(Please include as briefing background!!)

PROVIDING SUPPLEMENTAL HEALTH BENEFITS TO CHILDREN WITH MODERATE TO SEVERE DISABILITIES WHO ARE RECEIVING SERVICES UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

ISSUE:

With the advent of national health care reform, the availability and financing of essential health services for children with disabilities remains unclear. With the basic health benefit package placing limitations on services and treatments at the point in which recovery or remediation could no longer be expected, services needed to maintain a disabled child's functional capability or prevent further deterioration will not be included. This omission in health services has significant implications for the 5% of America's children experiencing limitations due to a disability.

How this issue is addressed is of particular importance to the education community because of its relationship to: (1) the Administration's commitment to investing in children as the best investment in our Country's future; (2) the national goal of having all children healthy and ready to learn; (3) existing special education and early intervention mandates, which include an entitlement to health related services regardless of income and (4) the current EPSDT reimbursement available to schools for the provision of health related services to children with disabilities.

BACKGROUND:

The Individuals with Disabilities Education Act (IDEA) is the primary federal legislation with a mandate to provide early intervention, and special education and related services for children with disabilities. The centerpiece of the Act is a formula grant program, authorized under Part B, which requires States to make available to all children with disabilities, aged 3-21, a free, appropriate public education.

To ensure that a child receives such an education, Part B requires school districts to determine whether an individual child requires health-related services which include physical, occupational, and speech therapies; audiology services; diagnostics and evaluation; psychological services; and school health services; and if so, to provide those services at no cost to the family. The determination and provision of necessary health related services is made by the child's Individualized Education Plan (IEP) team, composed of parents, medical and school personnel.

Part H of IDEA, supports States in the implementation of a statewide system of services for infants and toddlers with disabilities/ or at risk for disabilities and their families. Many of the primary services under Part H are health related.

FINANCING OF HEALTH-RELATED SERVICES

Public Law 99-660 allows school districts to bill Medicaid as a funder for related services provided by the schools. Data from the States suggests that although 30% to 40% of children served by IDEA are Medicaid-eligible, schools are being reimbursed for approximately 1/2 of those eligible children. Families who qualify for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) under Medicaid receive health and rehabilitative assistance for their chronically ill and/or disabled children.

Families above the means-tested level for Medicaid: (1) do not qualify for public assistance, except under the Medicaid waiver program (TEFRA) and (2) do not generally receive extended coverage to cover the costs of continuing health related services or therapeutic interventions because of the post acute limitations currently imposed by private insurers. Thus, when a child is not Medicaid-eligible, the schools generally bear the costs of medically-related services, even for children with private insurance because of the coverage limitations and IDEA billing restrictions.

COSTS TO THE EDUCATION COMMUNITY:

There are approximately 4.5 million children aged 6-21 receiving special education and related services under Part B of IDEA. An estimated 1.3 million of these children are receiving health-related services. The current statistics are as follows with the starred categories representing the majority of children (1.3 million), receiving related services:

Aged 6-21:

	2.2		Learning Disabled
Not health related services	1.0		Speech/Language Impaired
20%	*	550,000	Mentally Retarded / Severe
50%	*	400,000	Severe Emotional Disturbance
	*	60,000	Hearing Impaired
✓	*	100,000	Multiply Disabled
50%	*	50,000	Orthopedically Impaired
30%	*	59,000	Other Health Impaired
20%	*	24,000	Visually Impaired
✓	*	1400.	Deaf/Blind
50%	*	5,000	Autism

1.3

1.3

1-2

20% - 200,000

(These are the highest percentage of 6-21 that could possibly be E.T into the new LTC program

The excess per child cost for special education and related services in 1992 was $5800. The Federal government paid $419., and the state and local communities provide the remaining $5381. from general education funds. It is estimated that 23% of the $5381. or $1237. per child was spent on health-related services for children with moderate to severe disabilities.

The cost to the education community (excluding Medicaid reimbursement) is approximately $1.7 billion.

Approximately 172,000 children ages 0-2 receive early intervention services through Part H of IDEA and 422,000 children ages 3-5 receive preschool services through Part B of IDEA and Chapter 1. Estimates on costs attributable to health related services are not available for these children, but the total Federal cost for providing these 594,000 children the services mandated under IDEA was $683. million in 1992. Since the addition of assistive technology, devices and services under the 1991 reauthorization of IDEA, per child costs are expected to increase.

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MESSAGE:

April 6, 1994

MEMORANDUM

TO: Files

FR: Sara Rosenbaum

RE: Alternative to HSA, §4222

The following is an alternative approach to the Medicaid wrap-around for children contained in the HSA.

- Add coverage of hearing aids to Title I. DME including customized wheelchairs already has been included.

- Include in section 4221 a requirement that all care and services described in §§1905(a)(4)(B) and (r) and not otherwise covered in the comprehensive benefit package be covered for individuals under the age of 21 who are eligible for medical assistance under the state plan under paragraphs (A) or (C) of section 1902(a)(10) or 1902(e).

Under normal TPL rules for Medicaid, this would mean that Medicaid would pay only for those items and services not included in the comprehensive benefit package at all or not covered in as great amount, duration or scope as that which is either required or authorized under the state Medicaid plan.

Using the HSA Title I benefit package as the frame of reference, the principal benefits that would continue to be covered by Medicaid on a first dollar basis would include (a) services of clinics (including rural health clinics, federally qualified health centers and other public and private non-profit general and special purpose clinics; (b) the cluster of other services commonly paid for by Medicaid but not included in Title I (e.g., "other medical and remedial care", other "diagnostic, preventive, screening and rehabilitative" services; (c) case management services ; (d) inpatient psychiatric services; and (e) services described in the HSA as long term care services.

I have attempted to pick up all individuals under age 21 including children in home and community care settings since many of the §1905(r) services are not covered as long term care services. This is particularly true for IDEA educationally related health services covered in school settings.

Under this model, normal federal/state Medicaid administration and FFP rules would apply. There would be no separate federal "wrap-around" program for children.

D. Avoid Reductions in Eligibility and Service Coverage for Low Income Children

1. *Issues:* Section 4221 of the Health Security Act, as introduced, would add a Section 1933 to the Social Security Act, in part to exempt certain groups of non-cash eligible Medicaid recipients from the general requirement that such persons have their basic health services subsidized through the regional health alliances, rather than through the federal-state Medicaid program. Non-exempt individuals would no longer be eligible to have "wrap-around" services (i.e., those services not included in the basic guaranteed coverage package but covered under the state's Medicaid plan) financed through Title XIX.

Children under the age of 18 (or up to age 21 at the option of the state) would be one of the four exempted populations under Section 1933(b) of the Social Security Act, as added by Section 4221 of the bill. However, spokespersons for the Clinton Administration have told the Task Force co-chairs that this exemption of non-cash eligible children represents a drafting error that will be corrected at an early stage of the legislative process. Instead, such children are to have their wrap-around services financed through a new closed-ended, fully federally-financed grant program that would be established under Section 1934 of the Social Security Act (as authorized by Section 4222 of the Health Security Act). [N.B., Long term care services to children from non-cash eligible families, along with all other Medicaid recipients, would continue to be financed through the federal-state Medicaid program.]

Because all Medicaid-eligible children are now entitled to receive the full range of medically necessary services that are identified as a result of an EPSDT screen, the question of how wrap-around services are financed takes on added significance. The existing EPSDT requirements would not be altered under the terms of the Health Security Act; however, whether federal funds would be available to help finance such services is far from clear.

Federal financial participation under the new Section 1934 program would be capped at the states' FY 1993 spending levels and, worse yet, the formula for determining state allotments under this program would establish an unrealistically low funding base, given the incomplete response to the EPSDT mandates in most states. Consequently, unless low income children retain offsetting rights to wrap-around services under Section 1933 of the Act, the Task Force believes that there is a strong likelihood that non-cash eligible children will be denied access to the full range and intensity of restorative and remedial services they require.

One subset of this population -- children whose Medicaid eligibility is based on Section 1902(e)(3) of the Social Security Act (commonly referred to as Katie Beckett or TEFRA-134 eligibles) -- would be particularly vulnerable to having their benefits substantially reduced or eliminated under this scenario. These SSI-qualified children live at home with their families despite the fact that the severity of their disabilities would qualify them for admission to a Medicaid-certified institution. Often these youngsters require a relatively costly mix of acute medical services and long term supports to remain at home; but, the alternative of full-time care in an institutional setting would be far more expensive -- not to mention the human anguish associated with separating the child from his or her family.

FACSIMILE

HCFA/OACT/OMMCE/DMCE
03/30/94

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Comments:

Don,

Herewith numbers for:

1. Alternative kid wrap proposals
2. Alternative mental hospital treatment
3. Breakout of wraparound services (Blumbergs)

John

Cost of Alternative Kid Wrap Programs
3-30-94

	FY96	FY97	$ billions FY98	FY99	FY00	96-00
Curr Fed Baseline (w/ phase-in)	0.1	0.4	1.2	1.9	2.2	5.9
New Program Fed Spending (100% match)						
Curr HSA pricing (no elig changes)	0.2	0.7	2.0	2.9	3.1	8.9
Curr Law Max Participation	0.3	0.9	2.7	3.8	4.1	11.8
150% PL Max Par	0.3	1.3	3.6	5.1	5.5	15.7
200% PL Max Par	0.4	1.6	4.5	6.3	6.8	19.5
State MOE	0.1	0.2	0.6	0.8	0.9	2.6
Net Fed Cost						
Curr HSA pricing (no elig changes)	0.0	0.1	0.2	0.1	0.0	0.4
Curr Law Max Participation	0.1	0.3	0.9	1.1	1.0	3.3
150% PL Max Par	0.2	0.6	1.8	2.3	2.3	7.2
200% PL Max Par	0.3	0.9	2.6	3.6	3.7	11.0

Impact of Uniform Poverty Level Eligibility for Medicaid Kids

Enrollee Counts in 000's

		1993	1994	1995	1996	1997	1998	1999	2000	2001
Current Law	Infant	1,366	1,399	1,428	1,457	1,488	1,520	1,553	1,588	1,625
Current	Age 1-5	5,860	6,090	6,283	6,423	6,529	6,630	6,743	6,858	6,978
Particip.	Age 6-18	8,355	8,617	8,949	9,352	9,810	10,314	10,852	11,459	12,167
	Total	15,581	16,106	16,660	17,232	17,827	18,464	19,148	19,905	20,770
Curr Law	Infant	2,005	1,986	1,964	1,943	1,926	1,911	1,899	1,889	1,882
Maximum	Age 1-5	8,573	8,643	8,657	8,601	8,502	8,402	8,323	8,250	8,187
Particip.	Age 6-18	10,151	10,689	11,231	11,814	12,383	12,962	13,544	14,149	14,818
	Total	20,729	21,318	21,852	22,358	22,811	23,275	23,766	24,288	24,887
150% Uniform	Infant	1,796	1,779	1,760	1,742	1,726	1,712	1,702	1,693	1,686
Eligibility	Age 1-5	8,878	8,950	8,965	8,906	8,804	8,701	8,619	8,543	8,478
(Maximum	Age 6-18	16,930	17,171	17,444	17,731	18,007	18,246	18,396	18,512	18,604
Particip.)	Total	27,604	27,900	28,169	28,379	28,537	28,659	28,717	28,748	28,768
200% Uniform	Infant	2,099	2,080	2,056	2,035	2,017	2,001	1,989	1,978	1,970
Eligibility	Age 1-5	10,595	10,681	10,699	10,629	10,507	10,384	10,286	10,196	10,118
(Maximum	Age 6-18	21,538	21,845	22,191	22,556	22,908	23,212	23,402	23,549	23,667
Particip.)	Total	34,232	34,606	34,946	35,220	35,432	35,597	35,677	35,723	35,755
% Increase	Infant	31%	27%	23%	20%	16%	13%	10%	7%	4%
150% over	Age 1-5	52%	47%	43%	39%	35%	31%	28%	25%	21%
Curr Law	Age 6-18	103%	99%	95%	90%	84%	77%	70%	62%	53%
Curr Par	Total	77%	73%	69%	65%	60%	55%	50%	44%	39%
% Increase	Infant	-10%	-10%	-10%	-10%	-10%	-10%	-10%	-10%	-10%
150% over	Age 1-5	4%	4%	4%	4%	4%	4%	4%	4%	4%
Curr Law	Age 6-18	67%	61%	55%	50%	45%	41%	36%	31%	26%
Max Par	Total	33%	31%	29%	27%	25%	23%	21%	18%	16%
% Increase	Infant	54%	49%	44%	40%	36%	32%	28%	25%	21%
200% over	Age 1-5	81%	75%	70%	65%	61%	57%	53%	49%	45%
Curr Law	Age 6-18	158%	154%	148%	141%	134%	125%	116%	106%	95%
Curr Par	Total	120%	115%	110%	104%	99%	93%	86%	79%	72%
% Increase	Infant	5%	5%	5%	5%	5%	5%	5%	5%	5%
200% over	Age 1-5	24%	24%	24%	24%	24%	24%	24%	24%	24%
Curr Law	Age 6-18	112%	104%	98%	91%	85%	79%	73%	66%	60%
Max Par	Total	65%	62%	60%	58%	55%	53%	50%	47%	44%

Alternative Treatment of Mental Hospital Services
3-30-94

Baseline Breakout of MH Services (Fed Share in $mill)

	FY96	FY97	FY98	FY99	FY00
Total	1894	2074	2252	2442	2648
Alliance-Covered	752	824	895	970	1052
Comm LTC	390	428	465	505	548
Medigap	390	426	463	502	544
Wraparound Tot	362	396	430	465	504
Kids	302	330	358	388	421
Cash Adult	6	7	7	8	9
MCD-only Adult	54	59	64	69	75

Current Fed Spending under HSA (not phased-in or capped)

	FY96	FY97	FY98	FY99	FY00
Kids (100%)	529	579	629	681	739
Cash Adult (Reg Match)	6	7	7	8	9
MCD-only Adult (no covg)	0	0	0	0	0
Total	535	586	636	689	747

Cost(Savings) of retaining regular match

	FY96	FY97	FY98	FY99	FY00
Kids (100%)	-228	-249	-270	-293	-318
Cash Adult (Reg Match)	0	0	0	0	0
MCD-only Adult (no covg)	54	59	64	69	75
Total	-173	-190	-206	-224	-243

FY95 Pres Budget Baseline Federal Medicaid Projections

$ in millions

(Non-Medicare) Wraparound Services

OBS	STATUS	CAT	SERVICE	_TYPE_	_FREQ_	F1993	F1994	F1995	F1996	F1997	F1998	F1999	F2000
1	.	.	.	0	4053	2915.88	3454.59	3875	4546.97	5311.94	6183.36	7175.42	8317.7
2	.	.	MentHosp	1	270	287.58	306.76	324.96	361.88	396.02	429.56	465.44	504.3
3	.	.	Dental	1	808	384.36	386.17	422.01	474.05	533.48	599.95	672.86	754.2
4	.	.	OthPrac	1	1000	66.75	75.68	82.85	93	104.5	117.53	131.85	147.8
5	.	.	TgtCasMg	1	361	225.46	278.58	321.09	402.98	490.02	577.06	679.16	799.4
6	.	.	FQHC	1	564	27.36	31.62	36.29	43.49	52.12	62.31	74.17	88.1
7	.	.	OthCare	1	1050	1924.37	2376.78	2687.8	3171.57	3735.8	4396.95	5151.93	6023.8
8	.	ADULT	.	2	955	623.82	703.17	789.36	913.8	1054.31	1209.31	1386.16	1589.2
9	.	AGED	.	2	676	396.91	483.6	546.67	634.84	738.55	862.29	1006.27	1175.7
10	.	CHILDREN	.	2	1444	848.13	1006.86	1101.19	1279.02	1475.19	1691.92	1937.9	2219.2
11	.	DISADULT	.	2	661	961.78	1166.34	1335.09	1603.56	1914.58	2276.18	2685.63	3156.5
12	.	OTHER	.	2	289	83.92	92.72	99.46	112.05	125.05	138.75	153.82	170.6
13	.	UNALLOC	.	2	28	1.32	2.91	3.23	3.71	4.27	4.91	5.64	6.4
14	.	ADULT	MentHosp	3	99	9.61	10.96	11.69	13.03	14.27	15.48	16.79	18.2
15	.	ADULT	Dental	3	199	225.09	227.43	248.05	275.08	306.29	341.29	379.84	422.7
16	.	ADULT	OthPrac	3	195	16.97	19.33	20.97	23.17	25.68	28.54	31.69	35.1
17	.	ADULT	TgtCasMg	3	155	115.87	141.48	163.39	205.25	249.82	294.48	346.87	408.6
18	.	ADULT	FQHC	3	104	4.48	5.08	5.67	6.66	7.86	9.28	10.94	12.9
19	.	ADULT	OthCare	3	203	251.81	298.89	339.59	390.61	450.39	520.26	600.03	691.4
20	.	AGED	Dental	3	185	45.89	46.21	50.07	55.73	62.2	69.57	77.74	87
21	.	AGED	OthPrac	3	191	7.99	9.13	10.03	11.17	12.48	13.99	15.68	17.6
22	.	AGED	FQHC	3	101	1.24	1.42	1.58	1.87	2.21	2.61	3.1	3.6
23	.	AGED	OthCare	3	199	341.79	426.84	484.99	566.07	661.66	776.12	909.75	1067.4
24	.	CHILDREN	MentHosp	3	132	238.23	255.09	270.69	301.57	330.16	359.27	388.38	421
25	.	CHILDREN	Dental	3	187	10.51	10.31	11.47	13.3	15.36	17.62	20.09	22.8
26	.	CHILDREN	OthPrac	3	376	20.11	22.82	24.4	27.09	30.16	33.63	37.46	41.7
27	.	CHILDREN	TgtCasMg	3	152	102.28	127.91	147.03	184.63	224.66	264.72	311.76	367.1
28	.	CHILDREN	FQHC	3	202	7.18	7.87	8.93	10.59	12.59	14.96	17.73	21
29	.	CHILDREN	OthCare	3	395	469.82	582.67	638.67	741.84	862.28	1002.7	1162.49	1345.4
30	.	DISADULT	Dental	3	187	100.13	98.37	109.36	126.63	146.03	167.56	190.94	216.9
31	.	DISADULT	OthPrac	3	182	20.8	23.39	26.38	30.42	34.93	40.01	45.55	51.7
32	.	DISADULT	FQHC	3	99	12.71	13.93	16.41	20.13	24.57	29.82	35.93	43.1
33	.	DISADULT	OthCare	3	193	828.14	1029.65	1182.95	1426.39	1709.05	2038.79	2413.21	2844.6
34	.	OTHER	MentHosp	3	37	39.74	40.72	42.58	47.28	51.59	55.8	60.28	65.1
35	.	OTHER	Dental	3	50	2.74	2.85	3.06	3.32	3.6	3.92	4.25	4.6
36	.	OTHER	OthPrac	3	54	0.89	1.02	1.07	1.16	1.25	1.36	1.47	1.6
37	.	OTHER	TgtCasMg	3	54	7.32	9.19	10.67	13.09	15.55	17.88	20.53	23.5
38	.	OTHER	FQHC	3	34	0.43	0.41	0.47	0.54	0.63	0.72	0.83	0.9
39	.	OTHER	OthCare	3	60	32.81	38.53	41.61	46.66	52.43	59.07	66.46	74.7
40	.	UNALLOC	MentHosp	3	2	0	0	0	0	0	0	0	0
41	.	UNALLOC	OthPrac	3	2	0	0	0	0	0	0	0	0
42	.	UNALLOC	FQHC	3	24	1.32	2.91	3.23	3.71	4.27	4.91	5.64	6.4
43	CASH	.	.	4	972	1902.33	2256.21	2529.28	2972.76	3474.68	4041.65	4679.44	5405.1
44	MCDONLY	.	.	4	3053	1012.23	1195.47	1342.49	1570.51	1832.99	2136.8	2490.34	2906.1
45	UNALLOC	.	.	4	28	1.32	2.91	3.23	3.71	4.27	4.91	5.64	6.4
46	CASH	.	MentHosp	5	68	130.86	140.65	150.08	166.92	182.49	197.75	214.08	231.7
47	CASH	.	Dental	5	200	250.88	243.36	264.84	296.92	333.2	373.23	416.6	464.4
48	CASH	.	OthPrac	5	244	42.48	48.38	53.07	59.55	66.83	74.97	83.83	93.6
49	CASH	.	TgtCasMg	5	74	140.82	171.24	196.78	244.86	295.35	344.94	402.75	470.2
50	CASH	.	FQHC	5	132	18.22	19.8	23.04	27.87	33.63	40.4	48.25	57.4
51	CASH	.	OthCare	5	254	1319.08	1632.78	1841.48	2176.64	2563.19	3010.36	3513.93	4087.6
52	MCDONLY	.	MentHosp	5	200	156.72	166.12	174.9	194.95	213.52	231.8	251.37	272.5
53	MCDONLY	.	Dental	5	608	133.48	141.81	157.17	177.13	200.28	226.72	256.26	289.8
54	MCDONLY	.	OthPrac	5	754	24.27	27.31	29.78	33.45	37.68	42.56	48.01	54.2
55	MCDONLY	.	TgtCasMg	5	287	84.65	107.33	124.3	158.12	194.67	232.13	276.41	329.1
56	MCDONLY	.	FQHC	5	408	7.82	8.91	10.02	11.92	14.22	17	20.28	24.2
57	MCDONLY	.	OthCare	5	796	605.29	744.01	846.32	994.94	1172.61	1386.6	1638	1936.2
58	UNALLOC	.	MentHosp	5	2	0	0	0	0	0	0	0	0
59	UNALLOC	.	OthPrac	5	2	0	0	0	0	0	0	0	0
60	UNALLOC	.	FQHC	5	24	1.32	2.91	3.23	3.71	4.27	4.91	5.64	6.4
61	CASH	ADULT	.	6	244	422.868	474.304	523.71	601.29	688.54	783.95	892.05	1015

FY95 Pres Budget Baseline Federal Medicaid Projections

$ in millions

(Non-Medicare) Wraparound Services

OBS	STATUS	CAT	SERVICE	_TYPE_	_FREQ_	F1993	F1994	F1995	F1996	F1997	F1998	F1999	F2000
62	CASH	AGED	.	6	172	162.531	198.507	220.81	249.06	280.33	315.94	355.06	398.5
63	CASH	CHILDREN	.	6	378	581.94	694.139	757.91	879.13	1013.47	1161.92	1329.52	1519.9
64	CASH	DISADULT	.	6	178	734.995	889.265	1026.86	1243.27	1492.35	1779.84	2102.78	2471.6
65	MCDONLY	ADULT	.	6	711	200.954	228.883	265.65	312.51	365.77	425.36	494.08	574.1
66	MCDONLY	AGED	.	6	504	234.381	285.093	325.87	385.77	458.22	546.95	651.21	777.1
67	MCDONLY	CHILDREN	.	6	1066	266.192	312.724	343.28	399.89	461.72	530	608.38	699.3
68	MCDONLY	DISADULT	.	6	483	226.782	276.076	308.24	360.29	422.23	496.34	582.85	684.8
69	MCDONLY	OTHER	.	6	289	83.924	92.716	99.46	112.06	125 05	138.75	153.82	170.6
70	UNALLOC	UNALLOC	.	6	28	1.317	2.908	3.23	3.71	4.27	4.91	5.64	6.4
71	CASH	ADULT	MentHosp	7	31	4.652	5.185	5.83	6.26	6.84	7.42	8.03	8.6
72	CASH	ADULT	Dental	7	50	160.483	145.977	156.78	172.23	190.07	209.87	231.53	255.4
73	CASH	ADULT	OthPrac	7	49	11.918	13.343	14.41	15 8	17.38	19.16	21.12	23.2
74	CASH	ADULT	TgtCasMg	7	37	73.898	89,175	102.64	127.71	154.05	179.91	210.07	245.2
75	CASH	ADULT	FQHC	7	26	2.742	3.07	3.37	3.91	4.57	5.35	6.25	7.3
76	CASH	ADULT	OthCare	7	51	179.175	217.553	240.88	275.38	315.62	362.25	415.09	475
77	CASH	AGED	Dental	7	48	17 396	16.715	17.85	19.4	21.08	22.92	24.87	26.9
78	CASH	AGED	OthPrac	7	48	3.173	3.811	4.16	4.51	4.88	5.3	5.74	6.2
79	CASH	AGED	FQHC	7	26	0.552	0.601	0.69	0.79	0.91	1.05	1.2	1.3
80	CASH	AGED	OthCare	7	50	141.41	177.381	198 11	224.37	253.46	286.68	323.24	363.9
81	CASH	CHILDREN	MentHosp	7	37	126.209	135.462	144.43	160.67	175.65	190.33	206.05	223
82	CASH	CHILDREN	Dental	7	51	8.3	8.067	9.02	10.53	12.21	14,04	16.02	18.2
83	CASH	CHILDREN	OthPrac	7	98	14.082	15.918	16.96	18.75	20.77	23.03	25.51	28.2
84	CASH	CHILDREN	TgtCasMg	7	37	66.918	82.07	94.14	117.14	141.3	165.02	192.68	224.9
85	CASH	CHILDREN	FQHC	7	53	4.636	5.024	5.67	6.7	7.94	9.39	11.08	13
86	CASH	CHILDREN	OthCare	7	102	361.796	447.597	487.66	565.34	655.61	760.09	878.18	1012.3
87	CASH	DISADULT	Dental	7	51	74.699	72.603	81.2	94.77	109.85	126.4	144.18	163.7
88	CASH	DISADULT	OthPrac	7	49	13.312	15.304	17.52	20.5	23.8	27.48	31.46	35.8
89	CASH	DISADULT	FQHC	7	27	10.288	11.11	13.32	16.46	20.2	24.61	29.72	35.7
90	CASH	DISADULT	OthCare	7	51	636.696	790.247	914.82	1111.54	1338.5	1601.34	1897.42	2236.2
91	MCDONLY	ADULT	MentHosp	7	68	4.954	5.77	6.07	6.77	7.42	8.07	8.76	9.5
92	MCDONLY	ADULT	Dental	7	149	74.607	81.45	91.27	102.85	116.22	131.42	148.31	167.3
93	MCDONLY	ADULT	OthPrac	7	146	5.048	5.988	6.56	7.37	8.31	9.38	10.57	11.9
94	MCDONLY	ADULT	TgtCasMg	7	118	41.969	52.304	60.75	77.54	95.77	114.54	136.8	163.3
95	MCDONLY	ADULT	FQHC	7	78	1.741	2.011	2.3	2.74	3.28	3.93	4.7	5.6
96	MCDONLY	ADULT	OthCare	7	152	72.634	81.34	98.7	115.23	134.77	158.02	184.94	216.4
97	MCDONLY	AGED	Dental	7	137	28.497	29.498	32.22	36.33	41.13	46.65	52.88	60
98	MCDONLY	AGED	OthPrac	7	143	4 82	5.322	5.87	6.67	7.6	8.69	9.94	11.3
99	MCDONLY	AGED	FQHC	7	75	0.686	0.815	0.89	1.07	1.3	1.57	1.89	2.2
100	MCDONLY	AGED	OthCare	7	149	200.378	249.458	286.88	341.71	408.2	489.45	586.5	703.5
101	MCDONLY	CHILDREN	MentHosp	7	95	112.025	119.631	126.26	140 9	154.51	167.94	182.33	197.9
102	MCDONLY	CHILDREN	Dental	7	136	2.211	2.24	2.45	2.77	3.15	3.58	4.07	4.6
103	MCDONLY	CHILDREN	OthPrac	7	278	6.024	6.898	7.42	8.34	9.39	10.6	11.95	13.4
104	MCDONLY	CHILDREN	TgtCasMg	7	115	35.362	45.837	52.88	67.49	83.36	99.7	119.08	142.2
105	MCDONLY	CHILDREN	FQHC	7	149	2.548	2.849	3.26	3.89	4.65	5.57	6.65	7.9
106	MCDONLY	CHILDREN	OthCare	7	293	108.023	135.268	151.01	176.5	206.67	242.62	284.31	333.1
107	MCDONLY	DISADULT	Dental	7	136	25.428	25.763	28.16	31.86	36.18	41.15	46.76	53.1
108	MCDONLY	DISADULT	OthPrac	7	133	7.49	8.082	8.86	9.92	11.13	12.53	14.09	15.8
109	MCDONLY	DISADULT	FQHC	7	72	2.421	2.824	3.09	3.67	4.37	5.21	6.21	7.4
110	MCDONLY	DISADULT	OthCare	7	142	191.443	239 407	268.13	314.85	370.55	437.44	515.79	608.4
111	MCDONLY	OTHER	MentHosp	7	37	39.743	40.716	42.58	47 28	51.59	55.8	60.28	65.1
112	MCDONLY	OTHER	Dental	7	50	2.74	2.854	3.06	3.32	3.6	3.92	4.25	4.6
113	MCDONLY	OTHER	OthPrac	7	54	0.986	1.016	1.07	1.16	1.25	1.36	1.47	1.6
114	MCDONLY	OTHER	TgtCasMg	7	54	7.316	9.19	10.67	13.09	15.55	17.88	20.53	23.5
115	MCDONLY	OTHER	FQHC	7	34	0.428	0 408	0.47	0.54	0.63	0.72	0.83	0.9
116	MCDONLY	OTHER	OthCare	7	60	32.811	38.532	41.61	46.66	52.43	59.07	66.46	74.7
117	UNALLOC	UNALLOC	MentHosp	7	2	0	0	0	0	0	0	0	0
118	UNALLOC	UNALLOC	OthPrac	7	2	0	0	0	0	0	0	0	0
119	UNALLOC	UNALLOC	FQHC	7	24	1.317	2.908	3.23	3.71	4.27	4.91	5.64	6.4

To: Jennifer Kline

Fax #: (202) 456-7739

From: Lisa Simpson, MB, BCh, MPH, Office of the Assistant Secretary for Health

Date: 1/6/94

Pages: , including this cover sheet

fax

Here is what I said I would send over:

1. The memo on child health prepared for Dr. Lee last month.

2. The two passes at the benefit and other issues in the design of the "children's wrap" program.

In addition, Bob Valdez is preparing that issues memo I mentioned, and I will try to get you a copy when it is completed.

From the desk of...

Lisa Simpson, MB, BCh, MPH
Policy Advisor for Health Care Reform
Office of the Assistant Secretary for Health
Room 713E, 200 Independence Avenue, SW
Washington, DC, 20201

tel: (202) 401-7736
fax: (202) 690-5432

interoffice
MEMORANDUM

to: Bill Corr
cc: Phil Lee, Jo Ivey Boufford
from: Lisa Simpson, MB, BCh, MPH, Office of the Assistant Secretary for Health
re: CHILD HEALTH FOLLOW UP
date: 12/29/93

Here is an update on activities related to child health for your meeting with Phil today.

- Attached is a copy of the 12/14 memo that I generated after Phil met with Peter B. I have since spoken with Peter, and Sara said that she is faxing me her comments later today. The issues to discuss include: 1) policy issues that are time sensitive that must be addressed; and 2) commitments that Phil may have made to individuals to study these and other issues.

1) **TIME SENSITIVE ISSUES** - i.e. likely to need quick responses for Congress. In addition, there are several efforts underway to address at least two of them, both within and outside HHS.

   A. Benefits for children with special needs/chronic illness - [this is referred to as the "illness/injury" issue in HHS] Three of the benefits in the package are limited to services after illness or injury: outpatient rehabilitation services (OT, PT, ST), home health care, and extended care services. Continuing services are also restricted to improving function. This has raised two issues: 1) are children with birth defects and other congenital conditions excluded? and 2) what about children who need a more chronic benefit as well as services to prevent deterioration?

   [cont.]

From the desk of...

Lisa Simpson, MB, BCh, MPH
Policy Advisor for Health Care Reform
Office of the Assistant Secretary for Health
Room 713E, 200 Independence Avenue, SW
Washington, DC, 20201

The first issue requires an immediate "fix" as it is seen by most within HHS that excluding birth defects is not a tenable position[1]. The latest proposal (which Judy F. likes) which we are checking with J. Kline on is to define through regulations that birth defects and congenital conditions are included under illness and injury, and to also define strict re-assessment criteria so that the benefit does not become a more chronic one.

The second issue stems from a larger concern in the pediatric community that children need different services from adults and that these should be tailored to their developmental needs. In other words, habilitation, rehabilitation, and other services such as case management should be both more available and long term to maximize a child's potential. In addition, it is believed that many families are now getting these services (I have no data to back this up) through current insurance through years of "working the system".

To address both of the above, I know of the following activities:

- The March of Dimes is collecting information about current coverage for birth defects in today's insurance market;
- Peter B. said that the Packard Roundtable (a group of pediatricians working in health policy that is organized by Peter's shop) is also working on costing out non-covered services for children;
- Neal Halfon (UCLA) is interested in further developing a "pediatric standard of care" that includes a list of which benefits should be covered (see below for more complete description);
- ASPE has a contract with Systemetrix using Medicaid tape-to-tape and Medstat databases to examine distribution of rehabilitation services;
- ASPE is pulling together a group of outside "experts" to discuss a pediatric "rehabilitation benefit". This group will include representatives of the insurance industry. This should lead to the costing out of a full rehabilitative benefit for all, and one just for children;
- ASPE is overseeing an effort to establish a longer term research agenda related to children's rehabilitative services, which begins with a description of who is getting what;

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[1]Attached is a copy of the standard Q&A to respond to this which states the Departmental position: this is an acute care benefit.

B. Preventive benefits for children - the periodicity of the preventive services in the Act is less than is currently recommended by the AAP (3 visits short for adolescents). However, it falls even shorter of new draft guidelines that are under preparation by our very own MCH Bureau with joint funding from HCFA. This initiative is called "Bright Futures" and is being done under contract with Peter B.'s shop. The AAP will continue to push for broader coverage of prevention for children

2) **COMMITMENTS FOR OUTSIDE WORK** - From my conversation with Peter B. last week, it is his understanding that the following areas were of great interest to Phil and should be worked on:

A. Pediatric Standard of Care - (referred to above and draft proposal attached). This would be worked on by Neal Halfon at UCLA via the existing work order that OASH has with Peter B. at GW.

B. High Risk Populations and Preventive Benefits - to look at which child populations should be defined as high risk and attempt to cost out which additional services should be covered for which populations as a clinical preventive services (i.e. with no cost sharing). Peter B. feels that this could be done as part of an existing work order (this might be the one that is funding Bright Futures - I am not sure) either by "re-directing funds or providing supplemental funds".

C. Health Access and Health Status Data - PRL expressed to Peter B. a "strong interest" in having them work on developing performance indicators for health plans, as they relate to children. Peter believes that they (Sara R. and Ann Zuvekas) already have a good "base" from which to start using an index that was developed for NACHC and CDF (I am not familiar with it).

D. Pediatric Health Personnel - Peter B. has a delivery order from Brian B. to look at health personnel issues and believes that pediatric health personnel should fall under that. However, if additional work specific to children were needed, a supplemental to the work order would be needed.

MEMORANDUM

TO: Philip R. Lee, MD, Assistant Secretary for Health

FROM: Neal Halfon, MD, MPH, Associate Professor of Pediatrics and Public Health, UCLA

DATE: November 8, 1993

RE: Jameson and Wehr's Child Standard of Coverage

Please read this memo in conjunction with a two-page summary of the *Stanford Law & Policy Review* article, on a child standard of health care coverage, by Elizabeth Jameson and Elizabeth Wehr. Elizabeth Wehr is faxing the summary to your office at the time this memorandum is being sent. As I mentioned to you she is now working for Sarah Rosenbaum, and is available to talk with you in Washington, and to provide you and your staff with any additional information and rationale for this principle.

As a non-lawyer I find the argument for a child standard of coverage very compelling. The standard of coverage proposed by the authors has wider applicability than would a standard of care, (which are the technical standards set by professional organizations like the American Academy of Pediatrics and the American College of Physicians), or alternatively a standard of benefits, (which would be limited to the basket of benefits provided to children by any one plan).

While pediatricians and other child health providers take for granted that children are not just little adults, with unique health needs arising in their developmental vulnerability and the degree to which they depend on their parents and other social and governmental institutions, this special status of children is not adequately reflected in the Health Security Act.

The Act requires health plans to offer such pediatric benefits as immunizations and well-child care, as well rehabilitative, home-care and other services of special importance to children. But children's actual access to many of the required services is now and would continue to be controlled by administrative practices of managed-care plans that effectively restrict the amount, scope and/or duration of offered services. Except for a continuation of the Medicaid EPSDT standard, for impoverished children only, the Act lacks a child-specific rule that would require plans to use *pediatric* clinical values with regard to appropriate access for children to certain mandated services. Moreover, because the EPSDT standard is limited to one population to children, it cannot be a generalizeable principle for health reform. Yet such a principle is needed to assure, for instance, the existence of appropriate health-delivery systems

for children. Finally, one can expect poor children to fair better if their interests are shared by children of the middle class (as in Medicare and Social Security programs, compared with Medicaid).

By developing and using a child standard of coverage, four important goals can be accomplished: 1) ensure fairness (equity); 2) serve as an important organizing principal for systemic health reform; 3) shield the health interests of children from interpretations of "medical necessity" that inappropriately deny them medically indicated care; 4) make remedial actions more effective for children.

1. **Ensuring fairness** - Building on the Supreme Court decision in the Zebley case the child standard of coverage would mean that children's health needs must be determined in a way that takes into account children's developmental and dependency needs, and their needs for specialized diagnostic, treatment and medical management skills. Making explicit and addressing these differences between children and adults as patients should result in fairer treatment of children than under current adult models of coverage.

2. **Serving as an organizing principle for the health care reform proposal** - A child's standard of coverage has implications for improving the effectiveness, appropriateness, and allocative efficiency of services provided to children as part of the Health Security Act.

    - A. Benefits - *The scope, intensity, and duration of benefits*: the unique developmental and dependency characteristics of children require that benefits for them be broader in scope, and in certain instances, of greater intensity and longer duration, for healthy growth and development. A child standard should assure young patients an appropriate degree of access to appropriate services (i.e. habilitative, rehabilitative, case management benefits, etc.) provided by an appropriate practitioner (i.e. pediatrics specialist) in an appropriate setting (i.e. centers of excellence for child health), when required by a child's condition.

    - B. Delivery System - The health care delivery system must be organized to respond efficiently to the developmental and dependency characteristics of children. A child standard would help justify the inclusion of children's hospitals, and other centers of excellence, both for technical medical procedures, (i.e. pediatric cardiovascular surgery or child cancer centers), and for special regionalized services, such as, centers for child abuse, foster care, etc. that integrate health with social and other supportive services that are required by children's dependent status. Thus, a child standard would improve allocative efficiency of the system.

- C. Quality assessment - The unique developmental characteristics of children as well as the distribution of morbidity in the child population poses particular technical difficulties in the development of quality assessment systems. As opposed to adults that have high prevalence, high-morbidity, and technology-intensive needs, children have either high prevalence, low morbidity, low-tech conditions (e.g. asthma, otitis media), or low prevalence, high morbidity, high-tech conditions (e.g. heart disease, diabetes). These characteristics of child morbidity pose particular technical/measurement problems for the development of quality assessment systems. For example, in any one health care plan there will not be a sufficient number of children with diabetes to be able to judge the technical quality of care in the plan.
- D. Safeguards - The special development and dependency characteristics of children necessitate standards of care that are sensitive to medically relevant differences in developmental status for a given condition, e.g. asthma care in the infant vs. asthma care in the teen. A standard of coverage must also be responsive to the child-specific needs that cannot be articulated by the patient and may not be recognized by or effectively asserted by a patient's parents.

3. **Defining medical necessity** - A child standard of coverage will help prevent determinations of "medical necessity." that inappropriately limit or deny access to services that are medically indicated for a child (but may be of lesser importance for an adult). The instrumental concept of medical necessity has been transformed over the past ten years from a doctor-determined judgment with regard to and individual patient to a plan/system-determined principle for a class or population of patients in managed care. Medical necessity in this context refers not only to clinical values but also to the legal authority for limiting patient access to services. A child's standard of coverage would ensure that medical necessity is interpreted in a way that is not hostile to children's distinctive health profile.

4. **Permitting remedial action** - Having a child standard of coverage included in the Health Security Act, would supply the appropriate standard for use in remedial actions against plans and alliances or regulatory agencies on behalf of a child or class of children who are not receiving *appropriate services* from *appropriate providers* in the *appropriate delivery system.*

NH/svg
enclosure

DRAFTING NATIONAL HEALTH CARE REFORM LEGISLATION TO PROTECT THE HEALTH INTERESTS OF CHILDREN

Elizabeth J. Jameson, J.D.
Elizabeth Webr, J.D.

Stanford Law & Policy Review, November, 1993

[SUMMARY]

Introduction. Health reform legislation should require private, employment-based group health plans to meet a separate standard for coverage of children. The prevailing adult, acute-care model of coverage inappropriately limits preventive and other types of services that are important to children because of their unique characteristics as patients. These characteristics include children's developmental vulnerabilities, their dependence on adults, and the idiosyncratic incidence and expression of their disorders.

I. *A children's standard of health-care coverage.* The standard would consist of two parts. First, reform legislation should require health plans to offer specific health-care services for children. Second, it should require the plans to use the clinical values of pediatric health care in determining the amount, scope and duration of these services for children. For example, certain technology-dependent individuals can live at home with appropriate home services, but a plan may realize economies of scale by institutionalizing them at a plan-owned facility. Under the proposed standard, however, institutionalizing a technology-dependent infant or toddler who could live at home would be medically contraindicated, because of the substantial negative effects of institutionalization on children's developmental processes (which are not at issue in adult health care).

Children now have difficulty getting certain types of services in health plans that fail to take children's unique medical needs into account when seeking to control plan costs. Two favored methods of cost control, i.e. cost-sharing and "management" to eliminate wasteful or unnecessary care, inappropriately withhold care that is not wasteful but necessary for children. Administrative limitations on covered services are authorized under standard clauses limiting care to that which is "medically necessary." But as a legal term, "medical necessity" has come to represent economic as well as clinical determinants.

The function of the proposed standard is to assure that in balancing the cost of a service against its clinical benefit, a health plan considers the value *to children* of the service. The standard is grounded in the legal principle that using a single standard for differently-situated groups without adjusting for their relevant differences will disadvantage the group --

in this instance, children -- whose characteristics are ignored.

The coverage problems of children include delay or refusal to refer children requiring specialized care out of a plan, to pediatric subspecialists and specialized centers of care; cost-sharing that discourages immunization and other important preventive services; and restricted access to rehabilitative therapies that are critical to realization of a child's innate capacities.

At least six bodies of state and federal law govern private plans. Because none singly, or in combination, can now support systemic coverage reform of the type proposed, Congress should enact a children's standard of coverage.

II. *Efficacy of a children's standard of coverage*. A children's standard of coverage in health reform legislation will be effective only to the extent that the legislation also provides legal tools for assuring compliance with the standard. First, the legislation should authorize private rights of action that would enable individuals to hold plans, and the entities that regulate them, responsible for meeting the standard of children's coverage. A decades-old statutory requirement that federally-qualified HMOs provide home health services to beneficiaries on an "as needed" basis has been virtually ignored by major HMOs because of disinterest in enforcement on the part of the responsible federal agency.

Second, the legislation should authorize damage awards exceeding the actual cost of an inappropriately denied service. Unless a plan risks a substantial penalty as well as the value of the service, there is little reason for a plan not to err on the side of withholding when there is a question about coverage. The plan's financial risk is limited to the cost of the benefit it may have to eventually provide, and the plan may assume that many if not most families will be unable to assume the burden of challenging the decision.

Third, reform legislation should stipulate that judicial review of questionable health-plan restrictions or denials of benefits must be *de novo*. This standard of judicial review authorizes the most direct reevaluation, by an impartial tribunal, of the factors determining a benefit denial. This degree of judicial "oversight" is a necessary counterweight to the powerful financial incentives in managed health care to withhold services.

The George Washington University
WASHINGTON DC

CENTER FOR HEALTH POLICY RESEARCH

December 24, 1993

MEMORANDUM

TO: Liss Simpson

FR: Sara Rosenbaum

RE: Comments to your December 14th memorandum

Thanks very much for sending me a copy of you memorandum on children and health care. I think that you have hit most of the major issues. Here are my comments:

1. Use of the IOM criteria

The IOM criteria were developed a couple of years ago in an attempt to develop a broad consensus among many different individuals and organizations, some of whom were opposed to universal, mandatory health insurance. As a result, several of the criteria (most notably the first criterion) were somewhat obliquely stated. I would therefore refine the Goal #1 as follows:

- #1: All children and women should be guaranteed continuous and uninterrupted health insurance.

2. Migrants

One of the population groups receiving particular attention from the Public Health Service is migrant families. They will have particular trouble navigating a state-based or sub-state -based system. Periodically I have discussed with both HCFA and BPHC ways to ease the Medicaid burdens on migrant families. These families will face the same types of barriers under health reform, and we ought to be thinking about how to develop a fully transportable coverage system. Otherwise, most of the time migrant women and children will be eligible only for "out-of-area" emergency and urgent care services and will have unending trouble

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locating providers willing to furnish even these services (despite the requirement that plans pay of out-of-state services) unless they are near migrant clinics.

3. Measuring medical under-service

We need to rethink how the PHS measures under - service after national health reform. For 20 years, under-service measures have been driven principally by issues relating to uninsured or Medicaid status. We need a new type of medical under-service index; moreover, the index should have a built in sub-index of pediatric under-service, given the fact that the poor are disproportionately children and women of child-bearing age.

Under-service will continue to be a principal concern even after health reform. The principal health reform plans pending in Congress may have only a limited effect on the distribution of private health care resources. Many communities will continue to lack adequate levels of primary medical care, because despite their coverage they remain too poor to support practices. Causes of continued under-service will be :

- high poverty and unappealing work conditions
- the fact that undocumented persons disproportionately live in low income communities, thereby leaving communities with a lot of bad debt overall
- high cost sharing that poor families cannot pay, which will leave poorer communities with heavy "bad-debt" loads.
- coverage lapses among unstable community residents because of changes in residence, failure to sign up for coverage, loss of the card, etc. Even if providers qualify for payment when they serve people without their cards, they will be afraid to do so for fear of not getting paid enough or promptly.
- the disproportionately high percentage of low income persons who have poor health status, making health care a higher risk business. Plans will continue to avoid these communities

I think we need new index of medical under-service that uses a more sophisticated community environmental measure of need and that goes beyond lack of health insurance and traditional indicators such as infant mortality. This measure of medical under-service (which should also include a special measure of pediatric under-service in keeping with the PHS' special interest in children) will useful for the essential provider program, as well as a means of identifying communities in which resource development funds are necessary.

4. Limitations on coverage: the definition of medical necessity in a pediatric context

In addition to being concerned about the lack of any coverage for certain conditions in childhood (i.e., the "illness or injury" problem), we should be concerned about the definition of medical necessity that plans are permitted to use. The Medicaid EPSDT standard (i.e., does the service promote or maintain health and prevent illness or deterioration?) goes well beyond a more limited standard of restoration or improvement. Currently the President's bill does not contain the more generous medical necessity definition for children (nor do any other bills). This should be a principal concern.

5. Uncovered services

In several places in the President's bill we use Medicare definitions for covered services. Even where we cannot expand the basic benefit package to include coverage of uncovered long-term services, several of the definitions now used (such as the DME definition) may be inappropriate for children.

6. Coordination with other programs

There is nothing in the statute that requires health plans to honor (without separate determinations of medical necessity or appropriateness) treatment plans for children in special education, early intervention, child welfare placements or other programs in which care plans are drawn up. A health plan could refuse to honor or could outright ignore an IEP for a child in special education that calls for the provision of a covered service. Moreover, a plan could require the substitution of a health professional or provider recommended by the educaitonal program without any showing that the alternative provider is just as competent as the one used by the special program. Given the multiple service settings and programs for children with special needs, spelling out the relationship between health plans and other child serving programs is very important.

Finally I think that we need to meet quickly to sort out those items that require immediate work versus those that are on a slightly longer term track. I consider iterms 2, 4, 5 and 6 to be "must do" (initiated and well on track) within the next 8 weeks. Item 3 can be placed on a somewhat slower track.

I look forward to speaking with you.

cc: Peter Budetti

1/3/93

Note To: Cheryl Austein
Don Johnson
Robyn Stone
✓Lisa Simpson
Julia Paradise
Amy Nevel
Ruth Katz
Karen Davenport

From: Sharman Stephens

SUBJECT: Summary of 12/21/93 Meeting on Identifying Services for the New Children's Wrap Program

I have attempted to summarize the meeting. In addition, I have added some thoughts about how to consider services like physical therapy which for purposes of a children's wrap may only be a chronic care service, but might be desirable to include in the wrap from a preventing deterioration perspective. The meeting (with some of my additional thoughts) accomplished the following:

- Listing of the 1905(a) and (r) services that are either limited or uncovered in the HSA benefit package and thus could potentially be candidates for services under the children's wrap;

  --Within this context the issue was identified that enabling services such as transportation, childcare, and outreach are not among the services listed in 1905(a) or (r). Karen Davenport agreed to pursue this issue to get clarification, since Rick Kronick had previously indicated at the 12/20/93 meeting that there might be an interest in having the wrap program emphasize these types of services.

- Developed a conceptual framework for how to consider the services beyond the HSA benefit package in which:

  --Services that are not likely candidates for wrap coverage are those that are only considered long term care particularly facility based LTC (SNF, ICF) in nature.

  --Services that are likely candidates for wrap coverage are those that are acute in nature or, like hearing aides, are infrequent intermitent services and not covered by the benefit package.

--Services that are both acute and chronic in nature and potentially could be considered for wrap coverage or residual Medicaid, or while chronic in nature help prevent deterioration, e.g., physical therapy.

Attached is a draft table summarizing the discussion and how we classified the list of services developed. The major difficulties surround those services that can potentially be covered by both the wrap and a residual Medicaid. Based on the discussion at the meeting, I for one would find it helpful to better understand which children are or are not eligible for a residual Medicaid program and the presence or absence of a distinction on LTC services.

1905(a) AND (r) SERVICES LIMITED IN THE HSA BENEFIT PACKAGE

SERVICE CATEGORY	ACUTE / CHRONIC NATURE	POTENTIAL FINANCING SOURCE
Dental, orthodontia	Acute	Wrap
Clinic services (can include therapies and outpatient mental health -- note we might need to list other outpatient psychiatric since even the M.D. services are limited under HSA)	Acute / Chronic	Wrap & Medicaid
EPSDT Treatment	Acute / Chronic	Wrap (note we only classified as wrap even though we gave it an acute/chronic nature)
Physical therapy	Chronic (while PT also is acute, the acute services are currently presumed to be covered under HSA benefit)	Wrap & Medicaid
Outpatient rehabilitation	Chronic (see above comment on P.T.)	Wrap & Medicaid
Case Management	Not entirely clear, also not clear what the coverage is under the HSA benefit	Wrap and Medicaid
Home health	Chronic	Medicaid ?wrap
Ventilator dependent respiratory therapy	Chronic (it is not clear if this is covered in the HSA home health benefit or not)	Medicaid
Inpatient psychiatric	Acute and Chronic	?wrap & Medicaid
Nursing Facilities	Chronic	Medicaid

1905(a) AND (r) SERVICES NOT COVERED IN THE HSA BENEFIT PACKAGE

SERVICE CATEGORY	ACUTE / CHRONIC NATURE	POTENTIAL FINANCING SOURCE
Over the counter drugs and contraceptives	Acute	Wrap
Private duty nursing (presumably only during the course of a hospitalization	Acute	Wrap
Hearing Aides	Acute	Wrap
ICF/MR	Chronic	Medicaid
Community supported living arrangement	Chronic	Medicaid
Enabling Services (transportation, childcare, outreach) clarification is needed as to whether these are even eligible for wrap coverage since not listed in 1905(a)or(r)	Acute	

From: JULIA PARADISE (JULIAP)
To: CHERYLA, SHARMANS
Date: Monday, January 3, 1994 1:42 pm
Subject: enabling services REDUX

i just spoke with karen davenport (olp) to find out what she had learned about the authority for medicaid coverage of some of these services. here's the scoop --

transportation - included via 1905(a)(22): any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

translation - probably covered under administration

child care - we're not sure medicaid is even paying for it. if so, conceivably under administration, but not that likely.

December 1, 1993

Children's Wraparound Services

The HSA language enables the Secretary to determine the mix of services covered through the wrap-around benefit, but also requires that these services include all items and services described in 1905(a) and 1905(r) of the Social Security Act. The Secretary is also charged with developing a definition of "medically necessary" to be applied to these benefits.

Wraparound services will be primarily services covered through the comprehensive benefit package which are subject to duration and scope limits.

Service	Comprehensive Benefits Package	Wraparound Coverage	New Long Term Care	Residual Medicaid
Inpatient Mental Illness	30 days coverage; in specified severe cases additional 30 days covered.	Subsequent days to a specified limit (e.g., 120/150)	State option	Day 150+ (or other chosen day limit)
Outpatient Mental Illness (clinic or other setting)	30 visits of outpatient coverage; additional visits covered through 1:4 trade with inpatient coverage.	All services after alliance limits exceeded.	State option.	Not covered.

Outpatient PT	Initial 60 days after illness or injury; addl. 60-day periods covered if provider determines that function is improving.	Covers therapy needed on a chronic basis, no intervening acute episodes to "trigger" alliance coverage. Congenital illnesses covered.	State option.	Covered if included in State Plan.
Outpatient OT	Initial 60 days after illness or injury; addl. 60-day periods covered if provider determines that function is improving.	Covers therapy needed on chronic basis, no intervening acute episodes to "trigger" alliance coverage. Congenital illnesses covered.	State option.	Covered if included in State Plan.
Outpatient speech therapy	Initial 60 days after illness or injury; addl. 60-day periods covered if provider determines that function is improving.	Covers therapy needed on chronic basis, no intervening acute episodes to "trigger" alliance coverage. Congenital illnesses covered.	State option.	Covered if included in State Plan.

Home Health	60 days of home health services (Medicare benefit) and home infusion therapy as alternative to inpatient care after illness or injury; addl. 60-day periods covered if need continues.	Services not covered under the Medicare home health benefit; chronically ill children or kids who do not meet inpatient test for alliance coverage.	State option.	Covered if included in State Plan.
Hearing Aids	Not covered	Covered	State option.	Not covered
Non-Emergency Transport-ation	Not covered	Covered	State option.	Not covered
Dental Services	Emergency care. Until 2001, prevention and diagnosis, treatment, space maintenance and interceptive orthodontics covered only for individuals under 18.	Covered for eligible 18 year olds? Orthodontics	State option.	Not covered
Eyeglasses & Contact Lenses	Covered for individuals under 18	Covered for eligible 18 year olds?	State option.	Not covered

Discussion/Options

- Inpatient mental illness

  The alliance covers 30 inpatient days, with an additional 30 days in severe cases. Children who need inpatient services for mental illness typically will need care beyond 30 days. However, picking up inpatient mental illness in the wraparound is administratively complex and classifying services beyond 30 days as long term care complicates the transition to richer mental health benefits in 2001.

  Issue: At what point are these services covered by long term care?

  One alternative is to cover inpatient services through wraparound for 120 or 150 days (or some other number -- Medicare uses a 190 day life-time maximum), with any inpatient care beyond this limit financed through the Medicaid LTC program. These children would be covered first through the alliance, then by the Federal government (with 100% Federal dollars), and then through the State Medicaid program (with State and Federal dollars). Eligibility and enrollment issues may be complicated.

  Another option would be to eliminate the wraparound interim period and finance all inpatient mental illness beyond 30 days as long term care. This approach would be administratively simpler, but may jeopardize improved mental health benefits for 2001. Because inpatient days beyond the 30 day limit would be considered to be long term care, reclassifying additional days as an acute care benefit by 2001 may be politically or fiscally difficult.

- Outpatient mental health

  The alliance covers 30 outpatient visits; additional visits are available through a 1-for-4 trade with inpatient days.

  By general agreement, outpatient mental health services should be covered through wraparound once patients exceed 30 visits or are ineligible for alliance coverage.

- Rehabilitation therapies not covered by the alliance

  Alliance plans will cover one 60 day period of rehabilitation therapies (PT, OT and speech therapy) following an illness or injury. Additional 60-day periods will be covered if the provider determines that the patient is improving in function.

  Maintenance therapy for chronically ill -- and slowly deteriorating -- patients could be covered through wraparound

or long-term care.

Initial coverage for children with birth defects would be through Alliance health plans. However, while many needed services would be provided through the Alliance, maintenance therapies would be provided through wraparound or LTC.

Issue: At what point are these services covered by long term care?

The new LTC program would cover severely disabled children if the State opts to provide rehabilitation therapies. Since wraparound is 100 percent Federally funded, States may choose to exclude these services from new community-based programs to shift the burden to the Federal government. Continuing Medicaid LTC could also cover rehab, but at a lower matching rate than either the new LTC program or wraparound. Also, can States pick up coverage in the new LTC program or under regular Medicaid LTC when the capped wraparound program runs out of funds?

Even if States do provide rehabilitation services through the new community-based benefit, more severely disabled children (3 ADLs) will receive rehab with a (nominal) copayment through this program, while less disabled children will receive services without copayments through wraparound or the continuing Medicaid community-based LTC benefit.

- Home health

The alliance home health benefit is a post-acute benefit to substitute for inpatient treatment. Services are modeled on the Medicare benefit, and include part-time nursing care, rehabilitation therapy, medical social services, services provided by a home health aide, medical supplies, medical services provided by an intern or resident-in-training (for home health agencies affiliated with hospitals), and home infusion therapy.

Some Medicaid home health services -- for individuals who are not post-acute, do not meet the institution test, or for non-Medicare services -- do not fall under this framework and would be covered through wraparound.

Issue: At what point are these services covered by long term care?

- Hearing aids

  Hearing aids are not covered under the Alliance coverage. In general, hearing aids would be covered in the wraparound benefit.

  Issue: Would hearing aids provided to institutionalized children be covered through the wraparound program or long term care?

- Non-emergency transportation

  Bus tokens, van rides, and other transportation services would be covered as wraparound benefits.

- Dental services not covered by the alliance

  The wraparound program covers children through age 18, but, except for emergency care, alliance-covered dental services extend only through age 17. Because 18-year-olds are not covered for non-emergency dental care, the wraparound program could pick up these services for this age group.

  Issue: Do we want the wraparound program to cover 18 year olds for this or any other benefit where the Alliance does not cover them but Medicaid does?

- Eyeglasses and contact lenses

  Alliance coverage for corrective lenses extends only through age 17. Wraparound would/should also cover 18-year-olds for corrective lenses.

  Issue: Coverage for 18 year olds?

Other Concerns/Issues

- Age-related issues

  Current Medicaid coverage includes two types of services, EPSDT and inpatient psychiatric care, that specifically cover children up to age 21. By creating a children's wraparound package through age 18, we ensure that some current Medicaid children will lose coverage for some services not covered by the alliance -- including the broad-ranging EPSDT mandate.

  The wraparound benefit covers children through age 18, but several alliance-based services -- glasses and dental care -- extend only through age 17. Should the wraparound program cover these services for 18 year olds, or should alliance plans extend to age 18?

- Section 4221

  Section 4221 of the Health Security Act specifies that several groups of Medicaid eligibles -- cash recipients, dual eligibles and children under 18 (or, at State option, under 19, 20 or 21) retain Medicaid coverage for services not included in the comprehensive benefits package. The wraparound package will pick up these services for children 18 and under. Will Medicaid "continue" for additional services for 19 and 20-year olds?

- EPSDT

  Does the language in section 4221 mean that States are still responsible for the EPSDT mandate in spite of the wraparound program? Because the Federal wraparound is a capped program, States could therefore be left responsible for a range of additional services, or provider may be paid inadequately. If providers are unwilling to participate, could States provide these services at regular Medicaid matching levels?

  Also, since the EPSDT mandate requires States to provide children with any necessary Medicaid services, regardless of whether such services are covered in the State plan, States have no "optional" services for children. Therefore, although the attached table indicates that State plans may differ, States have no flexibility in their new and residual long term care programs for children's services.

- Congenital Illnesses

  Are rehabilitation, home health and post-acute institutional care covered through the alliance for children with congenital illnesses, or only through wraparound? Congenital illness is not an issue for the bulk of services covered through alliance plans without an illness and injury limitation. However, this limitation does apply to rehabilitation, home health and NF services. If, after reconsideration, alliance coverage for these services includes congenital illness, alternative limits may be placed on these benefits to prevent alliance coverage from becoming a chronic care benefit. Wraparound would then pick up services beyond these limits.

December 1, 1993

NOTE TO Bruce Vladeck
Judy Feder
Rick Kronick

Subject: Children's Wrap-around Benefit Issues

Attached is a issue paper addressing the benefits that would/could be covered under the new Medicaid children's wrap-around program based on on-going discussions within HHS. The focus of this paper continues to be the covered services, however, eligibility and enrollment issues must also be addressed and will be in future documents.

A major issue is whether this program can be modified to make it workable or whether we need a radical overhaul. We hope to meet on Friday to continue this discussion.

Don Johnson

cc: Sally Richardson
Barbara Cooper
Julia Paradise
Ruth Katz
Sharman Stephens
Lisa Simpson

Qs&As
Children's Wraparound

Reinab

- What is the wraparound program?
- Why does the wraparound program exist?
- What services will be covered?
- Who is eligible to receive wraparound benefits?
- If these services are so important, why do you restrict eligibility to children now on Medicaid?
- Why aren't these services included in the basic benefit package?
- How will this new program be administered?
- What if a State wants to run the program?
- Who is responsible for quality assurance?
- Who is financially responsible if program funding is insufficient?
- Would requiring plans to assume risk for wraparound services increase the general premium rates if capitated payments are insufficient?

Q: What is the children's wraparound program?

A: The children's wraparound program is a Federal program, funded with Federal dollars, to provide supplemental health services to children who are currently eligible for Medicaid.

Wraparound services are defined in the HSA as medically necessary services currently covered by Medicaid that are neither alliance-covered services nor Medicaid long term care services.

Generally, children who are eligible to receive Medicaid under current law will be eligible for the children's wraparound program.

The HSA caps program spending at the 1993 level of combined Federal and State Medicaid spending on wraparound services, adjusted for inflation and change in the number of eligible children.

Q: Why has the wraparound program been proposed?

A: The goals of the children's wraparound program established by the HSA are:

-- to demonstrate a strong Federal commitment to ensuring that children who are currently eligible for Medicaid as well off under the HSA as they were under Medicaid.

-- to provide all medically necessary services to these children without forcing States to expand their financial responsibilities; and

-- to continue to provide services currently covered through EPSDT and to coordinate with other Federal programs providing treatment services, including IDEA.

Q: What services will be covered?

A: Wraparound services are defined in the HSA as medically necessary services currently covered by Medicaid that are neither alliance-covered services nor Medicaid long term care services.

The HSA authorizes the Secretary to define wraparound services. We anticipate that wrap services will include coverage of rehabilitation therapies and treatment for mental illness in excess of alliance plan limits, and enabling services, such as non-emergency transportation and hearing aids, that are not included or are specifically excluded from coverage. Some part of these services, such as extended inpatient treatment for mental illness, will be covered through continuing Medicaid long term care benefits.

Q: Who is eligible to receive wraparound benefits?

A: Generally, children who are eligible to receive Medicaid under current law will be eligible for the children's wraparound program.

Background

The HSA applies current Medicaid eligibility rules to determine eligibility for wraparound benefits. Because current law includes some state options (i.e., infants between 133 and 185 percent of poverty and eligibility expansions through State Plan Amendments under 1902(r)(2) before 10/1/93), eligibility will vary by State. We are currently looking at options for "smoothing" this variation.

Q: If wraparound services are so important, why do you restrict eligibility to children who meet current Medicaid eligibility requirements?

A: The alliance benefit package design was based on insurance products in the current private market, and incorporates some of the limitations common to those policies. Medicaid does not have similar limitations. Instead, Medicaid-eligible children currently are entitled to a broad array of medically necessary treatment and support services similar in scope to the proposed wraparound services. We were concerned that the most vulnerable children -- children who, because their income is so low, cannot afford to pay for additional services -- would lose access to needed health care and support services when they enroll in mainstream health plans and are subject to their benefit restrictions.

Because program funding is based on Medicaid spending for these services, we were not able to extend wraparound benefits to all low-income children. However, because current Medicaid eligibility rules apply for wraparound eligibility, all children with incomes below poverty will be covered by 2001.

Background

We have asked HCFA actuaries to develop a cost estimate to extend wraparound eligibility to all children in families that qualify for premium discounts (i.e., 150 percent of poverty).

Q: Why aren't wraparound services included in the basic benefit package?

A: The alliance benefit is designed to cover primarily acute care services, with some post-acute services. It is not designed as a chronic benefit. Some poor children will have chronic needs for some alliance-covered services, such as rehabilitation therapies. The wraparound program will pick up these services where the alliance package leaves off. It will also cover some services not covered under the alliance package, such as non-emergency transportation.

Q: Who is responsible for running the children's wraparound program?

A: Instead of specifying the wraparound program's administrative structure, the HSA directs the Secretary to develop it. The Administration has been considering how this program could be implemented most effectively.

Two principal options have been outlined for administering the children's wraparound program:

-- capitated Federal payments to health plans, with plans responsible for delivering or arranging for wraparound services; and

-- State administration, which may resemble the current Medicaid program or use an alternative approach, such as a block grant.

The first option is preferred because plans could more readily coordinate wraparound services with the alliance benefit package and maintain continuity of care.

If Congress wishes to be more prescriptive or more detailed on wraparound administration in legislation, the Administration will work with Congress to develop a strategy consistent with the goals of this program.

Q: What if a State wants to run the children's wraparound program?

A: While the preferred option is to pay a capitated add-on to health plans, other options are also being considered.

One option would be to run wraparound through State Medicaid agencies. The program would be similar to today's Medicaid program, except that funding would be 100 percent Federal.

A more flexible alternative would be to allocate wraparound dollars to the States; States could then choose whether to directly pay health plans, run wraparound through the State Medicaid agency, or use an alternative approach.

Background

If states receive a Federal wraparound allocation, they will be required to provide all necessary services. States will therefore be left holding the bag if program funds are insufficient.

Q: If children's wraparound services are provided through health plans, how will they be held accountable for quality of care and appropriate access to services?

A: Under this model, wraparound services would be part of the continuum of services available through health plans. Because States will be responsible for quality assurance monitoring for alliance services delivered by health plans, States would also be the appropriate entities to enforce quality and access standards for wraparound services.

Because wraparound is a Federal program, with 100 percent Federal dollars, we envision that Federal quality standards would be appropriate. Involving appropriate State agencies and school-based programs may also be advisable.

Q: If program funding is insufficient, who will be financially responsible for additional wrap services?

A: Under the plan administration option, health plans will be responsible for providing services. Plans will therefore have the incentive to coordinate these services with alliance-covered benefits in an effective and efficient manner. Similarly, under other administrative models, the States or other administrative entities will be responsible for spending wraparound dollars efficiently and effectively.

Background (Rick suggests dropping)

Since the spending cap on wrap services is based on historic spending, rather than the actuarial value of covered services, funding may well be too low. We have not analyzed the impact that under-funded capitated wrap payments may have on overall premiums.

Children's Wraparound

- Current Medicaid children will be eligible for supplemental services not covered in the basic benefit package. Eligible children include:

  -- infants under 133 percent of poverty or, at State option, 185 percent of poverty;

  -- children under age six in families with income below 133 percent of poverty;

  -- children born after September 30, 1983, who are age six or older, and in families with income below 100 percent of poverty; [phased in 1 yr at a time]

  -- children under age 19 who live in States which use 1902(r)(2) methodology to determine Medicaid eligibility; States can be more liberal -- disregard 100% of poverty, disregard age 19 limit.

  -- medically needy children; and (med. needy income level -- higher than AFDC; spend down)

  -- children who receive cash assistance. (AFDC and SSI)

For those States that have adopted this as of 10/1/93

- Financing for wraparound services

  States will include the State share of Medicaid payments for services covered through the children's wraparound program for cash children in their non-cash, non-DSH maintenance of effort baseline. States will pay these MOE funds to Alliances.

  However, the Federal government will pay 100 percent of the cost of providing wraparound services, including administration. These Federal payments will be subject to an annual expenditure cap, based on total Federal and state spending for wraparound services under Medicaid State plans prior to reform.

	Cash	Non-Cash	Other
Children	Federal State MOE sent to Alliance	Federal	1902(r)(2) kids Federal; other groups State option, no match

- Services

  Services covered through the children's wraparound program include all medically necessary or appropriate services described in 1905(a) of the Social Security Act that are not included in the comprehensive benefit package.

JAN 13 1994

TO: Rick Kronick
Bob Valdez

FROM: Don Johnson

RE: Children's Wraparound

As agreed at the meeting on Friday, January 7, I am circulating three draft documents for your review. The first, "Options for Administration," discusses some of the issues that must be addressed before choosing an administrative structure for the program, and identifies the pro and cons of having the States or the health plans be responsible. The second document, "Children's Wrap Services," describes services to be covered under the wraparound program and under Medicaid LTC, reflecting decisions made at the meeting. The third, "Eligibility Alternatives," summarizes the questions we would like to answer about various eligibility options. The estimates however, are still under development.

Please give me comments by Tuesday, January 18 in anticipation of a meeting later next week.

cc: Robyn Stone/Ruth Katz
Cheryl Austein/Sharma: Stephens
Julia Paradise
Lisa Simpson
Barbara Cooper
Sally Richardson

DRAFT - January 12, 1994

Children's Wraparound Program:
Options for Administration

ISSUE

Since the HSA does not specify how the new children's wraparound program is to be organized, several options for administering the program are available. The only parameters specified in the current bill are that (1) the Secretary shall provide for payment on behalf of each qualified child, and (2) total dollars with which to pay for the wraparound services are capped.

Before deciding on the most efficient structure for administration, the following questions should be answered:

- What entity is best equipped to run the program?
- What is the best way to allocate the money to each administering entity?
- Once the administrative structure is decided, what are the necessary enrollment procedures?

ASSUMPTIONS

- Spending on the program cannot exceed the cap.
- The Federal government would set aside 5% of the funds to be used as "reinsurance" if necessary and 5% to be used for administrative costs.

OPTIONS FOR PROGRAM ADMINISTRATION

Two main options exist for who should have primary responsibility for administering the wraparound program: the States and the alliance health plans. The Federal government is a possible third option, however establishing a new Federal administrative structure to run a relatively small program is unlikely to be the most efficient.

Ideally, the entity responsible for running the wraparound program should have experience performing a number of tasks, including: eligibility determinations and enrollment, rate setting, claims payment, contracting or direct service delivery, general financial management, and managing a fixed budget. See attachment A for analysis of the strengths of various entities.

Whether the States or the health plans are chosen to run the children's wraparound program, the administering entity would have to abide by Federal guidelines regarding qualified children, covered services, and enrollment procedures.

- **States**

The wraparound dollars could be allocated to the States. If so, there would still be a number of options for what entity should run the program. Possibilities include: the State Medicaid agency, the State title V agency, the State agency administering part H of IDEA, the State long term care agency, or some other public or private entity in the State.

As attachment A illustrates, the State Medicaid agency has a historic relationship with the eligible population; it has experience enrolling individuals and performing eligibility determinations; it has experience administering an insurance type program which includes setting rates, paying claims, and managing finances. While State title V and part H agencies have experience delivering services directly and meeting the special needs of low-income and disabled children, they may not have experience managing a large or a fixed budget. State long term care agencies in most cases have not yet been established, but through administering the new, community long term care program, they will have connections with providers capable of providing many of the wraparound services. These agencies may or may not have the administrative capabilities to enroll eligible children.

As a final option, the Federal government could contract with some other State agency or private entity to deliver the services and administer the program. For example, the contractor could be a large provider, such as an academic health center, able to provide the full range of wrap around services itself. Alternatively, the contractor could serve as a case manager/administrator only. In this capacity, the contractor would manage and coordinate the care, but sub-contract with other providers to deliver the services. The contractor would also administer the program and pay all bills/claims.

In any case, the chosen entity would be required to provide (or arrange for the provision of) all federally required wraparound services; enroll all qualified children in the wrap program; and pay for all wrap services. But each entity would have the flexibility to decide the degree to which it would coordinate wrap-around services with alliance and other Medicaid services; whether to pay for services on a fee-for-service or a per capita basis; and whether to provide the services directly or sub-contract with other providers.

Given the different experiences of the different state entities discussed above and given the variation across states in the strengths of each agency, if the States are chosen to administer the children's wraparound program, it would make sense to give each State the flexibility to designate the agency it views as most qualified to run the program.

Pros

o The States, especially Medicaid agencies, have a historic relationship with the eligible population and experience providing these services and fulfilling the EPSDT

mandate.

- o States may be more able than health plans to integrate wraparound services with other medically necessary long term care services provided under continuing Medicaid or the new community LTC program

- o Releases Federal government from the administrative burden of running the kids wraparound program.

Cons

- o It will be difficult to design an equitable allocation formula for the funds. Would the allocation be based on historic data for each State, a national per capita amount, or some other formula?

- o States may not be able to fulfill the EPSDT mandate within the available dollars.

- o With 100 percent federal funding for wraparound services, States will have an incentive to provide more services under this program rather than pay for them under the new, community LTC program (w/87 percent Federal match), or continuing Medicaid LTC (w/57 percent Federal match). This behavior may cause the state to run out of money and risk trying to limit services.

- o If different agencies in each state administer the program, it might be difficult to ensure that the wraparound program is uniform across all States.

- o If qualified children enrolled in an alliance heath plan are deemed to be enrolled in the wraparound program, how will the State entity communicate with the plans to identify the children?

- o States may not be able to effectively integrate and coordinate wraparound services with services provided by health plans. Children might end up receiving services from several different programs (alliances, wraparound, Medicaid LTC, new LTC) with little coordination between them.

- **Alliance Health Plans**

The alliance health plans could be required to provide all medically necessary wraparound services to qualified children. Plans would receive an add-on to their captation rate for these services. Alternatively, all plans could be required to offer a children's insurance rider to supplement the comprehensive benefit package. The rider would cover all wraparound services for children and the Federal government would purchase the plans for all qualified children. The rider could be tax exempt to encourage families and employers to purchase supplemental coverage.

Pros

- Health plans will be able to ensure that wraparound services are integrated and coordinated with alliance covered services. Children would be covered through the same plan that provides their comprehensive benefit package.

- Health plans will have established relationships with providers and experience setting rates and paying claims.

- Alliances will be making eligibility determinations for cost-sharing and premium discounts and might be able to expand this administrative activity to include eligibility determinations for the wraparound program.

- Releases Federal government from the administrative burden of running the kids wraparound program.

Cons

- Health plans may not be able to fulfill the EPSDT mandate within the available dollars. Plans may be forced to raise premiums to cover the cost of the services, thereby maintaining a cost shift onto the private sector.

- Health plans may not have experience providing some of the wraparound services, such as chronic rehab services and non-emergency transportation.

- Health plans will not necessarily know which children qualify for the Federal wraparound program (other than cash recipients receiving cost-sharing discounts), and are therefore entitled to the additional services.

- Health plans may not be able to effectively integrate wraparound services with long term care services provided outside the alliance.

- Health plans may not be able to effectively coordinate wraparound services with Title V and IDEA, as directed in the legislation.

OPTIONS FOR ALLOCATION OF FUNDS

Once the appropriate entity for administering the children's wraparound program has been chosen, a mechanism for equitably allocating the funds must be established. Four main options exist for dividing the dollars between the administrating entities: a lump sum based on aggregate historic Medicaid expenditure data, per capita amounts based on historic Medicaid expenditure data, per capita amount based on total dollars divided by total children, per capita amount based on actuarial estimate of cost of services.

- **1. Lump Sum - aggregate historic Medicaid expenditure data**

Under this approach, the total capped amount of Federal dollars would be disaggregated into a capped amount for each state based on the state's current spending for wraparound services, trended forward. The state specific amount would therefore preserve the differences in state spending. This approach may not be appropriate if the health plans are expected to administer the program because an additional allocation would have to be made to each plan.

Pros

- o Locks in current State variation regarding eligibility, services, and payment levels, and therefore avoids arguments about adopting a new allocation formula.
- o No State would be viewed as "subsidizing" services in another State.
- o Ensures spending stays within the total cap.

Cons

- o Locking in current State variation regarding eligibility, services, and payment levels may not be viewed as "equitable" by all States, especially if aggregate amounts do not reflect the true cost of providing wraparound services in each state.
- o Lumps sum payments would not be appropriate if health plans were administering the program.
- o States with low allocations may have a more difficult time providing all required services within the cap.

- **2. Per Capita - historic Medicaid expenditure data**

This approach would take the capped state amounts calculated in option 1 above, and for each state, divide the cap by the number of qualified children in the state. Per capita rates could be used whether the State or the health plans administer the program.

Pros

- o Locks in current State variation regarding eligibility, services, and payment levels, and therefore avoids arguments about adopting a new allocation formula.
- o No State would be viewed as "subsidizing" services in another State.

Cons

- o Per capita variation may not reflect the true differences in the cost of providing wraparound services in each state or health plan.

- o States with low allocations may have a more difficult time providing all required services within the cap.

- **3. Per Capita - total dollars divided by total children**

This per capita amount would be calculated by dividing the total capped amount of Federal dollars by the total number of qualified children in the country. This approach would reduce the state-by-state variation that would result from the per capita calculation listed in option 2 above.

Pros

- o Ensures spending is near the total cap.

- o Every plan or State in the country would receive the same amount of money per child.

Cons

- o Amount is somewhat arbitrary and not necessarily related to the cost of providing wraparound services in an individual health plan or state.

- o Some States might complain that they are subsidizing services in other states.

- o Amount would be based on an estimate of total enrollment, not on actual enrollment. Therefore, cap might be exceeded if enrollment is higher than expected.

- **4. Per capita - actuarial estimate**

Under this approach, actuaries would estimate the national average, per capita cost of providing wraparound services to the eligible population. If the amount is less than that calculated in option 3, then the additional money could either be added on to the per capita rate, or held by the Federal government to use for "reinsurance." If the amount is greater than that calculated in option 3, then the per capita rate would have to be cut or a supplemental appropriation could be sought.

Pros

- Amount would reflect the national average cost of services.

- Every plan or State in the country would receive the same amount of money per child.

Cons

- Amount would not reflect the true cost of providing these services in an individual health plan.

- Some States might complain that they are subsidizing services in other states.

- If estimate is higher than in option 3 above, the capped pool of money would not be sufficient to pay the actuarial estimate for all enrolled children.

OPTIONS FOR ENROLLMENT OF QUALIFIED CHILDREN

Once the administrative structure and allocation formula have been worked out, procedures for enrolling qualified children into the program must be established in order to ensure adequate participation. Enrollment procedures should be designed to identify all eligible children, sign them up, and make sure they are receiving all necessary services under the new program. The HSA specifies certain enrollment procedures designed to provide for a broad range of intake sites for the new program, but leaves many of the details up to the Secretary. It specifies that:

- The Secretary shall establish procedures to enroll children.
- Essential community providers will serve as enrollment sites.
- Enrollment forms must make enrollment as simple as possible.
- Qualified children already enrolled in a health plan are deemed to be enrolled in the wraparound program.

In general, the enrollment procedures developed will stem directly from whatever administration structure is chosen for the new program. However, certain issues will need to be addressed regardless of the administration.

First, the role of essential community providers needs to be defined. Using essential community providers as enrollment sites is presumably intended to reach children that are not otherwise attached to the health care system. However, since all qualified children enrolled in health plans will automatically be deemed to meet the enrollment requirements for the wraparound program, only a few children, if any, will need to be enrolled separately. Additionally, the bill does not specify whether the Secretary is precluded from designating other providers as enrollment sites in addition to essential

community providers, and whether all essential community providers must serve as enrollment sites or if they can choose not to participate.

Second, how will an eligible child become an enrolled child? What procedures are necessary to sign a qualified child up for the wraparound program? Will the child get a separate card signifying eligibility for wraparound services, or will the Medicaid or health security care be used?

Other enrollment issues are specific to whether the States or the plans will be administering the program.

- **State administered**

States Medicaid agencies have experience from Medicaid and EPSDT in doing outreach to eligible populations and performing eligibility determinations. Other State agencies might have to establish new procedures to take over these tasks.

Cash eligible children will be identified by the welfare agencies, but States will need to be able to track down eligible non-cash children who are no longer receiving Medicaid. Since all qualified children enrolled in an alliance heath plan are deemed to be enrolled in the wraparound program, the State entity would have to establish a mechanism to communicate with the plans to identify the children.

- **Alliance/plan administered**

Alliances may have the most difficulty identifying qualified children. Although they will be checking a family's income to determine eligibility for premium and cost-sharing discounts and questions to determine eligibility for wraparound could be added to this process, the definitions of poverty level and family income used for determining subsidies is different than the one used for de rmining Medicaid poverty-related eligibility.

ATTACHMENT A

Analysis of Various Entities' Strengths
Necessary to Administer Wraparound Program

SKILL	State Medicaid Agency	State Title V Agency	State part H of IDEA Agency	State LTC Agency	Other State entity (public or private)	Alliance Health Plans
Eligibility Determin.	X		X			
Enrollment	X	X				
Rate Setting	X					X
Claims Payment	X					X
Contracting	X					
Service Delivery		X	X			X
Financial Management	X					X
Managing a fixed budget						X

DRAFT 1/12/94

CHILDREN'S WRAP SERVICES

1. Physical therapy
2. Outpatient rehabilitation (P.T., O.T., Speech)
3. Hearing Aides
4. Clinic Services
5. Outpatient mental health and subtance abuse (clinic services and private practitioners)
6. Case Management
7. Dental, orthodontia
8. Non-emergency transportation

MEDICAID LONG TERM CARE SERVICES

1. Nursing facilities
2. Rehabilitation Therapies delivered in institutions (may require statutory or regulatory language. Issue - are these part the basic cost of the institution or separately billable services?)
3. Home Health
4. Ventilator dependent respiratory therapy (still need to clarify what is in alliance benefit)
5. ICF/MR
6. Community supported living arrangement

Services Still Needing Further Discussion

1. Inpatient mental health - likely Medicaid LTC
2. Over the Counter Drugs - not discussed
3. Durable Medical Equipment - A question has been raised as to whether or not DME needs to be in kids wrap. Further discussion is needed because it is not clear what medically necessary or appropriate DME is thought not to be covered by the alliance.

Eligibility Alternatives

Population estimates and cost estimates for the following alternatives for wraparound eligibility:

- Include all children with income below 150 percent of poverty (the eligibility limit for premium discounts) in the wraparound program. Costs for additional children would be fully Federal.

- Eliminate the "grandfather" provision for children currently covered by Medicaid through the 1902(r)(2) methodology; include infants up to 185 percent of poverty for all States; follow current law for additional groups (i.e., medically needy, cash recipients, 133 percent of poverty under 6, 100 percent of poverty if born after September 30, 1983). Costs for additional infants would be fully federal (note: this hits states who have lifted eligibility under current option), State MOE would not include kids covered through 1902(r)(2) who do not qualify under other categories.

February 4, 1994

Note to Barbara Cooper
Bob Valdez
Rick Kronick
Sally Richardson

Subject: Children's Wraparound Program

Attached are a series of Q&As designed to explain the children's wraparound program, whose covered, what's covered, and the most likely approach for administering this benefit. This package is being shared with HCFA, ASPE, PHS, and White House staff concurrently. This has not been sent forward yet for our "principals" sign-off. I war+ all comments early next week and then we can get a package ready for sign-off.

Don Johnson

cc: Lisa Simpson
Julia Paradise
Ruth Katz
Sharman Stephans
Karen Davenport

Qs&As
Children's Wraparound

Q: Why does the wraparound program exist?

Q: What services will be covered?

Q: Who is eligible to receive wraparound benefits?

Q: If these services are so important, why do you restrict eligibility to children now on Medicaid?

Q: Why aren't these services included in the basic benefit package?

Q: How will this new program be administered?

Q: What if a State wants to run the program?

Q: Who is responsible for quality assurance?

Q: Who is financially responsible if program funding is insufficient?

Q: Would requiring plans to assume risk for wraparound services increase the general premium rates if capitated payments are insufficient?

Q: Why does the wraparound program exist?

A: The goals of the children's wraparound program established by the HSA are:

-- to ensure that all current Medicaid children are no worse off under the HSA than they were under the current Medicaid program;

-- to provide all medically necessary services to these children without forcing States to expand their financial responsibilities; and

-- to fulfill the broad mandates for treatment services enacted under EPSDT and IDEA.

Q: What services will be covered?

A: Wraparound services are defined in the HSA as medically necessary services currently covered by Medicaid that are neither alliance-covered services nor Medicaid long term care services.

We have not developed a definitive list of wraparound services. We anticipate that most wrap services will be those that are specifically limited in the alliance benefit, such as rehabilitation therapies and mental illness, and enabling services, such as non-emergency transportation and hearing aids, that are not included or are specifically excluded from coverage.

Q: Who is eligible to receive wraparound benefits?

A: Children who are currently eligible to receive Medicaid will be eligible for the children's wraparound program. (Do we want the song and dance about adults?)

Background

The HSA follows current Medicaid eligibility rules for wraparound eligibility. Because current law includes some state options (i.e., infants between 133 and 185 percent of poverty, eligibility expansions through State Plan Amendments under 1902(r)(2)), eligibility will vary by State. We are currently looking at options for "smoothing" this variation.

Q: If these services are so important, why do you restrict eligibility to children now on Medicaid?

A: The benefit package is based on insurance products in the current market, and incorporates some of the limitations common to these policies. Medicaid, however, does not have similar limitations. We were concerned that the most vulnerable children -- children who, because their income is so low, cannot afford to pay for additional services -- would lose out when they enroll in mainstream health plans and are subject to "mainstream" benefit restrictions.

Q: Why aren't these services included in the basic benefit package?

A: The alliance benefit is designed to be cover acute care services, with some post-acute services. It is not designed to be a chronic benefit. Some children will have chronic needs for some alliance-covered services, such as rehabilitation therapies. The wraparound program will pick up these services where the alliance package leaves off.

Q: Who is responsible for running the children's wraparound program?

A: Instead of specifying the wraparound program's administrative structure, the HSA directs the Secretary to develop the program's design. However, the Administration has been considering how this program could best be implemented.

Two principle options have been outlined for administering the children's wraparound program:

-- capitated Federal payments to health plans, with plans responsible for delivering wraparound services; and

-- State administration, similar to the current Medicaid program.

The first option is preferred in order to simplify service delivery and minimize system fragmentation.

Again, the HSA does not specify program administration. However, if Congress wishes to be more prescriptive, the Administration will work with them to develop an explicit strategy consistent with the goals of this program.

Q: What if a State wants to run the children's wraparound program?

A: While the preferred option is to administer the children's wraparound program through add-on capitated payments to health plans, other options are also being considered.

One option would be to run wraparound through State Medicaid agencies -- the program would be similar to today's Medicaid program, except that Federal matching would be 100 percent.

A more flexible alternative would be to allocate wraparound dollars to the States; States could then choose whether they want to make payments to health plans, run wraparound through the State Medicaid agency, or use an alternative approach.

Q: If children's wraparound services are provided through health plans, how will they be held accountable for quality of care and appropriate access to services?

A: Under this model, wraparound services would be part of the continuum of services available through health plans. Because States will be responsible for quality assurance monitoring for alliance services delivered by health plans, States are also the appropriate entities to enforce quality and access standards for wraparound services.

Because wraparound is a Federal program, with 100 percent Federal dollars, we envision that broad quality standards would also be appropriate.

Q: If program funding is insufficient, who will be financially responsible for additional wrap services? Will plans be required to finance any uncovered services under this model?

A: This model requires plans to assume financial risk for delivering wraparound services. Plans will therefore have the incentive to coordinate these services with alliance-covered benefits in an effective and efficient manner.

Background

Since the spending cap on wrap services is based on historic spending, rather than the actuarial value of covered services, funding may well be too low. We have not analyzed the impact that under-funded capitated wrap payments may have on overall premiums.