor neighborhood, about 80 percent of the children are covered under Medicaid, although a few do not have citizenship documentation and are not eligible for Medicaid. The program attributes a great deal of its success to the family service worker who encourages families to participate, remains in contact with them between actual sessions, and has established a "buddy system" that provides peer support in following up on lessons learned at the group sessions while at home in everyday life. This family service worker is a paraprofessional but with excellent "people skills" and an ability to relate to the families in this neighborhood, and she has also received training in family development services through a community college.

Current situation regarding Medicaid reimbursement. The program currently is funded by a community foundation, which has been advised that the program might be eligible for financing under Medicaid. The program director has had an initial visit with state Medicaid staff, but the discussion often appeared to be between people speaking different languages, and the program director recognized that obtaining any Medicaid funding would be a very complicated undertaking involving the need for much more expertise than the program itself had and that was likely to be available at the state level. The program director was also concerned that the amount of paperwork and documentation would stretch the ability of current staff to do the basic work with children and families they were designed to do. The director also felt that the community-based nature of the program and the informal interactions families enjoyed when participating were key to the program's effectiveness and could be jeopardized by moving to a clinical structure which seemed to be the approach to Medicaid funding being suggested by the state.

Questions regarding Medicaid reimbursement. The program is willing to provide somewhat greater documentation and establish additional protocols to ensure that all aspects of the program actions are taken under the supervision of a "licensed practitioner of the healing arts." The program might consider having a physical therapist assume the role of fitness instructor if that were necessary for billing purposes. While there currently is attendance taken, the program also would go a step further to maintain some limited case records on the individual children and families and any special actions taken on their behalf.

The questions regarding program funding are very similar to those for the 3rd example, but there are many more questions regarding professional requirements needed to secure Medicaid financing. The family service worker, in particular, is a paraprofessional and really performs her job on a 24-7 basis, but is regarded as essential to the success of the program. For her to keep detailed records and charts on individual children and families, however, is simply "not going to happen."

One option would be to determine what documentation, referrals, and licensing is needed for these to be considered group visits related to treatment of the child's weight and exercise/health, with this potentially billed at the rate of a well-child visit or other billing code. Alternatively, the amount which could be billed for each service could be based upon allowable costs for the visit, drawing in as much as possible the holistic costs. Alternatively, certain features (e.g. the physician screening or a specific nutrition counseling session) could be billed as discrete services.

CMS Response to Questions regarding Medicaid reimbursement.

Finally, you provided information on community-based health related programs. One community-based program you mentioned has developed a new nutrition and exercise program to respond to the dramatic growth in obesity among young children in Head Start. As you know, the ACA addressed preventive services in a number of ways. We expect guidance to be released shortly on the ACA provision, section 4106, which provides for enhanced federal matching for states that provide preventive services under their Medicaid program that are graded A or B by the United States Preventive Services Task Force. Preventive services are also part of the Essential Health Benefits requirement for the Medicaid expansion population and the CMS will be looking for robust packages of services when states submit their plans. The CMS is very interested in exploring and encouraging the use of preventive services to improve the overall health of our Medicaid population.

With respect to the issues you raised regarding reimbursement for the services and scenarios discussed during our conversations and in this letter, we and our Financial Management Group are happy to work with states to discuss reimbursement options and to address specific issues.

I hope this information is helpful and appreciate your work on behalf of this vulnerable population.