Child Care & Medicaid: Partners for Healthy Children

A Guide for Child Care Programs

U.S. Department of Health and Human Services
Health Care Financing Administration

FOREWORD

Today, approximately 12 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, President Clinton proposed a comprehensive children's health initiative which was passed by Congress last year. This new initiative, the Children's Health Insurance Program (CHIP), set aside $24 billion over five years for states to provide new health coverage for millions of children -- the largest children's health care investment since the creation of Medicaid in 1965.

But if we are to reach these uninsured children, we have to make sure that eligible families know about these new benefits. As child care and health care professionals, you provide a critical link to parents, and I am pleased to share with you "Child Care & Medicaid: Partners for Healthy Children." I hope this important resource will help you inform families about new ways to access health coverage that children need to grow up healthy and strong.

This guide includes successful models of Medicaid outreach such as the Department's own "Healthy Child Care America Campaign," which enlists early childhood programs and a wide array of other community organizations to target children from low-income working families who may be eligible for Medicaid. States and communities involved in this campaign are developing innovative approaches to ensure the health of children, including utilizing the child care setting as an opportunity to provide preventive health services for children. In addition to Medicaid outreach, services include immunizations, hearing and vision screening, and nutrition evaluations.

Also highlighted are creative approaches that individual states and communities have developed for reaching parents with information about available Medicaid resources. Successful outreach campaigns have persuaded store owners to tuck flyers into children's shoe boxes, home-delivered pizza boxes, grocery bags, toys, back-to-school notebooks and book bags.

This guide is an invaluable, practical resource and I encourage all those who work in the child care and health care professions to use it. We need your help to ensure that every child in America has access to quality health insurance and a healthy start in life.

Donna E. Shalala

A MESSAGE FROM THE CENTER FOR MEDICAID AND STATE OPERATIONS

AND

THE CHILD CARE BUREAU

The Center for Medicaid and State Operations and the Child Care Bureau understand the vital role that each must play in improving the health and well-being of children in this country. We must continue to work together to enroll children who are eligible into the Medicaid program. We also must continue to work to ensure that Medicaid-eligible children have access to and receive appropriate Medicaid services. This Guide is one of many tools intended to help reach this goal.

Child care programs and child care resource and referral agencies are essential in getting children enrolled into the Medicaid program and helping Medicaid beneficiaries to access health services. To assist in that effort, this Guide presents general information about the Medicaid program and its comprehensive child health component, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Guide also includes appendices of additional resources, including State and Federal contacts, that will be helpful in developing an effective, organized link between child care providers and EPSDT.

We extend our sincere thanks and appreciation to our staffs and our other Federal partners for their efforts in publishing this Guide. We also acknowledge the contributions of our private sector partners and

their continued support and interest in improving the health status of children and families in this country.

America's children are our Nation's most precious resource. We must continue to work in partnership with States, Tribes, Territories, other Federal agencies, consumers, advocacy groups, communities, health and human services providers, private sector organizations, the faith communities, and other interested groups to improve the health and well-being of our children.

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OVERVIEW OF THE GUIDE

This guide has been prepared for child care program administrators and child health organizations who are interested in establishing linkages with Medicaid and other State health insurance programs. This guide provides the basis for understanding the dynamics of the Medicaid program and Early Periodic Screening, Diagnostic and Treatment (EPSDT), Medicaid's comprehensive child health component. Furthermore, this guide will help child care programs and child care resource and referral agencies understand the

pivotal role they can play in improving the health status of children in this country.

The guide is organized as follows:

Introduction — The introduction includes the purpose of the guide and a brief background on the collaboration between the Health Care Financing Administration and the Administration for Children and Families. It gives an overview of early childhood programs that have successful linkages with the Medicaid program, and details the benefits of establishing linkages between child care and Medicaid.

Chapter 1 — Medicaid and EPSDT — This chapter presents a general description of the Medicaid program (Title XIX), and introduces Title XXI, the State Children's Health Insurance Program (CHIP) which was created by the Balanced Budget Act of 1997 (BBA). It also describes legislation included in the BBA designed to increase children's health care coverage through the Medicaid program, namely: (1) presumptive eligibility for low-income children, and (2) the option to provide 12-month continuous eligibility. EPSDT will be most useful in making the link between child care and Medicaid. The chapter focuses extensively on EPSDT addressing the EPSDT benefit package, the State Medicaid agencies' responsibility to provide EPSDT services to children and families, and types of EPSDT service providers. Additionally, this chapter explains the relationship between the Medicaid program and managed care organizations (MCO).

Chapter 2 — EPSDT Program Activities — One of the goals of linking Medicaid with child care is to get eligible but not yet enrolled children to Medicaid services. This chapter presents various EPSDT program activities that child care programs can do to reach this goal including conducting outreach, which is a major component of EPSDT, and making appropriate referrals, facilitating and encouraging EPSDT participation, scheduling appointments and transportation and conducting case management.

Chapter 3 — Roles for Child Care Programs — The chapter identifies eight outreach activities that child care programs can do and be *"paid*" by the State

Medicaid agency to bring potential eligibles into the Medicaid program and to assist in bringing Medicaid-eligible individuals into Medicaid services.

Chapter 4 — Models for Program Linkages — Sharing successful models is essential during a time of scarce resources. This chapter includes brief summaries of linkages between Medicaid and early childhood programs, child care resource and referral agencies, local health departments, and various community-based organizations. These linkages demonstrate outreach efforts that have proven to be successful and may be replicated in child care settings.

The **Appendices** include a matrix of States' Federal poverty level percentages used for determining Medicaid eligibility of pregnant women, infants and children. Each State's Maternal and Child Health toll-free number is listed to help child care programs obtain information about health care needs and resources throughout the States. The Appendices also provide reference material which will be useful to child care programs in establishing and/or enhancing collaborations with State Medicaid and Maternal and Child Health agencies, and State programs for children with disabilities. Additionally, these contacts may serve as a useful networking directory for child care programs as they develop strategies and materials for use in Medicaid outreach activities.

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Reaching children early and informing families of available comprehensive health services help support children's learning and developmental potential. Children who receive preventive and other necessary health services will be better prepared to learn and grow to be healthy productive citizens. The Health Care Financing Administration (HCFA) and the Administration for Children and Families (ACF) join in supporting and promoting the development of the health and well being of America's children.

HCFA's Medicaid program finances health services for certain individuals and families with low incomes and resources. Medicaid, a jointly funded Federal-State partnership, is administered by the States, Commonwealths, and Territories within broad Federal guidelines and provides health care coverage for more than 20 million children. While States have the flexibility to design their own Medicaid programs, each State is required to provide a package of comprehensive and preventive child health services to Medicaid-eligible individuals under age 21. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services is the name used to describe this package of health services.

The Child Care Bureau in ACF administers the Child Care and Development Block Grant (CCDBG) which provides funds to States, Territories, and Tribes to assist in providing child care services to children in low-income families, including children receiving services under the new welfare reform program, Temporary Assistance to Needy Families (TANF). Funds from this program enable parents in needy families to work or participate in education or training. These funds also may be used to serve the child care needs of families receiving protective services.

The Child Care Bureau enlists support and encourages activities that link children and their families to systems of continuous and accessible health care services. The coordination between child care programs and agencies responsible for children's health is key to supporting the healthy development of children. A good example of the Child Care Bureau's efforts is the *"Healthy Child Care America Campaign"* that encourages and supports linkages between child care and the health care community.

Purpose of the Guide

This Guide is intended for child care programs, child care providers, and child health organizations that are interested in establishing linkages with Medicaid and other State health insurance programs. It also provides a foundation for understanding the dynamics of the Medicaid program and EPSDT services. The common goal of these programs is to provide health care support for the children in their programs.

The Guide will:

- Acquaint child care programs with the benefits of Medicaid enrollment and EPSDT services;
- Discuss how child care relates to the development and/or expansion of Medicaid outreach activities;
- Discuss the pivotal role child care can play in improving the health status of children in this country; and
- Direct child care programs to additional sources of information, including models of successful program linkages.

At the end of the Guide are appendices providing additional resources which may be helpful in making a productive link between child care and Medicaid.

Medicaid and Early Childhood Programs

HCFA and ACF have a long history of collaboration. For example, the collaboration between Medicaid and Head Start has provided Head Start the opportunity to link families to a network of health services, including providing health care to certain children with disabilities. Joint efforts have focused on activities such as outreach or case finding, informing parents about services, and assistance in scheduling appointments.

Analysis of recent Medical Expenditure Panel Survey data supports the need and benefits for linking Medicaid with early childhood programs. The data showed that there are 4.7 million children age 18 and under who are uninsured despite being eligible for Medicaid. The reasons for such a large number of Medicaid-eligible children not enrolled in the program are undoubtedly many. However, lack of knowledge and information about who is eligible for Medicaid may be a major reason.

Also, more recent legislation de-linked Medicaid from welfare, so that coverage under Medicaid is no longer based upon whether a family receives public assistance and may make it difficult for families to become enrolled in Medicaid. In addition, many families are unaware of the 1989 legislative changes which expanded Medicaid eligibility. Now, all children under age 6, including those of low-income working families, whose family incomes are below 133 percent of the Federal Poverty Level (FPL) can enroll in Medicaid. Some States have chosen to raise the income standard to 185 percent of the FPL and higher (see Appendix A). In addition, children who are 5 years and under can receive services through the Supplemental Nutrition Program for Women, Infants, and Children (WIC) if they are at nutritional risk with family incomes below 185 percent of the poverty level.

In addition, some private sector organizations have promoted linkages between Medicaid and early childhood programs. For example, in 1994 the Center on Budget and Policy Priorities initiated a national outreach campaign called *"Start Healthy, Stay Healthy*." The campaign enlists early childhood programs and a wide array of other community organizations to link children to health and nutrition benefits available through Medicaid and WIC. Also, with the recent creation of the State Children's Health Insurance Program, the campaign has expanded to help get children enrolled in enlarged or newly-created State child health insurance programs and help to promote coordination between such programs and Medicaid.

Benefits of Child Care and Medicaid Linkages

It is well-known that maintaining a child's health leads to a more productive and better quality of life for the child. Linking child care programs with Medicaid and other State child health programs can be especially beneficial to young children, as health conditions that are not prevented or treated can easily progress to chronic diseases and lifelong barriers to self-sufficiency.

Often, a child care facility is the first place a child comes in contact with the Medicaid program. Millions of children spend all or part of their days in some type of early childhood setting while their parents work or participate in an education program. Recent changes in public assistance programs have encouraged larger numbers of beneficiaries to work or attend work programs. This greatly increases the need for child care. Low-income working parents too often have jobs that provide little or no health insurance coverage. Because they work, they think they earn more money than that allowed to be eligible for Medicaid or other publicly financed health insurance programs. They may not know that although they work and have some health insurance through their jobs, their children may still qualify for Medicaid. Most of the children receiving child care funded by the CCDBG live in families whose incomes are below

100 percent of the FPL. Analysis of 1995 CCDBG data indicates that one fourth of the children have family incomes between 100 and 150 percent of the FPL.

Benefits of Linkages

Linking Medicaid and child care services offers numerous benefits:

- An opportunity to identify uninsured children and speed up enrollment in the Medicaid program, other State-offered health insurance programs, and WIC programs;
- An avenue to help families identify and access quality health care services;

- The chance to assist with identifying and removing barriers to health care;

- Early detection of illnesses and/or diseases;

- Maximizing resources and eliminating duplication by combining the application process for child care subsidies or other forms of assistance with a preliminary Medicaid and/or other State health insurance program application;

- Linking families to a network of health and developmental services to improve the quality and efficiency of delivering health services for children. The ***"Healthy Child Care America Campaign",*** for example, promotes the healthy development of children in child care;

- Child care settings are ideal sites for the delivery of immunizations, health screenings, nutrition programs, health consultations, and referral services;

- Child care settings offer friendly, familiar settings to help parents understand health issues that may be culturally sensitive; and

- An opportunity to reach child care providers whose own children may qualify for Medicaid or other State-offered health insurance.

It is essential to reach children as early as possible to help ensure their total well-being in the future. Child care programs can be a valuable resource in this process by informing children and families about Medicaid and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The major advantage child care programs have in providing information comes from their daily interaction with young children and their parents or guardians.

This chapter will help child care programs understand Medicaid and EPSDT. The EPSDT component will be most useful in making the link between child care and Medicaid. For more specific information about EPSDT in a particular State, contact the State Medicaid EPSDT Coordinator (see Appendix D).

What is Medicaid?

Medicaid, Title XIX of the Social Security Act, is a program that provides medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 as a jointly-funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines that the Federal Government provides, each of the States:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services
- Sets the rate of payment for services; and
- Administers its own program.

Recent Legislation

State Children's Health Insurance Program (CHIP)

The Balanced Budget Act of 1997 (BBA) created Title XXI of the Social Security Act, also referred to as the State Children's Health Insurance Program. CHIP offers new opportunities for low-income families to have health insurance protection for their children. Its primary focus is to initiate and expand health insurance coverage for low-income uninsured children. The program allows States to expand health insurance coverage for children in one of three ways: through a separate child health insurance program, through the Medicaid program, or

through a combination of these programs.

For more information on CHIP, visit the Web site: <<www.hcfa.gov/init/children.htm>> or contact the HCFA regional office which serves your State (See Appendix C).

Medicaid Expansions

The BBA also included two additional provisions giving States the option to increase children's health care coverage through the Medicaid program: (1) presumptive eligibility for low-income children, and (2) the option to provide 12-month continuous eligibility.

- **Presumptive Eligibility Option —** Certain "qualified entities" may enroll children under 19 years of age in Medicaid on a temporary basis if they appear to be eligible based on their ages and family income. Qualified entities may include children's traditional health care providers, such as pediatricians and health professionals who deliver services in community health centers, WIC programs, Head Start programs, and **State and local agencies that determine**

eligibility for subsidized child care under the Child Care and Development Block Grant (CCDBG) Act.

Many child care agencies and Head Start programs already are engaged in efforts to inform working parents about the Medicaid program. Presumptive eligibility could effectively link these outreach activities to the eligibility process. It can be a particularly useful tool for enrolling children in Medicaid who are not receiving public assistance and whose parents are employed at low-wage jobs not offering health insurance coverage.

- **Twelve-Month Continuous Eligibility Option**——States can guarantee up to 12 months of coverage to children enrolled in Medicaid even if the child experiences changes in family income or other circumstances that would make the child ineligible for Medicaid during the 12-month period.

What is EPSDT?

EPSDT is the child health component of the Medicaid program. It provides a comprehensive set of preventive and health care services to most Medicaid-eligible individuals under age 21. Under the EPSDT component, States are required to provide a broad range of activities in addition to general Medicaid program requirements. These include health services, data reporting, and conducting outreach, i.e., States are required to provide for a combination of written and oral methods designed to inform EPSDT eligible individuals (or their families) about the EPSDT program. While the Federal term for this set of required services is EPSDT, many States have chosen different names for their individual programs. For example, Vermont calls its EPSDT program "Dr. Dinosaur." The term EPSDT describes the program's goals and gives information about the services that it covers:

***E**arly:* assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

***P**eriodic*: assessing a child's health at key points in her/his life to assure continued healthy development;

***S**creening:* the use of tests and procedures to determine if children being examined have conditions requiring closer medical (including mental health) or dental attention;

Diagnostic: determination of the nature and cause of conditions identified by screenings and those that require further attention; and

T*reatment:* the provision of services needed to control, correct, or reduce physical and mental health problems.

What Services are Covered Under EPSDT?

Each State must develop a State Plan which lists the eligibility criteria and covered services as well as other information required by Federal regulations. Like other health insurance programs, State Medicaid programs sometimes limit the type of covered services or the duration of the service. However, these limits do not apply to children eligible for EPSDT services. For example, Medicaid-eligible children may receive health services which may not be covered in the State Plan for adults, such as dental services. States are required to cover the following services under the EPSDT component:

- Screening services — the core of the EPSDT benefit package — must include:

  _ A comprehensive health and developmental history,including a physical and mental health assessment,

  _ A comprehensive unclothed physical examination,

  _ Appropriate immunizations according to the schedule of the Advisory Committee on Immunization Practices (ACIP),

  _ Laboratory tests, including blood lead level, and

  _ Health education, including anticipatory guidance;

- Dental services, including restoration of teeth and maintenance of dental health;

- Hearing services, including hearing aids;

- Vision services, including eyeglasses;

- Any other necessary health care diagnostic services, and treatment coverable by Medicaid, whether or not the service is covered under a particular State's Medicaid Plan, to correct or improve illnesses and conditions found in screening; and

- Assistance with transportation and scheduling of appointments.

Screening services must be available in accordance with a State's timetable (periodicity schedule). States must consult with medical and dental organizations involved in child health care to develop age-appropriate periodicity schedules. Screening services also should be available at times other than the regularly-scheduled intervals, if there is reason to suspect an illness or condition that did not exist or was not identified at the regular periodic screening.

Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation. The purpose of diagnosis is to determine the nature, cause, and extent of the problem found by the screening examination. This diagnosis may then result in development of a plan for treatment.

Treatment services are covered whenever they are medically necessary to correct or improve defects, physical or mental illnesses, or other conditions discovered through an EPSDT screening.

In general, EPSDT treatment services include all mandatory and optional services available under the Medicaid program. These optional services include: case management, physical therapy, rehabilitative services, and private duty nursing. Diagnostic

services and treatment are covered whenever there is a medical need to conduct further examination. Some enabling services also are required under the EPSDT component. For example, assistance with transportation and scheduling appointments must be offered and made available to ensure that beneficiaries obtain needed health services.

Who Can be Served?

Most children under age 21 who are eligible for Medicaid are automatically eligible for EPSDT services and can receive them any time. Family income is a main criterion used to determine Medicaid eligibility, but not all children in families with incomes below the FPL are eligible for Medicaid. When a child is determined to be Medicaid-eligible, information is given to the family regarding EPSDT services; they have the option whether to utilize these services or not. If, at first, the family decides not to utilize EPSDT services, they can obtain these services for the child at a later time.

Children under age 21 can qualify within a variety of groups, including:

- Individuals who meet the requirements of the former Aid to Families with Dependent Children (AFDC) program and, in some States, those who meet the requirements of the new Temporary Assistance for Needy Families (TANF) program;

- Beneficiaries of Supplemental Security Income (SSI) in most States - (The new children's health legislation requires States to continue Medicaid coverage for all disabled children who were receiving SSI on August 22, 1996 but who lost their Medicaid eligibility as a result of the 1996 changes in the definition of a child with a disability.);

- Beneficiaries of adoption assistance and foster care under Title IV-E of the Social Security Act;
- Infants under age 1 and children under age 6 in low-income families whose earnings are at or below 133 percent of the FPL (or a higher percentage in several States that have expanded these eligibility guidelines for children); and

- All children born after September 30, 1983 in families with incomes at or below 100 percent of the FPL. This phases in coverage so that all children under age 19 in such families will be covered by the year 2002.

Some States provide coverage to additional groups of individuals beyond the mandated provisions.

Who Provides EPSDT Services?

Ideally, EPSDT services are part of a continuum of care in which the child's health care services are always delivered by someone who is familiar with his or her health history and family situation. EPSDT services may be provided by a physician, nurse practitioner, pediatrician, or other type of health care provider who is certified by the State Medicaid program to be a Medicaid provider.

States cannot limit EPSDT providers to only those who can provide all EPSDT diagnostic and treatment services. If more than one provider is needed to complete the full range of EPSDT services to a child, these services should be coordinated to ensure the child receives all the necessary services and to avoid duplication. However, most children who have a family health care provider will receive most of their EPSDT screening, diagnostic, and treatment services from the same provider. Services may be furnished by qualified providers located in child care and Head Start programs, school-based health centers, State and local

health departments, managed care organizations (MCO), physician offices, Indian Health Service Centers, and Community Health Centers.

Today, there is a growing trend toward using non-office sites, particularly school-based and school-linked health centers, as EPSDT providers, especially for the screening component of services. The growing popularity of school-based health centers as EPSDT providers

is attributed to State and local initiatives designed to improve children's health care access. School-based centers provide close proximity to the targeted population and tailor their services to ensure age-appropriate preventive care. Most facilities are located in middle or secondary schools, although they are becoming more common at the elementary school level.

The Individuals with Disabilities Education Act (IDEA) provides for special education services in the schools. Part C of IDEA is the early intervention program for infants and toddlers. Each child receiving special education services has an Individualized Family Service Plan (IFSP) which details the services the child needs. Medicaid can pay for some health-related services required under the IFSP.

Child care programs can play an important role in helping young children receive the services they need to enhance development potential and learning. If a child care provider suspects that an infant or child has a physical disorder or developmental delay, they can help the parent or guardian contact the local office responsible for providing services to children with special health care needs. The child care provider also can help the parent or guardian contact the local Medicaid office.

What is the State Medicaid Agency's Responsibility?

State EPSDT components are often part of a larger network of social service agencies and health programs for children and families. Coordination among these entities is essential to ensure and maximize access to services and to prevent duplication. Medicaid agencies are required to coordinate with Maternal and Child Health Programs (MCH) and WIC. They also are encouraged to coordinate with child care and Head Start agencies, State and local education agencies, and social service agencies. These collaborative efforts may include interagency agreements, cross-referrals, child health coordinating committees from Head Start projects, and other activities that stimulate partnerships in ensuring health care for children.

States are required to:

- Seek out eligible children and families to:

- Encourage their participation in Medicaid/EPSDT,
- Inform them of the availability and benefits of preventive services,
- Provide assistance with scheduling appointments and transportation, and
- Help families use health resources effectively and efficiently;

- Assist families in finding EPSDT providers;
- Assure that providers assess health needs through initial and regular periodic examinations; and
- Assure that detected health problems are diagnosed and treated early before those problems become more complex and their treatment more costly.

Who Pays for Services?

State Medicaid agencies (SMA) are responsible for paying for medical and some non-medical services which are covered under the State Plan provided to Medicaid beneficiaries. Each SMA establishes its State-specific rates which usually are available to any qualified provider who agrees to provide the service. Regarding administrative services, SMAs have the flexibility to enter into contractual arrangements consistent with applicable State and Federal contracting requirements. Some contractual arrangements may be with other Federal and State agencies, schools, community-based organizations, providers of transportation services, child care programs, and child care resource and referral agencies (CCR&R). For example, Louisiana's Department of Health and Hospitals

contracts with community-based organizations to become Medicaid Application Centers. Trained staff at these centers conduct initial processing functions that enable the SMA to determine Medicaid eligibility. SMAs can enter into contractual arrangements with MCOs. Payments to MCOs are based on a capitated rate, and MCOs have great flexibility with respect to negotiating and establishing that rate.

State expenditures are matched by the Federal government for a share of the costs they spend for Medicaid services. The Federal share varies from one State to another. Expenditures for medical services, including screening, diagnosis, and treatment, are reimbursed by the Federal government at State-specific rates.

This rate varies from 50 to 83 percent with poorer States receiving a higher rate for the cost of Medicaid medical services and wealthier States receiving a lower rate. Administrative expenses for activities such as outreach, eligibility determinations, provider relations, some transportation activities, and follow-up are usually matched by the Federal government to the SMA at a rate of 50 percent.

Medicaid Managed Care

The significant shift from individual providers to managed care plans makes it essential that child care and affiliated programs understand the relationship between the Medicaid program and managed care organizations (MCO). An MCO is a health system that combines the delivery and financing of health care services. Managed care also can mean a system in which an individual primary care provider coordinates all care, including referrals to specialty services. It is broadly defined as an arrangement among the SMA, the Medicaid beneficiary, and health services providers. MCOs offer many medical specialities and services for their members. These organizations have the potential to offer increased access to preventive and primary health care for enrollees.

States efforts to enroll Medicaid beneficiaries into managed care have dramatically increased over the past few years and current data suggest that the trend will continue. As of June 30, 1997, approximately 15.4 million beneficiaries, or 48 percent of the

national Medicaid population, had been enrolled in managed care programs.

While there are many different types of managed care arrangements, there are general characteristics regarding the delivery and financing of services. For delivery of services, patients must be enrolled with a primary care provider who is responsible for the coordination of care. Primary care physicians furnish patients with access to selected provider networks in which services are coordinated with a focus on prevention and early detection of illnesses and conditions.

Managed care plans are generally paid a set amount (a capitation rate) in advance for providing an agreed-upon package of health services. In exchange for the prepaid premium, many managed care plans assume financial risk for the provision of this benefit package. The managed care plans also establish a provider network, pay providers, and educate providers and enrollees about the covered services available under the plan.

States and managed care plans often must coordinate and contract with providers outside of the managed care plans' provider networks to ensure that EPSDT services are provided. Sometimes a service that is covered under the EPSDT benefit package is defined as a "carve out" (not included) under the State managed care contract. When services are carved out, managed care plans

are not contractually obligated to provide them, and thus, beneficiaries may go to any other Medicaid provider to receive these services. However, the SMA or the MCO is required to coordinate the provision of these "carve out services" depending on the terms of the MCO contract.

Sometimes entire services are carved out and placed in another managed care program. The most common service that is carved out is mental health. This means there may be two managed care programs

that families must understand. Sometimes, these two systems do not coordinate very effectively so it is helpful when other service providers understand the two systems.

Beneficiaries sometimes become confused when they are required to receive the majority of their health care from a certain provider but must obtain the remaining services outside the plan's network. For that reason, education campaigns designed to increase beneficiaries' understanding of the services to which they are entitled, as well as where and how to access those services, becomes even more critical.

In other cases, community providers, such as school-based health centers and child care programs, may be best situated to serve children and adolescents. These programs are likely to be readily accessible and knowledgeable about the unique needs of low-income children and adolescents. To ensure the appropriate provision of health care, arrangements between the managed care plans and the community providers must include assurances of coordination of care and followup.

Varying degrees of coordination between MCOs and child care programs are possible. Establishing a relationship with MCOs as early as possible is important after the children are enrolled in the MCO. One possible arrangement is for the State agency and/or the MCO to reimburse the child care program for providing outreach; e.g., health education campaigns and other administrative services to families and children.

To find out more about special arrangements a State may have with MCOs, contact the State Medicaid agency (see Appendix D) or visit the HCFA Web site: <<www.hcfa.gov>>.

This chapter describes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program activities and the potential roles child care programs can play in these activities. These activities include: conducting outreach and making appropriate referrals, facilitating and encouraging EPSDT participation, scheduling appointments and scheduling transportation, performing periodic renotifications, and conducting case management. By performing and/or participating in these program activities, Child care programs have a broad potential to link eligible but not-yet-enrolled children to Medicaid services.

Outreach and Referral

Outreach is a required, major component of EPSDT. While States have the flexibility to design and conduct their own Medicaid outreach programs, i.e., outreach targeted at enrolling children in Medicaid, States are required to ensure that all eligible Medicaid beneficiaries who are under age 21 are informed about EPSDT services, including age-appropriate immunizations. This must be done within 60 days of their Medicaid eligibility determination and annually thereafter in instances in which eligible beneficiaries have not accessed services during the year. Both States and health care providers who serve Medicaid beneficiaries may inform eligible individuals about the program and emphasize the important role of preventive health care.

Child care programs and CCR&R agencies can participate in outreach. Key parts of an outreach strategy may include:

- Encouraging and facilitating enrollment in Medicaid and participation in EPSDT services;
- Informing the family about available EPSDT services and support services;
- Explaining EPSDT services in a clear, simple way; and
- Promoting the advantages of early detection and treatment.

Through innovative outreach initiatives performed in local communities through child care programs, emphasis on preventive health care should be made in a culturally sensitive manner. Likewise, these programs provide the opportunity to encourage participation in EPSDT through educating families in combination with outreach activities.

Participation

Child care programs also have the opportunity to play a role in encouraging EPSDT participation. They can assist families who choose to utilize EPSDT services by helping families arrange a health screening appointment. They also can obtain lists of Medicaid providers, including MCOs, from the SMA to help families select health care providers.

Appointments and Transportation

When moving into the screening phase of EPSDT, the child's family can either make an appointment for screening services individually or the Medicaid agency staff may help in scheduling the appointment. The Medicaid agency must offer and provide transportation assistance for such appointments when needed.

Child care programs can assist families with scheduling appointments and arranging for transpor-tation.

Periodic Renotification

At intervals set by each State, eligible children should be re-screened in order to maximize preventive health efforts. These intervals are relatively short in the first few years of life and get longer as the child gets older. The State is responsible for ensuring that renotification occurs. Medicaid agencies could contract with child care programs and CCR&R agencies to have them carry out the periodic renotification function.

Child care programs and CCR&R agencies can:

- Assist in reminding families of the next screening examination;
- Assist in facilitating rescreening exams;
- Remind families of the benefits of participating in EPSDT; and
- Offer necessary support services for them to successfully complete the screening examinations.

Case Management

The purpose of case management is to help enrolled children and families through the often confusing system of health and related services in their communities. Since EPSDT screening, diagnostic, and treatment activities are frequently not conducted at one time or in one place, case management is important to ensure that children receive appropriate services on a timely basis. Among other things, case managers may:

- Assist families in identifying and choosing health providers, and maintaining a "Health Home";
- Facilitate contacts between the Medicaid/EPSDT program and the family to verify activities, maintain records, and assure an efficient and accurate flow of information;
- Conduct followup measures to assure that children receive needed diagnosis and treatment;
- Help families maintain contact with health providers and provide ongoing counseling to answer questions and reduce feelings of uncertainty about the programs; and

- Teach families skills to become their own case managers.

Child care programs are well-suited to assist in the case management process. They have the capacity to provide a variety of administrative services which are similar to those case management services needed for EPSDT and which could be incorporated into their existing system. Child care programs interested in expanding their services to case management, or who are currently practicing it, may contact the local Medicaid agency for more information (see Appendix D).

Service Delivery

Child care programs have the potential to play several different roles in delivering EPSDT services to children. Sometimes nurses or nurse practitioners conduct EPSDT screenings on site at child care and Head Start programs, and then children are referred to community providers for diagnostic and treatment services. Child care programs could partner with the local public health departments or other health care provider organizations to explore ways of conducting on-site screenings for children in child care.

Whenever a family is asked to provide family size and income information, this presents an opportunity for Medicaid and EPSDT outreach and referral. This information may be requested to determine eligibility for subsidized child care, Child and Adult Care Food Program (CACFP), Head Start, WIC, school nutrition programs, energy assistance programs, food stamps, and cash assistance. Agencies requesting this information can expand their own intake procedures to help families make connections with Medicaid.

This chapter describes various outreach activities child care programs and child care resource and referral agencies (CCR&R) can do to: (1) bring potential eligibles into the Medicaid system for determining Medicaid eligibility, and (2) bring Medicaid-eligible individuals into Medicaid services.

Under contractual arrangements with State Medicaid agencies, child care programs and CCR&R agencies can be paid for doing the following outreach activities:

1. Assisting families in completing Medicaid applications:

- Making presumptive eligibility determinations in States that have selected this option. **(This applies only to CCR&Rs and child care programs that are authorized to determine eligibility for subsidized child care under the CCDBG Act - For a list of entities authorized to make presumptive eligibility determinations, refer to Chapter 1, section titled**

Recent Legislation, Presumptive Eligibility Option.); and

- Assisting with initiating the Medicaid application process, and helping individuals reapply for Medicaid; e.g., combining child care income evaluations for child care subsidies with a preliminary Medicaid and/or other State health insurance eligibility screening - In Louisiana the SMA pays the Head Start agency for completed Medicaid applications:

  _ Explaining the Medicaid eligibility process to prospective applicants,

  _ Gathering information needed for the application and eligibility determination including resource information and third-party liability information (other health insurance coverage or available health insurance), in preparation for submitting a formal Medicaid application,

  _ Providing the necessary forms and assembling all forms in preparation for Medicaid eligibility determinations.

2. Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program:

- Informing Medicaid eligible and potential Medicaid-eligible children and families of the benefits of preventive health and mental health services of the Medicaid program; and

- Informing children and their families of ways to effectively use and maintain participation in all health resources under the Medicaid program.

3. Assisting the Medicaid agency to fulfill objectives of the EPSDT component:

- Informing families about the early diagnosis and treatment services for health and mental health conditions that are available through EPSDT;

- Assuring that health problems found are diagnosed and treated early, before they become more serious and their treatment more costly; and

- Informing beneficiaries of the benefits of preventive services.

4. Assisting families in obtaining services:

- Making appropriate health care referrals;

- Assisting families with scheduling appointments and arranging transportation - contacting children and families by telephone or through personal letters (being sensitive to the reading level of the population enhances this process);

- Helping children and their families to effectively and efficiently use Medicaid health resources; and

- Assisting families in accessing Medicaid managed care systems.

5. Informing families about Medicaid through brochures or other promotional material:

- Conducting health education campaigns, and health fairs targeted specifically to Medicaid services and for Medicaid-eligible individuals (***note: Health education for patients and families is a required component of an EPSDT screen and is not separately reimbursed as an administrative activity***);

- Contacting pregnant and parenting teenagers about the availability of Medicaid, prenatal, and well-baby care programs and services;

- Obtaining materials from the SMA or county office and distributing posters, booklets and easily-understood, culturally-sensitive educational materials about Medicaid and the benefits of EPSDT;

    - Handing out brochures and referring individuals to the local medical assistance office to apply for Medicaid or provide information on other options such as applying by telephone or mail-in applications; and

- Assisting in early identification of children with special medical and/or mental health needs through various child find activities.

To avoid duplicating existing community outreach programs, child care programs and CCR&R agencies should identify what is already being done and find creative additions to link their programs with Medicaid. In addition to finding useful alternatives, this type of outreach will accelerate progress toward the overall goal of providing health care to all Medicaid-eligible children. A good starting place is to contact the State Medicaid programs and MCH (Title V) programs. Since State MCH programs are required to conduct a needs assessment, they have useful information on health care needs and resources throughout the State (see Appendix B, *"State MCH Programs-Hotline List of Toll Free Telephone Numbers").*

Payment For Providing Outreach Services

State Medicaid agencies are allowed to claim outreach as an administrative expenditure under the Medicaid program. The Federal government provides matching funds to States for conducting specific outreach activities.

In order to be reimbursed for performing outreach activities, child care programs and CCR&R agencies **must** have a contract with the SMA. Rates for performing outreach activities are set by the SMA. The State agency will establish the conditions of reimbursement with the child care program. Included in Appendix D is a list of State Medicaid agency contacts.

This chapter provides models of program linkages between early childhood programs and Medicaid. The models were researched and developed by the Center on Budget and Policy Priorities. The various models illustrate ways early childhood programs have undertaken outreach activities to help bring potential eligible individuals into the Medicaid program, and to assist Medicaid beneficiaries in accessing health services. The following models are presented as examples that may be replicated in a child care setting.

MODELS OF PROGRAM LINKAGES

Maryland — "*LOCATE: Child Care*," a Statewide CCR&R agency based in Baltimore at the Maryland Committee for Children, refers families who call the program's community line to appropriate and affordable child care. To determine whether families may be eligible to receive child care subsidies, *"LOCATE"* routinely asks callers about family income and their participation in

a variety of public benefit programs. "*LOCATE*" revised its intake questionnaire to accurately screen for Medicaid (and WIC) eligibility. A process for referral to Medicaid was developed in conjunction with the Maryland Department of Health and Mental Hygiene (DHMH) and the State Medicaid agency. Now, when children of families that call the community line are found likely to be eligible for Medicaid, a State-prepared brochure describing Medicaid services is mailed to the family, along with information on where and how to apply for benefits. State Medicaid officials trained *"LOCATE's"* family counselors to be able to answer parents' questions about Medicaid over the telephone. In addition, *"LOCATE"* worked with DHMH and the State's Child Care Agency to provide information on Medicaid to all licensed child care programs.

Alabama — The Child Care Resource Center in Opelika, Alabama, is one of 12 management agencies under contract with the State Department of Human Resources to determine eligibility for subsidized child care. Since Alabama's income eligibility guidelines for subsidized child care are lower than the State's Medicaid eligibility guidelines for children under age 6, it is easy for counselors to identify children likely to qualify for Medicaid. If the child is not enrolled in Medicaid already, the counselor helps the parent complete Alabama's short Medicaid application at the same time the application for subsidized child care is completed. The counselors ensure that the completed applications are delivered to the Medicaid office. In Alabama, Medicaid applications can be mailed in and applicants do not need to have a face-to-face interview. If a parent reports that the child already is enrolled in Medicaid, the counselor takes the time to discuss the importance of EPSDT benefits and how families can utilize them.

California — As part of its child care resource and referral services, the *"Children's Council of San Francisco*" collects family income information to determine whether a child is eligible to receive a child care subsidy. The *"Children's Council"* uses this

income information to identify children who may be eligible to receive health services through Medicaid (called MediCal in California). Referral of such children to MediCal is done routinely. In 1995, the *"Children's Council*" and the City and County of San Francisco Department of Social Services joined forces to make Medicaid enrollment easier for working parents. The *Children's Council* sent letters to all parents with children on its waiting list for subsidized child care advising them that their children appeared to be eligible to receive health insurance through MediCal. Families were invited to meet with MediCal enrollment workers at the "*Children's Council"* satellite office on a Saturday morning. This meant parents could enroll their children in a familiar, comfortable setting at an hour that did not require them to take time off from their jobs. Bilingual enrollment workers were available to assist parents in Spanish and Cantonese. Child care also was provided.

Louisiana - Louisiana's Department of Health and Hospitals contracts with community-based organizations to become Medicaid Application Centers. The LaFourche Parish Head Start Program, serving approximately 520 children, participates in the program. Head Start staff are trained and certified by the State to complete Medicaid applications. Throughout the year, staff members contact families that appear to have children eligible for Medicaid. Medicaid information is provided to parents through individual classroom orientations, and monthly parent newsletters and flyers are posted throughout the agency. Teachers also refer families to the Medicaid-certified staff for assistance. Medicaid-certified staff offer opportunities for parents to fill out applications when they drop off or pick up their children. Head Start's costs for providing this valuable service are reimbursed with Medicaid administrative funds; certified Medicaid Application Centers receive $14 for each completed application.

Be sure the Medicaid outstation site addresses the needs of applicants in the community. For example, child care could be provided so parents can give their attention to completing the application. Interpreters may be offered for applicants who speak languages

other than English. Hours should be scheduled that are convenient for working families, such as early mornings, evenings or weekends.

New Mexico — In New Mexico, the Laguna Pueblo, Division of Early Childhood, conducts an annual event called *"Child Find"* in seven villages. During *"Child Find"* activities, children under age 5 receive comprehensive screening for developmental, nutritional, medical, vision, dental, and hearing problems. Children with special needs are identified and appropriate referrals are made. Flyers and posters promoting the *"Child Find"* are distributed by members of the Laguna Interagency Coordinating Council for Young Children, and through schools, post offices and local merchants. Upon entering the *"Child Find,"* each parent is asked whether the child has private health insurance or is enrolled in Medicaid. If not, a social worker from the Indian Health Services hospital facility is on hand to assist parents in filling out New Mexico's three-page Medicaid application. In 2-3 weeks the social worker checks in with the family to ensure that the process has gone smoothly and to find out if the child's Medicaid eligibility has been approved. They can provide assistance if there are any procedural problems.

Virginia — Child Health Investment Program *("CHIP")* of Virginia improves the health of young, low-income children by linking them with private physicians and dentists. Home visitors are the key to making this happen for more than 4,000 children currently participating in "*CHIP*" throughout the State. As *"CHIP"* home visitors develop an ongoing relationship with families, they help their families keep doctor appointments, follow through with recommended medical treatment, and obtain other services they may need. At the first *"CHIP"* visit, the home visitor finds out whether the family has Medicaid coverage. If not, the home visitor helps the family complete the State's two-page Medicaid application, which can be submitted by mail. Home visitors carry cell phones, which can come in handy for calling the Medicaid office to troubleshoot if questions arise while an application is being processed. *"CHIP*" home visitors also help

families keep their coverage by assisting them with Medicaid recertification.

Washington— Washington State's Child Care Resource and Referral Network trained telephone counselors in its 14-member CCR&Rs to screen callers for Medicaid income eligibility. The network now identifies children likely to be eligible for Medicaid and arranges for the State's Medical Assistance Administration to send families Washington's one-page Medicaid application form and basic information about the program. This form is available in seven languages and the completed form can be mailed directly to the State Medicaid agency in a pre-addressed, postage-paid envelope.

Pennsylvania — "*CHOICE*" in Philadelphia, which runs both a child care line and a health care line, goes a step further, when families who call for help in finding child care also need health insurance for their children, *"CHOICE"* telephone counselors can complete an application for either Medicaid or the State's child health insurance program while the family is on the line. Local early childhood programs also refer families to *"CHOICE"* for help in enrolling their children in Medicaid. Sometimes this help can ensure that a child can take advantage of an open slot in a Head Start or child care program, since having Medicaid coverage can be the link to obtaining immunizations or a well-child checkup needed for Head Start enrollment.

Wisconsin— In an effort to provide low-income working families with information about WIC and Medicaid, Wisconsin's Outagamie County WIC Program conducts informational presentations for managers of local hotels, restaurants, and hospitals. WIC staff provides business leaders with information on Medicaid eligibility guidelines, benefits, and where to apply, as well as with materials to post and hand out to their employees. As a result of these efforts, the management of the Holiday Inn in Appleton now provides information on WIC and Medicaid to housekeeping staff.

In addition, the safety committee and employee relations manager at the Ray-O-Vac battery manufacturing plant now posts information for its 150 employees through a health and safety bulletin board in each of the factory's two buildings.

Georgia — Georgia's *Right from the Start Medicaid Program ("RSM")* sends its 200 outreach workers into communities all over the State to find and enroll eligible pregnant women and children in Medicaid. Recently, "*RSM*" workers were invited to attend a training session for family child care providers in the Atlanta area. *RSM* workers discussed the benefits of the Medicaid program and demonstrated the easy application process. Family child care providers who are well informed about the application process - or who have been through it themselves - are in the best position to share this information with families of children in their care. Medicaid brochures and a local number to call were provided for family child care providers to share with parents of children in their care. Providers were given an opportunity to get their own children enrolled after the training.

Finally, the link between good health and learning is never so critical as in a child's early years. This is the time to nurture optimum growth and development — and to be on the lookout for any problems that require medical attention to prevent them from becoming major health concerns. Staff of early childhood programs - such as Head Start, child care centers, family child care homes, CCR&R agencies, and others have an important role to play in assuring the health of children in their care. Parents often rely on early childhood professionals who they know and trust for advice and help in finding health care for their children. But, obtaining medical services, especially preventive care, can be difficult — or next to impossible — without health insurance.

DEFINITIONS OF TERMS

1115 Waiver - Research and demonstration waiver for wide variety of Health and Human Services programs. For Medicaid purposes, usually used to make broad changes in eligibility, services, or the service delivery system.

Advisory Committee on Immunization Practices (ACIP) - The inter-disciplenary committee designated by Congress that determines the pediatric immunization schedule to which Vaccines for Children Program must adhere.

Capitation Rate - The fee the State Medicaid agency pays periodically to a contractor such as an HMO for each beneficiary enrolled under a contract for the provision of medical services under the State plan., whether or not the beneficiary receives the services during the period covered by the fee.

Case Management - A generic term used to describe the process of coordinating services. Case management also can be used to refer to a specific clinical monitoring and referral process.

Child Care Development Block Grant (CCDBG) - The Child Care and Development Block Grant as amended by Congress in Public Law 104-193 (Personal Responsibility and Work Opportunity Reconciliation Act) unified what was a fragmented child care system. Welfare reform repealed the welfare-connected child care programs (AFDC, JOBS, At-Risk and Transitional Child Care), and placed new child care funding under the aegis of the lead State agency for the Child Care and Development block Grant. The combined and increased funding therefore becomes part of a holistic and streamlined system for child care. The integrated funding sources consisting of both discretionary and mandatory Federal funds have a single, unified purpose. To reflect this integration of multiple funding sources, the Department of Health and Human Services has established a Child Care and Development Fund. This Fund (CCDF) supports all child care activities conducted across the country.

Child Care Resource and Referral Agency (CCR&R)- CCR&R agencies are community-based agencies with State networks and a national system of support and

technical assistance. The core mission of the CCR&R field is to support families in their most important role: nurturing children while striking a healthy balance between work and family responsibilities. Promoting the health, safety and wellness of young children in child care settings is a vital part of that mission. CCR&R organizations make linkages every day among families, child care providers, schools, employers and community resources.

Federal Financial Participation - Federal dollars used to match State contributions in State administered programs such as Medicaid.

Federal Poverty Level - The phrase FPL as used in this document means the Department of Health and Human Services Poverty Guidelines which are published each year in the Federal Register. The Poverty Guidelines are the administrative version of the Federal Poverty Measure. To obtain more information about the Poverty Guidelines, you may visit the Web site on the Internet at: <<http://aspe.os.dhhs.gov//poverty/poverty.htm>>

Fee-for-service (FFS) - A service provision model in which providers bill the State Medicaid agency directly for services provided to Medicaid-eligible beneficiaries.

Health Maintenance Organization (HMO) - An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to beneficiaries.

Individuals with Disabilities Education Act (IDEA) - Formally called the Education of the Handicapped Act, contains two parts:

> **Part B of IDEA -** designed to ensure that school-aged children with special education needs receive a free, appropriate public education. Under Part B, schools must prepare an
>
> Individualized Education Plan (IEP) as appropriate for a child which specifies all of the special education and "related (health) services" needed by the child.

Part C of IDEA - provides for early intervention programs that include all of the available developmental services needed by a toddler or infant and the development of an Individualized Family Service Plan (IFSP). Medicaid can potentially pay for some of the health-related services in an IEP and IFSP as discussed in this guide.

Managed Care Organization (MCO) - An entity that combines the health care delivery and financing of services. The entity is generally paid a prepaid, capitated premium and assumes financial risk for the services to be provided to or arranged for enrolled beneficiaries. MCO models included fully-capitated, partially capitated and primary care case management.

State Children's Health Insurance Program (CHIP)- The Balanced Budget Act of 1997 created Title XXI of the Social Security Act, also named State Children's Health Insurance Program. Title XXI enables States to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

State Medicaid Agency - The organization in each State directly responsible for the administration of the Medicaid program. Each State must designate a "single State agency" for purposes of accountability to HCFA, even though a number of State (and local) agencies may help the program and/or function as medical providers.

State Plan - A document between the States and Federal government which details the scope of the Medicaid program in the State by listing the services offered, any applicable requirements and limitations and the payment rates for those services. The State plan consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State Medicaid program. The State plan is submitted by the State and subject to approval from HCFA.

Supplemental Security Income (SSI) - Title XVI of the Social Security Act provides financial assistance to

needy individuals who have attained age 65 or are blind or disabled.

Temporary Assistance for Needy Families (TANF) - The TANF program replaces the former Aid to Families with Dependent Children (AFDC) and JOBS programs. Under TANF, States, territories, and tribes each receive a block grant allocation to cover benefits, administrative expenses, and services; States have a maintenance of effort requirement. States, territories, and tribes determine eligibility and benefit levels and services provided to needy families.

Title IV-E - Title IV-E, Foster Care and Adoption Assistance, of the Social Security Act enables each State to provide, in appropriate cases, foster care and transitional independent living programs for children who are otherwise eligible under TANF. Funds are available for monthly payments to foster care providers on behalf of foster children; one-time payments for the costs of adopting a child as well as monthly subsidies to adoptive parents who may be income eligible for subsidies; assistance to current or former foster care youths age 16 and older to help in the transition to independent living; and administrative costs incurred by States in the administration of these programs.

Title V - Title V, Maternal and Child Health (MCH) Services Block Grant, is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. The MCH Services Block Grant program has three components: formula block grants to 59 States and Territories, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service systems (CISS) grants. These block grants enable States to create Federal and State partnerships to develop service systems in our Nation’s communities to meet critical challenges in MCH.

Medicaid Eligibility of Pregnant Women, Infants, and Children

Effective October 1997*

	Pregnant Women and Infants	Children Below Age Six	Children Ages Six and Older		Children Ages Fifteen and Older
State	**Percent of FPL**	**Percent of FPL**	**Percent of FPL**	**Through Upper Age Limit***	**AFDC Standard/ FPL on 7/16/96****
Alabama	133%	133%	100%	14	15%
Alaska	133%	133%	100%	14	76%
Arizona	140%	133%	100%	14	32%
Arkansas	[133%][200%]	200%	200%	17	N/A
California	200%	133%	100%	14	82%
Colorado	133%	133%	100%	14	39%
Connecticut	185%	185%	185%	16	N/A
Delaware	185%	133%	100%	18	N/A
Florida	185%	133%	100%	14	28%
Georgia	185%	133%	100%	19	N/A
Hawaii	300%	300%	300%	19	N/A
Idaho	133%	133%	100%	14	29%
Illinois	133%	133%	100%	14	46%

Indiana	150%	133%	100%	18	N/A
Iowa	185%	133%	100%	14	39%
Kansas	150%	133%	100%	17	N/A
Kentucky	185%	133%	100%	14	33%
Louisiana	133%	133%	100%	18	N/A
Maine	185%	133%	125%	19	N/A
Maryland	185%	185%	185%	14	34%
Massachusetts	185%	133%	133%	17	N/A
Michigan	185%	150%	150%	18	N/A
Minnesota[c]	275%	275%	275%	20	N/A
Mississippi	185%	133%	100%	14	34%
Missouri	185%	133%	100%	18	N/A
Montana	133%	133%	100%	14	41%
Nebraska	150%	133%	100%	14	34%
Nevada	133%	133%	100%	14	45%
New Hampshire	185%	185%	185%	19	N/A
New Jersey	185%	133%	100%	14	41%
New Mexico	185%	185%	185%	19	N/A
New York	185%	133%	100%	14	61%
North Carolina	185%	133%	100%	18	N/A
North Dakota	133%	133%	100%	18	N/A

Ohio	133%	133%	100%	14	32%
Oklahoma	150%	133%	100%	14	28%
Oregon	133%	133%	100%	19	N/A
Pennsylvania	185%	133%	100%	14	39%
Rhode Island[c]	250%	250%	250%	17	N/A
South Carolina	185%	150%	150%	18	N/A
South Dakota	133%	133%	100%	19	N/A
Tennessee[c]	400%	400%	400%	17	N/A
Texas	185%	133%	100%	14	17%
Utah	133%	133%	100%	18	N/A
Vermont[d]	[200%][225%]	225%	225%	17	N/A
Virginia	133%	133%	100%	19	N/A
Washington[d]	[185%][200%]	200%	200%	19	N/A
West Virginia	150%	133%	100%	19	N/A
Wisconsin	185%	185%	100%	14	62%
Wyoming	133%	133%	100%	14	55%

Notes for Table: Medicaid Eligibility of Pregnant Women, Infants, and Children

N/A means not applicable.

* Under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), States are required

to provide Medicaid coverage to children ages 6 and older born after September 30, 1983, living in families with incomes below 100 percent of the Federal poverty level (FPL). Since 1989 States have been required to cover all pregnant women, as well as children below age 6, living in families with incomes at or below 133 percent of the FPL.

** The data in this column reflects the federal minimum requirements for states for children ages fifteen and older. Federal law requires States to provide Medicaid to children if they live in families with incomes that meet the State's old Aid to Families with Dependent Children, (AFDC) income eligibility standards in effect on July 16, 1996. If a State has expanded eligibility to older children beyond the OBRA 1990 mandate, the old AFDC standard as it applies to Medicaid eligibility is not applicable. The expansion supersedes the Federal minimums that were based on the AFDC standards.

a In Arkansas pregnant women are covered at 133 percent of the FPL and infants are covered up to 200 percent of the FPL.

b Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a Section 1115 waiver managed care program. Some populations receive fully subsidized services and others pay premiums. The State is considering a change in income eligibility that would take effect in late 1997. Pregnant women and infants living in families with incomes up to 185 percent of poverty would be eligible for fully subsidized Medicaid; children below age 6 living in families with incomes up to 133 percent of poverty would be eligible; and older children living in families with incomes below 100 percent of poverty would be eligible.

c Maryland, Minnesota, Rhode Island, and Tennessee operate programs under Section 1115 waivers. Some populations receive fully subsidized Medicaid services. Other populations are required to pay a portion of the premium and may have a different benefits package.

d In Vermont, pregnant women are covered at 200 percent of the FPL and infants are covered up to 225 percent of the FPL. In Washington the income eligibility criterion for pregnant women is 185 percent of poverty; the income eligibility criterion for infants is 200 percent of poverty.

Health Resources and Services Administration

Maternal and Child Health Bureau

Office of State and Community Health

Title V - Hotline List

Healthy Start 800-311-BABY

STATE	**MCH 800 Numbers**
Alabama	800-654-1385
Alaska	800-478-2221
Arizona	800-833-4642
Arkansas	800-235-0002
California	800-222-9999
Colorado	800-688-7777
Connecticut	800-505-2000

Delaware	800-484-4357
District of Columbia	800-MOM-BABY
Florida	800-451-BABY
Georgia	800-822-2539
Hawaii	800-772-3020
Idaho	800-926-2588
Illinois	800-323-4769
Indiana	800-433-0746
Iowa	800-369-2229
Kansas	800-332-6262
Kentucky	800-462-6122
Louisiana	800-251-BABY
Maine	800-698-3624
Maryland	800-456-8900
Michigan	800-26-BIRTH
Minnesota	NA
Mississippi	800-721-7222
Missouri	800-835-5465

STATE	**MCH 800 Numbers**

Montana	800-421-MOMS		
Nebraska	800-862-1889	Nevada	800-862-1889
New Hampshire	800-852-3345		
New Jersey	800-328-3838		
New Mexico	800-552-8195		
New York	800-522-5006		
North Carolina	800-367-2229		
North Dakota	800-472-2286		
Ohio	800-755-GROW		
Oklahoma	800-42-OASIS		
Oregon	800-723-3638		
Pennsylvania	800-986-2229		
Puerto Rica	800-981-5567		
Rhode Island	800-346-1004		
South Carolina	800-868-0404		
South Dakota	800-529-5000		
Tennessee	800-428-BABY		
Texas	800-422-2956		
Utah	800-826-9662		
Vermont	800-649-4357		
Virginia	800-230-6977		
Washington	800-322-2588		
West Virginia	800-642-8522		

Wisconsin	800-722-2295
Wyoming	800-994-4769

REGIONAL CONTACTS

For each of the ten Federal regions, contacts are listed in the following order:

- HCFA Associate Regional Administrator
- EPSDT Regional Coordinator
- ACF Assistant Regional Administrator
- ACF Regional Child Care Liaison
- PHS Regional MCH Program Consultant

Region I: Connecticut, Maine, Massachusetts, Rhode Island, Vermont

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
JFK Federal Building, Room 2350
Boston, MA 02203-0003
(617) 565-1223
(617) 565-1083 Fax

HCFA, MCH/EPSDT Coordinator (617) 565-1248
(617) 565-1083 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
JFK Federal Building, Room 2000
Government Center
Boston, MA 02203
(617) 565-1150
(617 565-2493 Fax

ACF, Child Care Liaison
Program Specialist, Child Care Unit
JFK Federal Building, Room 2025
Government Center
Boston, MA 02203

(617) 565-1152
(617) 565-2493 Fax

PHS, MCH Program Consultant
JFK Federal Building, Room 1826
Government Center
Boston, MA 02203
(617) 565-1433
(617) 565-3044 Fax

Region II: New Jersey, New York, Puerto Rico, Virgin Islands

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
Room 3811
26 Federal Plaza
New York, NY 10278
(212) 264-4488
(212) 264-2580 Fax

HCFA, MCH/EPSDT Coordinator (212) 264-3841
(212) 264-2790 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
Room 1243
26 Federal Plaza
New York, NY 10278
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Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

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Region V: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

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Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

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Region VII: Iowa, Kansas, Missouri, Nebraska

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Region IX: American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Marianas Islands

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For Each State and Territory Contacts are Listed in the Following Order:

- State Medicaid Director
- State EPSDT Coordinator
- State Maternal and Child Health Director
- State Coordinator for Children with Disabilities
- State Child Care and Development Fund Contact
- **Tribal Child Care & Development Fund Contact

For information about State Child Care Resource and Referral Agencies, contact the National Association of Child Care Resource and Referral Agencies, 1319 F Street, NW, Suite 810, Washington, DC 20004. Telephone: (202) 393-5501 - Fax: (202) 393-1109

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Children's Rehabilitative Services
Alabama Department of Rehabilitation Services
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