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# Optional Purchasing Specifications for Child Development Services in Medicaid Managed Care

George Washington University Medical Center, Center for Health Services Research and Policy

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**OPTIONAL PURCHASING SPECIFICATIONS FOR  
CHILD DEVELOPMENT SERVICES IN  
MEDICAID MANAGED CARE**

**(July 2000)**

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*These sample purchasing specifications were prepared by the George Washington University Center for Health Services Research and Policy (CHSRP) with support from the Commonwealth Fund. Technical guidance on the content of child development services was provided by experts from the Fund and researchers at Northwestern University's Institute for Health Services Research & Policy Studies (IHSRPS). This document is intended as a tool to assist interested state officials in purchasing child development services from managed care organizations (MCOs) on behalf of children under age three who are eligible for Medicaid.*

***These sample purchasing specifications are optional, and do not necessarily reflect the views of the Commonwealth Fund or the Health Care Financing Administration (HCFA).***

*These child development specifications are a work in process. The knowledge base relating to child development services is still evolving. Many of the concepts reflected in these specifications reflect the "cutting edge" of pediatric practice with respect to children under age 3 who do not have special health care needs. As further research and field experience with the provision of child development services in Medicaid MCOs become available through the Fund's or other initiatives, these purchasing specifications will be updated accordingly.*

**Background**

***Child Development Services.*** *There is no universal definition of child development services. Different state purchasers define these services differently. As used in these purchasing specifications, child development services are a set of four interrelated benefits for all children during the first 2 years of life: (1) screening and*

developmental assessment; (2) health promotion; (3) developmental interventions; and (4) care coordination. This concept of child development services, which draws upon the work of Neal Halfon, M.D., M.P.H., UCLA School of Medicine and Health for The Commonwealth Fund, is designed to address cognitive, emotional, and physical development in children without special health care needs as well as those with such needs.<sup>1</sup>

**The ABCD Program.**<sup>2</sup> The Assuring Better Child Health and Development (ABCD) program is an initiative of The Commonwealth Fund to improve the delivery and financing of child development services for young children in low-income families. The major goals of the program include: (1) identifying innovative state programs that promote the healthy development of low-income children; (2) analyzing financial incentives and quality standards for the provision of cost-effective pediatric developmental services; and (3) encouraging Medicaid and other state and local programs to implement improvements in the delivery and financing of developmental services for young low-income children.

*In a February 2000 Issue Brief, the Commonwealth Fund found that:*

*"Medicaid managed care offers additional, specific opportunities. States could work collaboratively with plans to improve care, using their power as purchasers to ensure that important services are properly provided. These options may include:*

- *Using specifications in contract language to communicate policies on pediatric development services to managed care plans;*
- *Encouraging agreements between plans and public health agencies to ensure proper delivery of services;*
- *Making additional payments to MCOs to cover incremental costs associated with specific child development services, and enhancing capitation rates for those plans and pediatricians that provide more comprehensive child development services; and*
- *Enhancing capitation payments for primary care clinicians.*"<sup>3</sup>

*These sample child development specifications are intended to facilitate the inclusion of pediatric developmental services into the contracts that state Medicaid agencies use to purchase coverage for low-income children through managed care plans. Further information about the ABCD program is available at [www.cmf.org](http://www.cmf.org).*

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<sup>1</sup> For a full discussion, see Budetti, et al., "Assuring the Healthy Development of Young Children: Opportunities for States," *Issue Brief*, The Commonwealth Fund (February 2000).

<sup>2</sup> See Collins et al., "Improving the Delivery and Financing of Developmental Services for Low-Income Young Children," *Issue Brief*, The Commonwealth Fund (November 1998).

<sup>3</sup> See Budetti, et al., "Assuring the Healthy Development of Young Children: Opportunities for States," *Issue Brief*, The Commonwealth Fund (February 2000).

*The Commonwealth Fund is also sponsoring a 3-year initiative to provide grants to states to develop or expand service delivery and financing strategies to enhance healthy child development for low-income children and their families. The initiative is taking place in 4 states (North Carolina, Utah, Vermont, and Washington); it is administered by the National Academy for State Health Policy.<sup>4</sup>*

**Healthy Steps.** *The ABCD program draws upon the ongoing work of the Healthy Steps for Young Children program, a national initiative of The Commonwealth Fund, co-sponsored with the American Academy of Pediatrics. The purpose of Healthy Steps is to test a new approach to the delivery of pediatric services that provides parents and practitioners information about the intellectual, emotional, and social development that takes place during the first 3 years of life. The Healthy Steps approach is being tested in 24 pediatric and family practice sites across the country, 15 of which are part of a national evaluation. The sites are coordinated and supported by the Commonwealth Fund, as well as community-based foundations and local health care providers. Further information is available at [www.healthysteps.org](http://www.healthysteps.org).*

**Medicaid.** *Medicaid is the federal-state entitlement program that insures over 20 million low-income children up to age 21. Although there are over 30 statutory and regulatory Medicaid benefits categories, there is none labeled "child development services." As discussed below, Medicaid covers a range of health care services that overlap with the child development services set forth in these specifications. However, these specifications have not been approved by HCFA, and there is no guarantee that federal Medicaid matching funds are available for the costs of any particular child development service set forth in this document. Purchasers interested in an authoritative opinion as to whether federal matching funds are available will need to contact HCFA.*

*The primary benefit through which Medicaid finances services for low-income children under age 3 is the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit, to which every child eligible for Medicaid is entitled. The EPSDT benefit has 3 main elements: (1) screening services; (2) follow-up diagnostic and treatment services; and (3) outreach and informing services. Screening services, which include a comprehensive health and developmental history, as well as health education, must be provided to all eligible children at periodic intervals specified by each state. EPSDT services can be paid for on a fee-for-service basis or as part of a capitation payment to a managed care organization (MCO); the focus of these specifications is on the provision of child development services through an MCO.*

*Current HCFA administrative guidance relating to EPSDT does not speak specifically to "child development services for children under 3." While there is considerable overlap between EPSDT services for children under 3 and child*

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<sup>4</sup> For further information, see Curtis and Pelletier, NASHP, *Building State Medicaid Capacity to Provide Child Development Services: An Overview of the Initiative* (March 2000), <http://www.nashp.org/progs/prog0011.htm>.

*development services for this age cohort, the final determination as to whether federal Medicaid matching funds are allowable (through EPSDT or otherwise) for a particular child development service is made by HCFA. This document has been shared with HCFA, but HCFA has not approved or endorsed its contents. As a general rule, if an item or service falls into a statutory or regulatory Medicaid benefit category (such as EPSDT services or physician services), and if that service category is covered under a State's Medicaid Plan, federal matching funds will be available for that item or service in that State. For a detailed discussion of the relationship between child development services and EPSDT, see Perkins and Olson, National Health Law Program, Medicaid Early and Periodic Screening, Diagnosis and Treatment as a Source of Funding Early Developmental Services (forthcoming), The Commonwealth Fund.*

*These purchasing specifications are designed to enable interested states that enroll Medicaid-eligible children into managed care organizations (MCOs) for some or all EPSDT services to describe MCO duties with respect to child development services. Some states have already begun to address these issues in their Medicaid MCO contracts. For example, South Carolina's Medicaid program, in its 1997 HMO contract, included an Appendix of examples of "best practices" for contractors for use in designing their service delivery package; the State also included in its rate calculations the costs of these "best practices." Among the "best practices" was "BabyNet," South Carolina's single point of entry for children under age 3 into a system of coordinated early intervention services.*

### ***Process for Developing this Technical Assistance Document***

*Since 1995, CHSRP has conducted an intensive examination of contracts between state Medicaid agencies and MCOs. This analytic work has produced three editions of a comprehensive study of contract provisions. The most recent version is the five-volume document, Rosenbaum, et al., Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (3<sup>rd</sup> Ed. 1999), [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp). The study breaks down the contracts into a series of analytic tables. While there is no table specific to child development services, there are tables that address services generally (Table 2.1) and EPSDT in particular (Table 2.4).*

*Negotiating the New Health System is a part of a broader analytic studies and technical assistance project on managed care contracts financed by numerous funders, including the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the David and Lucile Packard Foundation, and The Commonwealth Fund. Original funding for this project was supported by the Pew Charitable Trusts and the Annie E. Casey Foundation. The development of optional specifications for purchasing managed care products constitutes one component under this project.*

*The process for developing these particular specifications began with guidance from research conducted for The Commonwealth Fund by child health researchers at*

*UCLA and Northwestern University. Drafts of these specifications were reviewed by a working group from The Commonwealth Fund and Northwestern University and through a series of vetting meetings involving state Medicaid and public health officials, providers, MCO representatives, consumers and child development experts. The changes suggested at these vetting meetings have been incorporated into the specifications and have been reviewed by representatives from these meetings. The specifications are also available at [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp).*

### ***Organization and Structure of this Technical Assistance Document***

*The illustrative language in this document specifies a child development services benefit. It is not intended to be used as a stand-alone contract. Instead, it is designed to be incorporated by interested state purchasers into the broader benefits provisions of their contracts with Medicaid MCOs. It is also designed to supplement the more general specifications developed by CHSRP for the purchase of pediatric health services from MCOs by state Medicaid agencies, [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp). In particular, the illustrative language in this document is intended to assist purchasers in articulating child development services for children under age 3 in the context of a basic Medicaid benefits package such as that set forth in Part 1 of CHSRP's general Medicaid pediatric specifications.<sup>5</sup>*

*The specifications for child development services in this document focus on the benefit itself. For illustrative language on such related issues as enrollment, provider networks, and quality improvement, interested purchasers should refer to the CHSRP general pediatric specifications. Specific cross-references within this document to the general pediatric specifications are cited as "MEDICAIDSPECS".*

*The illustrative language in this document is drafted to minimize ambiguity and maximize clarity. In its summary of a June, 1999 symposium on Medicaid managed care and children with special health care needs, the National Academy for State Health Policy reports that "MCO representatives caution states that they must be absolutely clear in the contract as to what the MCO's responsibilities are and that they cannot hold MCOs accountable for what is not in the contract."<sup>6</sup> The more clearly an MCO understands what is expected of it by the purchaser, and the more clearly a purchaser understands what the MCO is obligating itself to provide, the more likely it is that any agreement between the two parties will be carried out to the mutual satisfaction of each and to the benefit of the enrolled children.*

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<sup>5</sup> The general Medicaid pediatric specifications consist of an Overview of Contractor's Duties and a series of accompanying Parts, which elaborate on issues generic to all children, ranging from benefits to provider network to data collection and reporting. CHSRP has also developed parallel sample specifications for the purchase of State Children's Health Insurance Program (SCHIP) coverage.

<sup>6</sup> D. Curtis, N. Kaye, and T. Riley, *Transitioning to Medicaid Managed Care: Children with Special Health Care Needs* (October 1999), National Academy for State Health Policy, p. 35, [www.nashp.org](http://www.nashp.org).

*One exception to the specificity of the illustrative language concerns procedural time frames. In many cases, such timeframes are not specified; instead, a bracket ([ ]) is supplied as a placeholder, indicating that the state purchaser should insert a timeframe of its choosing.*

*In addition to the illustrative language, this document contains sample contract compliance measures. CHSRP's reviews of state Medicaid contracts with MCOs "have consistently observed an absence of clear and articulated measures for reviewing the extent to which contractors are in compliance with performance specifications, as well as a failure to specify the data that contractors will be expected to submit to demonstrate their compliance." Rosenbaum et al., Negotiating the New Health System, Special Report: Mental Illness and Addiction Disorder Treatment and Prevention, GW Center for Health Policy Research, March 1998, p.56. The compliance measures in these purchasing specifications have been drafted to assist interested purchasers in specifying data and articulating measures for reviewing the extent of compliance by contractors with their duties under the purchasing agreement.*

### ***How to Use this Technical Assistance Document***

*The drafting format used in these sample specifications is as follows:*

- *The specifications are divided into sections, identified by "§".*
- *Each section, in turn, is divided into one or more subsections: "(a)", "(b)", etc.*
- *A subsection may be divided into one or more paragraphs: "(1)", "(2)", etc.*
- *A paragraph may be divided into one or more subparagraphs: "(A)", "(B)", etc.*
- *A subparagraph may be divided into one or more clauses: "(i)", "(ii)", etc.*

*Every state purchaser has its own drafting format. The particular format used in these sample specifications is NOT intended as a substitute for each state's own format. Instead, this division and subdivision format is designed to enable a user of this document to identify quickly the policy choices contained in each provision and to identify which, if any, of the elements the user wishes to adopt. This format also serves as a checklist for those users who wish to compare portions of their current purchasing documents with the relevant portions of these sample specifications.*

*For example, assume that a state purchaser currently uses the following language relating to developmental/interperiodic screening in specifying a contracting Medicaid MCO's duties with respect to EPSDT services:*

“D. Members under the age of 21 years will be scheduled for periodic health assessments in accordance with the periodicity schedule recommended by the American Academy of Pediatrics...”

*Assume that this purchaser is interested in clarifying that, as part of their obligation to furnish EPSDT services to enrolled children under age 3, contracting Medicaid MCOs must conduct a developmental screen using a specified developmental assessment tool. The sample specifications at §102(a) suggest the following language (this particular draft assumes that the purchaser has selected, from among the standardized validation development screening tests listed in §102(a)(2), the Ages and Stages Questionnaire):*

“(a) **Developmental Screen** — A developmental screen is:

(1) an assessment, at every well-child visit beginning at age [ ] months, through the taking of a patient history and the conduct of a physical examination by or under the supervision of a licensed health professional (as defined in §108(d)); and

(2) the administration, by or under the supervision of a licensed health professional (as defined in §108(d)):

(A) of the *Ages and Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System* (2<sup>nd</sup> Ed.) (1995)...”

*The purchaser could then adapt this sample specification to its own drafting format as follows (suggested language in italics):*

“D. Members under the age of 21 years will be scheduled for periodic health assessments in accordance with the periodicity schedule recommended by the American Academy of Pediatrics.

*D.1. Members under age of 3 years will have an assessment at every well-child visit beginning at age [drafter insert desired months], through the taking of a patient history, the conduct of a physical examination, and the administration, by or under the supervision of a licensed health professional, of the Ages and Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System (2<sup>nd</sup> Ed.) (1995).*

### ***Related CHSRP Activities***

*As discussed above, CHSRP has developed optional specifications for the purchase of Medicaid services from MCOs on behalf of all Medicaid-eligible children. In addition, CHSRP is developing a number of sample purchasing specifications that*

*overlap with this document (see below). Each set of specifications is (or will be) posted on CHSRP's website, [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp):*

- *children with special health care needs;*
- *children with behavioral health needs;*
- *children in foster care;*
- *pediatric dental care (March 200);*
- *prevention of lead poisoning (November 1998);*
- *immunizations (May 1998);*
- *individuals who are homeless (June 2000);*
- *access standards (June 2000);*
- *cultural competence standards;*
- *memoranda of understanding between MCOs and public health agencies;*  
*and*
- *data and information collection and reporting.*

**OPTIONAL PURCHASING SPECIFICATIONS FOR  
CHILD DEVELOPMENT SERVICES IN MEDICAID MANAGED CARE**

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## §101. In General

*Commentary: The following illustrative language would impose a duty on contracting MCOs to provide (or arrange for the provision of) child development services to children under age 3. This package of services is divided into four elements: screening assessment, developmental health promotion, general developmental interventions, and care coordination. Purchasers interested in ensuring that the MCOs with which they contract provide the full panoply of child development services to all enrolled children under age 3 will need to specify all four elements. However, these specifications are also drafted so as to enable Purchasers interested in covering only a portion of child development services to select out the appropriate language. Purchasers may also elect to limit whatever child development services they wish to cover to a smaller class of enrollees -- e.g., children under age 2, or infants under age 1.*

*As discussed in the Introduction at pages 3-4, under current law all Medicaid-eligible children under age 3 are entitled to EPSDT services. This broad cluster of services includes (1) screening services; (2) follow-up diagnostic and treatment services; and (3) outreach and informing services. Neither the federal Medicaid statute nor current HCFA administrative guidance speak directly to child development services generally, or to any of the four elements of child development services discussed above. As a result, it is not possible to state with certainty that the services set forth in the illustrative language below would in each case qualify for Federal Medicaid matching payments. That determination is the responsibility of HCFA. This document has been shared with HCFA, but HCFA has not approved or endorsed its contents. As a general rule, if an item or service falls into a statutory or regulatory Medicaid benefit category (such as EPSDT services or physician services), and if that service category is covered under a State's Medicaid Plan, federal matching funds will be available for that item or service in that State.*

*Note that the following illustrative language is not intended to implement the entire EPSDT benefit. Instead, it is intended to detail child development services that could be provided in the context of EPSDT or otherwise to Medicaid-eligible children. If a purchaser elects to contract with an MCO for the delivery of EPSDT services, additional language to that offered below will be required. For illustrative language implementing EPSDT coverage, see §102 of CHSRP, Optional Purchasing Specifications: Medicaid Managed Care for Pediatric Services (September 1999), [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp). (hereinafter referred to as "MEDICAIDSPECS").*

**(a) Contractor Duties To Each Enrolled Child Under Age 3** — Contractor shall, for each enrolled child under age 3, cover and furnish, or arrange for the furnishing of, the following child development services:

- (1) screening assessment services described in §102;

- (2) developmental health promotion services described in **§103**;
- (3) general developmental interventions described in **§104**; and
- (4) care coordination services described in **§105**.

(b) **Guidelines and Training** — In carrying out its duties to an enrolled child under subsection (a), Contractor shall ensure that the services are furnished in accordance with:

- (1) the guidelines enumerated in **§106(a)**;
- (2) the training requirement under **§106(b)**; and
- (3) coverage determination standards enumerated in **§107**.

(c) **Family Participation Requirements**<sup>7</sup> — In carrying its duties to an enrolled child under subsection (a), Contractor, and each provider participating in Contractor's provider network, shall facilitate the participation of the family or caregiver of an enrolled child in the furnishing of child development services.

(d) **Written Agreements with Providers** — Consistent with **§501(b)** of Part 5 of MEDICAIDSPECS, Contractor shall enter into and maintain an enforceable written agreement with each provider participating in Contractor's provider network who furnishes items and services to enrolled children under age 3 that sets forth the provider's duties with respect to:

- (1) implementation of Contractor's duties to furnish child development services under subsection (a);
- (2) furnishing of child development services in accordance with guidelines and protocols specified under subsection (b)(1); and
- (3) facilitation of family participation under subsection (c) in the furnishing of child development services.

*Commentary: The illustrative language in these specifications focuses on the elements of child development services. Language regarding other related policies and procedures may be found in MEDICAIDSPECS, [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp).*

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<sup>7</sup>For more extensive language on family participation requirements applicable to all enrolled children under age 21, see GW CHSRP's *Optional Purchasing Specifications: Medicaid Managed Care for Children with Special Health Care Needs* (forthcoming) and *Optional Purchasing Specifications: Medicaid Managed Care for Children with Behavioral Health Needs* (forthcoming).

(e) **Other Contractor Duties** — The duties described in Part 2 through Part 14 of MEDICAIDSPECS shall apply to Contractor with respect to the furnishing of child development services under subsection (a).

**§102. Screening Assessment Services** — Screening assessment services are the services described in subsections (a) through (c).

*Commentary: The following illustrative language would require the administration of an instrument in connection with a developmental screen. Purchasers should note that many of the screening instruments listed below (from which a single instrument is to be selected) are proprietary and may involve acquisition costs. Purchasers will need to determine how these costs will be distributed among Purchaser, the contracting MCO, and the primary care providers administering the instruments. If the cost is to be borne by the administering providers, Purchasers will need to ensure the adequacy of reimbursement by the contracting MCO to the providers to avoid any disincentive for providers to use the specified instrument.*

(a) **Developmental Screen** — A developmental screen is:

(1) an assessment, at every well-child visit beginning at age [ ] months,<sup>8</sup> through the taking of a patient history and the conduct of a physical examination by or under the supervision of a licensed health professional (as defined in **§108(d)**); and

(2) the administration, by or under the supervision of a licensed health professional (as defined in **§108(d)**): [*drafter insert one of following standardized validation development screening tests, which are listed in alphabetical order*]

(A) of the *Ages and Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System* (2<sup>nd</sup> Ed.) (1995);<sup>9</sup>

(B) at age [ ] months and [ ] months, of the *Bayley Infant Neurodevelopmental Screen (BINS)* (1995);<sup>10</sup>

<sup>8</sup> The AAP's Committee on Children with Disabilities recommends the administration of a standardized assessment at each well-child visit. Most screening measures do not begin until age 3-4 months. See Committee on Children with Disabilities, "Screening Infants and Young Children for Developmental Disabilities," *Pediatrics* (1994) 93: 863-865, [www.pediatrics.org](http://www.pediatrics.org).

<sup>9</sup> There are 19 ASQ questionnaires designed to be administered at well-child visits at ages 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months. Only the first 15 questionnaires would be applicable to a population under age 3. Each form has 35 "yes-sometimes-not yet" questions to parents, is available in English, Spanish, and French, and takes about 7 minutes to administer. Available from Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285 (800-638-3775), [www.pbrookes.com](http://www.pbrookes.com).

<sup>10</sup> BINS is one form (in English only) of 10-13 items per each 3 to 6 month age interval for children age 3 months to 2 years. BINS uses direct measurement of children's skills to assess reflexes and tone,

(C) at age [ ] months, of the *Brigance Screens (1996)*;<sup>11</sup>

(D) at age [ ] months and [ ] months, *Child Development Inventories (CDI) (1992)*;<sup>12</sup>

(E) at age [ ] months, of the *Denver II Developmental Screening Test*;<sup>13</sup>

(F) at age [ ] months, of the *Nursing Child Assessment Satellite Training (NCAST) (1994)*;<sup>14</sup>

(G) at age [ ] months, *Parents' Evaluations of Developmental Status (PEDS)(1997)*;<sup>15</sup>

(H) of the [drafter insert reference to other standardized and validated assessment tools approved by Purchaser].

#### (b) Family Psychosocial Screen

(1) **Defined** — A family psychosocial screen is: [drafter insert one of following standardized validation development screening tests]

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movement and symmetry, and developmental skills. Administration requires 10 to 15 minutes. Available from: The Psychological Corporation, 555 Academic Court, San Antonio, TX 78204 (800-228-0752), [www.psychcorp.com](http://www.psychcorp.com).

<sup>11</sup> The Brigance Screens consist of 6 forms, one for each 12-month age range, for children 21 to 84 months of age. They are available in English, Spanish, and other languages. Administration takes 10 to 15 minutes. These Screens elicit skills from children in all developmental areas. Brigance Screens for children 0 to 21 months of age will be available in 2001. Available from: Curriculum Associates, Inc., 153 Rangeway Road, P.O. Box 2001, North Billerika, MA 01862. (800-225-0248), [www.curriculumassociates.com](http://www.curriculumassociates.com).

<sup>12</sup> The Child Development Inventories (CDIs) use 3 forms, one for 0-18 months, one for 18-36 months, and one for 36-72 months, containing 60 "yes-no" questions to parents in English only. Administration takes 10 minutes. Available from: Behavior Science Systems, P. O. Box 580274, Minneapolis, MN 55458 (612-929-6220).

<sup>13</sup> Available from: Denver Developmental Materials, Inc., P.O. Box 6919, Denver, CO 80206-0919 (800-419-4729). There is a debate within the pediatric community relating to this instrument. See Glascoe et al., "The Accuracy of the Denver-II in Developmental Screening," *Pediatrics* (1992); 89: 1221-1225. For further information regarding developmental screening instruments, see AAP's Section on Developmental and Behavioral Pediatrics, [www.dbpeds.org/articles/dbtesting](http://www.dbpeds.org/articles/dbtesting).

<sup>14</sup> Available from: University of Washington School of Nursing, P.O. Box 357920, Seattle, WA 98195-7920 (206-543-8528).

<sup>15</sup> Parents' Evaluations of Developmental Status (PEDS) (1997) uses one form throughout the 0-8 year age range containing 10 questions to parents eliciting their concerns. A second longitudinal form is placed in the child's medical records to help providers track developmental/behavioral status, guidance, referrals, etc. Indicates when to refer, advise, or reassure, and when to monitor or screen more closely. Form is available in English or Spanish; administration requires 2 minutes. Available from: Ellsworth & Vandermeer Press Ltd., P.O. Box 68164, Nashville, TN 37260 (615-226-4460), [www.pedstest.com](http://www.pedstest.com).

(A) the administration, by or under the supervision of a licensed health professional (as defined in §108(d)) of an instrument described in paragraph (2);

(B) performed with the participation of the child's family or caregiver under paragraph (3); and

(C) conducted within the time frames described in paragraph (4).

(2) **Instrument** — An instrument for a family psychosocial screen is:

(A) the *Family Psychosocial Screen* (1996);<sup>16</sup>

(B) the *Center for Epidemiologic Studies – Depression* (CES-D);<sup>17</sup>  
or

(C) [drafter insert reference to other formal assessment tools approved by Purchaser].

(3) **Family Participation** — Consistent with §101(c), Contractor shall ensure that a family psychosocial screen described in this subsection is administered only with the knowledge and consent of the family or caregiver of the enrolled child.

(4) **Timeframes**

(A) **Newly Enrolled Child** — Contractor shall ensure that, in the case of a newborn enrolled child or other newly enrolled child under age 3, the family psychosocial screen described in this subsection is administered no later than the earlier of:

(i) the first encounter between the newborn enrolled child and a provider participating in Contractor's provider network (whether at a home visit under §103(c) or at a provider practice site); or

(ii) within [ ] months of the child's enrollment.

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<sup>16</sup> Ambulatory Child Health, 1996; 4:325-339. Also included in "Collaborating With Parents: Using Parents' Evaluations of Developmental Status To Detect and Address Developmental and Behavioral Problems," in *Parents' Evaluations of Developmental Status (PEDS) Manual* (August 1998), Ellsworth & Vandermeer Press, Ltd., Box 68164, Nashville, TN 37206 (615-226-4460), <http://www.pedstest.com/peds-frames.html>.

<sup>17</sup> J.G. Orme, J. Reis, and E.J. Herz. "Factorial and discriminant validity of the Center for Epidemiologic Studies Depression (CES-D) Scale." *Journal of Clinical Psychology* (1986); 42:28-33. Also included in PEDS Manual cited in footnote 16, <http://www.pedstest.com/peds-frames.html>.

**(B) Other Enrolled Children** — Contractor shall ensure that, in the case of an enrolled child under age 3 not described in subparagraph (A), the family psychosocial screen described in this subsection is administered whenever in the professional judgment of a provider participating in Contractor’s provider network a screen is warranted (consistent with the family participation requirements under paragraph (3)).

**(c) Construction** — Contractor shall not be construed to be out of compliance with the requirements of subsection (b) (relating to family psychosocial screen) with respect to an enrolled child if:

(1) a provider participating in Contractor’s provider network has made, and documented in the child’s medical record, reasonable efforts to inform the child’s family or caregiver of the importance of the family psychosocial screen to the child’s well-being; and

(2) after such reasonable efforts have been made, the child’s family or caregiver has decided not to consent to the administration of the family psychosocial screen.

**(d) Documentation** — Contractor shall ensure that an enrolled child’s primary care provider (as defined in §108(e)) documents, in the enrolled child’s medical record, the screening assessment services under this section furnished to the child.

**§103. Developmental Health Promotion Services** — Developmental health promotion services are the services described in subsections (a) through (c).

*Commentary: Under current law, all Medicaid-eligible children under 3 are entitled to EPSDT services, which includes a range of screening services. As discussed in the Introduction at pages 3-4, the current HCFA administrative guidance on the EPSDT benefit does not speak directly to child development services generally, or developmental health promotion services in particular. HCFA's administrative guidance does, however, specify health education as part of the periodic and interperiodic screening services that states must cover under EPSDT:*

*“Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental screening gives you the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident*

and disease prevention.” Health Care Financing Administration, *Medical Assistance Manual* §5123.2E,  
<http://www.hcfa.gov/pubforms/pub45pdf/smm5t.pdf>.

For illustrative language relating to anticipatory guidance, see §102(b)(1)(E) and §1401(b) of MEDICAIDSPECS, [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp).

*Commentary: The following illustrative language would require the administration of an instrument in connection with a developmental screen. Purchasers should note that many of the anticipatory guidance materials referenced in subsection (a) and behavioral screening instruments referenced in subsection (b) below are proprietary and may involve acquisition costs. Purchasers will need to determine how these costs will be distributed among Purchaser, the contracting MCO, and the primary care providers administering the materials and instruments. If the cost is to be borne by the administering providers, Purchasers will need to ensure the adequacy of reimbursement by the contracting MCO to the providers to avoid any disincentive for providers to use the specified materials or instrument.*

(a) **Anticipatory Guidance**<sup>18</sup> — Contractor shall ensure that, at each encounter between an enrolled child and the child’s primary care provider (as defined in §108(e)), the provider makes available, and upon request by the child’s family or caregiver, explains to the child’s family or caregiver: [*drafter insert one or more of following materials which are listed in alphabetical order*]

(1) the anticipatory guidance suggestions incorporated in *Bright Futures* under §106(a)(1);<sup>19</sup>

(2) the anticipatory guidance suggestions incorporated in *Guidelines for Health Supervision III* under §106(a)(2);<sup>20</sup>

(3) the *Healthy Steps LINKletters*<sup>21</sup> appropriate to the child’s age at the time of the encounter;

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<sup>18</sup>See Glascoe et al., "Brief Approaches to Educating Parents and Patients in Primary Care," *Pediatrics* (1998); [www.pediatrics.org/cgi/content/full/101/6/e10](http://www.pediatrics.org/cgi/content/full/101/6/e10). There are numerous websites offering information to parents on issues relating to child development, including: Nemours Foundation (<http://kidshealth.org/parent>); The National Parenting Center ([www.tnpc.com](http://www.tnpc.com)); and Parent Partners (<http://parentpartners.com>).

<sup>19</sup> Bright Futures has produced Anticipatory Guidance Cards. For more information on how to obtain this product, call (703) 356-1964 or see [www.brightfutures.org](http://www.brightfutures.org).

<sup>20</sup> AAP has produced parenting brochures covering such issues as violence, television, single-parenting, toilet-training, hospital stays, health and safety issue. See [www.aap.org/family/mnbroc.cfm](http://www.aap.org/family/mnbroc.cfm) for more information on child-care books, videos, hand-held health records, waiting room magazines and additional materials for parents.

<sup>21</sup> See [http://www.healthysteps.org/healthysteps/homepage.nsf/All/Link18mos.pdf/\\$file/Link18mos.pdf](http://www.healthysteps.org/healthysteps/homepage.nsf/All/Link18mos.pdf/$file/Link18mos.pdf).

(4) the *Healthy Steps Parent Handouts*<sup>22</sup> (1996) appropriate to the child's age at the time of the encounter;

(5) the *Injury Prevention Program (TIPP) Age-Related Safety Sheets*<sup>23</sup> appropriate to the child's age at the time of the encounter;

(6) the *Parents' Evaluations of Developmental Status (PEDS) Manual*<sup>24</sup> (August 1998); or

(7) [drafter insert other materials on anticipatory guidance approved by Purchaser].

(b) **Behavioral Assessment to Assist Parents** — A behavioral assessment to assist parents in understanding their child is the administration, performed by or under the supervision of a licensed health professional (as defined in §108(d)): [drafter insert one of following instruments which are listed in alphabetical order]

(1) at age [ ], of the *Behavioral Assessment of Baby's Emotional and Social Style (BABES)* (1994);<sup>25</sup>

(2) at age [ ], of the *Eyberg Child Behavior Inventory* (1999);<sup>26</sup>

(3) at age [ ], of the *Neonatal Behavioral Assessment Scale (NBAS)*;<sup>27</sup>

(4) at age [ ], of the *Temperament and Atypical Behavior Scale (TABS)*(1999);<sup>28</sup> or

(5) at age [ ], of [drafter insert reference to other standardized and validated assessment tools approved by Purchaser].

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<sup>22</sup> See <http://www.healthysteps.org/healthysteps/homedocuments.nsf/key/parenthandouts>.

<sup>23</sup> See [www.aap.org/family/tippintr.htm](http://www.aap.org/family/tippintr.htm).

<sup>24</sup> See <http://www.pedstest.com/peds-frames.html>.

<sup>25</sup> Available from: California School of Professional Psychology-LA, 1000 S. Fremont Ave., Alhambra, CA 91803 (818-284-2777, ext. 3030).

<sup>26</sup> The Eyberg Child Behavior Inventory is one form in English only of 36 questions to parents of children 2-16 years of age. Administration requires about 5 minutes. Available from: Psychological Assessment Resources, Inc. (PAR), P.O. Box 998, Odessa, FL 33556 (800-331-8378), [www.parinc.com](http://www.parinc.com). See also *Journal of Clinical Child Psychology*, (1980); 9:22-8.

<sup>27</sup> T. Barry Brazelton and J. Kevin Nugent. 3<sup>rd</sup> Edition. London: MacKeith Press, 1995.

<sup>28</sup> The Temperament and Atypical Behavior Scale (TABS) is one 15-item form in English only for the children aged 11-71 months. TABS uses parent report and requires 5 minutes to administer. Available from: Paul H. Brookes Publishers, P.O. Box 10624, Baltimore MD, 21285 (800-638-3775), [www.pbrookes.com](http://www.pbrookes.com).

(c) **Home Visit Services**<sup>29</sup>

*Commentary: The following illustrative language sets forth the full scope of home visit services for children under age 3 recommended for child development services. Interested Purchasers may wish to limit the populations to whom contracting MCOs would have a responsibility to provide home visits. The language below is drafted to enable Purchasers to target home visits on particular subpopulations, such as newborns or certain children at risk.*

(1) **In General** — Contractor shall comply with the home visit requirements under:

- (A) paragraph (2) (relating to newborns);
- (B) paragraph (3) (relating to newly enrolled children);
- (C) paragraph (4) (relating to children at risk); and
- (D) paragraph (5) (relating to children in need of follow-up).

(2) **Home Visit Services for Newborns**

(A) **Initial Home Visit** — In the case of a child whose mother is enrolled in Contractor at the time of the child's birth (whether or not the child is a pre-term or low-birthweight infant), Contractor shall ensure that, within [ ] days of birth, a trained home visitor (as described in paragraph (6)) conducts a home visit to:

- (i) administer the family psychosocial screen consistent with §102(b) to determine whether the enrolled child needs a follow-up home visit under subparagraph (B);
- (ii) educate the child's family or caregiver about child development and parenting skills; and
- (iii) identify risks of injury to the child, if any, observed during the course of the visit.

(B) **Follow-up Home Visit for Newborns** — Within [ ] days of a determination under subparagraph (A) or otherwise that a newborn needs a follow-up home visit, Contractor shall furnish a

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<sup>29</sup>For additional information on evaluations and analyses of home visiting programs, see "Home Visiting: Recent Program Evaluations" in *The Future of Children*, Vol. 9, No. 1 (Spring/Summer 1999), [www.futureofchildren.org](http://www.futureofchildren.org).

visit to the child's home by a trained home visitor (as described in paragraph (6)) for the purpose of:

(i) educating the child's family and caregiver about child development and parenting skills; and

(ii) assessing the needs of the child and the child's family or caregiver for:

(I) behavioral health (including substance abuse) treatment or referrals;

(II) more stable housing arrangements;

(III) protection from domestic violence or abuse or neglect; and

(IV) care coordination services under §105.

**(3) Home Visit Services for Newly Enrolled Children Under Age 3** — In the case of a child under age 3 who is newly enrolled, Contractor shall ensure that, within [ ] days of Contractor's receipt of notice of the child's enrollment, a trained home visitor (as described in paragraph (6)) conducts a home visit in order to:

(A) administer, consistent with §102(b), the family psychosocial screen to determine whether the enrolled child is at risk for purposes of paragraph (4);

(B) educate the child's family or caregiver about child development and parenting skills; and

(C) identify risks of injury to the child, if any, observed during the course of the visit.

**(4) Home Visits for Enrolled Children at Risk**

*Commentary: The following illustrative language sets forth a broad definition of an enrolled child at risk for purposes of triggering a duty on the part of a contracting MCO to provide a home visit. Interested Purchasers seeking to limit the scope of this duty may wish to select from among the categories listed in subparagraph (B).*

(A) **Home Visit** — Within [ ] days of a determination (under paragraph (2) or otherwise) that an enrolled child is at risk (as described in subparagraph (B)), Contractor shall furnish a visit to

the child's home by a trained home visitor (as described in paragraph (6)) for the purpose of:

(i) assessing the needs of the child and the child's family or caregiver for:

(I) behavioral health (including substance abuse) treatment or referrals;

(II) more stable housing arrangements;

(III) protection from domestic violence or abuse or neglect; and

(IV) care coordination services under §105; and

(ii) educating the child's family or caregiver about child development or parenting skills specific to the child's risk factors.

**(B) Enrolled Child At Risk** — An enrolled child is at risk if:

(i) in the professional judgment of the child's primary care provider (as defined in §108(e)), the circumstances of the child's family or caregiver are such that the child is at risk;

(ii) the child's mother is an adolescent;

(iii) the child's family or caregiver has a mental health condition;

(iv) the child's family or caregiver has a cognitive impairment or developmental disability;<sup>30</sup>

(v) the child's family or caregiver has a history of, or is currently engaged in, substance abuse;

(vi) the child's family or caregiver has a history of, or is currently engaged in, domestic violence;

(vii) the child has a chronic illness or a mental health condition;

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<sup>30</sup>HCFA's Key Approaches to the Use of Managed Care Systems for Persons with Special Health Care Needs (October 1998), [www.hcfa.gov/medicaid/smd-snpf.htm](http://www.hcfa.gov/medicaid/smd-snpf.htm), provides that states should consider that "[c]ommunications with MCO enrollees must be consistent with the ADA prohibition on unnecessary inquiries into the existence of a disability."

(viii) the child is at risk for, or is a victim of, abuse or neglect;

(ix) the child has not resided in the same dwelling for at least [ ] consecutive months;<sup>31</sup>

(x) the child is at least [ ] months old, but at birth was a pre-term or low-birthweight infant; or

*Commentary: The following category would be necessary only if the Contract did not require home visits in the case of all newborns as per paragraph (2) above.*

(xi) the child is a pre-term or low-birthweight infant.

#### **(5) Enrolled Children in Need of Follow-up**

**(A) Duty** — In the case of an enrolled child determined to be in need of follow-up described in subparagraph (B), Contractor shall ensure that a trained home visitor (as described in paragraph (6)) conducts a visit to the child's home within [ ] days of the determination in order to:

(i) remind the child's family or caregiver of the child's scheduled appointments or medication schedules;

(ii) educate the child's family or caregiver about child development and parenting skills; and

(iii) identify risks of injury to the child, if any, observed during the course of the visit.

**(B) Enrolled Child in Need of Follow-up** — An enrolled child in need of follow-up is a child who is not a newborn described in paragraph (2), newly enrolled described in paragraph (3), or at risk described in paragraph (4), and who the child's primary care provider determines:

(i) repeatedly misses a scheduled appointment; or

(ii) is not complying with the medication regimen prescribed by the child's primary care provider.

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<sup>31</sup> For illustrative language relating to the identification of, and provision of services to, enrolled individuals who are homeless, see *Optional Purchasing Specifications: Medicaid Managed Care for Individuals Who are Homeless* (June 2000) on [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp).

(6) **Trained Home Visitor** — A trained home visitor is a nurse or nurse practitioner, an individual with a masters in social work or in early childhood education, a health educator, or a layperson who is adequately trained in the furnishing of home visitation services and is:

(A) an employee of Contractor;

(B) a provider participating in Contractor’s provider network; or

(C) an employee of a provider or a group or providers participating in Contractor’s provider network.

(7) **Referrals to Appropriate Public Authorities** — Contractor shall ensure that the trained home visitor conducting a home visit for a child at risk under paragraph (4) promptly complies with the requirements of [drafter insert reference to applicable state law] relating to reporting instances of child abuse or neglect observed by, or made known to, the professional during the home visit.

(d) **Documentation** — Contractor shall ensure that an enrolled child’s primary care provider (as defined in §108(e)) documents, in the enrolled child’s medical record, the developmental health promotion services specified under this section and furnished to the child.

**§104. General Developmental Interventions** — General developmental interventions are the items, services, and activities described in subsections (a) through (c).

(a) **Child Development Information Line**<sup>32</sup>

(1) **In General** — Contractor shall maintain [ ] hours per day, [ ] days per week a toll-free telephone line that meets the requirements of:

(A) the *Barton-Schmidt Pediatric Telephone Protocol*; or

(B) [drafter insert reference to other telephone protocol approved by Purchaser].<sup>33</sup>

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<sup>32</sup> An alternative option would be to require Contractor to ensure that each primary care provider participating in Contractor's provider network make available to the family or caregiver of an enrolled child under age 3 who is a patient of the provider the opportunity to obtain answers to questions relating to child development services by telephone during the provider's business hours.

<sup>33</sup> See [www.aap.org](http://www.aap.org). An alternative option would be Healthy Steps Telephone Information Line (October 1996), <http://www.healthysteps.org/healthysteps/homedocuments.nsf/key/telephoneinfo>.

(2) **Staffing** — Contractor shall ensure that the child development information line described in paragraph (1) is staffed during its hours of operation with a licensed health professional (as defined in §108(d)) who has expertise in child development.

(3) **Separate Line** — Contractor shall ensure that the child development information line described in paragraph (1) is not the same telephone line as the telephone line through which enrolled children and their families or caregivers may:

(A) request emergency or urgent care services;<sup>34</sup>

(B) schedule appointments for non-emergency, non-urgent services; or

(C) obtain information regarding prior authorization for payment and other inquiries relating to the operations of Contractor.

(b) **Child Health and Development Record** — Contractor shall make available to the family or caregiver of an enrolled child the American Academy of Pediatrics *Child Development Record*<sup>35</sup> at the earlier of:

(1) the birth of the child;

(2) the child's enrollment; or

(3) the first encounter between the child and a primary care provider.

(c) **Reading Readiness** — Contractor shall ensure that, at each well-child visit by an enrolled child to a provider participating in Contractor's provider network, the provider administers, or supervises a licensed health professional (as defined in §108(d)) in the administration of:

(1) the *Reach Out and Read Protocols*;<sup>36</sup> or

(2) [drafter insert reference to other reading protocols approved by Purchaser].

(d) **Documentation** — Contractor shall ensure that an enrolled child's primary care provider (as defined in §108(e)) documents, in the enrolled child's medical record, the interventions described in subsections (b) and (c) furnished to the child.

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<sup>34</sup> For illustrative language relating to a toll-free telephone line for emergency services, see §A2-5 of CHSRP's *Optional Purchasing Specifications: Access to Services* (June 2000), [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp).

<sup>35</sup> See [www.aap.org](http://www.aap.org). An alternative option would be a child health and development record developed by or for Contractor.

<sup>36</sup> See [www.reachoutandread.org](http://www.reachoutandread.org).

**§105. Care Coordination**<sup>37</sup> — Care coordination is the set of activities and services described in subsections (a) through (c).

*Commentary: Under current law, all Medicaid-eligible children under age 3 are entitled to EPSDT services, which includes case management. As discussed in the Introduction at pages 3-4, the current HCFA administrative guidance on the EPSDT benefit does not speak directly to child development services generally. It does, however, address case management. HCFA's State Medicaid Manual at §4302.2H notes that "Care coordination, including aspects of case management, has always been an integral component of the EPSDT program...." The State Medicaid Manual further explains that when case management services are found to be medically necessary, states have several options, the first of which is EPSDT: "Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist."<sup>38</sup> EPSDT case management services are matched at each state's regular matching rate for services (ranging from 50 to 80 percent), rather than at the administrative (50 percent) matching rate.*

*Under §1905(a)(19) of the Social Security Act, 42 U.S.C. §1396d(a)(19), States have the option of receiving federal Medicaid matching funds for the costs of case management services targeted at particular groups of Medicaid beneficiaries, such as children under age 3. The statute defines case management services as "services which will assist individuals eligible [for Medicaid] in gaining access to needed medical, social, educational, and other services." Using this authority, the State of Vermont has obtained HCFA approval of federal Medicaid matching funds for the cost of case management services to Medicaid-eligible children age 1 to 5 years who are at risk for unnecessary and avoidable medical interventions and who do not otherwise have a case manager. These include children who have "an observable and measurable delay in one or more of the following developmental areas: cognitive, physical (includes hearing and visual), communication, social or emotional and adaptive." Supplement 1 to Attachment 3.1-A, p. 15, Vermont State Plan under Title XIX of the Social Security Act (Approval date: 7/27/98).*

*For an extensive discussion of options for paying for case management services, see Rosenbaum and Sonosky, "Case Management as a Medicaid-covered Service," GW CHSRP Memorandum to ABCD Grantees (May 2000), forthcoming on [www.nashp.org](http://www.nashp.org).*

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<sup>37</sup> See also care coordination or case management sections of the following optional purchasing specifications available or under development from GW CHSRP, [www.gwu.edu/~chsrp](http://www.gwu.edu/~chsrp): *HIV/AIDS* (August 1999); *Children with Special Health Care Needs* (forthcoming); *Children with Behavioral Health Needs* (forthcoming); *Individuals Who Are Homeless* (June 2000); and *Access to Services* (June 2000).

<sup>38</sup> See <http://www.hcfa.gov/pubforms/pub45pdf/smm4t.htm>.

(a) **Notification** — Contractor shall ensure that, at the first encounter between an enrolled child under age 3 and a provider participating in Contractor’s provider network, the child’s family or caregiver is notified of the availability of:

- (1) the opportunity to request the assignment of a care coordinator under subsection (b); and
- (2) care coordination services under subsection (c).

(b) **Request for Assignment of Care Coordinator**

(1) **Request** — Contractor shall ensure that the family or caregiver of each enrolled child under age 3 has an opportunity to request the assignment of a care coordinator to furnish care coordination services under subsection (c).

(2) **Assignment of Care Coordinator** — In the case of a family or caregiver who has requested a care coordinator under paragraph (1), Contractor shall, within [ ] of the request, assign to the child and notify the family or caregiver of such assignment of a care coordinator (as defined in paragraph (4)).

(3) **Reassignment** — In the event that a family or caregiver is dissatisfied with the care coordinator assigned by Contractor to the enrolled child under paragraph (2), Contractor shall allow the family or caregiver to select a new care coordinator from among the care coordinators (as defined in paragraph (4)) participating in Contractor's provider network or employed by Contractor.

(4) **Care Coordinator Defined** — A care coordinator is an individual who has demonstrated experience and appropriate training in the coordination of medical and related services to children under age 3 and is one of the following:

- (A) a physician (including the primary care provider selected by the enrolled child's family or caregiver);
- (B) a registered nurse;
- (C) a social worker;
- (D) a family counselor;
- (E) a service coordinator assigned by an early intervention program under Part C of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. §1400 et seq.; or

(F) a health educator.

(c) **Care Coordination Services** — Care coordination services are services that will assist enrolled children in gaining access to needed medical, social, educational, and other services that are:

(1) identified through a screen under §102 as needed by the child or the child’s family or caregiver;

(2) covered under:

(A) §103 (relating to developmental health promotion services);

(B) §104 (relating to general developmental interventions); or

(C) other sections of [drafter insert name of purchasing document]; or

(3) available from [drafter insert reference to appropriate state or local agencies or programs, including Part C Agencies under the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. §1400 et seq.].<sup>39</sup>

## §106. Guidelines and Training

(a) **Guidelines**<sup>40</sup> — Contractor shall furnish, or arrange for the furnishing of, child development services under §101 to an enrolled child in a manner which is consistent with generally accepted principles of professional pediatric practice as reflected in the following guidelines:

(1) *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition (National Center for Education in Maternal and Child Health, 2000) [www.brightfutures.org](http://www.brightfutures.org);

(2) *Guidelines for Health Supervision III* (American Academy of Pediatrics, 1997) <http://www.aap.org/acb2/index.cfm?&DID=15>; or

(3) [drafter insert reference to periodicity schedule or child health guidelines required by State Medicaid Plan].

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<sup>39</sup>For additional information on each state’s Part C Programs, see National Early Childhood Technical Assistance Service at [www.nectas.unc.edu/contact/ptccoord.html](http://www.nectas.unc.edu/contact/ptccoord.html).

<sup>40</sup> For other guidelines, see §006(a)(1) of MEDICAIDSPECS.

*Commentary: The following illustrative language assumes that Contractor will ensure that each practitioner participating in Contractor's provider network has access to training in the use of screening instruments and anticipatory guidance and other materials required in connection with the provision of child development services. The language does not, however, assume that the practitioners must receive this training from Contractor or from an entity with which Contractor subcontracts for this purpose. The Contractor would be required to offer, or arrange for, the training at Contractor's expense if requested to do so by a network practitioner. If a practitioner prefers to obtain such training from a source other than Contractor or Contractor's designee, the practitioner would bear the cost.*

(b) **Training** — Contractor shall, upon request of a provider participating in Contractor's provider network, furnish, or arrange for the furnishing of, at Contractor's expense, training in the use of:

- (1) the developmental screening instrument specified in **§102(a)**;
- (2) the family psychosocial screening instrument specified in **§102(b)**;
- (3) the anticipatory guidance materials specified in **§103(a)**;
- (4) the behavioral assessment specified in **§103(b)**; and
- (5) the general developmental interventions specified in **§104**.

#### **§107. Coverage Determination Standards and Procedures**

(a) **In General** — Contractor shall comply with the requirements of **§§101A – 103A** of MEDICAIDSPECS and the requirements of this section relating to the standards and procedures used in determining whether a child development service under **§101** is covered with respect to an enrolled child.

(b) **Personnel Qualified to Make Coverage Determinations** — In the case of an enrolled child who seeks child development services under **§101**, at least one licensed health professional (as defined in **§108(d)**) with expertise or experience in child development services shall participate in the coverage determination (as defined in subsection (d)) with respect to the child.

(c) **Exclusion from Prior Authorization** — Contractor shall not require prior authorization of the following items and services:

- (1) screening assessment services under **§102**;
- (2) developmental health promotion services under **§103**;

(3) general developmental interventions under §104; and

(4) care coordination under §105.

(d) **Coverage Determination Defined** — A determination by Contractor (or by the provider or other entity to whom Contractor has delegated such determination) as to whether, in the case of an enrolled child, an item or service enumerated under §101 is necessary to:

(1) prevent, correct, or ameliorate a condition, disability, illness, or injury;

(2) prevent, correct, or ameliorate a developmental disability or delay;<sup>41</sup> or

(3) maintain functioning.<sup>42</sup>

## §108. Definitions

(a) Contractor – the managed care organization doing business as [*drafter insert name*] that has entered into an agreement with Purchaser under [*drafter insert name of purchasing document*].

(b) Enrolled child – an individual under age 3 with respect to whom Contractor assumes financial responsibility for furnishing, or arranging for the furnishing of, items and services covered under §101.

(c) Family or caregiver – a natural or adoptive parent of an enrolled child, a grandparent, or stepparent with whom the child lives, or an individual or entity that is a foster parent, legal guardian, or other individual or agency with legal authority or responsibility to care for the child.

(d) Licensed health professional – a physician, nurse, nurse practitioner, physician assistant, clinical psychologist, or [*drafter insert reference to other appropriate licensure categories under state law, such as social worker or health educator*].

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<sup>41</sup> The EPSDT benefit includes developmental assessments under §1905(r)(1)(B)(i) of the Social Security Act (42 U.S.C. §1396d(r)(1)(B)(i)), the purpose of which is to detect evidence of delays or disabilities among Medicaid-eligible children. Under HCFA guidelines for younger children, the required developmental assessments must at a minimum include the following elements: (1) gross motor development; (2) fine motor development; (3) communication skills or language development; (4) self-help and self-care skills; (5) social-emotional development; and (6) cognitive skills, *Medical Assistance Manual*, §5123.2A.1.a. This illustrative definition of medical necessity is intended to clarify Contractor's obligation to treat and prevent not just developmental disabilities, but also developmental delays.

<sup>42</sup> This illustrative language is intended to address items and services needed by enrolled children with chronic conditions, disabilities, or delays that cannot be prevented, corrected, or ameliorated.

(e) Primary care provider – a physician, nurse practitioner, or physician assistant who is responsible for delivering primary care to, and monitoring the growth and development of, an enrolled child.

(f) Provider – a health care professional, clinic, hospital, school, or other entity licensed by the State to furnish medical, dental, mental health, or other health care services.

(g) Provider network – the set of providers that have entered into enforceable written agreements with Contractor that comply with the requirements of [*drafter insert name of purchasing document*] to furnish, or arrange for the furnishing of, the items and services covered under §101 to enrolled children.

(h) Purchaser – [*drafter insert name of state purchasing agency*].

## **Compliance Measures**

**Contractor shall make available to Purchaser upon request copies of the following:**

**(1) Information Provided to Enrollees**

**(A) Anticipatory guidance materials made available to families or caregivers of enrolled children under age 3;**

**(B) The child health and development record offered to family or caregiver of enrolled children under age 3; and**

**(D) The listing of available care coordinators for enrolled children under age 3.**

**(2) Contractor Guidance to Providers Participating in Contractor's Provider Network**

**(A) The written agreement between Contractor and primary care providers treating enrolled children under age 3; and**

**(B) Training materials or programs, provider manuals, memoranda, and other materials used by Contractor to instruct participating providers regarding their duties to enrolled children relating to the provision of covered services and documentation thereof.**

**(3) Instruments and Protocols Used by Participating Providers**

**(A) Screening instruments and assessment tools used by providers in connection with the provision of services to enrolled children under 3 and their families;**

**(B) Reading readiness protocol used by providers; and**

**(C) Telephone protocol used by Contractor or participating providers in responding to enrollee inquiries relating to child development.**

**(4) Contractor Guidance Relating to Home Visits**

**(A) Manuals, memoranda, and other materials used by Contractor to instruct employees or participating providers regarding the conduct of covered home visits.**

**(5) Care Coordination Services**

**(A) Manuals, memoranda, and other materials used by Contractor to instruct employees or participating providers regarding the furnishing of care coordination services to enrolled children under age 3.**