Managed Care's Impact on Medicaid Financing for Early Intervention Services

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Medicaid has been a major source of financing for early intervention services since the inception of the Infants and Toddlers with Disabilities Program in 1986. In this article, the authors analyze Medicaid financing of early intervention services in 39 States before and after the introduction of managed care. The association between level of Medicaid financing and program characteristics, provider arrangements, managed care carve-out policies, and managed care contract requirements is assessed. The authors discuss the reduction of Medicaid financing after managed care and its implications for State Infants and Toddlers with Disabilities Programs, State Medicaid agencies, and managed care organizations.

INTRODUCTION

The Infants and Toddlers with Disabilities Program (ITDP), originally established as Part H of the Education of the Handicapped Act and later reauthorized as Part C of the Individuals with Disabilities Education Act (IDEA), provides financial assistance to States[1] for the development of coordinated, statewide service systems to meet the needs of infants and toddlers with disabilities and their families. These systems are to provide for a wide array of services, including screening and assessments, ancillary therapies, psychological services, home visiting and family training, medical services for diagnostic purposes, and certain health services, as well as special instruction. Services for each eligible child are to be furnished in accordance with an individualized family service plan (IFSP), which identifies specific goals for the child and family, specifies the services needed to meet these goals, and establishes a timeframe for attaining them.

As federally defined, an infant or toddler is presumed to have a disability, and therefore to be eligible for the ITDP, if he or she is under 3 years of age and meets State-specific criteria for delay in physical, cognitive, communication, social or emotional, or adaptive development,[2] or for a diagnosed physical or mental condition that has a high probability of resulting in such a delay. An infant or toddler, at the option of the State, may also be considered to have a disability if he or she is otherwise "at risk" for developmental delay,[3] and eight States

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[1] The fiscal year 1998 appropriation for Part C of the IDEA was $350 million. National estimates of State appropriations and third-party payments for early intervention services are not available from any Federal source. According to Georgetown University's Child Development Center, which is part of the National Early Childhood Technical Assistance System, State appropriations range from $0 to about $40 million.

[2] States define developmental delay in a variety of ways, using both quantitative and qualitative information, including the difference between chronological age and actual performance levels, number of months below chronological age, standard deviations below the mean or norm in one or more developmental areas, and informed clinical judgment.

[3] States define "at risk" to include children with a history of significant biological and/or medical conditions or children exposed to environmental risk, such as parental substance abuse or child abuse and neglect.

have elected to include these children in their early intervention programs (Shackelford, 1998).

Since the inception of the program in 1986, the intent of Congress has been for States to finance their early intervention service systems through a variety of public and private sources, including Medicaid. As stipulated in the enabling legislation, funds available for the ITDP cannot be used to substitute for other public or private funds that would otherwise have paid for an early intervention service. With respect to public financing sources such as Medicaid, States are to develop interagency agreements that delineate funding responsibility and establish the ITDP as the payor of last resort. In support of this policy, the Medicaid statute was subsequently revised to clarify that, although Medicaid programs are generally prohibited from paying for services that are available to recipients at no cost, such programs are not prohibited from paying for early intervention services covered under a State's Medicaid plan (Public Law 100-360).

The opportunities for Medicaid financing of early intervention services are considerable. Medicaid permits coverage for nearly all early intervention services except special instruction. In addition to hospital and physician services, Medicaid, through its various benefit categories, can cover preventive, diagnostic, therapeutic, or rehabilitative services furnished at any site by licensed professionals (such as nurses, psychologists, social workers, and ancillary therapists) or, if recommended by a physician or other licensed practitioner, by other staff. Services can also be furnished in clinic settings under the direction of a physician.

Moreover, a large proportion of children eligible to receive early intervention services are also eligible for Medicaid.[4] The Federal Medicaid statute requires States to extend Medicaid to infants with incomes up to 133 percent of the Federal poverty level, the equivalent of approximately $22,000 for a family of four in 1998. Through optional eligibility provisions and waivers, 35 States have elected to cover infants in families with incomes up to 150 percent of poverty or higher, and 14 have elected to cover toddlers as well as infants in the same income category (Long and Liska, 1998). It is estimated that approximately 30 percent of children from birth to age 3 are enrolled in the Medicaid program (Newacheck, 1998). With the implementation of the new State Children's Health Insurance Program (CHIP), as many as 16 States expect to bring infants and young children in families with higher incomes into the Medicaid program.[5]

The purpose of this study was to examine how the shift from fee-for-service (FFS) payments to the use of capitated managed care plans has affected the availability of Medicaid financing for early intervention services and, as a result, access to early intervention services by Medicaid beneficiaries. In 1993 only 10 percent of Medicaid beneficiaries were enrolled in some form of capitated managed care arrangement; 4 years later, that proportion had jumped to 47 percent.[6] No longer are

[4] National estimates of the number of children who receive early intervention services and are eligible for Medicaid are not available from any Federal source.

[5] This information was obtained from CHIP applications submitted to HCFA as of August 1, 1998.

[6] We calculated these figures using HCFA's data on Medicaid managed care enrollment statistics. The 1993 percentage of Medicaid managed care enrollees represents beneficiaries enrolled in health insuring organizations, health maintenance organizations (HMOs), and prepaid health plans. The 1997 percentage includes beneficiaries enrolled in health insuring organizations, HMOs, prepaid health plans, and other capitated arrangements such as preferred provider organizations. Because children represent a significant proportion of Medicaid managed care enrollees, these figures most likely underestimate the extent of their enrollment (Health Care Financing Administration, 1994, 1998).

Medicaid agencies paying all of their service providers directly. Increasingly, agencies are becoming purchasers of insurance and leaving service authorization and payment decisions to plans. The intent of this study was to understand how enrollment in managed care may have changed the flow of Medicaid resources to State programs for infants and toddlers with disabilities and to identify program characteristics and other factors associated with higher levels of Medicaid financing.

There has been no published literature on this topic. In 1992 an article examining public health insurance for early intervention services documented extensive coverage opportunities available through Medicaid, despite significant variation in coverage policies from State to State (Fox, McManus, and Newacheck, 1992). However, this study was conducted well before States began enrolling large numbers of Medicaid-eligible children into managed care organizations. What literature exists on managed care and children suggests that children enrolled in Medicaid managed care organizations may be more likely to receive preventive care but less likely to receive interventions to address special needs such as developmental or mental health problems than children in traditional FFS arrangements (Fox and McManus, 1996; Fox and McManus, 1992; Fox, Wicks, and Newacheck, 1993; Freund and Lewit, 1993; Kelleher and Scholle, 1995).

METHODS

Multiple data sources were used for this analysis. The primary source was a structured telephone interview survey of directors of State ITDPs, but we also drew upon a telephone interview survey of State Medicaid agency directors and an analysis of Medicaid managed care contracts.

The survey of programs for infants and toddlers with disabilities was conducted in the 39 States that, at the time of our study, had been enrolling at least some Medicaid-eligible children in managed care organizations for 6 months or longer and that had relied on Medicaid financing for at least some early intervention services prior to the introduction of Medicaid managed care.[7] The interviews were conducted in the fall 1997; followup questions were asked in subsequent months for purposes of clarification.

The early intervention survey questionnaire, which was pretested in a small number of States, was structured with a combination of closed and open-ended questions to elicit information about Medicaid payment for 12 different early intervention services prior to and following the introduction of managed care. The 12 services are those specified in Part C of the IDEA legislation: early identification, screening, and assessment; service coordination; speech pathology and audiology services; occupational therapy services; physical therapy services; psychological services; social work services; vision services; medical services for diagnostic purposes; health services that enable infants and toddlers to benefit from other early intervention services; family training, counseling, and home visits; and assistive technology. We chose not to include special instruction because this service is not technically covered under Medicaid law.

For each of the 12 services, we asked the State program directors to estimate the frequency of Medicaid coverage (defined as always, sometimes, or never). We did not attempt to obtain actual claims payment data. To understand what factors

[7] At the time of our study, 43 States were enrolling Medicaid-eligible children in managed care organizations, but 4 of these States were excluded from the study. Alabama's Medicaid managed care program had been operational for only 1 month; Arizona had no FFS history; and Iowa and Oregon had never used Medicaid to finance any early intervention services.

may have influenced payment, we inquired about the settings in which the service was delivered, the type of providers used, and the type of organizations that employed these providers, as well as the Medicaid benefit category used for billing prior to managed care. We also asked about the structure of the State program for infants and toddlers with disabilities and whether it would be described at the local level as a center-based system, a multi-agency system, a system in which early intervention services are integrated into various programs serving all young children and families, or some combination of these.[8] Finally, we asked about State directors' perceptions regarding the extent to which the shift to managed care had affected Medicaid financing. A 100-percent response rate was obtained through multiple callbacks.

In addition to surveying State directors of programs for infants and toddlers with disabilities, we obtained information about State Medicaid managed care polices through two other sources. One source of information was a structured telephone survey that we conducted with State Medicaid managed care staff also in the fall 1997. We asked about whether managed care was in place statewide, for which groups enrollment was mandatory, and which, if any, early intervention services were excluded from the managed care contract and paid for directly by the State Medicaid agency under a separate FFS arrangement. The other source of information was the State managed care contracts. We analyzed the contracts used by each of the 39 States to determine what, if any, directives were given to plans regarding their financial responsibilities for Medicaid-covered early intervention services covered under the contract.

As part of our analysis, we ranked each program for infants and toddlers with disabilities according to whether it had a high, medium, or low level of Medicaid financing for its services before and after managed care. States categorized as high were those that reported always having Medicaid financing for 8 or more of the 12 types of early intervention services. States categorized as low were those that reported never having Medicaid financing for four or more types of early intervention services. All other States were defined as medium. We arrived at this categorization based on the clustering of responses. The level of Medicaid financing was analyzed according to program structure and Medicaid managed care policies. We also examined the association between the State level of Medicaid financing and the lead State agency administering the program for infants and toddlers with disabilities (health, education, and other) and the State criteria for service eligibility. We obtained this information from the Federal Office of Special Education and Rehabilitative Services and, based on the measurable degree of developmental delay required and whether the at-risk population was included, we categorized

[8] A center-based system is defined as one that provides a variety of multi-disciplinary services delivered at designated facilities in each community primarily to address the developmental needs of the child. A multi-agency delivery system is defined as one that furnishes services through a network of individual programs from a variety of community agencies to address the child's educational and welfare needs as well as developmental needs. An integrated delivery system is defined as one that primarily offers services in natural environments, including non-medical settings such as child care programs, to address the developmental needs of children and their families in a mainstream fashion.

States' eligibility criteria as least restrictive, moderately restrictive, significantly restrictive, and most restrictive.[9]

The findings on Medicaid coverage of early intervention services are presented before and after the introduction of managed care for each service. Questions regarding coverage information after managed care were asked only with respect to children enrolled in managed care organizations. The extent to which programs for infants and toddlers with disabilities received Medicaid financing after managed care was analyzed in terms of State program characteristics, provider arrangements, managed care carve-out policies, and Medicaid managed care contract requirements.

RESULTS

Pre-Managed Care

Prior to the introduction of managed care (and continuing in geographic areas where managed care had not yet been introduced), early intervention providers who wanted to obtain payment for Medicaid-covered services furnished to eligible children submitted claims directly to their State Medicaid agencies. Of the 12 types of early intervention services delivered by the ITDPs, the number that were always, sometimes, or never covered by Medicaid varied considerably by State. On average, however, programs reported that 5.1 services were always covered, 5.7 were sometimes covered, and 1.5 were never covered.

The types of early intervention services most likely to be paid for by Medicaid were medical services, physical therapy, occupational therapy, speech therapy, and psychological services. These services were always paid for in one-half or more of the States and never covered in only a small percentage (Table 1). Service coordination and social work services also were always covered in one-half or more of the States, although the proportion of programs reporting that these services were never covered was higher. With the exception of service coordination—which programs tended to furnish using various combinations of health, education, and other providers—all the highly compensated services were conventional medical services delivered almost exclusively by licensed health professionals. Highly compensated services, however, were not distinguished from other services with respect to the settings in which they were furnished or the entity that employed the providers. Overall, they were just as likely as other services to be offered in clinics or centers, homes or child care centers, or a combination of settings, and just as likely to be furnished by providers employed by public or private agencies, various health care organizations or independent arrangements, or a combination of agencies and health employers.

The types of services least likely to be covered by Medicaid were vision services (which are essentially orientation and mobility training for visual impairments) and family training, counseling, and home visits. For both services, only about one-third of the State programs reported that they were always covered and an equal proportion reported that they were never

[9] The "least restrictive" category was defined to include States that served at-risk children as well as children with significant delay or difference between expected level of development and current level of functioning or with ≤25 percent delay in one or more areas or 1.5 standard deviations below the norm in one area. The "moderately restrictive" category was defined to include States that served at-risk children as well as children with 30-50 percent delay in one or more areas or 2.0 standard deviations below the norm in one area, or States that did not serve at-risk children but served children with significant delay or difference between the expected level of development and current level of functioning. The "significantly restrictive" category was defined to include States that served only children who showed ≤25 percent delay in one or more areas or 1.5 standard deviations below the norm in one area. The "most restrictive" category was defined to include States that served only children who demonstrated 30-50 percent delay in one or more areas or 2.0 standard deviations below the norm in one area.

Table 1

Frequency of Medicaid Financing for Early Intervention Services Before and After Managed Care, According to Medicaid Capitation Policies

	All States[1]				States With Some or All Services Capitated[2]				States With All Services Capitated[3]			
	Before Managed Care		After Managed Care		Before Managed Care		After Managed Care		Before Managed Care		After Managed Care	
Early Intervention Services	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Service Coordination												
Always	24	62	18	46	7	50	1	7	6	47	1	8
Sometimes	7	18	5	13	3	21	1	7	3	23	2	15
Never	8	21	15	38	4	29	11	79	4	31	9	69
Physical Therapy												
Always	21	54	14	36	11	52	4	19	6	46	2	15
Sometimes	17	44	24	62	9	43	16	76	6	46	10	77
Never	1	3	1	3	1	5	1	5	1	8	1	8
Occupational Therapy												
Always	21	54	14	36	11	52	4	19	6	46	2	15
Sometimes	17	44	24	62	9	43	16	76	6	46	10	77
Never	1	3	1	3	1	5	1	5	1	8	1	8
Speech Therapy												
Always	21	54	14	36	11	52	4	19	6	46	2	15
Sometimes	17	44	24	62	9	43	16	76	6	46	10	77
Never	1	3	1	3	1	5	1	1	1	8	1	8
Psychological												
Always	19	49	17	44	10	45	8	36	6	46	4	31
Sometimes	17	44	14	36	10	45	7	32	5	38	5	38
Never	2	5	6	15	1	5	5	23	1	8	2	15
Medical												
Always	23	59	23	59	13	57	13	57	5	38	6	46
Sometimes	14	36	13	33	9	39	8	35	7	54	6	46
Never	2	5	3	8	1	4	2	9	1	8	1	8
Enabling Health												
Always	13	33	16	41	5	22	8	35	4	31	4	31
Sometimes	21	54	19	49	15	65	12	52	7	54	8	62
Never	3	8	3	8	1	4	2	9	1	8	1	8

See footnotes at end of table.

Table 1—Continued

Frequency of Medicaid Financing for Early Intervention Services Before and After Managed Care, According to Medicaid Capitation Policies

Early Intervention Services	All States[1]				States With Some or All Services Capitated[2]				States With All Services Capitated[3]			
	Before Managed Care		After Managed Care		Before Managed Care		After Managed Care		Before Managed Care		After Managed Care	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Family Training, Counseling, and Home Visits												
Always	12	31	10	26	3	14	1	5	1	8	1	8
Sometimes	14	36	12	31	8	36	6	27	4	31	4	31
Never	13	33	17	44	11	50	15	68	8	62	8	62
Early Identification, Screening, and Assessment												
Always	6	15	7	18	2	9	3	13	1	8	0	0
Sometimes	30	77	22	56	19	83	16	70	11	85	2	15
Never	3	8	10	26	2	9	4	17	1	8	11	85
Vision												
Always	13	33	13	33	6	27	6	27	5	38	4	31
Sometimes	14	36	14	36	9	41	9	41	4	31	3	23
Never	12	31	9	23	7	32	5	23	4	31	6	46
Assistive Technology												
Always	6	15	3	8	5	23	2	9	4	31	1	8
Sometimes	28	72	28	72	14	64	14	64	6	46	3	23
Never	5	13	6	15	3	14	4	18	3	23	7	54
Social Work												
Always	19	49	14	36	8	40	3	15	4	31	0	0
Sometimes	14	36	17	44	8	40	11	55	5	38	4	31
Never	6	15	6	15	4	20	4	20	4	31	8	62

[1] n = 39, but numbers for each service may not always add to 39 because of "don't know" responses.

[2] n = 14, but total numbers for each service range from 14-24, depending on the State's carve-out policy for the particular service. For service coordination, n = 14. For social work services, n = 20. For physical therapy services, occupational therapy services, and speech therapy services, n = 21. For psychological services; family training, counseling, and home visits; vision services; and assistive technology, n = 22. For medical services; enabling services; and early identification, screening, and assessment services, n = 23. In addition, total numbers for each service sometimes reflect "don't know" responses.

[3] n = 13, but numbers for each service may not always add to 13 because of "don't know" responses. The 13 States with all services capitated are a subset of the 24 States with some or all services capitated.

SOURCE: Information obtained by Fox Health Policy Consultants through telephone surveys of Directors of State Infants and Toddlers With Disabilities Programs during the fall 1997.

covered. Although assistive technology and early identification, screening, and assessment were less frequently identified as "never covered" by Medicaid, they were also less frequently cited as "always covered." Compared with the highly compensated services, the poorly compensated group was far more likely to be furnished using a combination of education and health providers rather than licensed health professionals alone.

We found that State programs for infants and toddlers with disabilities showed substantial variation in their ability to obtain Medicaid financing prior to managed care. Those that secured a high level of Medicaid financing were most likely to be health agencies, to operate a center-based system of services and, surprisingly, to apply either the most or least restrictive criteria for program eligibility. More significantly, they were programs that had negotiated special billing arrangements with their Medicaid agencies enabling them to bill for several types of early intervention services (sometimes as many as seven) under a single Medicaid benefit category (usually rehabilitative services) or to have special billing codes under various benefit categories. States with such arrangements were more than twice as likely to fall into the high-Medicaid-financing group than States were generally.

Post-Managed Care

After the introduction of managed care, programs for infants and toddlers with disabilities became dependent on private plans to provide or pay for their services, and they experienced a decrease in Medicaid financing. Programs reported, on average, that of the 12 types of early intervention services they furnished, Medicaid financing was always available for only 4.3 services under managed care, compared with 5.1 services before, and never available for 2.0 services, compared with 1.5 services before. The decrease in Medicaid financing was not consistent across services (Table 1). Six types of services (service coordination, the three ancillary therapies, assistive technology, and social work services) saw a substantial decrease in the proportion of programs reporting that they were always financed by Medicaid. Four services (service coordination; psychological services; family training, counseling, and home visits; and early identification, screening, and assessment) saw a substantial increase in the proportion reporting they were never financed by Medicaid. Yet, enabling health services, which were unexplainably not in the highly compensated group prior to managed care, were more often always Medicaid-financed under managed care arrangements; and vision services were less frequently reported as "never financed" by Medicaid.

However, as Medicaid agencies began to enroll children in managed care, most of the 39 carved at least some early intervention out of their capitated managed care contracts in order to ensure continued FFS coverage for early intervention services to Medicaid-eligible children. In fact, only 12 of the 39 Medicaid agencies did not establish any special financing arrangements for early intervention services after the introduction of managed care.[10] Fifteen Medicaid agencies chose to exclude all early intervention services from their capitated contracts and an additional 11 chose to exclude some services—as few as 1 or as many as 11, but most often including service coordination and ancillary therapies. Programs that were able to secure a

[10] We included Rhode Island in this group of States without a carve-out policy for early intervention services, although the State does pay for physical therapy, occupational therapy, and speech therapy services on a FFS basis after a plan has expended $3,000.

Table 2

Characteristics of State Infants and Toddlers with Disabilities Programs, According to Medicaid Capitation Policies

Program Characteristics	All States After Managed Care[1]		States With Some or All Services Capitated[2]		States With All Services Excluded From Capitation[3]	
	Number	Percent	Number	Percent	Number	Percent
Lead Agency						
Health	18	46	10	42	8	53
Education	10	26	7	29	3	20
Other	11	11	7	29	4	27
Type of Program						
Center-based	23	59	12	50	11	73
Multi-agency	12	31	8	33	4	27
Other	4	10	4	17	0	0
Eligibility Definitions						
Least Restrictive	7	18	6	25	1	7
Moderately Restrictive	8	21	6	25	2	13
Significantly Restrictive	13	33	8	33	5	33
Most Restrictive	11	28	4	17	7	47
Billing Arrangement Prior to Managed Care						
Special Billing Arrangement	14	36	6	25	8	53
No Special Billing Arrangement	25	64	18	75	7	47

[1] $n = 39$.

[2] $n = 24$.

[3] $n = 15$.

SOURCE: Information obtained by Fox Health Policy Consultants through telephone surveys of Directors of State Infants and Toddlers With Disabilities Programs during the fall 1997.

Medicaid carve-out arrangement for all of their early intervention services tended to be health agencies, to operate center-based service systems, and to use the most restrictive eligibility criteria. In addition, they were much more likely than other programs to have had special billing arrangements prior to managed care (Table 2).

Not surprisingly in States with early intervention service carve-outs, programs reported little or no change in Medicaid financing for excluded services. After managed care, all services excluded from managed care contracts—except for medical services and assistive technology—had a substantially higher proportion of programs reporting that they were always covered, compared with early intervention services overall. For family training, counseling, and home visits, the difference was twofold.

In States where Medicaid-covered services were presumed to be included in managed care contracts, Medicaid financing for early intervention services was much less available. The 24 programs in States with some or no early intervention carve-outs reported, on average, that only 3.2 of the 12 types of services were always financed by Medicaid, and the 13 programs in States with no carve-out protection reported that only 2.1 services were always paid for by Medicaid (Table 3). In addition, programs in both situations, but particularly those with all of their services presumed to be included in managed care contracts, experienced a more dramatic decrease in Medicaid financing after the introduction of managed care than programs for infants and toddlers with disabilities did generally. These programs, however, had been far less successful in securing Medicaid financing even prior to managed care.

Without carve-out protection, Medicaid financing for most types of early intervention services decreased substantially once children were enrolled in managed care

Table 3

Average Frequency of Medicaid Financing for 12 Types of Early Intervention Services Before and After Managed Care, According to Medicaid Capitation Policies

	All States After		States With Some or All Services Capitated		States With All Services Capitated	
Average Frequency	Before Managed Care	After Managed Care	Before Managed Care	After Managed Care	Before Managed Care	After Managed Care
Always	5.1	4.3	4.6	3.2	4.2	2.1
Sometimes	5.7	5.8	5.9	6.2	5.6	5.3
Never	1.5	2.0	1.8	2.5	2.4	4.5

NOTE: Numbers do not add to 12 because of rounding.

SOURCE: Information obtained by Fox Health Policy Consultants through telephone surveys of Directors of State Infants and Toddlers With Disabilities Programs during the fall 1997.

plans. Eight services (service coordination; the three ancillary therapies; psychological services; family training, counseling, and home visiting; early identification, screening, and assessment services; and social work services) had a substantially lower proportion of States reporting that these services were always covered when included in managed care contracts than overall. Moreover, the decreases these services experienced in always being financed by Medicaid after managed care were fairly dramatic (ranging from 20-98 percent), particularly compared with those for early intervention services overall (ranging from 11-46 percent). Interestingly, though, services that were financed by Medicaid plans were far more likely to be furnished through the plans' own provider networks than through providers associated with programs for infants and toddlers with disabilities.

Although some State Medicaid agencies established financing requirements for early intervention services in their managed care contracts, contract language apparently did not have an effect on a program's level of Medicaid financing. As shown in Table 4, in States where plans were required to provide any medically necessary early intervention service or even to provide all Medicaid-covered services recommended in an IFSP, programs were just as likely to fall into the low-financing category as programs in States with no plan requirements.

In fact, after the introduction of managed care, the majority of the 39 programs for infants and toddlers with disabilities had a low level of Medicaid financing, whereas previously the Medicaid financing level for most States was in the medium range (Table 5). The more types of early intervention services that were presumed to be included in a State's Medicaid managed care contract, the greater the likelihood that the State's level of Medicaid financing would be categorized as low. Among programs in States with all early intervention services capitated, the proportion with a low level of Medicaid financing was 85 percent.

Yet the growing enrollment of Medicaid-eligible children in managed care plans apparently did not affect the overall availability of Medicaid financing for early intervention services, according to most programs. Fifty-nine percent reported that managed care had not reduced overall Medicaid financing, 21 percent reported that it had, and an equal proportion reported that they were not able to assess the overall impact. Among programs in States that had some or all early intervention services presumably included in managed care contracts, the proportion unable to respond was the same, but a larger share,

Table 4

Level of Medicaid Financing for State Infants and Toddlers With Disabilities Programs Before and After Managed Care, According to Contract Language

Managed Care Contract Language	Level of Medicaid Financing					
	High[1]		Medium[2]		Low[3]	
	Number	Percent	Number	Percent	Number	Percent
States With Some or All Services Capitated (*n* = 24)						
Before Managed Care	7	29	13	54	4	17
After Managed Care	3	13	3	13	18	75
Requires Plans to Provide All Medicaid-Covered Services Recommended in an IFSP (*n* = 4)						
Before Managed Care	2	50	2	50	0	0
After Managed Care	1	25	0	0	3	75
Requires Plans to Provide Any Early Intervention Service That Is Medically Necessary (*n* = 5)						
Before Managed Care	2	40	2	40	1	20
After Managed Care	1	20	0	0	4	80
No Contract Specifications (*n* = 15)						
Before Managed Care	3	20	9	60	3	20
After Managed Care	1	7	3	20	11	73

[1] Programs that reported always having Medicaid financing for 8 or more early intervention services.

[2] Programs that were not categorized as either high or low.

[3] Programs that reported never having Medicaid financing for 4 or more early intervention services.

NOTE: IFSP is individualized family service plan.

SOURCE: Information obtained by Fox Health Policy Consultants through telephone surveys of Directors of State Infants and Toddlers With Disabilities Programs during the fall 1997.

though still not the majority, reported that Medicaid financing was reduced. When asked whether changes in Medicaid financing affected access to early intervention services, three-quarters of the 39 programs reported that they did not know.[11]

DISCUSSION

Our results indicate that prior to managed care, State programs for infants and toddlers with disabilities relied significantly on Medicaid to finance their early intervention service system. Although there was enormous State variation, certain early intervention services were far more likely to be covered than others, namely those delivered by licensed health professionals. Medical services, ancillary therapies, psychological services, social work services, and service coordination were commonly covered by Medicaid, but early identification, screening, and assessment services; family training and home visits; assistive technology; and vision services were not.

Following the introduction of managed care, programs reported reductions in Medicaid financing for most early intervention services. Only financing for enabling health and vision services improved. Programs with a high level of Medicaid financing after managed care were more likely to have carve-out arrangements for some or all of their services. Not surprisingly, many of these were programs that had negotiated special Medicaid billing arrangements prior to managed care. Twenty-four States had transferred to managed care organizations at least some early intervention service responsibility. Despite this historic shift, only 9 of the 24 State Medicaid agencies that capitated some or all early intervention services articulated in their contracts that plans were responsible for financing

[11] Data additional to that presented in the tables may be obtained from the authors upon request.

Table 5

Level of Medicaid Financing for State Infants and Toddlers With Disabilities Programs Before and After Managed Care, According to Medicaid Capitation Policies

Managed Care Contract Language	Level of Medicaid Financing					
	High[1]		Medium[2]		Low[3]	
	Number	Percent	Number	Percent	Number	Percent
All States (*n* = 39)						
Before Managed Care	13	33	21	54	5	13
After Managed Care	9	23	3	8	27	69
States With Some or All Services Capitated (*n* = 24)						
Before Managed Care	7	29	13	54	4	17
After Managed Care	3	13	3	13	18	75
States With All Services Capitated (*n* = 13)						
Before Managed Care	4	31	5	38	4	31
After Managed Care	0	0	2	15	11	85

[1] Programs that reported always having Medicaid financing for 8 or more early intervention services.

[2] Programs that were not categorized as either high or low.

[3] Programs that reported never having Medicaid financing for 4 or more early intervention services.

SOURCE: Information obtained by Fox Health Policy Consultants through telephone surveys of Directors of State Infants and Toddlers With Disabilities Programs during the fall 1997.

these services. However, even where States specified plan requirements for providing these services, our survey revealed no association with the level of Medicaid financing. In other words, contract language was obviously necessary but not sufficient to affect the continued Medicaid financing of early intervention services, which are likely to be viewed by plans as educationally related and not medically necessary. Appropriate guidance from State Medicaid agencies regarding pediatric medical-necessity standards is critical. Equally important is the need for Medicaid agencies to monitor access to covered services recommended in IFSPs through focused studies and to specify provider network requirements that include early intervention service providers in their managed care contracts.

Reductions in Medicaid financing after managed care may also be because of the reluctance on the part of staff for the ITDPs to negotiate with State Medicaid agencies and managed care plans. Our interviews suggested that many programs may not be sufficiently involved in financial planning for their services. The vast majority had not conducted any formal or informal evaluation of the impact of Medicaid managed care on early intervention financing and access. In addition, many programs may not be involved with medical diagnosis and assessments and, therefore, may be unable to provide plans with the necessary documentation of medical necessity for specific interventions or to secure authorization for a referral from the child's primary care provider. Although medical services for diagnostic purposes are included in the list of services authorized under the Federal legislation, a significant number of programs reported that these services were rarely part of an IFSP.

We were somewhat surprised to find that relatively few State programs reported an overall reduction in financing for early intervention services after the introduction of managed care. The lack of overall impact apparently is because in most States managed care is new and has not been introduced statewide. Also, families whose children are receiving early intervention services are frequently opting out of managed care where enrollment is voluntary. In addition, some programs, not knowing

whether a child is in managed care, reportedly have continued to bill Medicaid agencies on a FFS basis, and Medicaid agencies, for their part, have continued to pay these claims, perhaps recognizing their legal obligation to finance all medically necessary covered services.

Many State Medicaid agencies may want to continue to protect the flow of revenue to programs for infants and toddlers with disabilities by carving the services they furnish out of managed care contracts and paying for them on a FFS basis or eventually capitating them separately. This strategy, as our findings show, would benefit the programs financially. It would not, however, ensure that managed care plans enrolling Medicaid-eligible children were organized to furnish the continuum of service coordination, ancillary therapy, and family support services that young children with various degrees of developmental delay and disability may require. Without this capacity, the needs of children eligible for early intervention services may be well met outside of plans, but those of children who fail to meet these criteria may be neglected.

In closing, it must be stated that the policy implications of this study are limited by the fact that findings are based on interview data from State directors of programs for infants and toddlers with disabilities. Although the study reveals important changes in Medicaid financing for early intervention services after the introduction of managed care, additional research is needed to provide evidence of actual Medicaid and Part C program payments for these services. Research is also needed to evaluate the impact of various Medicaid capitation policies on access to early intervention services and on the outcomes of intervention.

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