



State Medicaid and Early Intervention Agency Partnerships to Promote Healthy Child Development

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Introduction

Facilitating a robust system of communication and coordination between medical and community service providers, an important goal of many health care delivery system reforms, is challenging for many states. With a variety of federal and state agencies sharing responsibility for child health and development, creating effective linkages among services is critical to optimizing outcomes. This issue resonates strongly with state Medicaid and Part C Early Intervention (EI) agencies, which are

responsible for creating comprehensive systems of care that coordinate a wide range of services to support healthy child development. To ensure children receive timely access to necessary care within the scope of limited state budgets, Medicaid and EI agencies must establish carefully articulated processes for medical and community-based service providers to deliver developmental screening, referral, and follow-up services. Building stronger partnerships between Medicaid and EI agencies can facilitate better coordination of these services to expedite the referral and follow-up process, helping agencies adhere to federally mandated timelines¹ and enabling children and families to receive more timely services. Strong partnerships between these agencies are also key to avoid excess costs that result from duplicative services. This issue brief provides concrete examples of how Medicaid and EI agencies in Connecticut, Illinois, and Oregon have partnered to improve care for young children in their states who are identified with, or at risk for, developmental delays.² A forthcoming companion brief will closely examine Medicaid screening reimbursement policies in several leading states.

Background on Medicaid and Early Intervention Agencies

Though Medicaid and EI agencies are intricately involved in ensuring children have access to the services necessary for healthy development, they operate under very different policies and funding mechanisms. The Medicaid program is administered by states within federal parameters and is jointly funded by states and the federal government. Given that Medicaid is an entitlement program, the federal government does not set pre-determined funding caps; instead states receive federal funding for a specified percentage of a state's Medicaid expenditures. This percentage, the federal medical assistance percentage (FMAP), is calculated based on a state's per capita income and ranges from 50 to 75 percent across the nation, meaning the federal government pays for between 50 and 75 percent of a state's Medicaid expenditures.³

Medicaid agencies play an important role in promoting healthy child development. Medicaid and the Children's Health Insurance Plan (CHIP) are major sources of health care coverage, serving more than one-third of children across the country.⁴ All Medicaid programs are required to cover a full range of services for children that include screening, diagnostic, and medically necessary treatment services.⁵ However, since delivery of Medicaid services is unique to each state, there is often variation in the precise coverage and reimbursement mechanisms for services. These state level variations have important implications for how Medicaid providers, especially primary care providers (PCPs), deliver and coordinate developmental screening and referral services at the local level.

Established under Part C of the Individuals with Disabilities Education Act (IDEA), EI programs provide services for children from birth to age three who are identified with, or determined to be at risk for, developmental delays. To mitigate the impact of conditions causing developmental delays, EI programs provide eligible children and families with Individual Family Service Plans that specify the services a child needs. Each state designates a lead agency to administer the EI program, typically a state Education Department or Health and Human Services Department. Similar to Medicaid, EI programs operate at the state level, resulting in diverse state and local policies and procedures across the nation. For example, states are responsible for defining their own EI eligibility criteria based on their definitions for what constitutes developmental delay. States can also choose whether or not to extend services to children "at risk" for developmental delay as defined in Part C regulations.⁶ As a result of varying eligibility criteria across states, the percent of infants and toddlers receiving early intervention services in each state ranges widely, from 1.0 percent in Arkansas to 8.89 percent in Massachusetts as of 2014.⁷

While the United States Department of Education provides funding for state EI programs, funding allocations are capped amounts based on the number of children in the state's population from birth to age three as determined through census data. Given that states electing to participate in the Part C program must ensure services are available to all eligible infants and toddlers, they are responsible for covering all programs costs once their federal allocation is spent. As a result, many states leverage a combination of Medicaid and EI funding to cover EI services,⁸ making it imperative for the two agencies to collaborate.

Cross-Agency Strategies

There are numerous ways in which state Medicaid and EI agencies can collaborate to support healthy child development. The following are concrete examples of cross-agency strategies adopted in Connecticut, Illinois, and Oregon to improve the developmental screening, referral, and follow-up process for young children.

Connecticut, Illinois, and Oregon have all adopted **standardized EI referral forms** that enable providers, including PCPs, to make referrals to EI programs through a standard, streamlined process. In all three states, these referral forms are compliant with Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) standards, the privacy rules that ensure individuals' medical and education records and information are protected.^{9, 10} By obtaining parental consent that adheres to both privacy standards, the referral forms readily facilitate the exchange of information between PCPs and EI providers through a streamlined process that can ultimately allow for children and families to receive services in a more timely manner. Standardized referral forms can also contribute to improved developmental screening rates in PCP offices, as they provide a clear path for making referrals.¹¹ All three states have made these forms available online and in Connecticut, referrals can be submitted electronically through the state's 211 Child Development Infoline (CDI).¹²

Spotlight on Connecticut: 211 Child Development Infoline

The United Way of Connecticut operates the Child Development Infoline (CDI) to help connect children and their families with appropriate developmental, behavioral, and health-related services. CDI serves as a centralized access point for many of Connecticut's programs serving children and their families, and is the single point of entry into the EI program. This simplifies the process for families as the line handles all intake, regardless of where a family lives in the state. If someone other than the family makes a referral, CDI staff call the referred families to gather relevant information and obtain consent to proceed with the referral. The information is shared with the local EI provider, who then contacts the family to schedule an evaluation. When PCPs make the referral, they receive a disposition letter with the name and contact information for the EI provider assigned to the child and family. The EI referral process through the Infoline was developed by the EI agency, with input from the Medicaid agency and other key stakeholders.

Connecticut, Illinois, and Oregon have all established a **formal follow-up process** that allows PCPs to connect with EI providers. Illinois and Oregon have adopted a referral faxback form that enables a PCP to receive the results of an EI referral. In Connecticut, a PCP making a referral receives a disposition letter with contact information for the EI provider assigned to the child. As these systems continue to mature, states have identified several areas for improvement and have adjusted the process accordingly. For example, Oregon now includes a condensed summary of the referral outcome in its follow-up form to PCPs and Illinois has aligned the parental authorization section of its referral form with other consent forms in use by its EI agency.

Agencies in all three states have taken steps to foster widespread adoption of developmental screening and referral resources by **promoting standardized screening tools and procedures** and **training medical providers** in their use. The Illinois Medicaid agency issued a formal notice to all Medicaid providers with guidance on developmental screening, including the use of the standardized referral and faxback forms.¹³ Medicaid and EI agencies in Illinois and Oregon have collaborated to create toolkits for PCPs and EI providers that offer clear guidance on specific aspects of the developmental screening process, including acceptable screening tools, referral and care coordination processes, and billing procedures.^{14, 15} Furthermore, all states have established a process to train PCPs in the EI referral process. In Connecticut, the EI program is responsible for training PCPs while Medicaid programs in Oregon and Illinois partner with the Oregon Health and Sciences University and the Illinois Chapter of the American Academy of Pediatrics, respectively, to deliver this training. Oftentimes, these trainings are important tools to help PCPs achieve certain certifications or quality improvement measures.¹⁶ Connecticut, Illinois, and Oregon have made valuable developmental screening resources, such as the recent Illinois Care Coordination Toolkit and Oregon's Developmental Screening Guidance, available on the websites of multiple agencies and organizations.^{17, 18}

Medicaid and EI agencies can collaborate to develop a process for **state-level data exchange** that allows for a state agency to collect and share aggregate data to inform quality improvement efforts. Both Oregon and Illinois have created such a system, enabling agencies to exchange data pertaining to EI referrals. Oregon's EI agency added fields to its database that indicates the source of a referral and whether the program sent a report back to the referring provider. This allows for the EI agency to track activities such as how many referrals are made by the PCP using the standardized referral form and instances when a PCP receives the results of an EI referral. The EI agency then shares that information

with Medicaid, who can use the data to guide technical assistance and provider training. While the Illinois EI agency does not currently collect data on the use of the referral form, it does share EI enrollment data with the Medicaid agency through an intergovernmental data sharing agreement in place between the Department of Human Services (the department that houses the EI program), the Department of Healthcare and Family Services (the department that houses Medicaid) and the Department of Public Health. Specifically, the EI agency is able to inform the Medicaid agency of children enrolled in, or deemed eligible for, EI. Given the transition Illinois has made from Medicaid fee-for-service reimbursement to Medicaid managed care, the state is currently developing a mechanism to share EI data with managed care organizations (MCOs).

Payment for EI services is a key area where Medicaid and EI agencies can align to maximize state funds, ensuring that children with developmental delays are identified early and receive needed services. Cross-agency collaboration on billing policies is also important to alleviate confusion over which parties are responsible for covering certain EI services. Medicaid and EI agencies in Oregon and Illinois have taken steps to clarify billing of EI services for agencies, providers, families, and payers through formal notices, toolkits, and other resources available on their websites. In an effort to clarify the reimbursement methodology for EI services, Connecticut is currently transitioning payment for EI services from bundled payments to a fee-for-service system. While the implications of this change remain to be seen, Medicaid and EI agencies claim it has already enhanced their level of collaboration. Medicaid and EI agencies in Connecticut are currently taking steps to jointly develop formal policy transmittals to ensure providers are well informed of the change.

Next Steps

As states continue to develop improved processes for coordinating care at the state and local level, the capacity to expand data sharing often emerges as a critical goal. The Medicaid and EI agencies in Oregon and Illinois have taken steps to facilitate a process that will allow the agencies to feed state data to the local level for quality improvement purposes. Illinois is developing the capacity to share data with MCOs on Medicaid enrolled children receiving, or eligible for, EI services for care coordination purposes (see text box for more information). Oregon hopes to strengthen a similar process in place so that useful data on Medicaid enrolled children receiving EI services can be shared with the state's Coordinated Care Organizations (CCOs). The state has found the current data CCOs receive is not always useful or complete due to issues with the way EI services are billed to Medicaid. Oregon plans to continue trainings to resolve this issue and ensure more complete data can be collected.

Spotlight on Illinois: Facilitating State-Local Data Sharing

Medicaid and EI agencies in Illinois currently exchange data under the authority of an inter-agency data sharing agreement. Medicaid is in the process of developing the capacity to share EI data with MCOs by adding this data to the existing care coordination claims data (CCCD) files Medicaid shares with MCOs on a weekly basis. CCCD files include flags for high-risk indicators and care coordination indicators that alert MCOs when another agency is delivering care to a family so the MCO can coordinate, and avoid duplicating, services. Once the state includes EI eligibility and enrollment data in CCCD files, the system will flag at-risk children for MCOs so they can reach out to the family for care coordination services.

Lessons Learned

Through a variety of health care delivery system reform initiatives aimed at providing more comprehensive, coordinated care to Medicaid beneficiaries, many states are working to strengthen the linkages between clinical and community service providers. Medicaid and EI agencies in Connecticut, Illinois, and Oregon shared the following lessons learned from their experiences partnering to promote healthy child development that can be applied to numerous issues requiring strong community-clinical linkages, such as primary care and behavioral health integration among others.

- A systematic process for cross-agency collaboration and decision-making ensures sustainability and minimizes disruptions from staff turnover.
- Once established, a standardized referral and follow-up procedure can be adapted for use between PCPs and a variety of community-based service providers beyond EI. For example, a home visiting program in Illinois has adapted the referral and follow-up forms developed by the Medicaid and EI agencies for its own use.
- States can consider phasing in initiatives over time to help ensure success. Oregon piloted the developmental screening, referral, and follow-up process in the largest counties first, enabling the state to spread the program more easily to smaller counties.
- Engaging stakeholders (e.g. multiple agencies, providers, health plans, consumers, and other affected entities) at every step in the policymaking process is critical to success.
- Funding evaluation facilitates tracking to assess program progress and improvement. Evaluations of the developmental screening, referral, and follow-up process in Oregon have allowed agencies to develop an evidence base to inform implementation of other programs.
- Leveraging and aligning with other initiatives can help support and further mutual goals. Oregon has been able to maximize the spread of its screening and referral process by aligning with multiple ongoing health care delivery system and education reform initiatives. (See textbox for more information.)

Spotlight on Oregon: Aligning with Other Initiatives

Medicaid and EI agencies in Oregon have been able to strengthen and spread the standardized process for developmental screening by aligning with several other health care delivery system and education reform initiatives in the state. Developmental screening is one of 18 incentive metrics Oregon uses to monitor its Medicaid managed care organizations, called Coordinated Care Organizations (CCOs). These are regional networks of physical and mental health providers with whom the state contracts to deliver health care to Medicaid beneficiaries. The developmental screening metric incentivizes CCOs to improve their developmental screening rates, and the availability of the standardized referral form simplifies the process for providers to make referrals once they identify potential developmental delays. CCOs then align with their educational counterparts, Early Learning Hubs. Designed to coordinate early childhood education services in communities, the Early Learning Hubs focus on achieving universal kindergarten readiness and engage the school system in promoting healthy child development. Oregon has intentionally aligned these programs and resources to create a statewide system that, ideally, identifies children at risk for developmental delays, links them to appropriate community services, and ensures a follow-up procedure is in place to alert the referring provider of the referral outcomes. By leveraging locally focused initiatives such as Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) of Multnomah County, the state is then able to take a deep dive into the early child development system and address any glitches that may be occurring to work towards a seamless system of care.

Endnotes

1. Per New § 303.310, within 45 days of receiving a referral for a child to early intervention services, the lead agency must complete an initial evaluation, initial assessments, and the initial Individual Family Service Plan meeting. For more information, see: <https://www.federalregister.gov/articles/2011/09/28/2011-22783/early-intervention-program-for-infants-and-toddlers-with-disabilities>
2. Much of the cross-agency work underway in Oregon and Illinois stems from The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) III initiative, administered by the National Academy for State Health Policy (NASHP), under which five state piloted strategies to improve care coordination between primary care providers (PCPs) and community service providers, mainly EI providers. For more information, see: <http://nashp.org/measuring-and-improving-care-coordination-lessons-abcd-iii/>
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4. Robin Rudowitz, Samantha Artiga, and Rachel Arguello, Children's Health Coverage: Medicaid, CHIP, and the ACA (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2014). Retrieved May 4, 2016. Available at: <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/>
5. This is required under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. For more information, see: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>
6. Per Part C Statutes, "The term at-risk infant or toddler means an individual under 3 years of age who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual." For more information, see: <http://idea.ed.gov/part-c/statutes>
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14. Oregon Health Authority, Developmental Screening for Young Children Guidance Document (Portland, OR: Oregon Health Authority, 2015). Retrieved May 4, 2016. Available at: <https://www.oregon.gov/oha/analytics/CCODData/Developmental%20Screening%20Guidance%20Document%20-%20Nov%202015.pdf>
15. Illinois Department of Healthcare and Family Services. "Early Intervention Care Coordination Provider Toolkit." Retrieved May 4, 2016. Available at: <http://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/Early-Intervention-Care-Coordination-Provider-Toolkit.aspx>
16. For example, developmental screening trainings can help providers attain Part IV Maintenance of Certification or count as Continuing Medical Education credit. For more information, see: <http://trilliumchp.com/documents/providers/START%20Program%20Article.pdf> and <http://www.illinois.gov/hfs/SiteCollectionDocuments/NovemberCoordinatingMedicalHomes.pdf>.
17. Illinois Department of Healthcare and Family Services. "Early Intervention Care Coordination Provider Toolkit."
18. Oregon Health Authority, Developmental Screening for Young Children Guidance Document.

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