ROOM TO GROW: PROMOTING CHILD DEVELOPMENT THROUGH MEDICAID AND CHIP

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EXECUTIVE SUMMARY

A strong program of preventive health care is crucial to early childhood development, especially for children from low-income families. This report examines how public insurance programs covering low-income children—namely, Medicaid and the State Children's Health Insurance Program (CHIP)—can be used to support and foster child development interventions.[1] Such interventions encompass comprehensive preventive health care, anticipatory guidance and support for parents, and activities that provide children with cognitive and sensory stimulation. Together, Medicaid and CHIP form the largest combined source of financing for developmental services to children under age 3. While both programs are subject to federal financial standards, each offers states substantial flexibility in creating strong preventive pediatric services.

The report begins with an overview of Medicaid and CHIP and then examines opportunities available to states to use these programs' funds to design quality preventive health services for young children. These services would emphasize comprehensive coverage, innovation in service delivery, and an accessible and supportive health care system for families and children.

OPPORTUNITIES TO ENHANCE MEDICAID AND CHIP

Medicaid is the nation's single largest insurer of children of all ages. The program provides health coverage to an estimated 23 million low-income children, or more than one in four U.S. children. In fiscal year 2001, federal and state governments are projected to spend nearly $32 billion for services for Medicaid-eligible children ($18 billion federal, $14 billion state). Because federal Medicaid funds are not subject to an aggregate limit, states may extend the reach of their programs for children through broader eligibility standards or additional benefits and services and still continue to receive federal financial assistance.

An important complement to Medicaid, CHIP provides states with funding at an enhanced federal matching rate to extend coverage to certain low-income children. These are children in families whose incomes and resources are too high to qualify for Medicaid but who nonetheless are in need of financial assistance. Unlike Medicaid, CHIP does not entitle children who meet program eligibility requirements to a defined set of health care benefits. Instead, children qualifying for CHIP receive financial assistance toward the cost

[1] This report is the second in a series on child health and development. For the first report, see Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, *Health Policy and Early Child Development: An Overview,* The Commonwealth Fund, July 2001. Two additional reports, forthcoming in 2001, explore the potential roles of community health centers and Maternal and Child Health programs.

of necessary health care as determined by the state and subjected to certain federal requirements.

Both Medicaid and CHIP can use the latitude they enjoy under the federal government to shape their benefits in a way that promotes high-quality early child development services. There are a number of ways to enhance the provision of such preventive care under these programs. One of the most important is to establish eligibility rules and enrollment procedures that ensure prompt enrollment and access to care at the earliest possible time. States have the flexibility to effectively raise CHIP coverage higher than federal nominal standards by disregarding additional income in determining whether a family's income falls below a specified standard. In determining whether the family income of a Medicaid-ineligible child falls within 50 percentage points of a state's Medicaid eligibility standard, for instance, a state might elect to disregard the entire cost of the family's monthly child care bill rather than a fixed amount.

Other options available to Medicaid and CHIP officials include:

- defining covered benefits to include preventive health care related to child development;
- enhancing the service settings in which covered benefits will be delivered in order to support innovations in service delivery identified in child development literature;
- broadening the range of health professionals who may participate in state programs;
- building financial incentives into provider compensation arrangements that reward the furnishing of child development services; and
- implementing quality measurement and improvement procedures that emphasize the provision of child development services.

OPTIMIZING BENEFIT DESIGN UNDER MEDICAID AND CHIP

Benefit design is important for both Medicaid and separate CHIP programs, not just as a means of ensuring adequate coverage but as a way of influencing the quality of health care. States have several opportunities to optimize benefits for enhanced child development services.

- *Using the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit as a template.* This program offers a particularly comprehensive guide

of preventive interventions from which to fashion a specific early intervention benefit for all young children. Since Medicaid-eligible children are entitled to coverage for scheduled and as-needed preventive screenings, states could fashion a basic screening program for children who show normal growth and development and an extended preventive program for children needing additional interventions to foster growth and development.

- *Redefining classes of covered services.* A state could use its latitude under Medicaid and CHIP to further define the classes of covered services to create a bundled benefit known as early childhood development. This benefit would be provided to all children as part of their routine preventive health care.

- *Restructuring compensation arrangements for participating providers.* One of the problems that has plagued Medicaid historically is exceedingly low payment rates, particularly for primary health care. State Medicaid and CHIP programs could structure their compensation arrangements to counteract this problem. Obviously, rates could be raised as a general matter. Beyond this, however, a state could institute a special early childhood development compensation arrangement that pays generous rates for extended office visits when conducted by physicians and other qualified health professionals. There could be payment incentives to support lengthier visits and finance additional units of anticipatory guidance during a visit.

IMPROVING THE QUALITY OF PEDIATRIC CARE

Depending on how they elect to organize their programs, Medicaid and CHIP agencies act as health purchasers when they buy managed care products or health insurers when they operate traditional fee-for-service plans. Regardless of the approach chosen, agencies now pay considerable attention to matters of health care quality.

The traditional EPSDT program contains few measures of health care quality other than counting the number of screenings performed or the percentage of children who receive a screen. State Medicaid and CHIP programs that buy managed care services may want to consider specific quality benchmarks (both intermediate and outcome measures), such as the proportion of families who receive educational counseling on infant growth and development during well-child visits. In addition, state Medicaid and CHIP agencies might consider convening working groups with participating pediatric clinicians to develop quality improvement programs for health professionals. These programs would be aimed at upgrading the quality of preventive practice to conform to literature on early childhood development; participation could be tied to qualification for enhanced

payment. Such quality improvement efforts would be permissible administrative costs under both Medicaid and CHIP.

In addition, states have the opportunity to purchase child development services when they contract with managed care plans to furnish EPSDT benefits to Medicaid enrollees. If state Medicaid agencies want to enhance child development services available through health plans, they could initiate steps such as requiring child development services in contracts with plans or providers; revising EPSDT language and engaging in more consistent enforcement; and enhancing capitation rates.

CONCLUSION

Medicaid and CHIP have enormous potential to promote the delivery of child development services to low-income children under age 3. The two programs cover more than 60 percent of all low-income insured children and offer states broad discretion in designing eligibility rules, a benefits package, and reimbursement arrangements that will encourage delivery of such services. While formal federal guidance on Medicaid and CHIP payment for child development services is sparse, the statutes, regulations, and earlier guidance from the Health Care Financing Administration delineate how much leeway state agencies have in fashioning a strong early childhood prevention component to their Medicaid or CHIP programs. State policymakers have the option of using this flexibility to promote access to high-quality child development services for eligible newborns and low-income children.

ROOM TO GROW: PROMOTING CHILD DEVELOPMENT THROUGH MEDICAID AND CHIP

I. INTRODUCTION AND OVERVIEW OF MEDICAID AND CHIP

INTRODUCTION

A strong program of preventive health care is crucial to early childhood development, especially for children from low-income families. It is thus particularly important to understand how public insurance programs covering low-income children can be used to support and foster optimal child development interventions.[2]

This report examines the role of Medicaid and the State Children's Health Insurance Program (CHIP) in the delivery of high-quality child development services to children under age 3.[3] Together, Medicaid and CHIP form the largest combined source of child health financing in the United States. Both programs, but especially Medicaid, must meet certain federal financial standards. At the same time, they each offer states substantial flexibility in creating strong preventive pediatric services.

The report first provides an overview of Medicaid and CHIP and then examines opportunities for states to use these programs' funds to design quality preventive health services for young children. These services would emphasize comprehensive coverage, innovation in service delivery, and an accessible and supportive health care system for families and children.

OVERVIEW OF MEDICAID AND CHIP

Roles of Medicaid and CHIP in Providing Preventive Pediatric Services

The importance of state Medicaid and CHIP program design to facilitate access to and use of child development services can hardly be overstated. First, Medicaid has a significant influence on low-income families' access to and use of routine child health care (Figure 1). State pediatric health insurance programs that formed the prototype for CHIP had a similar impact.[4]

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[2] Peter Budetti et al., *Assuring the Healthy Development of Young Children: Opportunities for States,* The Commonwealth Fund, February 2000.

[3] For a precursor to this report and more information on the role of the federal government in child development, see Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, *Health Policy and Early Child Development: An Overview,* The Commonwealth Fund, July 2001.

[4] See Jane Holl et al., "Evaluation of New York State's Child Health Plus: Access, Utilization, Quality of Health Care, and Health Status," *Pediatrics* 105 (March 2000, Supplement E): 711–718.

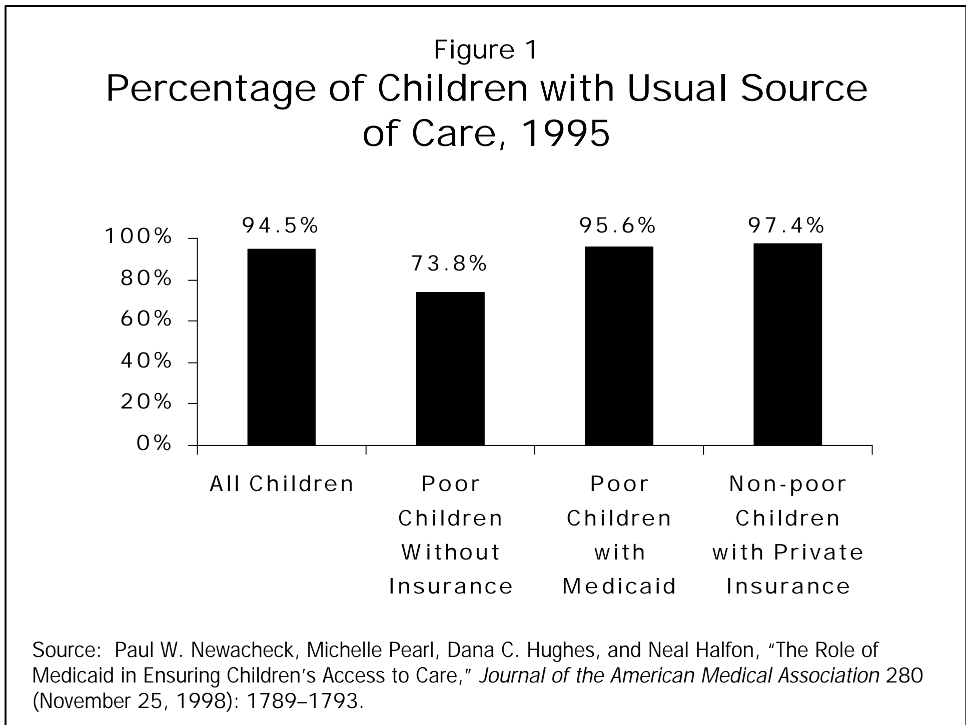


Figure 1
Percentage of Children with Usual Source of Care, 1995

Source: Paul W. Newacheck, Michelle Pearl, Dana C. Hughes, and Neal Halfon, "The Role of Medicaid in Ensuring Children's Access to Care," *Journal of the American Medical Association* 280 (November 25, 1998): 1789–1793.

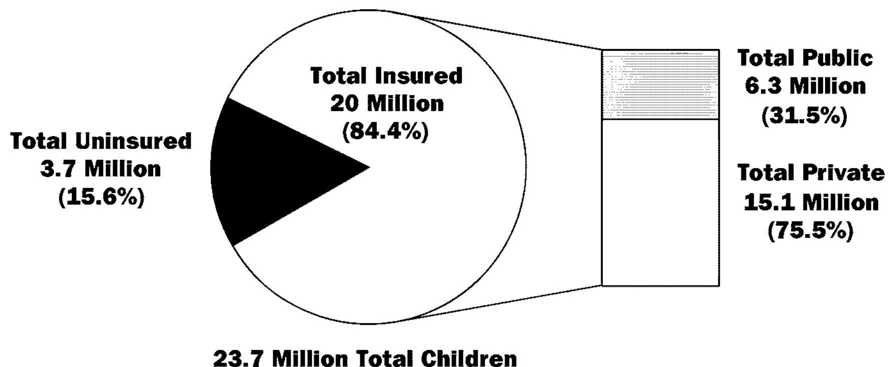
Second, Medicaid (and more recently CHIP) plays an extraordinary role in the well-being of all young children covered by health insurance. Insurance data prior to the full implementation of CHIP in all states in 1999 illustrate the magnitude of the public component of child health insurance. Figure 2 shows that in 1998, 6.3 million of the 23.7 million children under age 6—nearly 27 percent—were insured by public insurance (overwhelmingly Medicaid). But even this number understates the role of public insurance for children. Among all insured children under age 6, 31.5 percent relied on public health care financing for coverage. In other words, public insurance was the source of coverage for nearly one of three insured children.

Figure 3 illustrates the same point even more dramatically for young low-income children (those in families with incomes below 200 percent of the federal poverty level). In 1998, 57 percent of all low-income young children with any health coverage—nearly three of five—relied on public insurance, almost exclusively Medicaid.[5] Medicaid and CHIP dominate pediatric financing and can be expected to have an even greater presence as both programs expand and employer coverage levels for children remain fairly stagnant (Figure 4).

[5] Because CHIP was still in its early implementation stages, its presence was not captured in these data.

Figure 2

Insurance Status of All Children Under Age 6 by Source of Insurance, 1998



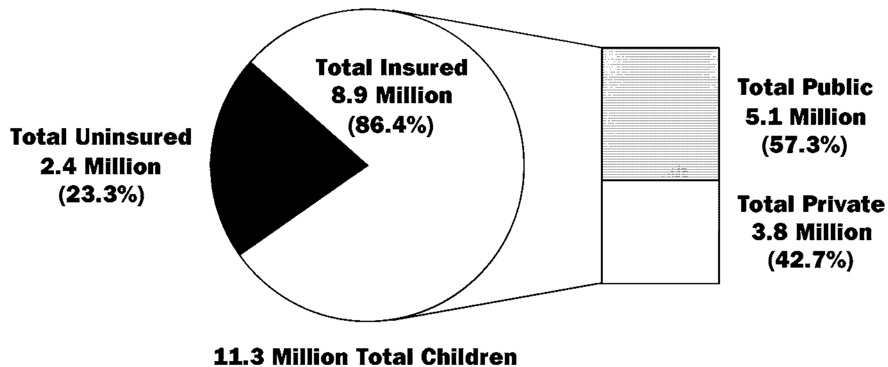
23.7 Million Total Children

Note: Numbers of insured children do not total 20 million because children may have more than one source of coverage.

Source: Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 *Current Population Survey*," Employee Benefit Research Institute, Issue Brief 217, January 2000, Table 11.

Figure 3

Insurance Status of Low-Income (Less than 200% of the Federal Poverty Level) Children Under Age 6 by Source of Insurance, 1998



11.3 Million Total Children

Source: Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 *Current Population Survey*," Employee Benefit Research Institute, Issue Brief 217, January 2000, Table 11.

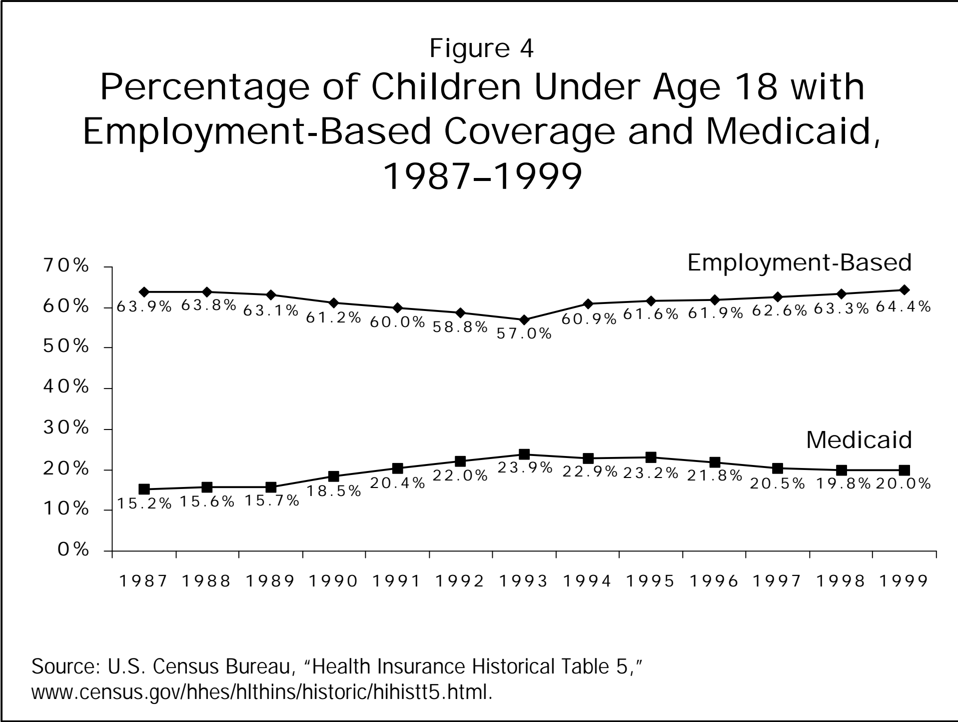


Figure 4

Percentage of Children Under Age 18 with Employment-Based Coverage and Medicaid, 1987–1999

Source: U.S. Census Bureau, "Health Insurance Historical Table 5," www.census.gov/hhes/hlthins/historic/hihistt5.html.

A third reason to focus on Medicaid and CHIP is their importance to the safety net providers serving disproportionately low-income communities and to the quality of the overall pediatric health system. Lower-income children are less likely to rely on private pediatric professionals for routine care and more likely to use primary care facilities that receive public or community subsidies to maintain their operations in poorer communities. These facilities include public health centers, children's hospital clinics, and local health departments.[6] Because third-party revenues all flow into the U.S. pediatric care system, how public insurance programs recognize and pay for routine and primary pediatric health care can ultimately have a substantial impact not only on the quality of care for low-income young children, but on the quality of care for all children.

However pronounced the impact of public insurance, its effects on those health care providers that disproportionately treat poor families cannot be stressed too strongly. Medicaid patients comprise more than one-third of the families and revenues of safety net primary care clinics, such as federally funded community health centers.[7] For these types of providers, public health financing decisions are vital to the health care quality they provide because public funds comprise such a large percent of total revenues.

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[6] Medical Expenditure Panel Survey. See Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, www.ahrq.gov.

[7] Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, D.C.: National Academy Press, 2000). Figures 2.1 and 2.3.

Medicaid

Medicaid, the nation's single largest insurer of children of all ages, provides health coverage to an estimated 23 million low-income children—more than one of four children in the United States.[8] Federal and state governments, which jointly administer the program, are projected to spend nearly $32 billion buying services for Medicaid-eligible children ($18 billion federal, $14 billion state) in FY 2001.

Federal Medicaid funds are not subject to an aggregate limit. As a result, states may further extend the reach of their individual Medicaid programs for children by broadening eligibility standards or providing additional benefits and services while still continuing to receive federal financial assistance.[9] Within the context of certain federal standards related to eligibility, enrollment, and access to covered health care, states have considerable discretion to tailor their programs to meet the needs of children and families.

Medicaid is also the nation's single largest insurer of maternity care, covering some 35 percent of all live births.[10] All infants born to Medicaid-enrolled women are themselves automatically enrolled in the program. Newborns remain eligible for at least a year—as long as their mother is income-eligible and the baby continues to reside with the mother.[11] Even if mothers no longer qualify for Medicaid, they can separately establish the Medicaid eligibility of their babies because of the expanded financial eligibility standards that apply to young children. Medicaid is thus an ideal delivery mechanism of child development services to infants born of low-income parents.[12]

Moreover, all states are required to cover all children under age 3 with family incomes at or below 133 percent of the federal poverty level ($18,819 per year for a family of three in 2000); many states have set even higher eligibility thresholds.[13] As a result, most of the infants who qualify for Medicaid during their first 12 months are likely to

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[8] Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001* (April 2000), Table 2-2. Estimate is for fiscal year 2001.

[9] Ibid.

[10] National Governors' Association, *Income Eligibility for Pregnant Women and Children* (January 20, 2000), Table 5, www.nga.org/pubs/issuebriefs/2000. Medicaid paid for nearly 1.1 million births in 1997 (19 states did not report data).

[11] §1903(e)(4) of the Social Security Act, 42 U.S.C. §1396b(e)(4).

[12] A recent analysis found that, overall, state Medicaid agencies finance few early childhood development services on a capitated or fee-for-service basis. For more information, see Harriette Fox et al., "An Examination of State Medicaid Financing Arrangements for Early Childhood Development Services," *Maternal and Child Health Journal* 4 (2000): 19–27.

[13] As of July 2000, 27 states had established income thresholds for children ages 1-5 above 133 percent of the federal poverty level. Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, Kaiser Commission on Medicaid and the Uninsured, October 2000, Table 1, www.kff.org.

remain eligible during the next 24 months. This gives Medicaid the ability to provide continuity in the financing of child development services during a child's first three years.

Eligibility and enrollment. In the case of young children, eligibility for Medicaid depends on whether they meet the program's financial and other criteria, including residency in the state in which application is made[14] and citizenship or legal status.[15] At a minimum, states must cover all infants and young children whose family incomes are at or below 133 percent of the federal poverty level. They also have the additional flexibility to set eligibility standards in accordance with state needs (most states have adopted standards for young children that exceed this minimum threshold). States may waive application of any assets test, and nearly all have done so. States must also provide all parents of children who wish to do so the opportunity to apply for Medicaid;[16] process applications within certain time frames; and provide enrollment opportunities for children under age 19 at federally qualified health centers and safety net hospitals.[17]

Benefits and cost-sharing.[18] Children enrolled in Medicaid are entitled to an extraordinarily broad array of benefits known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.[19] EPSDT services consist of periodic and interperiodic (i.e., as needed) comprehensive examinations (screenings) and comprehensive vision, dental, and hearing care. EPSDT also consists of any medical care and services that fall under the federal definition of "medical assistance" and are necessary to treat or ameliorate physical and mental conditions discovered during a screen. These services must be provided even if they are not furnished to adults.

EPSDT screenings consist of comprehensive health and developmental histories, assessments of physical and mental health development, comprehensive unclothed physical examinations, all age-appropriate immunizations, laboratory tests (including blood lead

[14] 42 C.F.R. §233.290. Non-institutionalized children are considered residents of the state in which their parents or caretakers intend to reside or work.

[15] Children who are citizens and otherwise entitled to Medicaid can receive full coverage. Children who are legal residents and who were living in the United States before August 22, 1996, are also entitled to full coverage if otherwise eligible. Legally resident children who arrived in the United States on or after August 22, 1996, are barred from receiving Medicaid (other than coverage for emergency medical conditions) for the first five years following entry.

[16] §1902(a)(8) of the Social Security Act; 42 U.S.C. §1396a(a)(8); 42 C.F.R. §§435.404 and 435.906.

[17] 42 C.F.R. § 911; §1902(a)(55) of the Social Security Act, 42 U.S.C. §1396a(a)(55); and 42 C.F.R. §435.904. The time frame for considering an application from a non-disabled person is 45 days. For persons with disabilities the time frame is 60 days from the date of application.

[18] For information on Medicaid's benefit package, see Andy Schneider and Rachel Garfield, *Medicaid Benefits*, Kaiser Commission on Medicaid and the Uninsured, August 2000, www.kff.org.

[19] §§1905(a)(4)(B) and 1905(r) of the Social Security Act, 42 U.S.C. §§1396d(a)(4)(B) and (r).

level), health education, and anticipatory guidance. The medical necessity standard used in the case of children must be consistent with the overall preventive purpose of the EPSDT program; therefore, children in need of health care must receive it at the earliest possible time before illness or disability becomes significant. Young children are completely exempt from otherwise applicable cost-sharing requirements under state Medicaid programs.

States must also provide scheduling and transportation assistance as well as assistance in obtaining necessary services that fall outside the scope of the Medicaid program. Coordination with non-Medicaid services is particularly stressed in the case of services offered by Title V Maternal and Child Health services and state WIC (Women, Infants and Children's Supplemental Nutrition) programs.[20] The full EPSDT benefit, as well as the pediatric coordination requirement, is shown in Appendix A.

Access to care. As a general matter, state Medicaid programs must ensure that medical assistance is furnished with reasonable promptness.[21] They must also ensure that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such services are available to the general population.[22] EPSDT specifically requires states to ensure that children have access to all necessary services.[23] Finally, states that use managed care arrangements to deliver care to enrollees must make certain that these arrangements are capable of ensuring reasonable access to care.[24]

CHIP

An important complement to Medicaid, CHIP provides states with funding at an enhanced federal matching rate[25] to extend coverage to certain "targeted low-income children" whose incomes and resources are too high to qualify for Medicaid under a state's Medicaid plan, but who nonetheless have low incomes and are in need of financial assistance.[26] Unlike Medicaid, CHIP does not entitle children who meet program

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[20] §1902(a)(11) of the Social Security Act, 42 U.S.C. §1396a(a)(11).
[21] §1902(a)(8) of the Social Security Act, 42 U.S.C. §1396a(a)(8).
[22] §1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(30)(A).
[23] §1902(a)(43) of the Social Security Act, 42 U.S.C. §1396a(a)(43); 42 C.F.R. §441.56.
[24] The reasonable access requirements apply regardless of whether managed care is furnished as a state option or pursuant to waiver. §1915(b) of the Social Security Act, 42 U.S.C. 1396n(b); and §§1932(b)(5) and 1932(c) of the Social Security Act, 42 U.S.C. §1396u-2(b)(5) and (c); 42 C.F.R. §431.55.
[25] The federal matching rate for Medicaid averages 57 percent; the enhanced federal matching rate under CHIP is approximately 70 percent.
[26] For purposes of CHIP eligibility, a child is a "targeted low-income child" if the child's family income (as calculated according to standards and methods established by the state) does not exceed 200 percent of the federal poverty level or 50 percentage points of the state's applicable Medicaid income eligibility level.

eligibility requirements to a defined set of health care benefits. Instead, these children receive financial assistance toward the cost of necessary health care as designed by the state, subject to certain federal requirements.

Eligibility and enrollment. CHIP is designed to assist children with low incomes who do not qualify for Medicaid. States have the option of using their CHIP funds to expand Medicaid, establish a completely freestanding program (i.e., separate program), or create a combination of the two. As of July 2000, 33 states operated separate CHIP programs, either exclusively or in coordination with an expanded Medicaid program.[27] Because CHIP funds are intended for use with children who do not qualify for Medicaid, children who apply for assistance in states with separate programs are first screened for Medicaid eligibility prior to enrollment. As of summer 2000, 28 of the 32 states operating separate CHIP programs used a single application form for both programs to simplify program navigation for families.[28]

Benefits and cost-sharing. States that elect to establish and operate separate CHIP programs are authorized under federal law to offer the same set of benefits (known as child health assistance) available under Medicaid.[29] At a minimum, however, states with separate programs must provide coverage up to a state-defined benchmark that reflects the level of coverage offered under one or more private health plans available in the state.[30] CHIP programs must also cover well-baby and well-child services as defined by the state.[31]

Most separate CHIP programs offer virtually the same set of preventive benefits as those offered through Medicaid, while differing from Medicaid with respect to the use of copayments (none, however, may be imposed on well-baby and well-child care). Separate CHIP programs may also differ with respect to limitations on the classes of treatment services covered and the application of certain coverage limitations, such as stricter medical necessity criteria or caps on the amount or duration of services.[32]

Access to care. The federal CHIP legislation contains no provisions similar to EPSDT that require states to ensure that children who need and request preventive services actually receive them within a time limit. In addition, CHIP leaves to state

[27] Ross and Cox, *Making It Simple,* 2000, p. 12.
[28] Ibid.
[29] §2110 of the Social Security Act, 42 U.S.C. §1397jj.
[30] §2103(b) of the Social Security Act, 42 U.S.C. §1397cc(b).
[31] §2103(c)(1)(D) of the Social Security Act, 42 U.S.C. §1396cc(c)(1)(D).
[32] Sara Rosenbaum, Anne Murkus, Colleen Sonosky, and Lee Repash, *State Benefit Design Choices Under SCHIP: Implications for Pediatric Health Care,* The George Washington University Center for Health Services Research and Policy, Washington, D.C., 2001, www.gwhealthpolicy.org.

discretion issues related to provider compensation rates as they apply to access to health care. Finally, the federal CHIP statute provides states with significantly greater discretion over managed care design, although state managed care contracts under CHIP tend to show a concern over access similar to that found in state Medicaid managed care contracts. As of fall 2000, 28 separate state CHIP programs used one or more forms of managed care arrangements. The contracts in these states suggest that, as with Medicaid, states establish relatively detailed standards related to accessibility of services.[33]

In summary, Medicaid and CHIP provide states with significant levels of federal funds to provide comprehensive health services to young children. Federal law sets more specific standards in the provision of preventive health care to young children enrolled in Medicaid. At the same time, studies of freestanding CHIP programs to date suggest a similar level of preventive health coverage and a similar focus on health care access. Because the focus of assistance under CHIP is near-poor children rather than the poorest infants and toddlers, cost-sharing might be somewhat higher. Moreover, CHIP was modeled on employer-based systems of coverage and provides financial assistance to help underwrite the cost of a benchmark premium for children in lower-income families. Thus, treatment services tend to track those programs available through employer-based plans rather than the expanded level of coverage available to children under Medicaid. But CHIP offers states considerable flexibility to pay for a level of well-baby and well-child care that, like Medicaid, reflects an emerging standard of preventive pediatric practice that stresses early childhood development.

[33] Ibid.

II. OPPORTUNITIES TO PROMOTE HIGH-QUALITY CHILDHOOD DEVELOPMENT SERVICES

States enjoy broad discretion under Medicaid and CHIP to establish eligibility rules, to determine the type and scope of benefits covered, and to reimburse providers and health plans. Medicaid and CHIP programs are not required to cover child development services per se, but they have the latitude to cover most of them and to receive federal matching funds for the costs they incur.[34] Several basic options enhance the provision of child development-related preventive health care under Medicaid and CHIP. These programs can:

1. establish eligibility rules and enrollment procedures that ensure prompt enrollment and access to care at the earliest possible time;

2. define covered benefits to include preventive health care related to child development;

3. enhance the service settings in which covered benefits will be delivered in order to support innovations in service delivery identified in child development literature;

4. permit innovations in the range of health professionals who may participate in state programs;

5. build financial incentives into provider compensation arrangements that will reward the furnishing of child development services; and

6. implement quality measurement and improvement procedures that emphasize the provision of child development-related preventive health services.

These issues are relevant regardless of whether a state purchases services for Medicaid and CHIP beneficiaries on a fee-for-service basis, through managed care arrangements, or both. At the same time, certain issues affecting the delivery of child development services to eligible children arise that are unique to managed care plans; these are reviewed in Section IV of this report.

[34] These range from 50 cents to 77 cents on the dollar in the case of Medicaid, with higher limits for children whose coverage is financed through a state's CHIP allotments.

Eligibility Rules and Enrollment Procedures

Effective public health insurance coverage for children has two basic requirements: 1) eligibility criteria must reach as many low-income children under age 3 as possible, and 2) those children must be enrolled in, and remain enrolled in, the program.

States have broad discretion to design their Medicaid and CHIP program rules and procedures to enroll virtually all low-income children under age 3 on a continuous basis. States can define "low income" to mean any level at or above 133 percent of the federal poverty level; one state (Tennessee) has set the level at 400 percent of poverty ($56,600 per year for a family of three). The administrative costs of enrollment, as well as the actual costs of coverage, are all matched by the federal government at no less than 50 cents on the dollar—and in most states at higher rates.[35] Unlike a block grant such as CHIP, in the case of Medicaid there is no limit on the amount of federal matching funds a state may claim for the costs of enrolling and covering young children eligible under the rules it has established.

Setting eligibility standards. Under Medicaid, states must, at a minimum, cover children up to age 6 in families with incomes at or below 133 percent of the federal poverty level ($18,819 per year for a family of three in 2000). The same policy applies to pregnant women through a 60-day postpartum period. States have the option of raising this income standard for pregnant women and infants up to age 1 from 133 percent to 185 percent of the federal poverty level ($26,177 per year for a family of three in 2000). As of July 2000, all but nine states had set their income standards for infants above 133 percent of the poverty level.[36] Because infants born to Medicaid-eligible women are themselves eligible for Medicaid, broader eligibility criteria for pregnant women will most likely lead to higher enrollment of low-income infants.

States also have the discretion to raise the effective income standard for pregnant women, infants, and children under age 3 above 185 percent of the federal poverty level. They can do this simply by disregarding a state-specified portion of a family's income in determining whether the child or pregnant woman meets the poverty level-related income standard.[37] States may, but are not required to, impose resource limits upon pregnant women and young children; as of July 2000, only seven states had opted to do

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[35] See Andy Schneider and David Rousseau, *Medicaid Financing,* Kaiser Commission on Medicaid and the Uninsured, forthcoming, www.kff.org.

[36] The nine states with an income standard for infants at the federal minimum are Alabama, Colorado, Montana, Nevada, North Dakota, Oregon, Utah, Virginia, and Wyoming. Ross and Cox, *Making It Simple*, 2000, Table 1.

[37] See Andy Schneider, Kristin Fennel, and Peter Long, *Medicaid Eligibility for Families and Children*, Kaiser Commission on Medicaid and the Uninsured, September 1998, www.kff.org.

so.[38] Appendix B sets forth the income and asset eligibility standards for pregnant women and young children used by each state as of July 2000.

In the case of freestanding CHIP programs, states may set income standards at 200 percent of the federal poverty level or at 50 percentage points above their Medicaid standard, whichever is higher. As with Medicaid, states have the flexibility to effectively raise CHIP coverage higher than these nominal standards by disregarding additional income in determining whether a family's income falls below a specified standard. For example, in determining whether the family income of a Medicaid-ineligible child falls within 50 percentage points of a state's Medicaid eligibility standard, a state might elect to disregard the entire cost of the family's monthly child care bill rather than a fixed amount. In general, the broader eligibility standards are (i.e., the higher the income standard), the more generous the methods used to calculate income are.

Improving application and enrollment processes. To ensure that expanded eligibility standards achieve their purpose, it is important that state Medicaid and CHIP programs have in place processes and procedures that make it easy to apply for and enroll in coverage. Application procedures should allow families to enroll their children in a manner as relatively simple and effortless as it is for workers when signing up for an employer-sponsored health plan. When reviewing existing enrollment procedures, state policymakers may wish to focus on those areas that have received particular attention in recent years, including:

- simplification of application forms;
- allowing application by mail;
- eliminating the requirement for a face-to-face interview at a welfare office;[39]
- providing parents with application assistance; and
- accepting applications at hospitals, clinics, and other sites unconnected with welfare offices.[40]

[38] The seven states that impose assets tests in determining Medicaid eligibility for children under age 6 are Arkansas, Colorado, Montana, Nevada, North Dakota, Oregon, and Texas. Ross and Cox, *Making It Simple,* 2000, Table 1.

[39] As of July 2000, 40 state Medicaid programs and 31 separate CHIP programs had eliminated the face-to-face interview. Ross and Cox, *Making It Simple,* 2000, p. 7.

[40] In the case of Medicaid, outstationed enrollment at federally qualified health centers and disproportionate share hospitals is required. §1902(a)(55) of the Social Security Act, 42 U.S.C. §1396a(a)(55); 42 C.F.R. §435.904.

States might also consider making pregnant women and their children "presumptively eligible" for Medicaid coverage, so that they have access to health care while state officials determine their actual eligibility.[41] Appendix C summarizes states' efforts to simplify Medicaid and CHIP enrollment.

Ensuring continuous coverage. Enrollment in Medicaid does not guarantee continuous insurance coverage. Small fluctuations in family income can lead to involuntary disenrollment of a Medicaid-eligible child or pregnant woman. This "churning" of Medicaid enrollment can undermine the efforts of doctors and other health care providers to furnish child development services without interruption during the child's first two years. States can mitigate this problem, however, by redetermining income only once every 12 months, or whenever the family reports a change in income, resources, or size. A preferable approach would be to use the option available to all states of providing eligible children under age 3 with up to 12 months of continuous eligibility, regardless of changes in family circumstances. As of July 2000, 14 states had adopted 12-month continuous eligibility for Medicaid, and two separate CHIP plans had done so as well.[42]

Enrolling the whole family. Because Medicaid eligibility standards for children tend to be considerably higher than those for their parents, frequently a young child will be enrolled in Medicaid but his or her parents will not.[43] In the case of CHIP, of course, parental coverage is not part of the federally allowed group of options. The lack of eligibility for parents can be a serious obstacle to effective child development interventions. Some interventions—for example, parent education, a core component of child development services—are simply not possible if parents are not also covered.[44] Health Care Financing Administration (HCFA) guidances make clear that health education for ineligible parents is an essential component of the eligible child's EPSDT

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[41] See Health Care Financing Administration and Health Resources and Services Administration, *Letter to State Health Officials on Outreach to Uninsured Children* (January 23, 1998), www.hcfa.gov/init/choutrch.htm. As of July 2000, eight states had established presumptive eligibility under Medicaid for children. Ross and Cox, *Making It Simple,* 2000, p. 7. §803 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554, extends the presumptive eligibility option for children under Medicaid to CHIP as well.

[42] Ross and Cox, *Making It Simple,* 2000, p. 7.

[43] For a summary of policy options for increasing Medicaid coverage of low-income parents, see Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms,* Center on Budget and Policy Priorities, September 5, 2000, p. 16, www.cbpp.org.

[44] Peter Budetti et al., *Assuring the Healthy Development,* 2000, p. 1.

benefit,[45] but that a service such as counseling is not covered when "it becomes a means of treating [ineligible individuals]."[46]

Because states have such broad latitude to define the services provided by their CHIP program, policymakers might presume that HCFA would allow federal financing for certain services geared toward parents—such as health education—as long as the intervention did not amount to treatment for the ineligible parent. HCFA issued a letter clarifying that "HCFA policy permits contacts with non-eligible or non-targeted individuals to be considered a Medicaid case management activity, and to be billed to Medicaid, when the purpose of the contact is directly related to the management of the eligible individuals' care."[47]

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[45] "Helping parents to identify when medical care is needed, by teaching milestones of normal child health and development, is parent education, or health education. Medicaid includes health education as a Medicaid service, specifically a component of the EPSDT screening services." Letter from Louis T. Schiro, Director, Medicaid Operations Branch (HCFA Region II), to Barbara Frankel, New York Maternal and Child Health Care (November 4, 1994).

[46] Covered counseling services include "meeting with, counseling with the child, family, legal guardian, and/or significant other. Consultation with, and training others, can be a necessary part of planning and providing care to patients. It can, however, devolve to a point where it becomes a means of treating others. States must make clear that services are only provided to or directed exclusively toward the treatment of Medicaid-eligible persons. Reasons for services must be medical in nature and not to prevent a dysfunctional family life or family disintegration." Memorandum from Wilma M. Cooper, Acting Associate Regional Administrator (HCFA Region IV), to Acting Director Medicaid Bureau (April 22, 1993).

[47] HCFA, Dear State Child Welfare and State Medicaid Director Letter, January 19, 2001 (SMDL #01-013), www.hcfa.gov/medicaid/smd119c1.htm.

III. ROLE OF BENEFIT DESIGN IN PROMOTING COVERAGE OF EARLY CHILDHOOD DEVELOPMENT SERVICES

How a state designs its Medicaid or CHIP benefit package not only affects the adequacy of coverage for enrolled children, but influences the quality of the health care provided. The concept of using benefit design to promote high-quality care is integral to the modern health system—regardless of whether a child is cared for under a managed care plan, a primary care case management program operated directly by the state, or a traditional fee-for-service arrangement.[48]

In designing child development services, it is important for states to bear in mind the substantial flexibility that both Medicaid and CHIP offer. Both programs provide for coverage for a broad class of preventive services—Medicaid on a mandatory basis as part of the EPSDT program, CHIP at the option of the individual state—that could serve as the basis for a new bundle of preventive services known as "early childhood development." These procedures and interventions would include those that now fall under existing federal service categories—physician services, nursing services, case management, health assessment, anticipatory guidance—that have been shown in the literature to enhance child development.[49] States could attach special considerations to the provision of these services, such as enhanced delivery locations (e.g., the home, or Head Start centers where a visiting nurse treats children) and special payment arrangements.

The Medicaid EPSDT benefit (all components of which are options for separate state CHIP programs) offers a particularly comprehensive template of preventive interventions from which to fashion a specific early intervention benefit for all young children. As previously noted, EPSDT contains three basic elements:

1. An access component consisting of informing and referral; transportation and scheduling; and assistance obtaining necessary health, nutritional, educational, and social services.
2. Provision for periodic and as-needed screenings.
3. follow-up diagnostic and treatment services for any problems identified during screenings.

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[48] In managed care, the line between coverage and care becomes blurred. In articulating standards of practice for managed care organizations of various types, quality improvement bodies such as the National Committee for Quality Assurance effectively advise purchasers on the standard of coverage.

[49] Peter Budetti et al., *Assuring the Healthy Development*, 2000, p. 1. These services include home visiting by a health professional and health education regarding the growth and development of an infant and toddler.

These elements touch upon a broad range of pediatric health concerns, including not just basic health and developmental issues but also hearing, vision, and dental care. The EPSDT benefit allows states to fashion a comprehensive children's preventive benefit program that supports thorough assessment of growth and development, active health interventions, and assistance in obtaining access to other needed services.

The discussion of EPSDT's preventive care coverage that follows draws heavily from a detailed analysis of EPSDT undertaken for The Commonwealth Fund by Jane Perkins and Kristi Olson of the National Health Law Program.[50]

Informing and Referral. When the EPSDT benefit was designed, it was expected that outreach efforts would help educate families with Medicaid-enrolled children about the importance of preventive health care and inform them of the availability of services.[51] This informing function is presently carried out by participating providers or by state Medicaid agency staff, staff of state or local health agencies funded under the Title V Maternal and Child Health Services Block Grant, or another entity under contract to the state agency. The function could be structured to include education of parents regarding the availability of child development services, including the developmental assessment that is part of any health examination meeting the standard of pediatric care. As parents request these services, federal funds would be available to assist them in obtaining care.[52] If the pediatrician determines a need for treatment, arrangements would be made to ensure that the child receives the needed intervention.[53]

Health and Developmental Screenings. As noted earlier, EPSDT health and development screening services include certain minimum elements. The American Academy of Pediatrics, whose Guidelines for Health Supervision are heavily relied on by most state Medicaid programs, recommends a minimum of 11 screenings for children up to age 3. Medicaid-eligible children are also entitled to coverage for preventive screenings on an as-needed basis (i.e., interperiodic screenings). This means that states could fashion a basic screening program for children who show normal growth and development levels and an advanced or extended preventive program for children whose treating professionals recommend additional interventions to foster growth and development.

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[50] Jane Perkins and Kristi Olson, *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Developmental Services,* National Health Law Program, for The Commonwealth Fund, September 1999.
[51] §1902(a)(43)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(43)(A).
[52] §1902(a)(43)(B) of the Social Security Act, 42 U.S.C. §1396a(a)(43)(B).
[53] §1902(a)(43)(C) of the Social Security Act, 42 U.S.C. §1396a(a)(43)(C).

Appendix D shows the number of child development services identified in the literature that fall within the definition of the EPSDT health and development screenings.[54] It also shows HCFA's interpretations of developmental assessments for Medicaid-eligible children. Other types of development services include home visitation, health education and counseling for children and parents, and nutritional assessments.[55]

While the statutory and regulatory language describing the EPSDT screening benefit appears to be sufficiently broad to accommodate additional child development services, federal regulatory interpretations have not yet been updated to reflect this new approach to pediatric care for children under age 3. However, various communications between HCFA regional offices and state Medicaid agencies expressly authorize the coverage of certain services, such as parent education.[56] In the case of services for which written federal guidance is not available, state policymakers may wish to seek guidance from their regional HCFA offices on whether federal Medicaid matching funds are allowable.

Follow-Up Diagnostic and Treatment. Screening plays a significant role in the structure of the EPSDT benefit. Conditions discovered during the course of a screening—whether periodic or interperiodic—trigger coverage of follow-up diagnostic and treatment services. This trigger is unique in two respects. First, follow-up services are covered when "necessary … to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."[57] This standard is far more inclusive than the conventional "medical necessity" standard common to commercial insurance policies.[58] In addition to the treatment of existing conditions, the complete prevention of disabilities or other conditions was also a major goal of EPSDT. From the start, EPSDT's guiding principle has been to prevent illnesses and conditions in order to achieve normal growth and development. Furthermore, this principle has been consistently recognized by the courts. A 1981 HCFA transmittal clarified the preventive nature of EPSDT services and their goal of promoting normal growth and development.

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[54] State Medicaid Manual §5123.2A, www.hcfa.gov.

[55] For further federal statutory and HCFA interpretation, see Jane Perkins and Kristi Olson, *Medicaid Early and Periodic Screening,* September 1999.

[56] Letter from Louis T. Schiro to Barbara Frankel, November 4, 1994.

[57] §1905(r)(5) of the Social Security Act, 42 U.S.C. §1396d(r)(5).

[58] Insurers generally limit coverage to certain treatment that is medically necessary to restore functioning following an illness or injury. This traditional rule of insurance is designed to limit financial risk exposure and to prevent "moral hazard," an industry term used to describe the problems incurred when individuals with costly long-term and chronic health conditions seek coverage. Traditional insurance principles therefore may result in coverage for only a subset of all procedures that Medicaid may cover. See Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts,* The George Washington University Center for Health Services Research and Policy, Second Edition, 1998, Vol. 1, Page 18.

Thus, this standard is intended to promote treatment *before* a condition becomes disabling, not merely to "treat or ameliorate" a diagnosed condition.[59]

Second, the child is entitled to follow-up services whether or not such services are also available to adults participating in the state Medicaid program.[60] The only requirement is that the necessary follow-up services fall into one of the more than 30 Medicaid statutory benefits categories for which federal matching funds are authorized.

The EPSDT template thus can be thought of as a guide to the range of services for which federal assistance is available. Services can be furnished on a procedure-by-procedure basis and billed under existing codes. Alternatively, a state could use its latitude under Medicaid and CHIP to further define the classes of covered services to create a bundled benefit known as early childhood development. This benefit would be provided to all children as part of their routine preventive health care services.

Service Settings and Qualified Personnel

Effective financing of child development services requires not only that the appropriate benefits categories be covered but also that the services be delivered by qualified health professionals in appropriate settings. In this regard, state Medicaid and CHIP programs enjoy wide latitude. Any constraints on where covered services may be furnished, and by whom, are likely to arise from state medical practice laws rather than from the federal Medicaid statute or regulations.

In the case of Medicaid, federal law specifies certain service settings as part of service coverage. For the most part, CHIP tracks Medicaid: with the exception of federally qualified health center and rural health clinic services, all other federal Medicaid coverage categories are part of the CHIP definition of "child health assistance" from which states fashion their state plans. Examples of service settings are hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs).[61]

At the same time, federal law does *not* require that all services be provided in such settings. In particular, the services covered under the mandatory EPSDT benefit are not limited to any particular setting; indeed, the only real constraint would arise from state law

[59] HCFA Transmittal No. 80-93, p. 3 (1981).

[60] §1905(r)(5) of the Social Security Act, 42 U.S.C. §1396d(r)(5).

[61] The Medicaid statute at §1902(a)(10)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(10)(A) in the matter before clause (i) requires the coverage of RHCs and FQHCs. These services are identified in §1905(a)(2)(B) and (C) of the Social Security Act, 42 U.S.C. §1396d(a)(2)(B) and (C).

related to the practice of medicine or nursing or other form of health intervention.[62] For example, unless state law prohibited it, health exams could be conducted in Head Start centers and Medicaid and CHIP could pay for them. Similarly, health education could be conducted in a family's apartment and Medicaid and CHIP could pay for the service unless prohibited under state law. In Vermont, personal care services, home visiting, and health education are provided as special EPSDT services where previously authorized by the Title V agency as part of the Healthy Babies Program.[63]

With respect to practitioners, federal law again combines some minimum requirements with broad discretion. State Medicaid programs are required to cover services furnished by certain types of practitioners—notably physicians, certified nurse midwives, and certified nurse practitioners.[64] States are not, however, required to furnish EPSDT (or other Medicaid-covered) services through only such practitioners. Among the options states have is to cover the services of any category of licensed practitioner within the scope of practice authorized by state law.[65] These practitioners include nurses, social workers, psychologists, health educators, nutritionists, and family counselors. Moreover, federal Medicaid law expressly prohibits states from restricting beneficiary access to EPSDT services through "comprehensive" providers who are qualified to provide a range of services. For example, states must allow children to receive EPSDT vision services from qualified practitioners who do not also provide general screening, dental, hearing, or other EPSDT services.[66] Appendix E illustrates the range of providers and practitioners that states may use to provide Medicaid services.

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[62] Neither the statute, §1905(r)(5) of the Social Security Act, 42 U.S.C. §1396d(r)(5), nor the implementing regulations, 42 C.F.R. Part 441, Subpart B, contain any limitation on the setting in which EPSDT services may be provided.

[63] Vermont State Plan Under Title XIX of the Social Security Act, Attachment 3.1-A, page 2b.

[64] The Medicaid statute at §1902(a)(10)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(10)(A) in the matter before clause (i) requires the coverage of physician services, certified nurse midwives, and nurse practitioners. These services are described in §§1905(a)(5)(A), (17) and (21) of the Social Security Act, 42 U.S.C. §§1396d(a)(5)(A), (17) and (21).

[65] 42 C.F.R. §441.57 states that "[u]nder the EPSDT program, the [state Medicaid] agency may provide for any other medical or remedial care specified in part 440 of this subchapter, even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope." Part 440 includes 42 C.F.R. §440.130(c), which authorizes coverage of preventive services provided by a physician or "other licensed practitioner of the healing arts within the scope of his practice under state law …."

[66] §1905(r) of the Social Security Act, 42 U.S.C. §1396d(r), provides: "Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services [covered by the benefit] or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services."

Not all practitioners who are qualified to deliver child development services are licensed under state law. Outreach workers with community health centers who conduct home visits with new mothers may not be licensed. This does not necessarily bar reimbursement for their services under Medicaid, however. Their services may be allowable as an administrative cost at a 50 percent matching rate, rather than as a covered service matched at the state's regular matching rate. HCFA, for example, has approved as an administrative cost a home visiting program that includes tracking of compliance with well-child visits, providing scheduling and transportation assistance, and helping parents enroll in WIC.[67] Interested state policymakers would need to work with the appropriate HCFA regional office to clarify the availability of Medicaid funding for the settings and practitioners through which they seek to deliver child development services.

Provider Compensation Arrangements

Federal Medicaid and CHIP law give states enormous latitude in structuring compensation arrangements for participating providers. States may pay on a fee-for-service basis, on a capitation basis, or both. This section reviews compensation arrangements other than those used to pay managed care organizations for comprehensive managed care services.

As noted earlier, CHIP is silent on compensation, leaving the matter completely to the states. Medicaid provides that services be "consistent with efficiency, economy, and quality of care"[68] and that payment rates be "sufficient to enlist enough providers so that care and services are available under [the state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."[69]

One of the problems that has plagued Medicaid historically (sufficient evidence does not exist to know whether this is an issue for separate CHIP programs as well) is exceedingly low payment rates, particularly for primary health care. These low rates have had two effects. First, they have probably discouraged most pediatric professionals from making Medicaid children more than a marginal part of their practices, simply because the economics of ambulatory practice make it impossible to have a significant proportion of one's revenues derive from such a low payer.[70] Second, low payment rates necessarily shorten the time that a professional can spend with a patient, for much the same reason:

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[67] Letter from Louis T. Schiro to Barbara Frankel, November 4, 1994.

[68] §1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(30)(A).

[69] Ibid.; 42 C.F.R. §447.204.

[70] This assumed impact is supported by studies of provider participation in Medicaid showing that most private professionals maintain at most a marginal Medicaid practice and that very few professionals account for the bulk of care furnished in ambulatory settings. See, for example, Stephen Norton and Stephen Zuckerman, "Trends in Medicaid Physician Fees, 1993-1998," *Health Affairs* 19(4):222-232 (July/August 2000).

lengthy office visits are not financially feasible if families cannot pay for the time and complexity required for a thorough examination, a developmental assessment, and extended counseling. Very low insurance payment rates inhibit practices from providing such a high level of comprehensive care.

Fortunately, state Medicaid and CHIP plans can structure their compensation arrangements to counteract these problems. Beyond raising rates, a state could institute a special early childhood development compensation arrangement that pays generous rates for extended office visits when conducted by physicians and other health professionals who meet its qualifications. The rate structure could include payment incentives to support lengthier visits and finance additional units of anticipatory guidance during a visit at which a provider determines that additional time is warranted.

Since most providers would need to schedule a follow-up visit where additional early childhood development time is needed, the state could structure the enhanced payment arrangement not as part of the basic EPSDT screen, but as a separate early childhood development service. The service could be billed simply as a physician visit or as a specified preventive visit of the type discussed earlier.

Medicaid has special payment rules for FQHCs and RHCs. Effective January 1, 2001, state Medicaid programs must pay FQHCs and RHCs in accordance with a revised cost-based payment methodology (or an alternative methodology fashioned by the state that equals at least the amount that would be payable under the new system). The cost methods used for FQHCs and RHCs are designed to ensure that funds allocated for care of uninsured patients are not used to offset Medicaid payments that provide for less than the reasonable cost of care. Under the new method, FQHCs and RHCs receive a payment in fiscal year 2001 that reflects their 1999–2000 average cost of care. This base year payment will be updated by the Medical Economic Indicators in out-years. Furthermore, the base year payment must be adjusted to take into account changes in the scope of services offered by the provider. Thus, if a state were to add coverage for a specific set of early childhood development-related preventive health services, the cost of these additional services would be factored into the clinic's base payment and then increased based on estimates of future service use.

Because health centers take care of such a large volume of low-income, publicly insured children, special attention to support high-quality developmental services in health centers is warranted. State CHIP programs have the flexibility to follow their state's Medicaid payment methodology for FQHCs and RHCs.

IV. IMPROVING THE QUALITY OF DEVELOPMENTAL SERVICES

The traditional EPSDT program contained few measures of health care quality other than counting the number of screenings performed, or tracking the percentage of children who received a screen (which, given the low reliability of data, may not be a particularly effective way of determining the number of children receiving preventive care).[71] State Medicaid and CHIP programs that buy managed care services may want to consider specific quality benchmarks (both intermediate and outcome measures), such as the proportion of families who receive counseling regarding infant growth and development during the course of a preventive office visit.[72]

State Medicaid and CHIP agencies might also consider convening working groups with participating pediatric professionals to develop quality improvement programs for health professionals. These programs would be aimed at upgrading the quality of preventive practice to conform to literature on early childhood development. Participation in the program could be tied to qualification for enhanced payment. Such quality improvement efforts are permissible administration costs under both Medicaid and CHIP.

Special Issues in Managed Care

As of June 1999, about 17.8 million Medicaid beneficiaries, or more than 55 percent of all Medicaid beneficiaries, were enrolled in some form of managed care organization (MCO). Roughly 17 percent of these were enrolled in a PCCM plan, which does not assume financial risk for physician and hospital services. The remainder were enrolled in MCOs that assume financial risk for the services they contract with the state Medicaid agency to furnish.[73] An unknown number of children insured through separate CHIP programs were enrolled in PCCM or managed care arrangements, which were in use in 28 of the 33 states operating freestanding programs.[74]

Because the incentives under which MCOs and their participating providers operate differ significantly from the those in the fee-for-service and PCCM sectors, this discussion will focus on the managed care model.

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[71] EPSDT program data suggest that the proportion of screened children is low. However, national probability studies of low-income children suggest that publicly insured children receive preventive health services at a rate comparable to privately insured non-poor children. See Figure 1.

[72] This is similar to the Health Plan and Employer Data Information Set measure of quality care for preventive services for adults that examines the proportion of adults who are advised on quitting smoking as part of their office encounter.

[73] Health Care Financing Administration, "Medicaid Managed Care Plan Type and National Enrollment—June 30, 1999," www.hcfa.gov/medicaid/plansum9.htm.

[74] Rosenbaum et al., *State Benefit Design Choices Under SCHIP*, 2001.

Although the Medicaid managed care enrollment data cited above are not broken out by eligibility category (e.g., children, disabled, elderly), it is reasonable to assume that the majority of both PCCM and MCO enrollees nationwide are children. This means that state policymakers have an opportunity when purchasing care through MCOs to make child development services available to large numbers of low-income children, particularly in those states with high levels of Medicaid managed care enrollment. Federal law has no requirement that state Medicaid programs enroll eligible children in MCOs or that they purchase child development services on behalf of enrolled children through MCOs. However, if a Medicaid-eligible child is enrolled in an MCO, the state Medicaid agency has an obligation to ensure that the child has access, either through the MCO or otherwise, to the full scope of EPSDT services to which the child is entitled.

Since development services and EPSDT benefits overlap significantly, a state that contracts with an MCO to furnish EPSDT benefits to Medicaid enrollees has the opportunity to purchase—as part of or as an adjunct to these benefits—child development services. Researchers at Northwestern University's Institute for Health Services Research and Policy Studies recently surveyed all Medicaid MCOs providing routine, primary medical care to children in 1998–99 to learn about the extent to which these plans offered child development services.[75] The majority of plans responding to the survey reported that they offered child development services, usually funded through EPSDT, in each of the following areas: feeding and nutrition, infant behavior, child behavior, development milestones, lactation counseling, parent issues, and parent/child interaction. The researchers concluded that "[i]f state Medicaid agencies want to enhance the child development services available through health plans, they could initiate steps such as requiring child development services in contracts with plans or providers; revising EPSDT language and engaging in more consistent enforcement; and enhancing capitation rates."[76]

For those state policymakers interested in requiring child development services in their contracts with MCOs, the George Washington University Center for Health Services Research and Policy, with support from The Commonwealth Fund, has developed specifications whose purpose is to guide the purchase of child development services.[77] These specifications set forth illustrative contract language on the different elements of these services (e.g., screening assessment, developmental health promotion, general developmental interventions, and care coordination), as well as on practice

[75] Carolyn Berry et al., "Child Development Services in Medicaid Managed Care Organizations: What Does It Take?," *Pediatrics* 106 (July 2000, Part 2): 191–198.

[76] Ibid.

[77] Center for Health Services Research and Policy, *Optional Purchasing Specifications for Child Development Services in Medicaid Managed Care* (August 2000), www.gwu.edu/~chsrp.

guidelines and coverage determination standards. The illustrative language could be incorporated into master contracts between state Medicaid agencies and MCOs, into subcontracts between MCOs and their participating providers, or both.

V. CONCLUSION

Medicaid and CHIP have enormous potential to promote the delivery of child development services to low-income children under age 3. The two programs cover more than 60 percent of all low-income insured children and offer states broad discretion in designing eligibility rules, a benefits package, and reimbursement arrangements that will encourage delivery of such services. While formal federal guidance on Medicaid and CHIP payment for child development services is sparse, the statutes, regulations, and earlier guidance from HCFA delineate how much leeway state agencies have to fashion a strong preventive intervention component to their Medicaid or CHIP programs.

With support from The Commonwealth Fund, four states—North Carolina, Utah, Vermont, and Washington—are currently exploring ways to make child development services available to Medicaid-eligible children.[78] Moreover, over 30 states are covering the following types of prenatal services for Medicaid-eligible pregnant women: risk assessment, home visiting, health education, nutritional counseling, psychosocial counseling, and case management.[79]

Medicaid and CHIP offer a great deal of flexibility for creative benefits design. State policymakers have the option of using this flexibility not just to improve prenatal care for eligible pregnant women, but to promote access to child development services for their eligible newborns and low-income children.

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[78] Deborah Curtis and Helen Pelletier, *Building State Medicaid Capacity to Provide Child Development Services: An Overview of the Initiative,* National Academy for State Health Policy, March 2000, www.nashp.org/progs/prog0011.htm.

[79] National Governors' Association, *Income Eligibility for Pregnant Women and Children* (January 20, 2000), Table 4, www.nga.org/pubs/issuebriefs/2000.

APPENDIX A. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

- Screening services (age-appropriate periodic schedules and as needed):

  - Comprehensive health and developmental history, including mental and physical development assessment
  - Comprehensive unclothed physical examination
  - Age-appropriate immunizations
  - Laboratory tests, including blood lead level assessments
  - Health education and anticipatory guidance

- Diagnostic services

- Comprehensive vision services, including eyeglasses

- Comprehensive preventive, restorative, and emergency dental care beginning no later than age 3 or earlier if medically indicated

- Comprehensive hearing care, including hearing aids and speech therapy

- A preventive medical necessity standard

- Treatment that is medically necessary and requires the provision of any of the benefits and services that fall within the federal definition of "medical assistance," including the following:

  - Physician services
  - Hospital services (outpatient and inpatient)
  - Federally qualified health center services
  - Rural health clinic services
  - Family planning services and supplies[80]
  - Medical care or any other type of remedial care recognized under state law or furnished by licensed practitioners within the scope of their practice, as defined by state law

[80] Low-income infants are disproportionately likely to be born to young mothers. The EPSDT entitlement ends at age 21; therefore, EPSDT may be important both for a young child and her young mother.

- Home health care
- Private duty nursing services
- Dental services
- Clinic services
- Physical therapy and related services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21
- Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law
- Case management
- Respiratory care
- Personal care services
- Any other medical or remedial care recognized by the Secretary of Health and Human Services

- Transportation and scheduling assistance, and assistance in securing necessary non-Medicaid services, particularly services offered by state WIC programs and Title V agencies

APPENDIX B. INCOME AND ASSET STANDARDS[81] FOR CHILDREN AND PREGNANT WOMEN UNDER STATE MEDICAID AND SEPARATE CHIP PROGRAMS, JULY 2000

State	Asset Test Eliminated, Medicaid and CHIP	Medicaid Income Eligibility Standard, Infants (% of FPL)	Medicaid Income Eligibility Standard, Children Ages 1–5 (% of FPL)	Separate CHIP Program Income Eligibility Standard (% of FPL)
Alabama*	CHIP only	133	133	200
Alaska	Yes	200	200	—
Arizona*	Yes	140	133	200
Arkansas	No	200	200	—
California*	Yes	200	133	250
Colorado*	CHIP only	133	133	185
Connecticut*	Yes	185	185	300
Delaware*	Yes	185	133	200
Dist. of Columbia	Yes	200	200	—
Florida*	Yes	200	133	200
Georgia*	Yes	185	133	235
Hawaii	Yes	200	200	—
Idaho	No	150	150	—
Illinois*	Yes	200	133	185
Indiana*	Yes	150	150	200
Iowa*	Yes	200	133	200
Kansas*	Yes	150	133	200
Kentucky*	Yes	185	150	200
Louisiana	Yes	150	150	—
Maine*	Yes	200	150	200
Maryland	Yes	200	200	—
Massachusetts*	Yes	200	150	200 (400+)
Michigan*	Yes	185	150	200
Minnesota	Yes	280	275	—
Mississippi*	Yes	185	133	200
Missouri	Yes	300	300	—
Montana*	CHIP only	133	133	150
Nebraska	Yes	185	185	—
Nevada*	CHIP only	133	133	200
New Hampshire*	Yes	300	185	300
New Jersey*	Yes	185	133	350
New Mexico	Yes	235	235	—
New York*	Yes	185	133	250
North Carolina*	Yes	185	133	200
North Dakota*	CHIP only	133	133	140
Ohio	Yes	200	200	—
Oklahoma	Yes	185	185	—
Oregon*	No	133	133	170
Pennsylvania*	Yes	185	133	200 (235)

[81] Shows only the income standard; does not reflect the methodologies used to calculate the standard.

State	Asset Test Eliminated, Medicaid and CHIP	Medicaid Income Eligibility Standard, Infants (% of FPL)	Medicaid Income Eligibility Standard, Children Ages 1–5 (% of FPL)	Separate CHIP Program Income Eligibility Standard (% of FPL)
Rhode Island	Yes	250	250	—
South Carolina	Yes	185	150	—
South Dakota	Yes	140	140	—
Tennessee	Yes	N/A	N/A	—
Texas*	CHIP only	185	133	200
Utah*	CHIP only	133	133	200
Vermont	Yes	300	300	—
Virginia*	Yes	133	133	185
Washington*	Yes	200	200	250
West Virginia*	Yes	150	150	150
Wisconsin	Yes	185	185	—
Wyoming*	Yes	133	133	133

* The state maintains both a Medicaid program and a separate CHIP program.

Source: Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures,* Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2000, Tables 1 and 2.

APPENDIX C. STATE MEDICAID AND CHIP APPLICATION AND ENROLLMENT SIMPLIFICATION EFFORTS, JULY 2000

State	Joint Medicaid/ CHIP Application	Mail-In Application**	Eliminate Face-to-Face Interview	Presumptive Eligibility (Medicaid only)	Continuous 12-Month Eligibility
Alabama*	Yes	Yes	CHIP only	No	Yes
Alaska	N/A	Yes	Yes	No	No
Arizona*	Yes	No	Yes	No	CHIP only
Arkansas	N/A	No	Yes	No	No
California*	Yes	Yes	Yes	No	CHIP only
Colorado*	Yes	Yes	Yes	No	CHIP only
Connecticut*	Yes	Yes	Yes	Medicaid only	Yes
Delaware*	Yes	Yes	Yes	No	CHIP only
Dist. of Columbia	N/A	Yes	Yes	No	No
Florida*	Yes	Yes	Yes	Medicaid only	Medicaid (under age 5)
Georgia*	Yes	No	CHIP only	No	No
Hawaii	N/A	Yes	Yes	No	No
Idaho	N/A	No	Yes	No	Yes
Illinois*	Yes	Yes	Yes	No	Yes
Indiana*	Yes	No	Yes	No	Yes
Iowa*	Yes	No	Yes	No	CHIP only
Kansas*	Yes	No	Yes	No	Yes
Kentucky*	Yes	No	Yes	No	No
Louisiana	N/A	Yes	Yes	No	Yes
Maine*	Yes	Yes	Yes	No	No
Maryland	N/A	Yes	Yes	No	No
Massachusetts*	Yes	Yes	Yes	Yes	No
Michigan*	Yes	Yes	Yes	CHIP only	CHIP only
Minnesota	N/A	Yes	Yes	No	No
Mississippi*	Yes	Yes	Yes	No	Yes
Missouri	N/A	Yes	Yes	No	No
Montana*	Yes	No	CHIP only	No	CHIP only
Nebraska	N/A	No	Yes	Yes	Yes
Nevada*	No	No	Yes	No	CHIP only
New Hampshire*	Yes	No	Yes	Medicaid only	No
New Jersey*	Yes	Yes	Yes	Yes	No
New Mexico	N/A	Yes	No	Yes	Yes
New York*	Yes	No	CHIP only	Yes	Medicaid only
North Carolina*	Yes	Yes	Yes	No	Yes
North Dakota*	No	Yes	Yes	No	CHIP only
Ohio	N/A	Yes	Yes	No	No
Oklahoma	N/A	Yes	Yes	No	No
Oregon*	Yes	Yes	Yes	No	No
Pennsylvania*	Yes	Yes	Yes	No	CHIP only
Rhode Island	N/A	Yes	Yes	No	No
South Carolina	N/A	Yes	Yes	No	Yes
South Dakota	N/A	Yes	Yes	No	No

State	Joint Medicaid/ CHIP Application	Mail-In Application**	Eliminate Face-to-Face Interview	Presumptive Eligibility (Medicaid only)	Continuous 12-Month Eligibility
Tennessee	N/A	No	No	No	No
Texas*	No	No	CHIP only	No	CHIP only
Utah*	No	Yes	No	No	CHIP only
Vermont	N/A	Yes	Yes	No	No
Virginia*	Yes	Yes	Yes	No	No
Washington*	Yes	Yes	Yes	No	Yes
West Virginia*	Yes	Yes	CHIP only	No	CHIP only
Wisconsin	N/A	No	No	No	No
Wyoming*	Yes	Yes	CHIP only	No	CHIP only

* The state maintains both a Medicaid program and a separate CHIP program.

** As of 1998. Source: Donna Cohen Ross and Wendy Jacobson, *Free & Low-Cost Health Insurance: Children You Know Are Missing Out*, Center on Budget and Policy Priorities, Start Healthy Stay Healthy Campaign, 1998, Appendix C.

Source: Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2000, Table 2.

APPENDIX D. EPSDT AND PEDIATRIC DEVELOPMENTAL ASSESSMENT SERVICES PROGRAM BENEFITS

Developmental Assessment, §1905(r)(1)(B)(i) of the Social Security Act

- The agency must provide regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Code of Federal Regulations, Title 42, §441.56(b).

- The agency must implement a periodicity schedule that specifies screening services applicable at each stage of the recipient's life, beginning with a neonatal examination. Code of Federal Regulations, Title 42, §441.58(b).

- Includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Included as part of every periodic examination. HCFA, State Medicaid Manual §5123.2.A (Apr. 1990).

- In younger children, assess at least gross and fine motor development; communication skills or language development, focusing on expression, comprehension, and speech articulation; self-help and self-care skills; social-emotional development, focusing on ability to interact with other children and parents; and cognitive skills. HCFA, State Medicaid Manual §5123.2.A (Apr. 1990).

- While no list of specific tests is prescribed, the following principles must be considered: acquire information from the child, parent, or other familiar person; incorporate and review this information; be culturally sensitive; do not use premature labels; refer to appropriate development resources. HCFA, State Medicaid Manual §5123.2.A (Apr. 1990).

- Also includes professionals to whom children are referred for structured tests and instruments after potential problems identified by the screen. HCFA, State Medicaid Manual §5123.2.A (Apr. 1990).

Source: Jane Perkins and Kristi Olson, *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Developmental Services,* National Health Law Program, for The Commonwealth Fund, September 1999, Table 7, pp. A-17.

APPENDIX E. TYPES OF PROVIDERS WHO CAN DELIVER MEDICAID/EPSDT SERVICES*

Service	Type of Provider
Inpatient hospital services (other than services in an institution for mental disease)	Under the direction of a physician or dentist
Outpatient hospital services	By or under the direction of a physician or dentist
Rural health clinic services (including home visits for homebound individuals)	Physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner, as allowed by state law
Federally qualified health center services	Federally qualified health center
Other laboratory and X-ray services (in an office or similar facility)	Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts, as allowed by state law, or ordered by a physician but provided by referral laboratory
EPSDT services	Cannot be limited to providers who are qualified to provide all the items and services
Family planning services and supplies	Any qualified person, at the recipient's choice
Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)	By or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy
Medical and surgical services furnished by a dentist	Doctor of dental medicine or dental surgery who is authorized to furnish those services under state law
Medical care or any other type of remedial care	Licensed practitioners within the scope of their practice as defined by state law
Home health care services (in place of residence)	Home health agency or, if there is no agency in the area, a registered nurse who received written orders from the patient's physician
Private duty nursing services (in the home, hospital, and/or skilled nursing facility)	Registered nurse or licensed practical nurse under the direction of the recipient's physician
Clinic services (including services outside of clinic for eligible homeless individuals)	By or under the direction of a physician or dentist
Dental services	By or under the supervision of a dentist
Physical therapy and related services (including occupational therapy and services for individuals with speech, hearing, and language disorders)	Prescribed by a physician or other licensed practitioner of the healing arts, as allowed by state law; provided by or under the direction of a qualified physical therapist, occupational therapist, speech pathologist, or audiologist
Prescribed drugs	Prescribed by a physician or other licensed practitioner of the healing arts, as allowed by state and federal law; dispensed by licensed pharmacists and licensed authorized practitioners
Dentures	Made by or under the direction of a dentist
Prosthetic devices	Prescribed by a physician or other licensed practitioner of the healing arts, as allowed by state law

Service	Type of Provider
Eyeglasses	Physician skilled in diseases of the eye or by an optometrist, whichever the individual may select
Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)	Recommended or provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law
Services in an intermediate care facility for the mentally retarded	Licensed ICF/MR facility
Inpatient psychiatric hospital services for individuals under age 21	Under the direction of a physician
Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle	Nurse-midwife, as allowed under state law, whether or not the nurse-midwife is under the supervision of, or associated with a physician or other health care provider; a nurse-midwife must be a registered professional nurse
Hospice care	Hospice program
Case-management services	Not specified
TB-related services	Not specified
Respiratory care services	Respiratory therapist or other health care professional trained in respiratory therapy, under the direction of a physician
Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law	Certified pediatric nurse practitioner or certified family nurse practitioner, as allowed under state law, whether or not they are under the supervision of, or associated with, a physician or other health care provider
Community-supported living arrangement services (e.g., personal assistance, habilitation services, assistive technology), to the extent allowed and defined in 42 U.S.C. §1396u	Must have minimum qualifications and training requirements for provider staff
Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease	Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; authorized by a physician, or (at state option) otherwise authorized in accordance with a service plan approved by the state
Primary care case management services	Physician, physician group practice or entity employing or having other arrangements with physicians to provide services and (at state option) a nurse practitioner, certified nurse-midwife, or physician assistant under contract with the state

Service	Type of Provider
Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation and personal care services in a recipient's home)	Personal care services in a recipient's home must be prescribed by a physician and provided by an individual who is qualified to provide the services, supervised by a registered nurse, and not a member of the recipient's family

* EPSDT covers all measures described in the U.S. Code, Title 42, §1396d(a), necessary "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." 42 U.S.C. §1396d(r)(5).

Source: Jane Perkins and Kristi Olson, *Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Developmental Services,* National Health Law Program, for The Commonwealth Fund, September 1999, Table 1, pp. A-2.

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