

**REPORT ON FINANCING
HEALTH-RELATED
EARLY INTERVENTION
SERVICES
IN MINNESOTA**

March 1989

**Prepared for the Governor's
Interagency Coordinating Council on
Early Childhood Intervention**

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INTRODUCTION

This report focuses primarily on issues relevant to the financing of health-related early intervention services or, more specifically, health-related services provided to infants and toddlers as a part of early childhood special education programs through local school districts.

This is just one subset of issues in the overall provision of early intervention services to young children with handicapping conditions or at risk for such. Since its inception at the federal level, P.L. 99-457, Part H, has been conceptualized as an interagency, multidisciplinary service system. It was never the intention that one single agency or service delivery system be fully responsible for the provision of the full range of early intervention services.

Minnesota has nearly a fifteen-year history of involvement in advocacy and planning for early intervention services to young children with handicaps and those at risk, as well as their families. The 1985 mission statement developed by the State Agency Committee for Early Intervention Services in Minnesota reflects this commitment:

"The Departments of Health, Education, and Human Services are committed to the development of a comprehensive array of services throughout the State, best facilitated by interagency collaboration based on state-of-the-art practices. Services to assure opportunities for optimal growth and development by young children with handicapping conditions are best provided in a manner which is individually responsive to the needs of the child and family, and guided by the principle of least restrictive environment."

Early intervention services in Minnesota clearly extend beyond the scope of services delivered through early childhood special education programs. Two Interagency Agreements have been signed, in 1984 and 1987, detailing each agency's role in the development and provision of coordinated, interagency early intervention services. Both of the Interagency Agreements are included in Appendix A of this report.

In spite of this level of commitment to interagency early intervention services in Minnesota, there still are many issues and systems changes to be worked out as a coordinated, collaborative service system is established. Parents, already overburdened and stressed by the day-to-day demands of raising a child with special needs, are often required to negotiate their way through the complexities of a variety of systems in order to obtain services or funding for services for their child. Additionally, local service providers are often overwhelmed and frustrated as they try to find their way through the various funding mechanisms.

In response to the needs of parents and service providers at a local level, as well as planning needs at the state level, the Governor's

Interagency Coordinating Council on Early Childhood Intervention and the State Agency Committee commissioned a study which is summarized in this report. Each of the three State agencies (Health, Education, and Human Services) was asked to recommend a consultant knowledgeable in their agency's particular funding mechanisms and service delivery systems. These three consultants worked together as a team with the Minnesota Part H Grant's State Planner to investigate various components of financing for health-related early intervention services. The group's major tasks are outlined below:

- Collect and analyze background information from the state agencies (Health, Education, and Human Services), providers, and parents regarding accessing third-party payments.
- Within each agency, determine what relevant baseline data currently exists, including numbers of children ages 0-3 currently receiving services, reimbursements through public and private funds, any existing definitions of related services, and the identification of the various providers of these related services.
- Investigate state and federal statutory and regulatory impediments to claiming third-party reimbursement for related services.
- Summarize the programmatic, administrative, operational, and fiscal implications of third-party reimbursements for families, school districts, counties, and state agencies.
- Summarize the potential effects on the private insurance industry's practices, health maintenance organizations (HMOs), and families caused by school districts systematically seeking third-party reimbursement.

Once these areas were fully investigated, the charge to the group of consultants was to identify issues and barriers with respect to the financing of health-related early intervention services, and to develop recommendations for action steps to be taken by the Governor's Interagency Coordinating Council on Early Childhood Intervention and the State agencies involved. The group was to identify specific next steps such as:

- Departmental policy changes,
- Legislative changes,
- Areas for further investigation or research, and
- Training needs for early intervention providers.

Throughout this process, the consultants actively sought input from parents, providers, and state agency personnel, as well as administrators representing HMOs and major private indemnity carriers.

This report should be viewed as a "working paper", which will continue to evolve as Minnesota addresses the issues related to financing health-related early intervention services. We sincerely hope that this document, in its final form, serves as a springboard for discussion and movement toward the resolution of these complex issues.

DESCRIPTION OF EDUCATION MANDATES FOR PROVISION OF SERVICES TO CHILDREN WITH HANDICAPPING CONDITIONS

P.L. 94-142

The Education for All Handicapped Children Act or Public Law 94-142 requires that a "free, appropriate, public education" be provided in the "least restrictive environment" by state and local education agencies to all school aged children (3-21 years) with handicapping conditions. The "related services" necessary to assist a child in meeting his/her educational goals and objectives must also be provided without cost to the child or family.

"Related services" can be medical, non-medical, evaluative, diagnostic, or treatment oriented. According to P.L. 94-142, "related services" are defined as "transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes early identification and assessment of handicapping conditions in children. The term may also include school health services, school social work services, and parent counseling and training."

The terms used in the above definition are defined in P.L. 94-142 as follows:

1. Audiology

- 1.1 Identification of children with hearing losses;
- 1.2 Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;
- 1.3 Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation;
- 1.4 Creation and administration of programs for prevention of hearing loss;
- 1.5 Counseling and guidance of pupils, parents, and teachers regarding hearing loss; and
- 1.6 Determination of the child's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating effectiveness of amplification.

2. Counseling Services:

- 2.1 "Counseling services" means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

Early Identification:

- 3.1 "Early identification" means the implementation of a formal plan for identifying a disability as early as possible in a child's life.

Medical Services:

- 4.1 "Medical services" means services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services.

Occupational Therapy:

- 5.1 Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- 5.2 Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
- 5.3 Preventing, through early intervention, initial or further impairment or loss of function.

Parent Counseling and Training

- 6.1 "Parent counseling and training" means assisting parents in understanding the special needs of their child and providing parents with information about child development.

Physical Therapy

- 7.1 "Physical therapy" means services provided by a qualified physical therapist.

Psychological Services

- 8.1 Administering psychological and educational tests, and other assessment procedures;
- 8.2 Interpreting assessment results;
- 8.3 Obtaining, integrating and interpreting information about child behavior and conditions related to learning.
- 8.4 Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
- 8.5 Planning and managing a program of psychological services, including psychological counseling for children and parents.

Recreation

- 9.1 Assessment of leisure function;

- 9.2 Therapeutic recreation services;
 - 9.3 Recreation programs in schools and community agencies; and
 - 9.4 Leisure education
10. School Health Services
- 10.1 "School health services" means services provided by a qualified school nurse or other qualified person,
11. School Social Work
- 11.1 Preparing a social or developmental history on a handicapped child;
 - 11.2 Group and individual counseling with the child and family;
 - 11.3 Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school; and
 - 11.4 Mobilizing school and community resources to enable the child to receive maximum benefit from his or her educational program.
12. Speech Pathology
- 12.1 Identification of children with speech or language disorders;
 - 12.2 Diagnosis and appraisal of specific speech or language disorders;
 - 12.3 Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
 - 12.4 Provision of speech and language services for the habilitation or prevention of communicative disorders; and
 - 12.5 Counseling and guidance of parents, children, and teachers regarding speech and language disorders.
13. Transportation
- 13.1 Travel to and from school and between schools;
 - 13.2 Travel in and around school buildings; and
 - 13.3 Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a handicapped child,

The services under P.L. 94-142 are provided to accommodate the individual child's strengths and weaknesses, which are determined through a variety of assessments by a multidisciplinary team, including parents or guardians. The assessment process must be completed within 30 school days. Once completed, the individual child's strengths and needs are summarized, and goals and

objectives are written. These goals and objectives serve as the basis for the child's individual education program (IEP). This plan must be reviewed at least annually, and reassessments conducted at least every three years in order to evaluate the appropriateness of the child's individual education program.

Special education services may include indirect consultation with the child's classroom teacher(s) or direct service provided to the child within the classroom environment, in a separate classroom, or at a separate site. These services must be provided within the "least restrictive environment", which means that the child must be afforded every opportunity to receive educational support services within the regular classroom environment prior to being placed in a more restrictive setting which may be isolated from his/her regular education peers.

Special education services must be provided by qualified personnel. These personnel may be special educators, speech and language pathologists, audiologists, occupational and physical therapists, psychologists, social workers, nurses and any other qualified personnel deemed appropriate to provide the service indicated in the IEP.

Public Law 94-142 includes procedural safeguards and rights to ensure that the child is receiving the most appropriate educational program. Parent permission must be obtained prior to proceeding with any assessment or program placement decisions.

P.L. 99-457

Congress amended the Education for All Handicapped Children Act to encourage states to provide early intervention services to all children with handicapping conditions ages birth to five years. Public Law 99-457 is designed to make early intervention services available for three-five year old children with handicapping conditions through a downward extension of P L 94-142.

Public Law 99-457 also contains provisions for a new state grant program (Part H). Through the Part H program, grants are available to states to assist them in developing and implementing statewide, coordinated, interagency systems of comprehensive early intervention services for infant3 and toddlers with handicapping conditions, and their families. As a result, P.L. 99-457 goes beyond being a mere amendment to an education law; instead, it is a family-centered, interagency law.

There are fourteen minimum components detailed in P.L. 99-457 that are each state's responsibility to address as they develop their system of early intervention services. These fourteen elements need to be in place by 1991:

- Definition of developmental delay,
- Timetable for availability of services,
- Comprehensive multidisciplinary evaluation of needs of children and families,

- Individual family service plan which includes case management services,
- A comprehensive child find and referral system,
- Public awareness program to focus on early identification,
- A central directory of services, resources, state experts, research and demonstration,
- A comprehensive system of personnel development,
- A single line of authority to a lead agency,
- A policy for contracting or making arrangements with local service providers,
- A procedure for timely reimbursement of funds,
- Procedural safeguards,
- Policies and procedures for personnel standards, and
- A system for compiling data regarding the early intervention programs.

Early intervention services are designed to meet the individual needs of infants and toddlers who are experiencing delays in cognitive development, physical development, speech and language development, psychological development, social and emotional development, self-help skills, or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay (1). Refer to Appendix B for an example of entrance criteria for infants and toddlers who may be eligible for educational services. Infants and toddlers who are not eligible for educational services **may** still be eligible for public programs offered through the Departments of Health and Human Services. Given the interagency emphasis of P.L. 99-457, it is feasible that a young child could be eligible for services from more than one agency or service provider. In this case, the intent of P.L. 99-457 would be that these services should be coordinated to provide maximum benefit to the infant or toddler and his/her family.

The individual needs of young children with handicapping conditions are determined through a variety of assessments given by a multi-disciplinary team, including parents or guardians. Once the child's strengths and needs have been determined, an individual family service plan (IFSP) is written. The family is recognized as a key player in the planning and provision of early intervention services. Early intervention services for 3-5 year olds **may** include: (34 CFR 300.13-303.14)

I. Audiology

1.1 Identification of children with hearing loss;

1.2 Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;

- 1.3 Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation;
- 1.4 Creation and administration of programs for prevention of hearing loss;
- 1.5 Counseling and guidance of pupils, parents, and teachers regarding hearing loss; and
- 1.6 Determination of the child's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating effectiveness of amplification.

Case Management Services

- 2.1 Services provided to families of infants and toddlers to assist them in gaining access to early intervention services identified in the individualized family service plan;
- 2.2 Coordinating the performance of evaluations and participating in the development of the IFSP;
- 2.3 Assisting families in identifying available service providers;
- 2.4 Coordinating and monitoring the delivery of services, including coordinating the provision of early intervention services with other services that the child or family needs or is being provided, by that are not required to be provided by the mandate (e.g., respite care); and
- 2.5 Facilitating the development of a transition plan to preschool services, where appropriate.

Early Identification, Screening, and Assessment Services

- 3.1 "Early identification" is defined as the implementation of a formal plan for identifying a disability as early as possible in a child's life; and
- 3.2 Screening and assessment are not defined.

Family Training, Counseling, and Home Visits

- 4.1 Assisting parents in understanding the special needs of their children and providing parents with information about child development; and
- 4.2 "Home visits" are any early intervention services provided in the home of the handicapped child.

Health Services

- 5.1 Services necessary to enable a child to benefit from other early intervention services; and
- 5.2 Includes such services as clean, intermittent catheterization, but does not include services that are surgical or purely medical in nature (e.g. cleft palate surgery).

Medical Services Only For Diagnostic and Evaluation Purposes

- 6.1 Services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services.

Occupational Therapy

- 7.1 Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- 7.2 Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
- 7.3 Preventing, through early intervention, initial or further impairment or loss of function.

Physical Therapy

- 8.1 Services provided by a qualified physical therapist.

Psychological Services

- 9.1 Administering psychological and educational tests, and other assessment procedures;
- 9.2 Interpreting assessment results;
- 9.3 Obtaining, integrating and interpreting information about child behavior and conditions related to learning;
- 9.4 Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
- 9.5 Planning and managing a program of psychological services, including psychological counseling for children and parents.

Special Instruction

Speech Pathology

- 11.1 Identification of children with speech or language disorders;
- 11.2 Diagnosis and appraisal of specific speech or language disorders;

- 11.3 Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
- 11.4 Provision of speech and language services for the habilitation or prevention of communicative disorders; and
- 11.5 Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

These services can be provided in the child's home, early intervention centers, hospitals or clinics, day-care settings, or any other setting deemed appropriate to meet the individual needs of the child. Early intervention services must be provided by qualified personnel, including, but not limited to: (34 CFR 303.14)

- audiologists
- nurses, including school nurses
- nutritionists
- occupational therapists
- physical therapists
- physicians
- psychologists, including school psychologists
- social workers, including school social workers
- special educators
- speech and language pathologists

The downward extension of P.L. 94-142 means that all of the conditions and requirements governing the school age population (transportation, least restrictive environment, procedural safeguards, non-discriminatory assessment, provision of "related services") must now be provided to three to five year old children with handicapping conditions.

In addition to these requirements there are a number of provisions which are unique to P.L. 99-457.

The term, "free and appropriate public education" is not used in describing services for birth-two year olds.

Instead, the law states that services are to be "provided under public supervision" and are to be "provided at no cost except where federal and state law provides for a system of payments by families including a schedule of sliding fees." The intent of this provision was to allow programs like Services for Children with Handicaps, Minnesota's Title V program, to continue to use sliding fee schedules.

To ensure that all infants and toddlers are identified and, where necessary, referred to the appropriate provider for evaluation, the proposed Part H regulations require that the state's child find system must "be coordinated with all other major child find efforts conducted by various public and private agencies" in the state.

The procedural safeguards under Part H are similar to several of the provisions under Part B, For example, both require written prior notice, parent participation and approval. However, the due process hearing

requirements under Part B are more detailed than the complaint resolution provisions under Part H, Instead of detailing hearing, appeal, and review procedures, the corresponding provision in Part H requires each statewide system to provide for "timely administrative resolution of complaints by parents."

In addition to a complaint resolution process for parents, P.L. 99-457 requires that the lead agency establish an interagency dispute resolution process.

Since P.L. 99-457 emphasizes an interagency approach, the interagency dispute resolution process is a necessary component which will ensure that children and families will receive essential and timely services regardless of which agency is fiscally or programmatically responsible for delivering the service. While there is no such requirement in Minnesota Statutes section 120.17, it is strongly recommended that a dispute resolution process be established and implemented.

There are several goals which can be facilitated through a dispute resolution mechanism. First, the process would serve to determine the proper payor of early intervention services when responsibility is disputed- When parents are informed of this avenue for recourse, the "bouncing" of families from one organization or agency to another should be alleviated. A dispute resolution mechanism would also help to ensure appropriate allocation of payment responsibilities. Members of the dispute team will be in a position to see the problem areas and make periodic reports, with suggestions for *change* or clarification, to state agency heads. Finally, the dispute resolution process will promote judicious and expeditious payment determinations. If this is to be accomplished, the dispute team should set a precedent for swift action, otherwise payors other than education (which has to pay for services pending resolution of disputes) could have an incentive to raise payment disagreements.

A significant question for consideration is whether the dispute resolution mechanism should address payment disputes involving private third-party payors. Inclusion of these disputes in the process will require resolution of many complex administrative and procedural issues. However, exemption of them from the mechanism will render the process inadequate and inappropriate in many instances. A recurring problem for members of health plans is the inability to achieve speedy resolution of problems in a manner ensuring appropriate and timely delivery of health care services to their children.

Establishing a dispute resolution mechanism will involve consideration of many additional issues such as proper composition of the dispute team, identification of the point at which it can be concluded a payment dispute exists, determinations regarding the proper process for claims submission, the dispute team's decision-making process and the effect and weight of the team's decision.

Another difference between Part B and Part H is in the provision of related services". Under Part B, "related services" may only be provided if **the** child is receiving special education services and requires "related services" to benefit from special education services.

In contrast to Part B, under Part H, an infant or toddler may receive a "related service" without receiving special education instruction.

Finally, the Part H provision for individualized family service plans (IFSP), is more comprehensive than the individualized education plan (IEP) required under Part B, The IFSP includes several components that go beyond the scope of the IEP, including:

- a. A statement of the family's strengths and needs relating to enhancing the development of the child;
- b. A statement of the major outcomes expected to be achieved for the child and the family;
- c. A statement of the specific early intervention services necessary to meet the unique needs of the child and the family;
- d. The name of the case manager from the profession most immediately relevant to the child's **or family's** needs, who will be responsible for the implementation of the IFSP **and** coordination with other agencies and persons; and
- e. The steps to be taken supporting the transition of the child to services provided under Part B of the Act, to the extent that those services are considered appropriate (2).

MINNESOTA STATUTE 120.17

The Minnesota State Statute (120.17) mandates provision of educational and "related services" to children and youth with handicapping conditions, ages birth to 21 years. Consistent with P.L. 99-457, a Governor's Interagency Coordinating Council on Early Childhood Intervention of 15 members was established. The Council is responsible for "recommending policies to ensure **a** comprehensive and coordinated system of all state and local agency services for handicapped children under age five and their families.... The policies must address how to incorporate each agency's services into **a** unified state and local system of multidisciplinary assessment practices, individual intervention plans, comprehensive systems to find children in need of services, methods to improve public awareness, and assistance in determining the role of interagency early intervention committees."

According to M.S. 120.17, school districts and county boards are **now** responsible **for** coordinating the provision and facilitating the payment of early intervention services. These services **may** include "family education and counseling, home visits, occupational and physical therapy, speech pathology, audiology, psychological services, case management, medical services for diagnostic and evaluation purposes, early identification, screening, and assessment, and health services necessary to enable children with handicapping conditions to benefit from early intervention services."

School districts are designated as the lead agency in this cooperative effort, although both school districts and county

boards are responsible for facilitating payment for services from private and public sources.

The statute further clarifies school district and county financial responsibility in subdivision 14. Maintenance of effort is described as follows: "A county human services agency or county board shall continue to provide services set forth in their county social service agency plan for handicapped children under age five and their families or as specified in the individual service plan and individual habilitation plan of each child. Special instruction and services for which a handicapped child is eligible **under** this section are not the responsibility of the local human services **agency** or county board. School districts and county boards are encouraged to enter into agreements to cooperatively serve and provide funding for children handicapping conditions and their families." Much confusion exists as to **what** maintenance of effort means in real terms.

Further clarification and interpretation of the maintenance of effort provision in H.S. 120.17 is needed.

The responsibility for payment of early intervention services by third party payors is not changed by this amendment to the statute. Subdivision 15 clarifies this by stating: "Nothing in this section relieves an insurer or similar third party from an otherwise valid obligation to pay for services to handicapped child."

To facilitate local coordination between education, health, and human service providers, the statute requires that local interagency early intervention committees be established. The committees are required to carry **out** the following duties on an ongoing basis:

- "(1) Identify current services and funding being provided within the community for handicapped children under the age of five and their families;
- (2) Establish and evaluate the identification, referral, and community learning systems to recommend, where necessary, alterations and improvements;
- (3) Facilitate the development of individual education plans and individual service plans when necessary to appropriately serve handicapped children under age five and their families, and recommend assignment of financial responsibilities to the appropriate agencies;
- (4) Implement a process for insuring that services involve cooperating agencies at all steps leading to individualized programs;
- (5) Review and comment on the early intervention section of the total special education system for the district and county social service plan; and
- (6) Facilitate the development of a transitional plan if a service provider is not recommended to continue to provide services."

The Minnesota mandate to serve children with handicapping conditions beginning at birth presents several unique challenges. Conflicts with some of the language in P.L. 99-457 exist because Minnesota's mandate to provide services to children with handicapping conditions from birth extends the provisions of P.L. 94-142 down to birth.

"Free, appropriate" education as described in P.L. 94-142, or Part B of the Education of All Handicapped Children Act, requires that education and related services designed to meet the unique needs of each school aged child (3-21 years) with a handicapping condition must be provided at no cost to the child or his/her family. P.L. 99-457 states that services are to be "provided at no cost to families except where federal and state law provides for a system of payment by families including a schedule of sliding fees." The exact interpretation of this phrase is as yet unclear. It has been suggested that the intent of this language was that P.L. 99-457 would not interfere with existing fee schedules such as those used by Services for Children With Handicaps.

Whether or not sliding fee schedules violate the "free, appropriate" requirement must be determined.

"Least restrictive environment" is language which P.L. 94-142 uses to emphasize that special education and "related services", to the greatest extent possible must be provided within, or as close to the environment within which a child would receive those services if he/she did not have a handicapping condition. P.L. 99-457 extends this language to include children with handicapping conditions from 3-21 years of age. Since the Minnesota Statute now extends mandatory provision of education and "related services" to children **with** handicapping conditions beginning at birth, the provisions outlined in P.L. 94-142 now apply to handicapped children from birth in the State of Minnesota.

"Least restrictive environment" must be interpreted for preschool age children.

For many children, the "least restrictive" setting may be their home environment. The role of private and public day care providers must also be defined. If a day-care setting becomes a least restrictive educational setting, then it must be determined if day-care providers are subject to the same personnel licensing requirements and due process procedures as providers **who** are employed by school districts.

Under Part B, related services may be provided only when the child has an individual education plan (IEP) to receive special education services. Language **in** Part H states that "an infant or toddler might receive only a service described under Part B as a 'related service' (e.g., physical therapy or occupational therapy) without receiving special instruction." This language seems to indicate that if a child needs physical therapy, but does not qualify for special education services, the school district would be expected to provide and pay for a service that has previously been the programmatic and fiscal responsibility of the family and/or health and human service entities. The critical questions are:

would school districts be obliged to pay for related services if the child is not receiving special education instruction; and

What is the programmatic and fiscal responsibility of families and/or health and human service agencies in these instances?

An individual education plan (IEP) is required for all children with handicapping conditions in the State of Minnesota who receive special education instructional or related services. An individual family service plan (IFSP) will be required beginning in 1991 for children receiving early intervention services according to P.L. 99-457. Since the IFSP contains several components which go beyond the scope of the IEP (see previous section P.L. 99-457), it must be determined if the IFSP format will apply only to children in preschool programs, or if the IEP format will apply to all age3 of handicapped children. The role of the IEP and IFSP as documents that are accepted by other agency service providers must also be explored.

The primary challenge lies in sorting out the intent of the language in P.L. 94-142, P.L. 99-457, and M.S. 120.17. Public Law 94-142 is generally viewed as a child-centered, education law, while P.L. 99-457 is very much a family-centered, interagency law. The Minnesota Statute attempts to unite **both** of these aspects.

HEALTH-RELATED SOURCES OF COVERAGE FOR EARLY INTERVENTION SERVICES

This section will address the various private, state and federal health-related funding sources available for coverage of early intervention services (please refer to Table 1 the following page. There will first be a discussion of definitions, followed by a description of each funding source, and an analysis of that program's coverage of early intervention services, as defined.

Definitions

Considerable attention was given to defining the specific early intervention services identified on Table 1. (Note that the services are the same as the list provided in Minnesota Statutes section 120.17). Rather than amalgamating definitions from the various coverage sources, it was determined by the authors of this report to be more appropriate to define the services as they are currently defined in the law³ which require the services to be provided.

At the state level, a definition of "early intervention services" is currently under discussion. While "related services" is defined in state law, there are no state statutory or regulatory definitions of the specific related services. It was therefore necessary to draw definitions from the federal regulations adopted pursuant to the Education of the Handicapped Act. When possible, definitions from the federal Proposed Rules Relating to the Early Intervention Program for Infants and Toddlers with Handicaps were substituted. (The rules had not been adopted at the time of this writing). A definition was crafted for "home visits," which is not defined in any federal law or rule. Please refer to Appendix C for the list of definitions.

It should be noted that the definitions developed for the specific early intervention services are for discussion and illustrative purposes only. It is clear the definitions ultimately adopted by the state may be consistent with those of the federal government, but they are not required to be. The state may choose to define each service in a way which it considers to be more appropriate or workable.

Private Indemnity Coverage

For the purposes of this discussion, private indemnity contracts include:

- insurance contracts, regulated by the Department of Commerce under Minnesota Statutes Chapter 62A (this includes preferred provider organizations, PPOs, funded by insurance companies); and
- nonprofit health service plan contracts (e.g., Blue Cross/Blue Shield contracts) also regulated by the Department of Commerce under Minnesota Statutes Chapter 62C,

Self-funded health plan³, including many PPOs offered by employers, are not included in the category of "private indemnity coverage" for the purposes of this report. While significant in that they account for approximately one-fourth of the insured employees in Minnesota (3), as employee benefit plans,

TABLE 1

	family Education A Counseling'	Home Visits'	Occupational Therapy*	Physical Therapy	Speech Pathology*	Audiology	Psychological Services'	Can Martagomunt	Medical Services*	EISA*	Health Services*
Indemnity Coverage	X		X	X			X		X	X	X
Health Maintenance Organization (HMOs)	X		X	X	X	X	X	X	X	X	X
MN Comprehensive Health Assoc, (MCHA)	X		X	X			X		X	X	X
Medical Assistance (MA) for Families	X	X	X	X	X	X	X		X	X	X
MA for Pregnant Women and Infants Under One	X	X	X	X	X	X	X		X	X	X
Early and Periodic Screening, Diagnosis, 4 Treatment (EPSDT)	X	X	X	X	X	X	X		X	X	X
Children's Home Care Option	X	X	X	X	X	X	X	X	X	X	X
Home and Community Based Waiver for MH/RC	X	X	X	X	X	X	X	X	X	X	X
Community Alternative Care Waiver	X	X	X	X	X		X	X	X	X	X
Community Alternatives for Disabled Individuals	X	X	X	X	X	X	X	X	X	X	X
Services for Children With Handicaps	X	X	X	X	X	X			X	X	X
Children's Health Plan	X		X	X	X	X			X	X	X

*See Appendix C for definitions of services. There may be discrepancies between what the programs provide with respect to each service and how the services are defined for the purpose of this report

(This chart is part of the Report on Financing Health-Related Early Intervention Services in Minnesota.)

they are exempt from state regulation under the federal ERISA law (Employee Retirement Income Security Act of 1974 (4)).

Minnesota indemnity carriers may offer qualified and not-qualified plans. Qualified plans are subject to more specific benefit requirements than not-qualified plans, and although an insurer may offer both types of coverage, the insurer must offer qualified plans. There are specific mandated benefits in state law which apply to both qualified and not-qualified plans, but the only mandate which could be considered an early intervention service is mental health care. Minnesota Statute section 62A.152 requires all group policies which cover inpatient mental health care to also cover ambulatory mental health services. A group is defined in this statute as 100 employees or more. The outpatient coverage required is at least 80% of charges for the first 10 hours of treatment, and at least 75% of charges for additional hours of treatment during the same benefit period for serious and persistent mental or nervous disorders. The total amount of visits required to be covered in any 12-month benefit period is a minimum of 40.

Under Minnesota **law**, families **may** be covered under non-group **or small group** Insurance policies **which do not cover any early** intervention services.

A qualified plan may be a number 1, 2 or 3 plan. The three qualified plans differ only in the amount of the deductible permitted in the contract (number 1 \$150/person/year; number 2: \$500/person/year; number 3: \$1000/person/year). Table 1 identifies the early intervention services listed in Minn. Stat, section 62E.06 as required of all Minnesota qualified plans. These services are:

- Family education and counseling – although not specifically required, this service is necessarily a component of other services -- physical and occupational therapy and mental health care, for example, delivered to handicapped children by physicians and other professionals.
- Occupational therapy – this benefit is not defined in statute, but it is assumed the service delivery aspects conform to those of the federal definition.
- Physical therapy.
- Psychological services -- covered as described above under Minn. Stat. section 62A.152.
- Medical services.
- Early intervention, screening and assessment – covered to the extent well child services are included in the contract.
- Health services necessary to enable a child to benefit from other early intervention services – whether these services are covered may depend on the nature of the service and who delivers the care. For example, the law requires coverage of home health services. Skilled nursing

services provided at home by a registered nurse would most likely be covered; non-skilled nursing services provided to a child at school might not be eligible for coverage.

Although the statute lists the above services as required items of coverage for qualified plans, the law also allows for these services to be Substituted with services which are the "actuarial equivalent" (5) . In other words, a contract could theoretically offer none of the early intervention services identified in state law, and still constitute a qualified plan.

It should be noted that the principle of actuarial equivalence substitution also applies to the legislation adopted in 1988 regarding well I care. If an insurer offers this benefit, it must be provided with no deductible or zero coinsurance attached. But, an insurer is not required to cover well child care, since a benefit of actuarial equivalence may be offered in its stead.

Families may be covered by group insurance policies which provide limited coverage for mental health care, and no coverage for other early intervention services.

As a practical matter, most insurance contracts probably offer a range of intervention services covered to varying degrees. This point, however, raises other issues:

- It may be difficult to determine the type and extent of coverage of early intervention services currently provided to children with handicapping conditions and their families. An assessment of utilization information must be made in order to determine whether it is administratively feasible and practical to access indemnity reimbursement.
- A decision to routinely and formally seek reimbursement from indemnity carriers for early intervention services may provide impetus for indemnity carriers to substitute other benefits which are the actuarial equivalent. This possible result could be remedied by formulation of an appropriate mandated benefit applicable to both qualified and not-qualified plans, and immune from actuarial equivalence substitution.
- It should be noted that under some policies, coverage generally provided to most members of the policy may be excluded or limited for others because of a pre-existing condition status or other circumstance.

The range and extent of early intervention services currently specified in contracts and actually covered by indemnity carriers must be assessed. If it is determined economically appropriate to access reimbursement from indemnity carriers, discussion regarding the appropriate levels of coverage should be anticipated.

Health Maintenance Organizations (HMOs)

An HMO is defined in Minn. Stat, section 62D.02, subdivision 4 as "a nonprofit corporation organized under chapter 317, or a local governmental unit,... which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed, prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee."

Like indemnity carriers, HMOs perform an insurance function by paying for the medical services received. Unlike traditional indemnity plans, however, HMOs also arrange for the delivery of necessary care, and require that services be performed by medical providers who participate with the HMO. The HMO and its providers bear the financial risk for the delivery of the services, and this encourages the providers to practice in a cost effective manner.

State law does not permit HMOs to cover services that have not been delivered by a participating provider. Exceptions are referral and emergency services and certain supplemental benefits.

HMOs are a much more common form of health coverage in Minnesota than in other parts of the nation. Recent statistics compiled by the Minnesota Department of Health indicate that approximately 1.2 million Minnesotans were covered by HMOs in 1987, including approximately 13,500 children between the ages of birth and five. A total of approximately 28% of the state's population and 46% of the Twin City metro area population received their health care through an HMO in that year.

HMOs are subject to some of the same statutory mandates as qualified and not-qualified indemnity plans. This includes the mental health benefit described in the previous section on Private Indemnity Coverage. Indemnity carriers are required to cover services provided by specific providers, for example, chiropractors; while HMOs are free to select the health care provider best able to deliver the service in the most cost effective manner.

In addition to specific statutory mandated benefits, HMOs are subject to a broader requirement to cover "comprehensive health maintenance services," defined in Minn. Stat. section 62D.02, subdivision 8 as services which enrollees "might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services and preventive health services." Minn. Rule 3 part 4685.0700, subpart 3 specifies a list of permissible limitations and exclusions which include:

- corrective appliances and artificial aids;
- dental services;
- routine refractions, contact lenses, eyeglasses;
- experimental procedures;

- custodial and domiciliary care; and
- * home health care.

Services which are not on the list of permissible limitations and exclusions must be covered if medically necessary and if received in accordance with the terms of the health maintenance contract. Under the law, HMOs are allowed to impose very few dollar or visit limitations on required services. Copayments on required services, except for preventive services, must generally not exceed 25% of the usual and customary charge. No copayment is permitted on preventive health services, and deductibles are allowed only on emergency benefits. As is the case with indemnity carriers, out-of-pocket expenses may not exceed \$3000 per person per year.

In many cases, families covered by HMO policies may have virtually unlimited coverage for certain early intervention services.

Table 1 identifies the specific early intervention services generally covered by HMOs. These services are:

1. Family education and counseling – as in the case of indemnity carriers, this service is delivered as a necessary component of other services. In addition, Minn. Rules part 4685.0100, subpart 5 item E define "preventive health services" (required to be covered by HMOs) as including health education. The rules do not define "health education," and accordingly the scope and content of this service may vary widely from plan to plan.
2. Occupational and physical therapy – neither of these benefits are listed explicitly in statute or rule, but to the extent they are medically necessary and delivered in accordance with the terms of the contract, they must be covered as part of comprehensive health services. Note that since an HMO is required to cover the service but not required to cover the services of any specific provider, the HMO may choose to deliver care through, for example, a physical therapist rather than an occupational therapist or an orthopedic surgeon as opposed to a physical therapist. In addition, and depending on how each HMO defines "home health care" (the term is not defined in state statute or rule), it is possible services such as occupational and physical therapy may be covered by some HMOs only in settings outside the home (6).
3. Speech pathology and audiology – HMOs generally provide some services in these areas, but the extent and range may vary from plan to plan. Speech therapy is a service which HMOs quite frequently determine is necessary not as a medical service but as an educational benefit, and accordingly deny coverage. Regarding audiology, testing and assessment may be a part of routine well baby care, but hearing aids or other corrective appliances are excludable under the current rules.
4. Psychological services – required by Minn. Stat, section 62D.102 to be covered in all group contracts. The level of coverage is the same as the indemnity mandate in 62A.152.
5. Medical services.

6. Early intervention, screening and assessment - covered as part of preventive health services.
7. Health services necessary to enable a child to benefit from other early intervention services - services are covered if medically necessary and delivered in accordance with the terms of the contract.

Unlike insurers, HMOs may not substitute benefits determined to be actuarially equivalent. However, most of the services required to be covered by HMOs are currently not defined in state statute or rule. As a result, the contracts of coverage and hence the benefits received may vary greatly from plan to plan.

A survey of HMOs conducted as background for this report indicates the benefits do indeed vary, as does the HMOs' understanding of their current obligations with respect to the provision of early intervention services. For example, one HMO stated coverage was available for all early intervention services, but only to the extent the services are not available through the school system or the state. Another HMO stated it provides limited coverage for family education and counseling and physical therapy; no coverage for occupational therapy, case management and health services necessary to enable children with handicapping conditions to benefit from early intervention services; and coverage only for the diagnostic and testing components of speech pathology, audiology and psychological services,

This variation in coverage and interpretation of coverage obligations raises some of the same issues previously discussed regarding assessment of the extent of early intervention services currently provided by health plans, and thus the economic feasibility of seeking reimbursement from third-party payers.

There are additionally other factors complicating the issue of HMO reimbursement for early intervention services. HMOs cover services only if they are "medically necessary," a term not currently defined in state law. Determinations of what constitute medically necessary services are of critical importance to an HMO since these decisions serve to structure and delineate benefits, and hence define financial exposure under the contract. While indemnity carriers also use the concept of medical necessity in making coverage determinations, the implications are perhaps more significant for HMOs because they lack the ability to impose lifetime maximums and some of the other limitations available to indemnity carriers (7).

HMOs generally look to the participating provider to determine whether a service is medically necessary. However, it is not uncommon for an HMO to designate administrative personnel who also make medical necessity determinations, at the same time as or after the provider has reviewed the case (8). Some HMOs exercise the authority to overrule the decision of the participating provider, and deny the enrollee coverage for the service in question. HMOs which review decisions of medical necessity generally impose a requirement that the enrollee seek prior authorization for the benefit, so that determinations of need are made before the benefit is received.

Families with HMO coverage may be required to receive prior authorization of certain benefits from the HMO, even if their HMO physician has indicated to the family the services their child needs are medically necessary.

issue of medical necessity raises many difficult questions regarding implementation of Minn. Stat. 120.17 and Public Law 99-457. First, and perhaps most significant, is defining and identifying those services which are "medical" as opposed to "educational." Some HMOs have taken the position that developmental delays are educational problems, and therefore there is no coverage for services delivered because of the delay. Other HMOs look to the nature of the services to be provided, and may, for example, cover rehabilitative care but not habilitative care.

One of these distinctions or restrictions are attempts at defining the broader policy issue of the proper role of third-party payers in the overall scheme of delivering services to handicapped children. Advances in medical technology and increasing medical costs, among other factors, have triggered an assessment of that role, and as a practical consequence, families often do not have clear expectations about the coverage available for a handicapped child under their health plan. In many cases, it seems the child's family is muffled from potential payer to potential payer, while the child waits for speech or physical therapy. At times it appears when and whether the child receives benefits at all depends more on the parent's sophistication and determination than on any other factor.

The possibility of schools seeking reimbursement for early intervention services highlights the need for clear definitions and expectations regarding the type and amount of services third-party payers are responsible for covering.

The role of third-party payers in this equation needs solidification. As a matter, this may be difficult to do statutorily. Policy makers in Minnesota appear to be considering closer scrutiny of mandated benefits in light of the rising costs of health care.

A second problem related to medical necessity determinations is the issue of HMOs involvement in development of the individualized family service plan and related case management services. HMOs generally do not develop plans of care similar to the IFSP, nor do they perform "case management" as the term has been defined for the purposes of this report (see Appendix C). However, HMOs serve some of the same functions by deciding whether services are medically necessary, by determining the extent and type of care required to treat the enrollee's condition and by choosing the type of provider best to deliver the services.

Since an HMO is at financial risk for the cost of health services, the HMO will determine the need for and extent of the services provided.

Generally, HMOs perform their own assessments rather than relying on those of others not affiliated with the HMO. For example, if a child is ordered by the court to participate in a drug treatment program, the HMO will nonetheless conduct its own evaluation to determine whether in its estimation the child

needs treatment. If the HMO believes treatment is not warranted, it will not cover the costs of the program. If it determines treatment is necessary, the HMO may suggest a different program, or insist the child receive counseling from a social worker rather than a psychologist. Similarly, if a school's multidisciplinary team determines that psychological services are a necessary element of a three year old's IFSP, the services will not be covered by the HMO unless it concurs with the assessment. Additionally, the HMO may select the type of provider it feels best able to provide the benefit. And finally, the provider will most likely be one who participates with that HMO.

If schools are to access HMO reimbursement for early intervention services, there must be a coordination of effort between schools and HMOs in assessing needs and delivering services to handicapped children.

Accomplishing this coordination will in itself be challenging. It may be possible for a representative of the HMO to sit on the multidisciplinary team, whatever the system designed, it must anticipate the federal prohibition against delays in service due to disputes in payment. Furthermore, if the school provides services to a child in an effort to avoid service delay, the school may be unable afterwards to solicit payment from the HMO if the service was one of the many which required participating physician referral or prior authorization.

A related problem is the common practice of HMOs to authorize coverage of benefits up to a certain number of visits or for a limited period of time, sometimes only a month or two. Parents are routinely required to seek reauthorization of service at the end of that time period. There is currently nothing in state law addressing review of the IFSP after its initial development, but this becomes an issue in seeking third-party reimbursement.

Yet another obstacle to accessing HMO reimbursement is the requirement that services be delivered by participating HMO providers. HMOs are obligated to refer enrollees to nonparticipating providers, but only in the event the services needed cannot be delivered by a participating provider. The prospect of schools becoming HMO participating providers raises some complex problems. HMOs generally select participating providers based on criteria such as whether the HMO needs providers of that type in that geographic location, whether the provider has demonstrated an ability to positively affect quality of health care, and whether the HMO has confidence in that provider's utilization review performance. HMOs may be unwilling to contract with schools for reasons related to any of these criteria. Legislation requiring HMOs to contract with schools raises equally difficult competitive issues and other public policy issues as well.

As participating providers, schools would also be reimbursed in a different manner and at a different rate by each HMO. The administrative difficulties this poses, coupled with the administration involved in billing HMOs and indemnity carriers is noteworthy.

As an alternative to schools becoming HMO providers, consideration should be given to the option of schools working closely with HMOs in identifying participating providers able to deliver the services in question.

Finally, parents of children with handicapping conditions have raised several concerns regarding the ability of schools to use their health policies HMO or indemnity plans -- to pay for services provided to their children.

For many families, especially those whose policies include lifetime maximums or other benefit limitations, the policy represents a "savings account" of sorts, and they may object to a party outside of the family making decisions regarding how the funds in that account are spent.

As the owner of the policy, and as payer of the premiums, parents are entitled to be involved in case-by-case decisions regarding claims submitted against the policy. This is especially critical when the coverage of others under the policy is affected by the claims paid for the handicapped child.

A related problem is the inability of some families to obtain coverage due to the health status of a member of the family. Individual applicants, and increasingly group applicants, are screened very closely by potential health carriers before policies are issued or when the policy is up for renewal. (There have been instances where employer groups have been dropped by every plan writing the group because of the health of one employee's child.

There have been other instances where the employer group has been offered less coverage for a higher premium because of the health of one employee's child, it is possible that a family would have difficulty obtaining or maintaining health coverage even if schools did not access the family's health coverage. If third-party carriers are mandated to cover early intervention services schools routinely seek reimbursement from them for services provided, a family with a child with handicaps is in many instances virtually certain to lose or fail to obtain health coverage.

Minnesota Comprehensive Health Association (MCHA)

MCHA was created by the Minnesota Legislature in 1976 as a vehicle for assuring the availability of minimum hospital and medical expenses for those who, due to medical conditions, are unable to acquire the health coverage available to others. Any Minnesota resident is eligible for MCHA if he or she has, in the last six months, been refused health coverage, been offered coverage at a higher than standard premium rate or been offered coverage with a rider or pre-existing condition limitation which has a substantial effect on coverage available under the policy. Evidence of the above is not a prerequisite for MCHA coverage if the applicant has been treated in the last three years for a "presumptive condition," which includes, among others, cystic fibrosis, motor or sensory aphasia and muscular dystrophy.

MCHA is funded by annual assessments levied against insurers, fraternal, nonprofit health service plan corporations, and HMOs in the state. Assessments are based on the amount of the association members' total premium revenue.

MCHA offers coverage under number 1 and number 2 qualified plans. As is the case with other qualified plans, benefits may be substituted for those that are the actuarial equivalent, but it is not common practice for this to occur.

MCHA provides no coverage for the first six months for any expenses relating to pre-existing conditions, defined as health conditions for which a person was diagnosed or treated during the 90 days immediately preceding the effective date of coverage.

MEDICAL ASSISTANCE REIMBURSEMENT ISSUES

The Medical Assistance program in Minnesota is authorized through federal Medicaid legislation. Section 1102 of the Social Security Act, 42 U.S.C. 1302. The Minnesota Department of Human Services is required to submit a State Plan in compliance with federal regulations, 42CFR, Chapter IV, Subchapter C governing Medical Assistance Programs. Only those services described in the State Plan and approved by the Department of Health and Human Services can be provided as part of the Medical Assistance Program (see Table 1). State legislation, Minnesota Statute 256.B and Minnesota Rules 9500-9580, provide details on specific program responsibilities and lines of accountability. The state agency issues two manuals regarding specific procedures for determining eligibility, providing benefits, and billing for services. Eligibility for Medical Assistance is determined by the county in which the applicant resides.

Under recent federal legislation, the Medicare Catastrophic Coverage Act, P.L. 100-360, the Medicaid program can be considered a source of reimbursement for certain services included in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP). In Minnesota, this method for reimbursement would allow school districts to become enrolled providers and bill the Medical Assistance program for previously agreed-upon services.

School Districts as Medical Assistance Providers

As enrolled providers, school districts would be subject to the same terms and conditions as other Medical Assistance providers. These regulations are found in Minnesota Rules 9505.0170-9505.0475 and are listed briefly in the Provider Agreement which is attached.

The Provider Agreement for the Medical Assistance program lists several conditions of participation that may be new to school districts and may require additional systems or mechanisms in the local districts. For example, item a) the requirement for discrete record keeping; item f) financial responsibility of third party payors; and item k) professional qualifications of service providers may place new requirements on school districts wishing to access Medical Assistance.

Cost implications for these and other regulations should be examined by school districts prior to deciding whether to become a Medical Assistance provider (9).

Billing for Services

As Medical Assistance providers, school districts will be accountable for all billable services provided under the auspices of the IEP/IFSP to students, whether these services are directly provided by district staff or by contractors.

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES



PROVIDER AGREEMENT

As a participating provider in the Minnesota Medical Assistance and General Assistance Medical Care Programs, the provider agrees to the terms and conditions as set forth below.

To maintain records which fully disclose the extent of benefits provided to individuals under these programs, in accordance with Minnesota Rules, Parts 9505.1750 through 9505.2150.

To furnish the Department of Human Services, the Secretary of the Department of Health and Human Services, or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for benefits provided under these programs.

To comply with all federal and state statutes and rules relating to the delivery of benefits to individuals and to the submission of claims for such benefits.

To comply with the utilization control requirements of 42 Code of Federal Regulations Part 456, if applicable

To accept as payment in full, amounts paid in accordance with schedules established by the Department of Human Services, except where a payment by the recipient has been authorized by the Department of Human Services.

To ensure, when required by law, that the Medical Assistance or General Assistance Medical Care Program is the payor of last resort by ascertaining the legal and financial liabilities of third parties to pay for covered services.

To comply with Section 1902 (a)(2)(I) of the Social Security Act, which prohibits refusal to furnish services to an eligible recipient because of the requirement to bill responsible third parties prior to billing Medical Assistance

To assume full responsibility for the accuracy of claims submitted to the Department of Human Services by the provider or the provider's agent, including a billing agent, and to submit claims in accordance with the certification requirements of 42 Code of Federal Regulations Section 455.18 and Minnesota Statutes Section 256B.27, Subd. 2.

To include, on claims submitted for payment, procedure and diagnosis codes specified by the Department of Human Services.

To submit claims at no more than the provider's usual and custom-

any fee to the general public and only after the medical care or service has been provided.

K. To submit claims only for those benefits provided by health care personnel meeting minimum professional qualifications as established by the Department of Human Services

L. To submit claims only for services, supplies, and equipment that are medically necessary, that meet professionally recognized standards of health care, and that the provider knows or has reason to know are properly reimbursable under federal and state statutes and rules

M. To make such disclosure of ownership and control information as is required by 42 Code of Federal Regulations Section 455.100-455.106.

N. To inform the Department of Human Services, no later than thirty days before the effective date, of any sale or transfer of ownership or control of any enrolled provider, and inform the Department of Human Services prior to, if possible, but no later than thirty days after, of any changes in licensure, certification, or registration, title or name, and address.

O. To request the recipient to produce a current Medical Assistance or General Assistance Medical Care identification card each time benefits are rendered in accordance with Minnesota Rules, Parts 9505.0170 through 9505.0475

P. To comply with Title VI of the Civil Rights Act of 1964 and all regulations thereunder, which prohibits discrimination based on race, color, or national origin in any program receiving Federal financial assistance.

Q. To comply with Minnesota Statutes, Chapter 363, known as the Minnesota Human Rights Act, if applicable

R. To refrain from placing restrictions or criteria on the services made available, the type of health conditions accepted, or the persons accepted for care or treatment, unless those restrictions or criteria apply to all individuals seeking services

S. To render to recipients services of the same scope and quality as would be provided to the general public

An individual practitioner is required to personally sign this Provider Agreement. Agreements for groups, clinics, or institutions must be signed by an administrator, manager, director, or person with similar authority.

Please retain the copy of the Provider Agreement for your files, and return the original to this department.

Name of provider (please print or type)

Minnesota Department of Human Services

(Signature)

(Signature)

Title: _____

Health Care Support Division

Date: .

Date:

Provider Agreement , ItemHreads :

To assume full responsibility for the accuracy of claims submitted to the Department of Human Services by the provider or the provider's agent, including a billing agent, and to submit claims in accordance with the certification requirements of 42 Code of Federal Regulations Section 455.18 and Minnesota Statutes Section 256B.27, Subd.2.

In cases of noncompliance with state or federal regulations, the school district, as the enrolled provider, would be the responsible party. Backtracking to establish compliance or finding another funding source could result in confusion, embarrassment, and extra cost to the school district.

It is possible in the Medicaid program for non-compliance to result in a requirement to repay excess funds received.

Medical Assistance providers have the option of billing MA directly, or contracting with a business agent to do the billing. If school districts choose to contract with a business agent, state and federal regulations require that compensation to the billing agent is related only to the actual costs of processing the bill. Compensation must not be a percentage of the amount billed, nor can it be dependent on collection of payment. (Minnesota Rules 9505.0455 - Billing Procedure, Business Agent.)

One option would be to establish a nonprofit billing entity that would coordinate all aspects of the delivery systems from the onset. The advantage of such a system would be the capability to promote coordination of record keeping, third party billing, eligibility guidelines, and claims submission.

Medical Assistance Criteria for Health Professionals

The credentials required for health professionals providing services through Medicaid are defined in federal and state regulations specifying educational and certification requirements. School districts, once enrolled as Medicaid providers, will be required to comply with the terms and conditions itemized on the Provider Agreement and specified in the Provider Manual. In addition, any service provider contracted with by the school district for direct provision of services to children with handicapping conditions must meet all applicable requirements in order for the district to seek Medicaid reimbursement.

School districts may encounter Medical Assistance reimbursement problems if members of their staff do not meet state and federal certification standards. If the services have been provided in the past by a person who does not meet these requirements, the school district will be faced with the choice of hiring new personnel who meet the requirements or foregoing Medical Assistance reimbursement for the effected services.

The Role of the Individual Education Plan (IEP)

An Individual Education Plan (IEP) is required by the Department of Education for each child identified to be in need of early childhood special education or related services. The Medical Assistance program requires a "plan of care" as a prerequisite for reimbursement. The plan of care is a written plan that specifies the recipient's condition, functional level, treatment objectives, physician's orders, plans for continuing care, modifications to the plan, and plans for discharge from treatment.

MA's "plan of care" requirements could be incorporated into the IEP so that one document could serve both purposes by itemizing reimbursable services for the child and providing an area for sign-off by the child's physician.

Data Collection Issues

As part of the referral process for children with handicapping conditions, schools will obtain information from families regarding third party payors and eligibility for Medical Assistance. This presents a potential conflict of interest for schools because the knowledge of Medical Assistance eligibility could influence whether or not certain therapies or other services are provided.

However, ability to recover reimbursement cannot, under education guidelines, influence the provision or prescription of services to the child in an educational setting.

Potentially, there is also a data privacy issue since the child's file would likely be available to individuals on the child's interagency planning team as well as the the billing agent. There is a need for guidelines governing the handling of this information both at the state and local level.

Sequence of Billing

Since 1986, federal law has required state Medicaid programs to provide assurance that all third party payors are billed before Medical Assistance in those situations where the recipient has other sources of health coverage.

Under this cost avoidance requirement, providers must identify liable third party payors and obtain payment or denial of payment from these sources before submitting claims to Medical Assistance.

The provider must obtain information about a recipient's potential third party coverage from the recipient, from the recipient's responsible relative, or from the remittance advice provided by the Department of Human Services upon rejection of a claim because of the Department's identification of a third party payor.

caseManagement

Case management is required as a related service in P.L. 99-457. Reimbursement of case management by Medicaid is allowed only in specific situations with a proven need to manage those situations. Case management is viewed as an additional needed service and is not intended simply to coordinate or pull together a variety of services. Conditions of case management reimbursement are specifically designated in the State Medicaid

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

Similar Goals Between Federally Required Child Assessment Programs

A recent amendment to the Education of the Handicapped Act (P.L. 99-457, Part H) includes a mandate to screen and provide treatment for children with handicapping conditions and those who may be at risk of developing a handicapping condition. Many aspects of the new amendment parallel the older Medicaid child screening provision, known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT). The goal of each is early detection of handicapping problems in children and referral to appropriate sources of treatment or care.

Minnesota also provides child screening services through two other sources, Early Periodic Screening (EPS) through the Department of Health, and Early Childhood Screening (ECS) through the Department of Education. (Please refer to Table 2 for a comparison of these screening programs).

Requirements of P.L. 99-457, Amending EHA, Part H

Public Law 99-457 requires states to address the care and service needs of infants and toddlers, birth to 36 months, with handicapping conditions. Public Law 99-457 requires "early identification, screening, and assessment services" which are further defined as "a multidisciplinary assessment of unique needs and the identification of services appropriate to meet such needs". In order to receive ongoing federal education funding for children in this age group, states must demonstrate that infants and toddlers have been screened and that appropriate early intervention services are available.

Public Law 99-457 (Part H, Sec. 676 [b,5]) requires establishment of a comprehensive child find system "required for making referrals to service providers that includes timelines, and provides for participation by primary referral services."

The system must also be coordinated with all other major child find efforts conducted by various public and private agencies throughout the state.

The regulations (34 CFR 303.64) note that "coordination with other child find efforts in the state helps to maximize the state's resources by eliminating duplication of effort and ensuring that all eligible children are identified. To ensure appropriate coverage, a state may wish to establish a central registry."

This is an important area for interagency attention, not only because it is a required component of the Part H amendment, but because it will enable the state to identify and track children with handicapping conditions or at risk for such. The information gathered through such a system would be helpful in planning and budgeting for services on a state and local level.

TABLE 2
MINNESOTA'S CHILD SCREENING PROGRAMS

SCREENING PROGRAM	SPONSORING AGENCY	AGE OF POPULATION	INCOME INDEX	INCOME AMOUNT*	SCREENING SCHEDULE	SOURCE OF REIMBURSEMENT
Medical Assistance/ Early Periodic Screening, Diagnosis, and Treatment	Department of Human Services and Department of Health	0-18 Years	133% AFDC (90% of FPL)**	\$6,948	Upon Request	Medicaid Federal State Local
Prenatal Care Initiative	Department of Human Services and Department of Health	Birth through Age 1	185% FPL	\$14,292	Upon Request	Medicaid Federal State Local
Children's Health Plan	Department of Human Services	1-8 Years	185% FPL	\$14,292		State Funding
Services for Children With Handicaps	Department of Health	0-21 Years	60% Gross Family Income	\$14,993	As Referred	State Funding and MCH
Early Childhood Health and Developmental Screening	Department of Education	3-1/2 to 4-1/2 Years		No Restrictions	One time prior to entering school	State Funding

* Refers to a family of two
FPL = Federal Poverty Level

(This chart is part of the Report on Financing Health-Related
Early Intervention Services in Minnesota.)

Additionally, there are research questions, such as potential associations between environmental risk factors and the occurrence of certain health problems or disabilities, that could be explored through a coordinated comprehensive child find and tracking system.

Requirements of the EPSDT Program

The EPSDT component of the Medicaid program began in 1967 and was amended in 1984 to include additional parental notification procedures. The basic purpose of EPSDT is to screen children for physical and developmental handicaps and refer them to appropriate services and treatment (see Table 1). Minimum requirements of the EPSDT screening component are "growth and developmental assessments; unclothed physical exams; appropriate vision, hearing, and laboratory tests; and also required immunizations." Although states are required to have an EPSDT component as part of the Medicaid program, participation by eligible families is voluntary.

There are obvious similarities between the two provisions, primarily in the areas of program goals, screening requirements, and populations to be served. Given these similarities, it seems logical that coordination of certain components would be beneficial. In addition, Minnesota Statute 120.17, Subd. 11a. requires "screening, assessment, and health services necessary to enable handicapped children to benefit from early intervention services". From both a programmatic and economic point of view, coordination of the services, where feasible, should be considered in order to meet the requirements of these legislative mandates.

Need for Program Integration

The following discussion focuses on specific components of EPSDT and P.L. 99-457 where coordination appears possible as well as beneficial.

A. Compatibility of EPSDT and P.L. 99-457

Several national studies have proposed that EPSDT screening could easily serve as the required Part H screening for Medicaid-eligible children. The Fox Health Policy Consultants at the Georgetown University Child Development Center conducted an extensive study of potential financing for services called for in P.L. 99-457. Since many of the special services provided by schools are provided to Medicaid-eligible children, the Fox study included an analysis of Medicaid reimbursable services offered within each state. The findings indicated that there was a high degree of potential for state level coordination of EPSDT and the Part H screening component. The Fox report states:

there is considerable compatibility between the objectives of EPSDT and EHA-Part H programs. Both programs are intended to identify disabling problems early in childhood and assure that appropriate measures to correct or ameliorate them are provided. As a result, the opportunities for using Medicaid financing to support the medical and health-related components of Part H are significant for low income children" (10).

Not surprisingly, the study found a great deal of variation in the way states currently implement and manage health and education programs. The Study urges each state to adopt strategies that build on existing programs so that federal requirements are met and federal financial support can continue.

In another example, a recent book titled. Mapping the Future for Children with Special Needs (11), discussed P.L. 99-457 and found EPSDT to be "probably the most important Medicaid service for early intervention programs." It is noted that by using EPSDT as an integral part of the child find and diagnosis components of the Part H program, states would be able to extend the use of Medicaid funding to cover early intervention services. The author concludes:

"The most efficient and comprehensive use of EPSDT for this purpose will require that the assessment procedures for EPSDT be consistent with the needs and requirements of P.L. 99-457 in terms of eligibility, determination, and IFSP development."

Along these same lines, in the December 1987 minutes of the Consortium on More Effective Utilization of Medicaid and Third-Party Payments to Support Early Intervention Programs Under P.L. 99-457 (Karl White, Chair), a priority goal was established to investigate "more extensive use of EPSDT to conduct initial assessments for handicapped children".

These studies strongly suggest state coordination of the EPSDT screening component and the proposed screenings under P.L. 99-457 in order to strengthen child screening services.

3. Child Screenings Available to Different Populations

Differences in availability and accessibility of child health and developmental screenings and follow-up care must be addressed in order to avoid inequities among population groups. There are differences in availability of child screenings, depending on the individual's financial situation. EPSDT screenings are available only to children from families that are eligible for Medical Assistance benefits. Children in families with incomes just above MA eligibility limits and up to 185% of the Federal Poverty Level, can receive screenings identical to the EPSDT screenings through the Children's Health Plan (see section on Children's Health Plan). Children in families above this income level can receive screening services from their family physician. These screenings may not be covered by private insurance, even if the family is insured, since insurance plans are currently allowed to exclude this service. Another resource for childhood screenings is through local public health nursing services which charge for screening on a sliding fee basis.

Early Childhood Health and Development Screening (ECS), formerly Preschool Screening, is available through local school districts and is offered one time to all children ages 3-1/2 to 6. Until 1982 this program was equivalent to screenings given through EPS and EPSDT, but funding cuts in 1982 substantially reduced the program.

Because of **these program cuts, ECS preschool screenings no longer** provide the in-depth range of physical and developmental evaluations that are available through EPS and EPSDT. In addition, there is some evidence that early childhood screening should be conducted before the age of 3-1/2 in order to detect problems needing earlier attention.

Screening Instruments

The developmental screening instrument now used in the state EPS and EPSDT screenings is determined by state and federal regulations. As with other Medicaid programs, the state can add to and improve on the basic requirements as long as the provisions are approved in the State Medicaid Plan. The notion of strengthening the developmental component of the EPSDT screening has been explored in the Fox study on Medicaid financing (10). The study noted three areas in which the developmental component of the EPSDT screening could be improved:

1. Use of the Denver Developmental Screening Test(DDST). According to the Fox study, all states include a developmental component as required by EPSDT. Fourteen states require DDST and most of the remaining 36 states choose to use it. In Minnesota, EPS screeners use the DDST, while physician EPSDT providers rely on the Prescreening Developmental Questionnaire (PDQ) for children ages birth through five. If children fail the PDQ, they must be tested by the DDST. Fox notes that the effectiveness of the DDST has been seriously questioned by several researchers (12, 13, 14).
2. Certified providers. Most states were found to use the same screener or provider for both the physical exam and developmental screening. Providers are typically private physicians or other providers who are not experienced in screening for developmental delays. The study noted that only four states (Idaho, North Dakota, Tennessee, and Utah) required that the developmental screening be conducted by a certified provider with expertise in this area. Minnesota conducts extensive training for EPS and EPSDT screeners.
3. Time allowed for Screening. The study noted that along with the lack of expertise, professionals were found to devote too little time to the developmental screening component. According to the study, thirty minutes to one hour is required for the screening, depending on the age of the child. There are no written guidelines for amount of time spent on the developmental screening component of EPSDT in Minnesota,

EPSDT and the Payment Sequence

Services included in an Individual Education Plan (IEP) provided through the schools to children with handicapping conditions have traditionally been the financial responsibility of the school district. However, on July 1, 1988, the Catastrophic Health Act, P.L. 100-360, was signed into law. This law contained an amendment to the Social Security Act stating that Medicaid

reimbursement cannot be restricted or prohibited for covered services for a child with handicaps because the services are included in an IEP.

When a child with a handicapping condition is eligible for Medicaid, covered services provided by the local school district may be reimbursed through the Medical Assistance system. Further, if EPSDT was involved in the diagnosis, the services would be covered through the Medical Assistance program as long as the child is eligible. The potential for using EPSDT/MA funding to support early intervention programs for Medicaid eligible children was studied extensively by White and Immel, who noted:

"Any 'needs' discovered as a part of any EPSDT examination will also be covered by Medicaid funding. By using EPSDT as an integral part of the child find and diagnosis components of the Part H program, states would be able to substantially expand the use of Medicaid funding to cover early intervention services." (16)

The sequence of payment and procedures of reimbursement are left to each state to work out depending on its individual situation. Some states are restrictive in Medicaid-EPSDT coverage, and there will be excessive barriers to getting service reimbursement. In Minnesota, Medical Assistance currently offers the full range of services with only moderate restrictions on frequency of obtaining services.

Utilization of the EPSDT Program

In order to coordinate with Part H screenings, the rate of utilization of EPSDT should be increased. Child screenings for Medicaid eligible children are conducted outside of the EPSDT reimbursement system. Efforts should be made to bring these screenings into the EPSDT System.

SPECIAL PROGRAMS FOR CHILDREN WITH HANDICAPS THROUGH THE MEDICAID PROGRAM

Background

The federal government allows exceptions to certain restrictions placed on services and eligibility requirements normally provided and regulated through the federal Medicaid (MA) Program. These "waivers" are authorized by the Omnibus Budget Reconsideration Act (OBRA) of 1981 (P.L. 97-35), Section 2176, adding section 1915(c) to the Social Security Act. There are four elements that can be waived: 1) eligibility requirements; 2) statewideness; 3) comparability of services; and 4) amount, scope, or duration of services regularly provided under Medicaid. The basic premise of a waiver is that it cannot cost MA more to provide community-based care than it would cost MA to provide the same services in an institutional setting.

Funding for the waived services is the same as for other services provided through Medicaid with the federal share being 53 percent, state 42.3 percent, and counties 4.7 percent (subject to adjustments in the Federal Financial Participation, FFP). Providers must follow the usual process for billing other third party coverage before billing Medical Assistance as required by Medicaid cost avoidance regulations.

The TEFRA option is included here, although it is not a waived service. Children eligible through the TEFRA option can receive the entire array of Medical Assistance Services.

Community Alternative Care (CAC)

The Community Alternative Care (CAC) Program is a model waiver that provides home and community-based services to chronically ill children under 21 years of age and became effective in Minnesota for a three year period beginning April 1985. The waiver was expanded to serve chronically ill persons under 65 years of age in mid-1987.

The CAC waiver program is available to individuals who 1) are under 65 years of age; 2) are hospital residents or at risk of frequent inpatient hospital care; 3) are eligible for Medical Assistance based on the individual's income and assets - not family income and assets; and 4) could be provided home and community-based care at a cost to Medical Assistance which is less than would be paid by MA if the individual resided in a hospital.

In addition to services normally covered under Medical Assistance, participants in the CAC Program are eligible for reimbursement of case management, environmental modifications in the home, family counseling and training, foster care, homemaker services and respite care, as well as extended home health services, medical supplies/equipment, prescription drugs, medical transport and professional services.

The program is approved to serve 52 individuals during the waiver year ending April 1989, gradually increasing to 102 in April 1992. At the time of this report, 38 individuals (6 adults, 32 children) were enrolled in the CAC program.

Community Alternative for Disabled Individuals (CADI)

The CADI waiver was designed to serve physically disabled individuals under the age of 65 who are applicants to or residents of nursing homes. In addition to services normally covered under Medical Assistance, participants in the CADI program are eligible for case management, adaptations to the home, vehicle or adaptive devices, homemaker services, respite care, adult day care, family counseling, training, independent living skills, extended personal care attendant services.

Medical Assistance eligibility under CADI is determined using solely the income and assets of the disabled individual. This is in contrast to the regular Medical Assistance program which requires that income and assets of spouses and parents of children under age 21 be counted if the individual lives with them.

In order to be eligible for this waiver, the individual must be certified as disabled, screened by Pre-admission screening, and require institutional level of care. Other factors considered in determining eligibility are the types of services the client needs in order to remain in the home. After the home care service plan is developed, it must be determined whether Medical Assistance or other funding sources can meet all of these service needs. Home care must cost Medicaid less than it would to provide nursing home care. If the applicant needs case management or other services that only this waiver program can provide, the individual can then be considered for CADI enrollment.

As of December, 1988, 242 individuals (10 children) were enrolled in the CADI program with a potential for 450 in 1988 and 650 in 1989.

Medical Assistance for Certain Disabled Children: TEFRA 134 Option

TEFRA was authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248). It is principally known as the Children's Home Care Option and operates under the same principle as the Deeming waiver and the Katie Beckett waiver. The primary function of TEFRA is to enable certain children to become eligible for Medical Assistance due to the non-deeming, or setting aside, of parental income and assets.

The child can be eligible for TEFRA if: 1) the child is certified as disabled; 2) the child were in a medical institution, he or she would be eligible for MA; 3) the child requires a level of care provided in a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) including an intermediate care facility for the mentally retarded (ICF/MR); 4) it is appropriate to provide the care to the child at home; and 5) the estimated cost to Medical Assistance to provide the care at home will not be more than the estimated cost to Medical Assistance to provide the care within the institution. Children eligible for MA under the TEFRA Option are eligible for all of the services provided under MA in Minnesota. Because it is not a waiver, but a State Plan Option, there are no "special" services.

Federal Waiver for Mentally Retarded Persons

The federal Medicaid waiver for mentally retarded persons in Minnesota began in 1985 and has been renewed for a five-year period, now effective through June, 1992. The purpose of the waiver is to aid the state in complying with the Welch vs. Levine Court Decree to reduce the number of mentally retarded persons residing in institutions. As an alternative to institutionalization, the waiver provides a range of Medicaid-reimbursable services to mentally retarded persons who are living in community settings. The waived services available are case management, habilitation, homemaker, respite care, and adaptive aid services to individuals who would otherwise be required to live in an institution.

DHS Rule 9525.0010-0100 (previously referred to as Rule 185) governs the case management aspect of the service plan, which is considered to be the key feature in successful implementation of the alternative services program. Included under case management are responsibilities for diagnosis of mental retardation based on a standard set of definitions, assessment of client needs and development of an individual service plan, and the role of the local agency in placement and follow-up services for each person.

The county of the recipient's residence is responsible for providing the waived services, as well as other Medical Assistance benefits provided to the mentally retarded person. Each county is responsible for determining what services are appropriate, and whether the services will be provided directly by the county or through contractual arrangements. Counties also authorize expenditures for the waived services, and they are held accountable for delivery of the services.

The approved waiver services are available only for mentally retarded persons who are eligible for medical assistance, and who are at risk of being placed in an intermediate care facility (ICF/MR), or have been released from one of these facilities because of opportunities created by the waiver. County screening teams assess each individual to determine what type of service plan is most appropriate. The screening team makes individual determinations using criteria that are consistent with federal and state requirements.

As of January 1, 1989, there are 1,692 persons receiving waived services through the program, and it is estimated that approximately 285 to 350 of these are children.

Discussion

It is important to be aware of MA waivers and the services they can provide for children with handicapping conditions. It appears at this time that the most significant effect on school age children with handicapping conditions would result from the TEFRA option. By allowing more children to reside at home rather than in institutions, this option increases the pool of children who can, with additional services, attend school.

CHILDREN'S HEALTH PLAN

Background

The 1987 Minnesota Legislature created the Children's Health Plan to provide health care coverage for children in the state who do not have access to primary health care through private insurance or public programs. This action was prompted in part by the realization that children comprise nearly 10 percent of the state's uninsured population, which means that nearly 100,000 children are uninsured (please refer to Chart A). Just over 46 percent of these uninsured children come from families with income levels just above Medical Assistance standards (please refer to Chart B). These families make up the "working poor," who typically cannot afford to purchase health insurance nor can they pay for health care services for their children.

Eligibility

The Children's Health Plan is now available to Minnesota children who are between one and nine years of age. To be eligible, children must be from families with incomes below 185 percent of the federal poverty level, not eligible for Medical Assistance, and without private health insurance coverage

- outpatient services.

Funding

Funding for the Children's Health Plan is provided through a one cent state tax on cigarettes. Families that meet income guidelines pay an annual fee of \$25.00 per child to enroll in the program. A few families are unable to pay the enrollment fee, prompting at least one local public health agency to pay the fee for enrollment in the program.

Benefits

The Children's Health Plan pays for outpatient care such as physician or clinic services, dental service (except braces), prescription eyeglasses and medications, rehabilitation therapy and home care services. The Plan does not pay for inpatient hospital or nursing home services, mental health or chemical dependency services.

Children enrolled in this plan receive screenings that follow EPSDT guidelines and are billed on the EPSDT form, but are reimbursed through Children's Health Plan funds. It would, therefore, be possible for this data to be used if Minnesota establishes a child find system as required by P.L. 990457. (See discussion under the EPSDT section.) School districts, if enrolled as Medical Assistance providers, will be able to submit claims to the Children's Health Plan for reimbursement of related services as allowable under the Plan.

Program Administration

The Children's Health Plan is administered by the Department of Human Services. It has an outreach component carried out through informational mailings, department staff visits to counties, and poster and brochure displays wherever applicable.

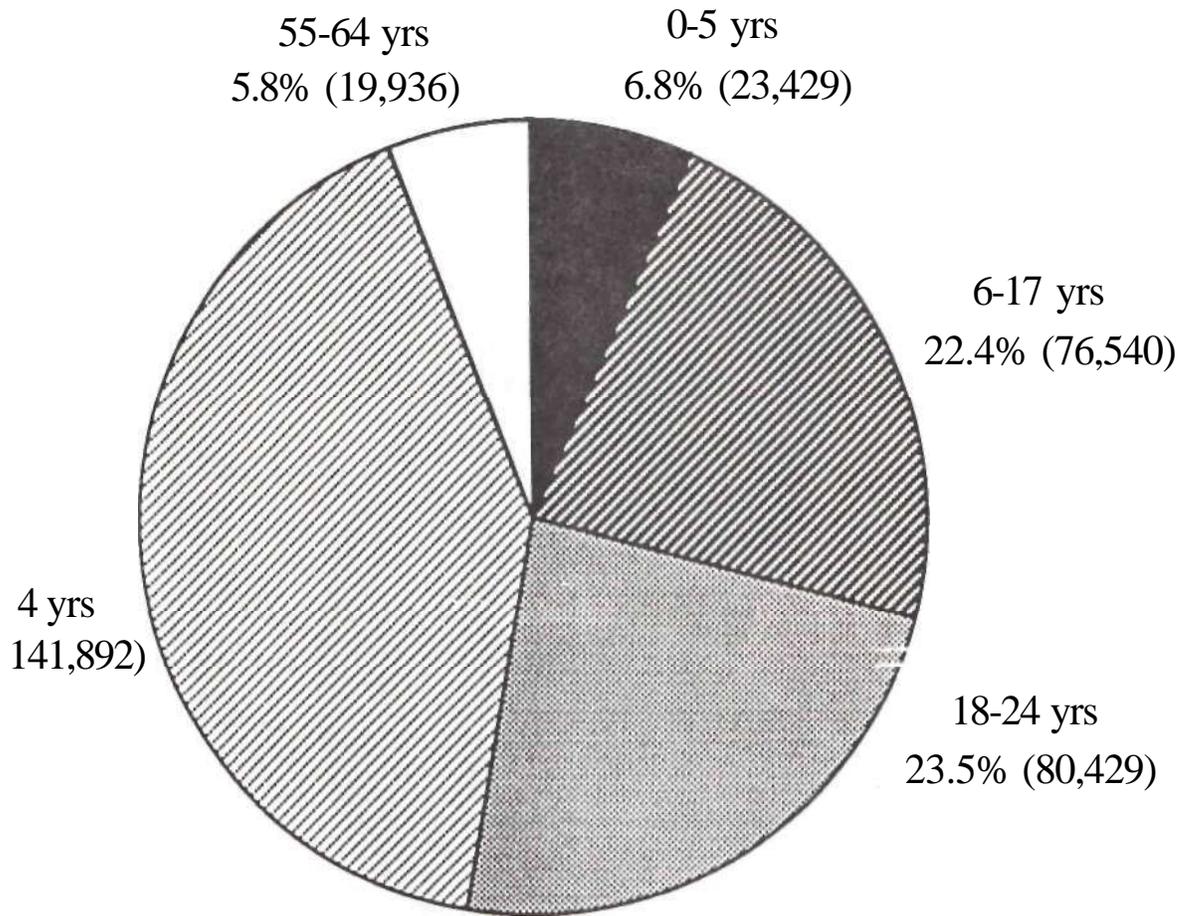
Referrals are made into the Children's Health Plan through the WIC program, well baby clinics, Head Start, and preschool screening services. The Children's Health Plan application asks whether more than \$3,000.00 has been spent for the child's health care in the past twelve months in order to determine if a referral should be made to another program such as Services for Children With Handicaps or the Children's Home Care Option.

Enrollment began July 1, 1988, and as of December 11, 1988, enrollment was 4,570 children representing 2,379 families. It is projected that 9,000 children will be served in the first fiscal year ending July 1989 with current funding. The projected group of 8,000 represents approximately 30 percent of children believed to be eligible for the Plan.

Future Efforts

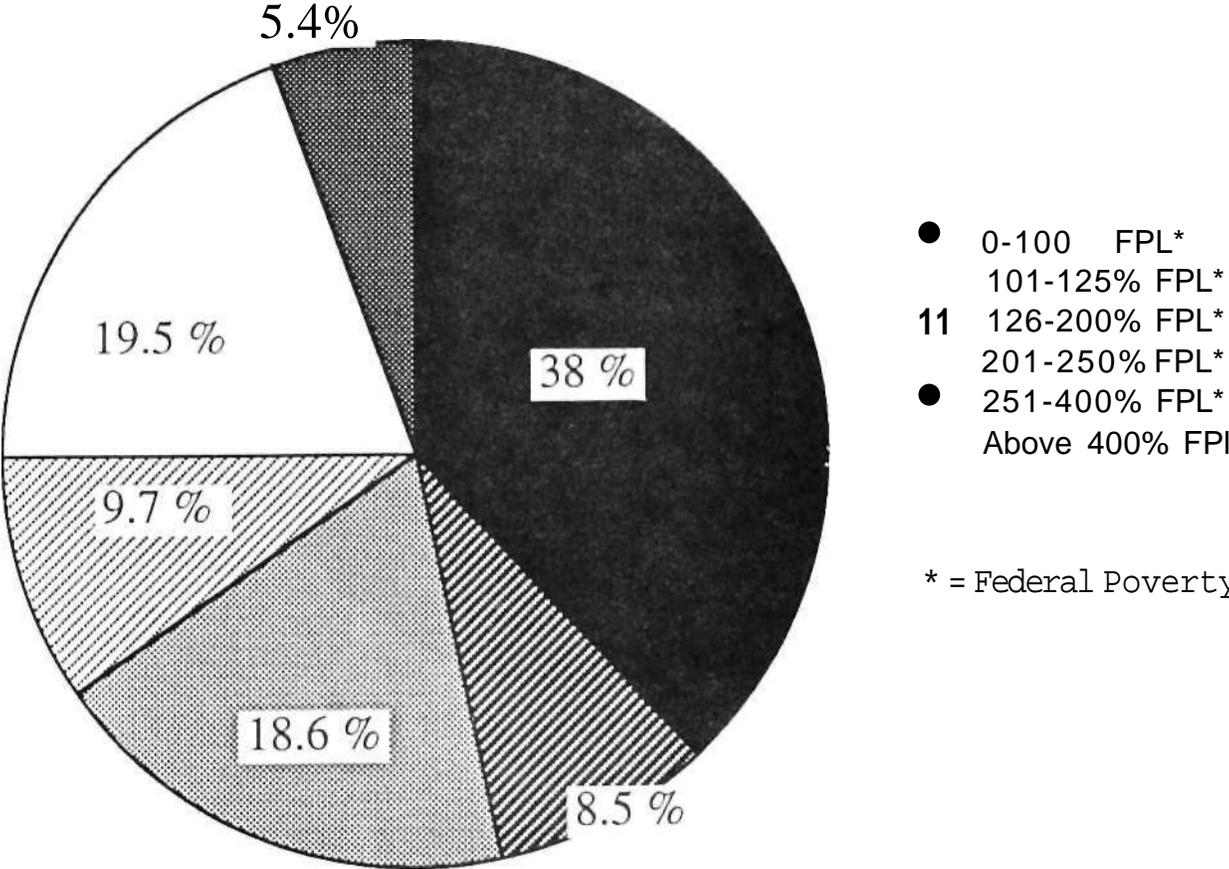
There are several changes anticipated for the Children's Health Plan in the 1989 legislative session. The Department of Human Services will propose expanding the Children's Health Plan to cover children up to age eighteen. This component would be reimbursed by the General Fund.

:HART A - PERCENT UNINSURED IN MINNESOTA BY AGE



TOTAL NUMBER UNINSURED 342,236
30% are Children

Chart B - Uninsured Children and Family Income



- 0-100 FPL*
- 101-125% FPL*
- 126-200% FPL*
- 201-250% FPL*
- 251-400% FPL*
- Above 400% FPI

* = Federal Poverty

**Nearly 1/2 (46.5%) of Uninsured Children
Are in the Poor or Near Poor Income Categories**

Chart Represents 100% of Children Under 18
Total Number of Children Under 18 - 99,969

SERVICES FOR CHILDREN WITH HANDICAPS

Background

The Services for Handicapped Children program (SCH) is authorized by federal legislation, Title V, U.S. Code, Title 42, Chapter 7. The program was historically known as Crippled Children's Services and merged into the Maternal and Child Health block grant in federal year (FY) 1982. The purpose of the program is to improve the ability of handicapped children to attain normal growth and development by assuring early diagnosis of handicapping conditions, arranging for appropriate treatment and improving integration of services.

Eligibility

The target population includes any Minnesota child who is suspected of having an existing or potentially handicapping condition. The program also serves Minnesota residents over 21 with cystic fibrosis or hemophilia as well as individuals who are currently being administered a growth hormone.

In order to receive diagnostic services, the child must be under 21 years of age, have a handicapping or possibly handicapping condition, have completed the SCH application, and, except for emergencies, have obtained preauthorization by Services for Children with Handicaps. In order to receive treatment, the individual must have a diagnosed medically eligible condition, a completed application, meet financial eligibility requirements, and have arranged for SCH preauthorization.

Funding

The federal Maternal and Child Health Act provides annual formula funds to the state. This money is augmented by a state allocation and other funds, such as individual family resources, insurance and prepaid fees, private contributions, and public program resources from Medical Assistance, General Assistance Medical Care (GAMC) and Education. Family contributions are determined by income, using the state gross median income as an index.

Benefits

Diagnosis, evaluation and referral services are provided largely in clinics conducted throughout the state. Treatment is provided by many individual practitioners and hospitals. For example, Gillette Children's Hospital in St. Paul contracts with SCH for treatment as well as diagnostic, evaluation and referral services. Treatment services may include physician and specialty visits, laboratory visits and x-rays, medications, appliances and equipment, hearing aids, surgery and anesthesia, hospitalization, and major restorative dental care.

Program Administration

The Maternal and Child Health Division of the Minnesota Department of Health administers the Services for Children with Handicaps program. Evaluations are conducted in community settings throughout the state, using multidisciplinary teams of specialists, which allows for quality screening: that are geographically accessible. The billing and reimbursement system for SCH parallels that of Medical Assistance and SCH is currently exploring the possibility of contracting that function to the Department of Human Services,

A number of changes have been made to the SCH in recent years. With the current federal and state focus on programs that provide services to children with handicapping conditions, the SCH program should be looked at to see if there is duplication with other programs. Modifications made in the SO program must be implemented carefully so the amount and quality of care **for** persons served by the program are not diminished or reduced in any way. Equally important from a financial viewpoint is a concern that program costs are controlled and that income generated by sliding fee payments and third party reimbursement continue to be recovered.

SUMMARY COMMENTS WITH ISSUES AND RECOMMENDATIONS

When Congress enacted Public Law 94-142 in 1975 it was not intended that educational entities would become fiscally responsible for all the services which a handicapped child may need; regardless of whether or not these services had been previously paid for by other sources. Nonetheless, the "free and appropriate" phrase in P.L. 94-142 was interpreted by many to mean that any service specified in an individual educational plan (IEP) would automatically become education's fiscal responsibility. Whether or not a particular "related service" is an educational or medical responsibility has long been a debated topic. Much confusion still exists over which entity (education or health) should be assigned fiscal responsibility. Much of this confusion exists because many of the "related services" described in P.L. 94-142 are services which can be and have been the fiscal responsibility of the health care industry.

Common practice has been to assign fiscal responsibility to education if the service is described in an IEP or provided at a school site by school district personnel. The Medicare Catastrophic Health Care Act, P.L. 100-360, (Report # 100-661, pp. 122-123 and pp. 268-269) which was signed into law on July 1, 1988, clarifies that Medicaid reimbursement cannot be prohibited for services solely on the basis that these services are included in an IEP or individual family service plan (IFSP), or provided at a school site by school district personnel.

Public Law 99-457 further clarifies education's fiscal responsibility by describing education as the "payor of last resort" (Sec. 681).

- (a) "Nonsubstitution. Funds provided under section 673 may not be used to satisfy a financial commitment for services which may have been paid for from another public or private source but for the enactment of this part....
- (b) Reduction of Other Benefits. Nothing in this part shall be construed to permit the State to reduce medical or other assistance available or to alter eligibility under title V of the Social Security Act (relating to maternal and child health) or title XIX of the Social Security Act (relating to medicaid for handicapped infants and toddlers) within the State."

There are no simple solutions to the issues surrounding the financing of services for children with handicapping conditions. Many larger, more complex issues surface as solutions are discussed. Some broad issues include:

- Delineating the financial responsibility of private third party payors, education, public health, and human service agencies;
- Operationalizing the lead agency concept with multiple agencies sharing in the fiscal responsibility;

- Determining where parental responsibility ends and public responsibility begins;
- Developing a system which focuses on the needs of the whole child and their family; and
- Addressing respite care needs as a part of a system which finance community and family support services.

The following discussion of issues and recommendations is an initial attempt in addressing these concerns. The overriding challenge is found developing a system of shared financial responsibility which assures equitable access to quality services for all children with handicapping conditions.

FINANCE

ISSUE #1:

The cost of providing health-related treatment and services to individual children ages birth to five with handicapping conditions unknown; consequently there is insufficient information to determine **the** economic and public policy ramifications of accessing third-party reimbursement. Schools currently record costs on a program basis, as opposed to an individual unit basis. Data is not easily accessible in most instances and must be obtained from individual client records.

RECOMMENDATIONS:

- 1.1 Compile data, if available, from the Departments of Health and Human Services with respect to children with handicapping conditions who are eligible for Medical Assistance.
- 1.2 Compile data from private third party payors related to the number and types of claims submitted for children with handicapping conditions ages birth to five in the last five years.
- 1.3 Compile the Department of Education's child count data for children ages birth to five years which includes information regarding the health-related services that individual children are eligible for.
- 1.4 Conduct pilot studies in representative areas (outstate and metro) to determine the costs of various health-related services for children with handicapping conditions ages birth to five years.
- 1.5 Compile the data in Recommendations 1.1, 1.2, 1.3, and 1.4 to estimate costs for providing health-related treatment and services to children with handicapping conditions ages birth to five years.
- 1.6 Publish the information from Recommendation 1.5 to determine the impact educational billing of related services will have on third party payors.

ISSUE #2:

As enrolled Medical Assistance (MA) providers, school districts will be required to comply with all provisions of the Medicaid program that apply uniformly to all MA providers, as well as specific requirements that may only apply to schools. School districts may incur increased costs due to these Medical Assistance requirements. For example, schools may have to add clerical staff to comply with recordkeeping requirements. Salary expenditures may increase as school districts choose to hire staff to comply with personnel licensing standards in order to seek MA reimbursement.

RECOMMENDATION:

Conduct pilot studies in representative areas (outstate and metro) to determine the costs associated with all aspects of school districts being enrolled as MA providers. Documentation and licensing requirements, as well as implementation and training procedures, are all factors which must be considered in this study.

ISSUE #3:

It is unclear as to whether or not accessing third party reimbursement along with state education aids presents a problem of supplanting. If supplanting is determined to be an issue, the potential exists that state and federal aids will be adjusted accordingly.

RECOMMENDATION:

Request state and federal policy clarification.

ISSUE #4:

As this report has evidenced, there are many complex and overlapping systems and funding sources for health-related early intervention services. At times, negotiating the way through these systems can become so burdensome to parents, providers, and administrators alike, that it seems there are more barriers than facilitators to effective interagency, collaborative service financing.

RECOMMENDATION:

At the state level, new ways of combining systems and funding streams should be explored. Thinking should not be limited by current systems, but existing paradigms should be broken down in order to explore innovative ways of funding. One example that could be explored follows a model currently being used to finance chemical dependency treatment services via the creation of a pool of all funds related to such services in the state.

DEFINITIONS

ISSUE #1:

Medical, educational and human service fiscal responsibility for health-related services has not been clearly defined. The "gray areas" may make definition of responsibility more difficult.

RECOMMENDATIONS:

- 1.1 Develop specific definitions for health-related services with input from education, health, and human service providers.
- 1.2 Develop criteria for distinguishing medical, educational and human service responsibility. Include reference to scope and amount of service.

IMPLEMENTATION

ISSUE #1:

There is a need for a billing system that is cost effective for school districts in order to access third party payments for health-related services.

RECOMMENDATIONS:

- 1.1 In the absence of time to commission a statewide study or task force to develop guidelines for billing procedures, local districts should focus attention on this issue. It may be advisable for school districts to arrange for a consultant or advisor to provide guidance as they make critical decisions about billing arrangements that will effect them far into the future.
- 1.2 The State Department of Education should sponsor technical assistance sessions that will provide school districts with a background knowledge of the basic requirements for becoming billing agents, along with implementation procedures and examples of billing models.

ISSUE #2:

The local school district's service providers must meet state and federal guidelines for licensure requirements in order for the school district to be reimbursed by Medical Assistance (MA) for health-related services they provide. Some school personnel (namely, speech therapists and school psychologists) who currently provide such services may not meet these requirements.

RECOMMENDATION:

The State Department of Education should provide guidance for school districts faced with the choice of: a) using current non-MA qualified staff to provide services and foregoing MA reimbursement for their services; b) replacing the non-MA qualified person with someone whose

services would qualify for MA reimbursement; or c) coordinating with another school district to share an MA qualified staff person.

Issue #3:

There is a need for clarification regarding the role the IEP plays in the MA approval and billing sequence. Schools will want to minimize the number of documents required, especially if contracting with a billing agent, since compensation is directly related to processing costs.

RECOMMENDATION:

The IEP should be designed so that it can also serve as the "plan of care" and be approved and signed by the physician in order to meet MA guidelines. Success of this effort will require cooperation and coordination between the Departments of Education and Human Services.

Issue #4:

School districts will have to design the data collection system so that MA and other third-party eligibility information is a part of the child's file and 1) is kept confidential and 2) is not allowed to influence the quality or duration of services provided. There is a potential for costly litigation if these issues are not addressed early in the process.

RECOMMENDATIONS:

- 4.1 There is a need for the State Department of Education to formulate guidelines relating to maintenance of individual data privacy.
- 4.2 The data collection system must be designed to eliminate the possibility of public program eligibility influencing the type or amount of service prescribed or received.
- 4.3 Information regarding third party eligibility should be collected as a part of the referral process. Parents must be informed of their choice in providing this information.
- 4.4 Investigation should begin regarding the feasibility and public policy ramifications incorporating third party eligibility information into the data elements of the State Department of Education's electronic integrated data base.

ISSUE #5:

School districts will require a more sophisticated billing system than is now in place to bill third party payors for children on MA.

RECOMMENDATION:

The billing system chosen or designed by school districts must also be capable of billing other third party payors to ensure compliance with the "cost avoidance" requirement of Medical Assistance.

CHILD FIND: SCREENING AND ASSESSMENT

ISSUE #1:

Public Law 99-457, Part H requires a child find system, "including a system for making referrals to service providers that includes timelines and provides for the participation of primary referral sources." This requirement is currently being met in a piecemeal, uncoordinated fashion through Early Childhood Screening (Education), EPS/EPSTDT {Health/Human Services), Birth Certification Registration (Health), Child Registry (Education) and Services for Children With Handicaps (Health).

RECOMMENDATION:

The design of Minnesota's child find system should take into consideration existing requirements under P.L. 99-457. Representatives from each program with a child screening, child assessment, or child evaluation component, in addition to other public and private agencies such as hospital nurseries and public health departments, must be involved in designing the system. Each community must coordinate its services to provide the local child find system.

ISSUE #2:

There are considerable areas of overlap in the screening requirements of EPSTDT and P.L. 99-457. The screenings operate under different funding sources, legislation, and referral systems.

RECOMMENDATION:

There is a need for a statewide screening system that incorporates the requirements of EPSTDT screenings and P.L. 99-457. Coordination has the potential of improving the quality of the screenings, extending outreach efforts, and increasing public awareness of available services.

ISSUE #3:

Child screening procedures now in place are not equal in quality, scope, or accessibility; and some childhood conditions may go undetected until age 3-1/2 when Early Childhood Screenings are available.

RECOMMENDATION:

There is a need to view all child screening efforts as sharing a common goal and to consider coordination in order to provide equitable services to all population groups. Toward this end, ECS could be strengthened and made available at an earlier age, returning it to equivalency with EPS and EPSTDT screening in both quality and depth.

ISSUE #4:

Not all Minnesota children receive an in-depth physical and developmental screening early enough so that problems can be detected.

RECOMMENDATION:

There is a need for state policy enabling children to receive equal screening and referral services regardless of parental income or other qualifying factors. Situations where non-MA eligible children receive care that is inferior in quality and frequency to that provided to MA eligible children should be avoided.

ISSUE #5:

The screening instrument required to fulfill P.L. 99-457 requirements should have a stronger developmental component than is currently used in the EPSDT screening and should be administered by persons who are trained and certified in this area.

RECOMMENDATIONS:

- 5.1 There needs to be an examination of child screening instruments used in the state to determine whether they should be integrated or combined to better fulfill requirements.
- 5.2 A higher quality assessment of developmental achievement would result from having that component of the screening administered by persons who are specifically qualified to conduct it. Qualifications should be strengthened by requiring additional routine training for physicians and others who might participate in administering the developmental component.

ISSUE #6:

If a separate education-based screening program is developed in response to P.L. 99-457, rather than integration with the existing EPSDT reimbursement system, there could be loss of federal dollars available to Minnesota through the Medicaid program.

RECOMMENDATION:

The Department of Education should pursue with the Department of Human Services the notion of utilizing EPSDT for screening as well as follow-up, diagnosis and treatment for eligible children to the extent this is possible.

ISSUE #7:

Screenings received by children eligible for Medical Assistance are not always billed through the EPSDT reimbursement system which was established specifically for that purpose. Because billing on the EPSDT billing form is voluntary, physicians may conduct the screening exactly as required by EPSDT, but submit the bill through the regular MA billing system. This results in a higher cost to state and local resources, in addition to reimbursing physicians at a lower rate.

RECOMMENDATION:

All MA providers need to be aware that billing for child screening through the EPSDT reimbursement system provides better information about the child's health, reimburses providers at a higher rate, and ensures better outreach and follow-up for referrals.

ISSUE #8:

In spite of active county notification efforts, some parents fail to take children to clinics for the recommended screenings. Parental failure to get children screened may be attributed to many different causes, depending on the attitudes and the personal resources of each individual family. Since EPSDT is a voluntary program, it is difficult to increase participation beyond a certain point. These problems should not diminish the importance of active outreach,

RECOMMENDATION:

Methods should be employed to strengthen the outreach component of the EPSDT system in at least the following ways: 1) pregnant women who are MA eligible should be informed about the importance of having their newborn participate in regular EPSDT exam3; 2) the first examination performed at birth of MA eligible newborns should be billed to the EPSDT service; and 3) a schedule of future screenings should be set up with the mother before she leaves the hospital.

CASE MANAGEMENT

ISSUE #1:

Various agencies, third party payors and parents interpret the meaning of case management differently.

RECOMMENDATIONS:

- 1, 1 Develop a definition of case management services, (refer to MA and P.L. 99-457 definitions) and recommend whether or not this is a reimbursable service.
- 1.2 Define the family's roles and responsibilities as they pertain to case management.

Issue #2:

Case management is a related service under P.L. 99-457; however, it is only reimbursable by Medical Assistance under certain controlled situations. There is potential for high cost where case management is prescribed, mainly because it can duplicate other services. Whether Medical Assistance or the school district is the source of reimbursement for the service, case management should have tight controls to avoid duplication of services and costly, unnecessary expenditures.

RECOMMENDATION:

Interagency teams should provide criteria for determining when case management is appropriate and assigning responsibility for providing the services, regardless of the source of reimbursement.

LEGAL IMPLICATIONS

ISSUE #1:

There is currently no formal interagency dispute resolution process at the state or local level. State level interagency dispute resolution is one of the components required to be in place in 1991 by P.L. 99-457.

RECOMMENDATION:

An interagency dispute resolution process must be established to determine the proper payor when responsibility is disputed. This process should address a variety of issues including ensuring the appropriate allocation of payment responsibilities, provide feedback to involved state agencies regarding policy issues, determination of whether or not this dispute resolution mechanism should address payment disputes involving private third-party payors, proper composition of the dispute team, identification of the point of which a payment dispute exists, determinations regarding the proper process for claims submission, the dispute team's decision-making process as well as the effect and weight of **the** team's decision,

ISSUE #2:

Educators may be unwilling to participate in third party billing if by doing so they could be implicated in medical malpractice lawsuits.

RECOMMENDATION:

Determine what education's current liability is when providing health-related services; and determine how and if this would change if educational entities accessed third party reimbursement.

PRIVATE INDEMNITY COVERAGE

ISSUE #1:

It is unclear whether families can be required to provide information regarding third party *coverage or to allow schools* access to reimbursement under the coverage.

RECOMMENDATIONS;

1.1 Policy clarification at the state and federal level should be sought.

- 1.2 If it is determined appropriate to require parents' cooperation in third party billing, the circumstances under which parents' should be required must be identified.
- 1.3 Any determination that accessing third party coverage requires parental approval must be taken into account in the analysis of whether it is economically appropriate or feasible for a school district to institute third party billing.

ISSUE #2:

The extent to which family cost sharing is permitted under P.L. 99-457 is unclear. Issues regarding payment of coinsurance, deductibles and copayments, as well as effects on policy dollar limitations must be addressed.

RECOMMENDATIONS:

- 2.1 Policy clarification at the state end federal level should be sought.
- 2.2 If it is determined families may be required to cost share, **the** appropriate level and extent of cost sharing must be determined.

ISSUE #3:

The appropriate role of third party payors regarding coverage of related services is unclear. In practice, there is considerable variation in the nature and extent of coverage of related services among policies and plans.

RECOMMENDATIONS:

- 3.1 It should be determined what plans typically cover by way of early intervention services, to the extent possible.
- 3.2 The role private health plans should be playing with respect to coverage must be identified. This necessarily includes discussion of definitions, eligibility, coverage restrictions, and costs to the plan and the family. Defining the proper role of private plans will raise the troublesome issues involved in mandating benefits, including the costs of medical care to families and the problem of the uninsured.
- 3.3 Where necessary, legislative or regulatory changes should be made to ensure private payors assume the appropriate level of responsibility. A large portion of Minnesotans insured are covered by policies of self-insurance which are not subject to state regulations. Imposing benefit requirements only on regulated plans may have undesirable consequences.

ISSUE #4:

Many health plans impose procedural requirements on those seeking health care. For example, HMOs generally pay for services only when

provided by HMO participating providers. HMOs, and increasingly indemnity plans, require prior approval before certain services are covered and may impose administrative determinations of medical need. The schools' IEP/IFSP process and health plans' "case management" process are separate systems which historically have not operated in an integrated fashion. Requirements of one system may be barriers to service in another.

RECOMMENDATIONS:

- 4.1 Achieve coordination of effort between schools and third party payors in assessing needs and delivering services to handicapped children. Schools may be required to **follow** various different sets of rules in **order to** access reimbursement from each third party payor.
- 4.2 Explore the possibility of schools enrolling as HMO providers. In addition to, or in the alternative, consider a process whereby HMOs and schools work closely in identifying, participating providers to deliver the necessary related services. Efforts should be made to alleviate this.
- 4.3 Develop a process for integrating development of the IEP/IFSP with the third party payors' determination of medical and, scope of coverage and selection of providers.

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FOOTNOTES

1. Proposed Rules Relating to the Early Intervention Program for Infants and Toddlers With Handicaps, Federal Register, 52:222, 303.69.
2. Proposed Rules Relating to the Early Intervention Program for Infants and Toddlers With Handicaps, Federal Register, 52:222, 303.69.
3. Health Plan Regulation: A Report of the Legislative Auditor. (19881. State of Minnesota.
4. According to the Report of the Legislative Auditor, most employees covered by self-insured plans receive benefits akin to those received by enrollees in other insurance or HMO plans. (See page 61.) Of course, since these plans are not regulated, a definitive statement regarding the scope of services provided is not possible. Any discussion or third-party payor liability for early intervention services must address the issue of the equitability of spreading the costs of these services among only those employers and others who choose to purchase regulated products.
5. This term is defined in Minnesota Rules part 2740.0100, subpart 4 as "a benefit, the expected value of which when substituted for another benefit or benefits in a plan of health coverage will be the same as the health benefit or benefits for which it was substituted, and which will result in the plan of health coverage after substitution of the actuarially equivalent benefit, being the actuarial, equivalence of the original plan of health coverage."
6. Nonetheless, there have been instances when HMOs have been persuaded by families or providers to deliver services in the home when evidence of cost effectiveness has been presented.
7. It is precisely this inability which may be at least part of the basis for the unwillingness of HMOs at times to cover benefits for children with handicaps, particularly the technology dependent. Should they agree to cover services, their financial exposure is in some cases virtually unlimited.
8. While the personnel are not the patient's physicians, personnel do base decisions on protocols developed under medical supervision. Still others assume the premise that if there is coverage available for the services through the child's school, the HMO is not financially responsible at all.
9. For example, the State of New York legislated an Interagency Task Force to study the feasibility of public school districts claiming reimbursement from Medicaid and third party health insurance for the

FOOTNOTES (cont.)

related services they must provide to children with handicaps. The Task Force warned that the required compliance with billing and record keeping would "place a significant administrative burden on most school districts" and that they must "recognize and accept their financial commitment to potentially greater administrative costs. "The Feasibility of Claiming Third Party Health Insurance and Medicaid Reimbursement for Services Provided by School Districts to Students With Handicapping Conditions. (1987), Report of the Interagency Task Force on related services for Children With Handicapping Conditions. New York.

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A P P E N D I X A

**Birth
Through
Three**

Interagency Agreement



STATE OF MINNESOTA

Department of Education
Department of Health
Department of Human Services

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INTRODUCTION

! Minnesota Departments of Health, Education and Human Services share an interest in providing services to Minnesota's handicapped children from birth through three years of age. Each department has legislatively mandated or permissively allowed services for these children (see description of participating agencies).

planning efforts to develop interagency coordination around identification and service delivery to handicapped children birth through three years of age have been made in Minnesota. These efforts include the 1973 Child Development Planning Project and the 1976 Minnesota State Council for the Handicapped Task Force on Early Intervention. The 1980 Minnesota Legislature, in an effort to take a systematic look at the needs and related issues of providing services to children birth through three years of age directed the Commissioner of Education, in cooperation with the Commissioners of Health and Public Welfare, "to conduct a statewide needs assessment of special education and related service needs of handicapped children under the age of four. (Laws of Minnesota, 1980, Chapter 609, Article III, Section 13.)"

The "Birth-Three Needs Assessment" was completed in September 1981. There was no legislation in 1981 as a result of this, but the assessment exemplified the ability of the agencies to cooperate. The agencies recognize the potential benefits of further interagency efforts in serving handicapped children birth through three years of age.

In September of 1982 the three Commissioners signed the document, "Recommendations on Policy Regarding Birth - Three Handicapped Children" (Attachment A) and a statewide coordinating task force was convened. The task force was composed of representatives of public and private service providers and consumer and advocacy groups. Discussions by the task force centered on identifying who should be served (definitions), existing services and the structure needed at the State level to improve coordination and cooperation. The task force compiled a grid of services available to young handicapped children (Attachment B). Services vary from coordinated and comprehensive in one community to no services at all in the next and are delivered through a complex network of providers from a variety of public and private agencies. The task force recommended development of an interagency agreement to specify activities at the State level that would assist in the development of coordinated interagency services systems. By this agreement the three State agencies recognize and support the importance and need for a comprehensive plan for early intervention.

Each State agency agrees to the goal and objectives contained in this agreement and through collaborative effort will continue to gather information about local needs and provide assistance in the development of interagency systems.

 Ruth E. Randall, Commissioner
Department of Education

n\nkH


Leonard W. Levine, Commissioner
Department of Human Services

date


Sister Mary Madonna Ashton, Commissioner
Department of Health

date

GOAL

To promote the development of coordinated interagency systems for serving handicapped children birth through three years of age and their families.

OBJECTIVES

1. To increase public awareness of:
 - A. The rationale and need for early intervention services to handicapped children and their families.
 - B. The cost-effectiveness of collaboration to provide necessary services.
2. To encourage and facilitate exchange of ideas, plans, program models and resources across disciplines, programs and agencies on state and local level.
3. To clarify issues, define problems, propose alternatives related to screening, diagnosis and assessment and program models so as to promote coordinated services to birth through three year old handicapped children and their families.
4. Identify for the Departments of Health, Education and Human Services changes in fiscal and program policies that may be necessary to improve coordination and comprehensive services to these children and their families.

IMPLEMENTATION ACTIVITIES

1. A staff person will be assigned in each of the Departments of Health, Education and Human Services to:
 - A. Serve as the department representative on the State level Interagency Steering Committee,
 - B. disseminate information relating to interagency collaboration and program services to field staff and other agency representatives,
 - C. explore and document the need for technical assistance to achieve interagency collaboration, and
 - D. serve as a liaison within each department to coordinate technical assistance and inservice activities offered.
2. The Steering Committee will:
 - A. Serve as an information source to each department regarding interagency collaboration and early intervention for handicapped children birth through three years of age and their families.
 - B. Develop, in conjunction with others in the respective departments, an annual work plan to address the goal and objectives contained in the agreement.
 - C. Prepare a paper which:
 1. identifies screening, diagnosis and assessment services available,
 2. identifies duplications and gaps in services, and
 3. identifies activities necessary to assure comprehensive and appropriate screening, diagnosis and assessment services to children birth through three years of age suspected of having special needs.
 - D. Prepare a paper which:
 1. identifies intervention services available,
 2. identifies any duplications or gaps in the continuum of program services necessary, and
 3. identifies activities necessary to eliminate duplications or gaps in the various program service options so as to assure children with special needs of coordinated and appropriate services,

- E. Explore the possibility of using various existing community information systems for tracking and follow-up of children identified.
- F. Develop a statewide information/resource directory for staff serving young handicapped children.
- G. Explore funding and co-funding options (public and private) to facilitate the interagency planning, development and implementation of services.

DURATION OF THE AGREEMENT

This agreement shall be effective immediately and shall remain in effect until terminated, or upon thirty (30) days written notice by one or all of the parties involved. It shall be reviewed biannually by the Steering Committee and may be amended at any time by mutual agreement of the participating agencies.

DESCRIPTIONS OF PARTICIPATING AGENCIES

A. Department of Education

Special Education Services

Role of State Agency. The Special Education Section, Division of Program Effectiveness, Department of Education is the state agency responsible for the provision of mandatory (ages 4-21) and permissive (birth-age 3) special education services for handicapped students.

Authority. Authority for the provision of special education services includes but is not limited to: (1) The Education of All Handicapped Act as amended by Public Law 94-142, (2) Minnesota Statutes 120.03, M.S. 120.17 and M.S. 124.32, and (3) Minnesota Rules 5 MCAR S 1.0120-1.0129.

Target Population. Mandatory (for ages 4-21) and permissive for (birth-age 3) special education services are provided by local education agencies (LEAs) for all students who have the following handicapping conditions: Learning Disabilities (LD), Educable Mental Retardation (EMR), Moderately and Severely/Profoundly Mentally Handicapped (MSPMH), Emotional/Behavioral Disorder (E/BD), Physically Handicapped (PH), Speech Impairment (SP), Hearing Impairments (HI), Other Health Impairments (OHI), Visual Handicaps (VH) and Multi-Handicapped including Deaf-Blind.

B. Department of Health

Services for Children with Handicaps (SCH)

Role of State Agency. Services for Children with Handicaps (SCH) is the program within the Department of Health with responsibility to assure appropriate casefinding, diagnosis and treatment of children with a suspected or known handicap and to work to improve services to handicapped children.

SCH provides high quality diagnostic services at clinics throughout the state and at medical centers. The program's professional staff counsel, refer and advocate for families of handicapped children, provide inservice training and consultation to local health, education and social services professionals and agencies.

Authority. Authority for the provision of diagnostic and treatment services to handicapped children is provided in the Maternal and Child Health Block Grant Title VI, USC 42 Section 2192, Minnesota Statutes, 1977, Chapter 453, Section 24 and Minnesota Rules, 7 MCAR S 1.651-1.657.

Target Population. Any child with a handicapping condition that interferes - normal growth and development is eligible for services under the SCH program. Typical conditions served include congenital heart disease, epilepsy, cystic fibrosis, hemophilia, diabetes, hearing loss, scoliosis, cerebral palsy, cleft lip and palate, spina bifida, cancer, mental retardation and developmental delay.

Eligibility Criteria.

Diagnosis/Assessment, Treatment - Any Minnesota child 0-21 years of age with a Suspected or known handicap is eligible for services. Reimbursement for evaluation is provided with no out-of-pocket cost to families. However, families are required to share in treatment costs according to their ability to pay.

Comprehensive Child Health Screening

Role of State Agency. Comprehensive Child Health Screening within the Department of Health has responsibility for providing standards, technical assistance and training, monitoring and evaluation for the Early and Periodic Screening (EPS) program and components of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs. These local programs provide screening services for the early detection of problems in children who may need further evaluation, diagnosis and/or treatment. The EPS program also provides for health counseling so that improved practices can be learned.

Authority. Authority for the provision of comprehensive child health screening services is contained in the Maternal and Child Health Block Grant Title V, USC42 Section 2192, Minnesota Statutes, 1978, Chapter 473 as amended 1980, 1981, 1982 and Minnesota Rules, & MCAR S 1.174-1.178.

Target Population. Any child is eligible for the various screening programs. The screening services of the EPS program is provided through local Community Health Services Agencies.

Eligibility Criteria. There are no eligibility criteria for the EPS Program. EPSDT requires that children be eligible for Medical Assistance (Title XIX). Fees may be required for some screening programs according to ability to pay.

Public Health Nursing

Role of State Agency. Public Health Nursing consultation has responsibility to promote and facilitate the development of locally administered public health nursing services such as community nursing, home care of the ill and disabled, disease prevention and control and health education. This activity provides education programs for nurses and ancillary personnel employed by public health nursing agencies and school districts.

Authority. Authority for the provision of public health nursing is contained in Minnesota Statutes 144.05.

Target Population. Local nursing services in 87 counties employing 950 nurses and over 1000 home health aides. Many counties also contract with physical, occupational and speech therapists. Services are provided to all ages and include but are not limited to Early and Periodic Screening for children, local management of the federal nutrition program (WIC), screening for acute and chronic diseases and home health care for the ill and disabled.

Eligibility. Any local public health nursing service or Community Health Services Agency in Minnesota is eligible for assistance from this activity.

C. Department of Human Services

Role of State Agency. In the Department of Human Services (DHS), services for handicapped children are spread among three program bureaus. The Mental Retardation Division, Bureau of Mental Health, is responsible for Developmental Achievement Centers (DACs). The Social Service Bureau is responsible for services to dependent and/or neglected children, the blind and visually handicapped, and the deaf and hearing impaired. Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program in the Income Maintenance Bureau.

Developmental Achievement Center (DAC), dependent and neglected children, emotionally disturbed children, and EPSDT services are provided by the counties, while blind and deaf services are provided directly by DHS regional programs. All of these services are mandatory. However, some programs provide referrals as opposed to treatment, and participation in EPSDT is voluntary for clients.

Authority. Authority for provision of these services is set forth in Minnesota Statutes, 1982, as follows: DACs, Chapter 252.21; dependent and neglected children, Chapter 255E; emotionally disturbed children, Chapter 252.28; blind, Chapter 248; deaf, Chapter 245C. EPSDT is required by Title XIX.

Target Population. Any child with a handicapping condition that is a responsibility of these service programs may receive services. There is no disability exclusions for dependent and neglected children or for EPSDT. Although services for dependent and neglected children are not specifically targeted for the handicapped, some children become dependent or neglected because of their handicapping condition(s), and their parent's or guardian's failure or inability to meet the child's needs.

Eligibility. EPSDT requires recipients to be eligible for Medical Assistance; none of the other services have income limits. However, fees may be charged according to county fee schedules and third party payments, and according to a sliding fee schedule in the case of services for the blind.

Minnesota State Departments of Education,
Human Services, and Health:

Recommendations on Policy Regarding Birth-Three Handicapped Children

Policy Area I - Population to be Served

Children with a severe impairment which results in substantial functional limitation in a major life area such as: receptive and expressive language, learning, mobility, or other age appropriate developmental tasks, who should be served from birth or at the time of identification,

Policy Area II - Scope of Services

The Departments of Education, Health and Welfare will work toward the implementation of a system of services to meet the developmental needs related to each child's handicap. The system will utilize existing resources of the three Departments to the fullest. These services will be designed to maximize the potential for each child to benefit from later school enrollment, and delivered in the least restrictive environment.

Policy Area III — Service Provider

Local education agencies will be the primary coordinators for the development of the individual plans, will assure provision of developmental services and will involve social, health and medical services. Existing public health and social service agencies and programs will participate with the local LEA in the provision of services. To the extent possible, coordination efforts will include voluntary private resources.

Policy Area IV - Implementation Considerations

Services will be implemented through a phase-in process including at least the following:

- (A) Immediate establishment of a statewide coordinating task force made up of appropriate state agencies, parents and others, whose charge will be the development of a plan to achieve these policies. This task force will be advisory to the interagency steering group.

- (B) The Department of Education will serve as the lead agency in the establishment of an ongoing interagency steering group, with the Departments of Health and Welfare, that will facilitate the implementation of the plan and report progress to the respective Commissioners.
- (C) Provision of technical assistance to local communities to encourage and to assist in their development and implementation of interagency case management systems.

Attachment B

Interagency Service Grid

The following grid describes services available to birth through three year old handicapped children and their families from Health, Social Services, Education, Head Start, and Developmental Disabilities agencies. This grid, prepared by representatives on the Birth-Three Interagency Task Force, looks at existing services and provides a framework for future planning and recommendations.

Each agency described what services they provided to handicapped children and their families and under what conditions services are available.

Interagency Service Grid

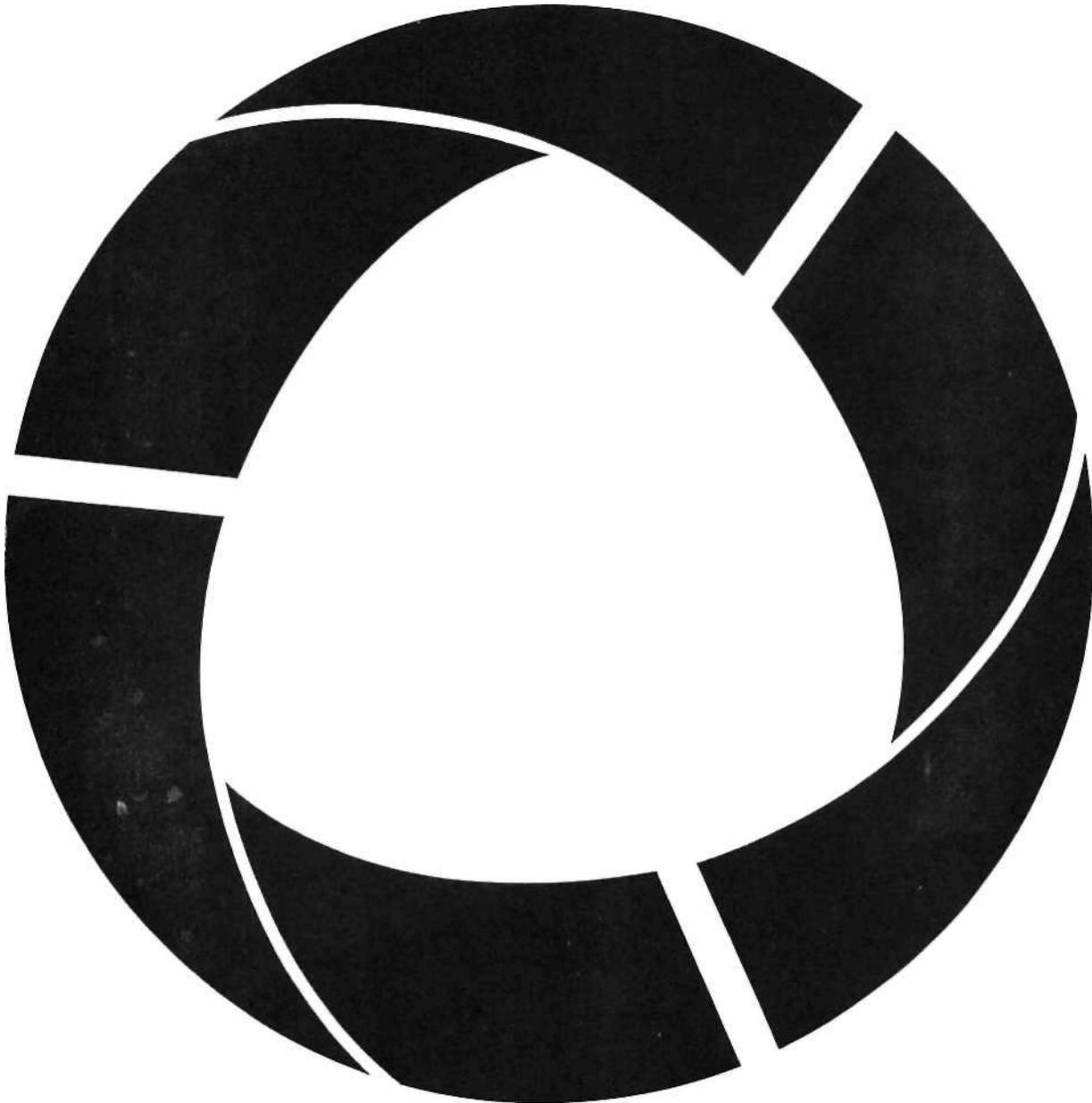
KEY: S - State
R - Regional
L - Local
M - Mandatory
P - Permissive
E - Exempt

SERVICE SYSTEMS	WHERE IS SERVICE AVAILABLE?	ELIGIBILITY										CHILD FIND	ASSESS DIAGNOSE	TREATMENT			INSTRUCTIONAL DEVELOPMENT	RESPIRIT CARE	TA & COORD.	COMMENTS		
		AGE					DISABILITY							INCOME	FAMILY	MEDICAL					EMOTIONAL	
		0	1	2	3	4	5	MR	PH	SI	LD											E/BD
Education																						
LEA's	S,R,L	P	P	P	P	M	M	M	M	M	M	-	No	M	M	E	E	E	M	E	E	
PSS	S,L	E	E	E	M	M	M	All Children				No	M	Refer	E	E	E	E	E	E		
Health																						
A. NY Dept of Health • Services for Children w/ Handicaps	S,R	M	M	M	M	M	M	M	M	M	M	Yes Treated	M	M	M	M	P	E	P		Fees for treatment for handicapped condition.	
• Public Health Nurse	S,R	P	P	P	P	P	P	P	P	P	P		E	E	E	E	E	E	M		Promote & facilitate local services.	
B. Community Health &/or County Health Nurse	L	P	P	P	P	P	P	P	P	P	P	Yes	P	P	P	P	P	P	P		Fee for service or 3rd party.	
C. EPS	S,L	M	M	M	M	M	M	P	P	P	P	P	No	M	Refer	E	E	E	E	P		
Welfare																						
MR/CP	S,L	M	M	M	M	M	M	M	MR/CP	E	E	E	E	No	M	M	M	M	M	P		Sliding fees for service
Depend./neglected	S,L	M	M	M	M	M	M	M	M	M	M	M	No	M	M	M	M	P	P		County or 3rd party pays	
All Other Children	S,L	P	P	P	P	P	P	P	P	P	P	P		P	P	P	P	P	P			
Blind Services	S,R	M	M	M	M	M	M	E	E	M	E	EE	E	No	M	M	M	M	P	M		Sliding fee for purchase of service.
Deaf Services	S,R	M	M	M	M	M	M	E	E	M	E	E	E	No	M	E	M	E	E	M		
EPSDT	S,L	M	M	M	M	M	M	M	M	M	M	M	Yes	M	M			E	E			
Referral is mandatory																						
HEADSTART	S,L	E	E	E	P	M	M	M	10% must be hand capped	Yes	M	M	M	M	M	M	M	E	M		Not entitlement.	
DEVELOPMENTAL DIS.	S,L	P	P	P	P	P	P	P	P	P	P	P	No	P	P	P	P	P	M		Demonstration programs on selected areas to meet selected needs.	
Volunteer Social Service Agencies																						
Private Physicians and Clinics																						

KEY: MR - Mentally Retarded PH - Physically Handicapped
SI - Sensorily Impaired (ie. hearing and/or vision) LD - Learning Disabled

E/BD - Emotionally/Behaviorally Disabled O - Other

**INTERAGENCY AGREEMENT
EARLY CHILDHOOD INTERVENTION**



STATE OF MINNESOTA

Department of Education
Department of Health
Department of Human Services

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INTRODUCTION

The Minnesota Departments of Health, Education and Human Services are committed to providing coordinated services to young handicapped children and children at risk, of handicapping conditions, from birth through five years of age. Each department provides legislatively mandated or permitted services for these children.

Planning efforts to develop interagency coordination of early identification and service delivery to these children have included the 1973 Child Development Planning Project and the 1976 Minnesota State Council for the Handicapped Task Force on Early Intervention. The 1980 Minnesota Legislature, in an effort to look systematically at the needs and related issues of providing intervention services to these children with special needs, directed the Commissioner of Education, in cooperation with the Commissioners of Health and Public Welfare (now Human Services), to conduct a statewide needs assessment (Laws of Minnesota, 1980, Chapter 609, Article II, Section 13.)

No legislation resulted from the needs assessment, but, in 1982, formal interagency policy was developed requiring services for young handicapped children. A statewide coordinating task force, comprised of representatives of public and private service providers and consumer and advocacy groups, was convened to identify agency responsibilities for provision of services and the coordination necessary to provide services most effectively. The State Interagency Early Childhood Intervention Steering Committee was established to provide an interagency focus for these efforts.

In 1984, the three departments signed an Interagency Agreement which recognized the need for comprehensive planning for early intervention for young handicapped children and those at risk of handicapping conditions and their families. Using the State Interagency Early Childhood Intervention Steering Committee, they obtained funds for planning, training, and implementation of local interagency early learning committees mandated by state statute (MS 120.17). The Committee conducted an early intervention services needs assessment. Based on that assessment, training sessions were held each of three years to assist local interagency early learning committees plan coordinated services for children in their communities.

AGREEMENT

By this agreement, the Minnesota Departments of Education, Health, and Human Services reaffirm their support for comprehensive planning for early intervention services for handicapped children and children at risk of handicapping conditions and their families. Each of these agencies agrees to the goal and objectives contained in this agreement and through collaborative effort will continue to assist in the development of interagency systems to meet the needs of young children and their families.

GOAL

The goal of interagency cooperation is to promote the development of coordinated multi-disciplinary systems for serving young handicapped children and children at risk of handicapping conditions, from birth through five years of age, and their families.

OBJECTIVES

1. To increase public awareness of the rationale and need for early intervention services to young handicapped children and children at risk of handicapping conditions and their families.
2. To demonstrate program models which utilize resources across disciplines, programs and agencies on the state and local levels to meet the needs of these young children.
3. To clarify issues, define problems, and propose alternatives related to screening, diagnosis, assessment and program models to promote coordinated services to young children, from birth through five years of age, and their families.
4. To identify for the Departments of Education, Health, and Human Services changes in fiscal and program policies that may be necessary to improve coordination of services to these children and their families.

To facilitate implementation of PL 99-457, through participation of the State Interagency Early Childhood Intervention Steering Committee with the federally mandated State Interagency Coordinating Council.

ACTIVITIES

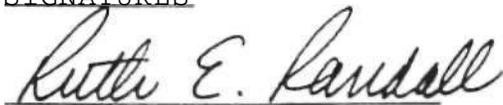
In order to implement this agreement, each department will assign a staff person to serve as the departmental representative on the State Interagency Early Childhood Intervention Steering Committee, which will:

1. Disseminate information relating to interagency collaboration and programs to departmental staff;
2. When provisions of PL 99-457 are in effect, assist the State Interagency Council in determining priorities for service planning, development, implementation, and evaluation;
3. Develop materials for information dissemination to school districts and local health and human services agencies, as well as local Interagency Early Learning Committees; and
4. Coordinate technical assistance with respect to early intervention technical assistance and in-service activities.

DURATION OF THE AGREEMENT

This agreement shall be effective immediately and shall remain in effect until terminated, or upon thirty (30) days written notice by one or all of the parties involved. It shall be reviewed biannually by the State Interagency Early Childhood Intervention Steering Committee and may be amended at any time by mutual agreement of the participating agencies.

SIGNATURES



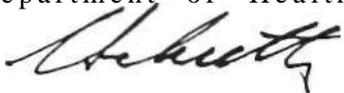
Ruth E. Randall
Commissioner
Department of Education

Date

AM 9-*v

fr. Mary (Madonna) Ashton
Commissioner
Department of Health

Date



(L) Sandra S. Gardebring
Commissioner
Department of Human Services

Date

DESCRIPTIONS OF PARTICIPATING AGENCIES

Department of Education

Special Education Services

Role of State Agency. The Special Education Section, Division of Instructional Effectiveness, Department of Education, is the state agency responsible for the provision of mandatory (ages 3 through 21) and permissive (birth through age 2) special instruction and related services for handicapped students.

Authority. Authority for the provision of special education services includes but is not limited to: (1) Public Law 94 - 142, The Education of All Handicapped Act, as amended by Public Law 99-457, (2) Minnesota Statute, Sections 120.03, 120.17, and 124.32, and (3) Minnesota Rules 3500.2330.

Target Population. Every child who has a hearing impairment, visual handicap, speech or language impairment, physical handicap, or other health impairment, mental handicap, emotional/behavioral disorder, specific learning disability, or deaf/blind handicap and needs special instruction and services is eligible for special education and services.

Early Childhood Family Education

Role of State Agency. Early Childhood Family Education Community and Adult Education Section, Division of Development and Partnership Effectiveness, Department of Education, is the state agency responsible for the provision of permissive parent-child education services for children, birth to kindergarten enrollment, and their parents.

Authority. Authority for the provision of Early Childhood Family Education is specified by Minnesota Statutes, Sections 121.822 and 124.2711.

Target Population. Early Childhood Family Education programs in districts which choose to implement the program are voluntary for all children during the period from birth to kindergarten enrollment, for the parents of such children, and for expectant parents who reside in the school district which levies funds for the programs.

Early Childhood Health and Developmental Screening

Role of State Agency. Learner Support Systems in the Division of Development and Partnership Effectiveness has the responsibility for administering the Early Childhood Screening program. This includes setting standards, program implementation guidelines, reporting procedures, and fiscal aspects of the program. Training, technical assistance, and monitoring responsibilities are shared with the Minnesota Department of Health.

Authority. Authority for provision of Early Childhood Health and Developmental Screening is found in Minnesota Statutes, Section 123.701 through 123.705 and Minnesota Rules 3530.3000 to 3530.4300. The program also meets, in part, the requirement for Child Find activities outlined in federal special education laws and regulations.

Target Population. Each school district in Minnesota is required to provide screening once before children enter school. The recommended age for screening is 3 1/2 to 4 years. All children in this age group are encouraged to participate in this review of vision, hearing, immunization status, growth, health history, and development (cognition, speech and language, socio-emotional and motor development).

Eligibility. All children in Minnesota are eligible for health and developmental screening once before they enter school.

Early Childhood Education

Role of State Agency. The Instructional Design Section, Division of Instructional Effectiveness is the agency responsible for curriculum and instructional services for public school programs for children, from birth to age eight.

Authority. Authority in Minnesota Statutes 123.35 allows school boards to conduct programs for prekindergarten children and mandates kindergarten programs for children who are age five by September 1. Minnesota Rules, part 3500.1150 specifies the programs to be offered in kindergarten and elementary grades.

Target Population. All children are to be served in the kindergarten and elementary programs. Districts may charge fees to operate programs for prekindergarten children.

B. Department of Health

Services for Children with Handicaps (SCH)

Role of State Agency. SCH is the Department of Health program responsible for assuring appropriate casefinding, diagnosis and treatment of children with suspected or known handicaps and to work to improve services to handicapped children,

SCH provides high quality diagnostic services at clinics throughout the state and at medical centers. The program's professional staff counsel, refer, and advocate for families of handicapped children, provide in-service training to local health, education, and social services professionals and agencies.

Authority. Authority for the provision of diagnostic and treatment services to handicapped children is provided in the Maternal and Child Health Block Grant, Title V , USC 42 Section 2192; Minnesota Statutes, 1977, Chapter 453, Section 24; and Minnesota Rules, Parts 4705.0100 - 4705.1500.

Target Population. Any child with a handicapping condition that interferes with normal growth and development is eligible for services under the SCH program. Typical conditions include congenital heart disease, cerebral palsy, cleft lip and palate, spina bifida, cancer, mental retardation, and developmental delay.

Eligibility Criteria. Any Minnesota child, birth through 21 years of age, with a suspected or known handicap is eligible for services. Families are required to share in treatment costs according to their ability to pay.

Comprehensive Child Health Screening

Role of State Agency. Comprehensive Child Health Screening within the Department of Health has responsibility for providing standards, technical assistance and training, monitoring, and evaluation for the Early and Periodic Screening (EPS) programs and for components of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These programs provide screening services for the early detection of problems in children who may need future evaluation, diagnosis, and/or treatment. The EPS program also provides health counseling so that improved practices can be learned.

Authority. Authority for the provision of comprehensive child health screening services is contained in the Maternal and Child Health Block Grant, Title V, USC42 Section 2192; Minnesota Statutes, 1976, Chapter 47J as amended 1980, 1981, 1982; and Minnesota Rules 4815.0900 to 4615.200.

Target Population. Any Minnesota child is eligible for child health screening services.

Eligibility Criteria. There are no income eligibility criteria for the EPS program. Fees may be required for some screening programs according to ability to pay.

Public Health Nursing

Role of State Agency. Public Health Nursing does not provide direct services but is responsible for promoting and facilitating development of locally administered public health services such as maternal and child health, home care of the ill and disabled, disease prevention and control, and health education. It also provides education programs for nurses and ancillary personnel employed by public health nursing services and school districts as well as consultation on program planning, evaluation, and administration. Local public health nursing services employ 950 nurses and more than 1,000 home health aides.

Authority. Authority for the provision of public health nursing is contained in Minnesota Statutes 144.05.

Target Population. Services available through local public health nursing services in all 57 counties include but are not limited to prenatal education, EPS, nutrition assistance through the federal WIC program, screenings for acute and chronic diseases, and home health care for the ill and disabled. Services are also provided to day care centers and group homes. Many counties also contract with physical, occupational and speech therapists.

Eligibility. Eligibility requirements vary by program.

C. Department of Human Services

Role of State Agency. Minnesota has a state-supervised, county-administered system of providing services. As a result, few services are actually provided by the state agency, which has primary responsibility for policy development and oversight. Most services are funded through Community Social Services Block Grants to Counties or through Medical Assistance. The Department has statutory responsibility for service provision to children with handicaps, including:

Children with mental retardation and related conditions

Emotionally disturbed children

Deaf and hearing impaired children

Chronically ill Children receiving services through the
Community Alternatives for Children (Medicaid)
Waiver

Children receiving health care services provided through
the Medical Assistance Program and its federally
mandated subprogram, the Early and Periodic
Screening, Diagnosis, and Treatment Program
(EPSDT)

Services provided in programs and facilities required by
law to be licensed by the Department.

Child welfare services, both voluntary and involuntary,
to families and children experiencing crisis or
stress.

The Department provides technical assistance, training, and monitoring of service provision. Regional representatives provide information about services for individuals with mental retardation and related conditions and hearing impairments.

Authority. Authority for provision of these services is found in the following Minnesota statutes:

Mental Retardation and Related Conditions, Minnesota
Statutes, Sections 252; 256B; and 256E; and
Minnesota Rules, 9525.0015 to 9525.0165.

Mental Health, Minnesota Statutes. Sections 25bE; 245.61 through 245.64; 24b.711 through 245.718; and 245.73 Deaf Services, Minnesota Statutes, Sections 256c.21 through 256C.27; and 256.971..

Medical Assistance, Minnesota Statutes, Section 256B and Minnesota Rules, 9b0b.0G10 to 9505.U150; and 9500.1060 to 9500.1080.

Licensure, Minnesota Statutes, Section 245.

Child Welfare Services, Minnesota Statutes, Sections **256.01**, subdivision 2 and 626.556.

Target Population. Any child with a handicapping condition may receive services. Although services may vary from county to county, depending on needs identified in the county's Community Social Service Plan, all counties are required to address the needs of persons with mental retardation and mental health problems. EPSDT services are designed to identify and treat conditions which may result in handicapping conditions in any child eligible for Medical Assistance. Home and community-based services are available to children with chronic illnesses or mental retardation and related conditions who qualify under the Medical Assistance Waiver Programs.

Eligibility. Programs related to Medical Assistance have certain income and asset eligibility requirements. Other services have no income requirements, but fees may be charged according to approved county fee schedules.

MINNESOTA DEPARTMENT OF EDUCATION

RECOMMENDED

CRITERIA FOR ENTRY

FOR

EARLY CHILDHOOD SPECIAL EDUCATION

January, 1988

I. EARLY CHILDHOOD SPECIAL EDUCATION

II. DEFINITION:

Early Childhood Special Education shall be available to those children from birth to seven years of age who have a substantial delay or disorder in development or have an identifiable sensory, physical, mental or social/emotional condition or impairment known to hinder normal development and need special instruction and services,

III ELIGIBILITY CRITERIA
FOR EARLY CHILDHOOD SPECIAL EDUCATION

These criteria are for the purposes of determining eligibility for special instruction and services in education programs. They do not automatically determine placement decisions or professionals who will serve the child- Placement in educational program, level of service, or early childhood educational program alternative and service decisions continue to be individually determined and occur subsequent to eligibility decisions and according to laws and rules governing the provision of special instruction and services.

These criteria apply to instruction and services offered by school districts and do not necessarily apply to other community, agencies or service providers.

Because of the nature of development in early years, these criteria are divided into two subgroups based on age and will exhibit slight differences. The chronological age of the child at the time of assessment or reassessment will determine which of the specific subcriteria is to be applied.

A. The team shall determine that a child age birth through 2 years-11 months is eligible for Early Childhood:Special Education when:

1. The child meets the criteria of one of the following disability categories: Autism, Deaf/Blind, Hearing Impaired, Mentally Handicapped, Other Health Impaired, Physically Handicapped, Speech/Language and Visually Handicapped

OR

2. The child has met the following criteria in a.1, a.2 or a.3 and b and c.

a. The child:

- 1.) has a medically diagnosed syndrome or condition that is known to hinder normal development (including, but not limited to, Cerebral Palsy, Chromosome Abnormalities, Fetal Alcohol Syndrome, Maternal Drug Use, Neural Tube defects, Neural Muscular Disorders, Cytomegalovirus, Grades III and IV Intracranial Hemorrhage and Bronchopulmonary dysplasia (BPD);

OR

- 2.) has a delay in overall development demonstrated by a composite score of 1.5 standard deviations or more below the mean on an assessment using technically adequate, norm referenced instruments. These instruments must be individually administered by an appropriately trained professional(s);

OR

- 3.) is less than 18 months and has a delay in motor development demonstrated by a composite score of 2.0 standard deviations or more below the mean on an assessment using technically adequate, norm referenced instruments. These instruments must be individually administered by an appropriately trained professional(a).

The child's need for instruction and services is supported by documented, systematic observation(s) in his/her daily, routine setting by an appropriate professional. If observation in the daily, routine setting is not possible, the alternative setting must be justified.

Corroboration of the developmental assessment with a developmental history and at least one other assessment procedure that is conducted on a different day than the medical or norm-referenced assessment. Other procedures may include: parent report, language sample, criterion-referenced instruments or developmental checklists.

B. The team shall determine that a child between 3 years and 6 years-11 months is eligible for Early Childhood Special Education when:

1. The child meets the criteria of one of the following disability categories: Autism, Deaf/Blind, Emotionally/Behavior Disorders, Hearing Impaired, Learning Disabilities, Mentally Handicapped, Other Health Impaired, Physically Handicapped, Speech/Language or Visually Handicapped.

OH

2. The child has met the following criteria in a.1 or a.2 and b and c.

a. The child:

- 1.) has a medically diagnosed syndrome or condition that is known to hinder normal development (including, but not limited to Cerebral Palsy, Chromosome Abnormalities, Fetal Alcohol Syndrome, Maternal Drug Use, Neural Tube defects, Neural Muscular Disorders, Bronchopulmonary dysplasia (BPD)

OR

- 2.) has a delay in each of two or more areas of development that is verified by an assessment using technically adequate, norm-referenced instruments. Subtests of instruments are not, in and of themselves, acceptable. The instruments must be individually administered by appropriately trained professional(a) and the scores must be at least 1.5 standard deviations below the mean.

b. The child's need for intervention is supported by documented, systematic observation(s) in his/her daily, routine setting by an appropriate professional. If observation in the daily routine setting is not possible, the alternative setting must be justified.

c. Corroboration of the developmental assessment with a developmental history and at least one other assessment procedure in each area that is conducted on a different day than the medical or norm-referenced assessment. Other procedures may include: parent report, language sample criterion-referenced instruments or developmental checklists.

IV ASSESSMENT AND PLACEMENT REQUIREMENTS

In meeting the eligibility requirement described in B.2a.2., it is intended that two separate, substantive measures be used to determine the child's delay in development.. One instrument will not be considered sufficient to meet this requirement. In addition to a composite score on one instrument, another measure of the child's development must be completed. Following are some examples of cases which meet this eligibility criterion:

1. A child with a composite score below 1.5 standard deviation on the Battelle Developmental Inventory and a composite score below the 7th percentile on the Scales of Independent Behavior.
2. A child with a composite score below 1.5 standard deviation on a language measure, such as the Sequenced Inventory Communication Development, and a composite score on the McCarthy Scales of Children's Abilities which is also at or below 1.5 standard deviation.
3. A child with a composite score at 1.5 standard deviation on the Battelle Developmental Inventory, and a composite score on the Vineland Adaptive Behavior Scales at or below 1.5 standard deviation.

V CRITERIA FOR EXIT

The team, including parents/guardians, as per due process procedures, reviews the child's progress on the IEP based on the ongoing evaluation of a child's functioning and ability that is part of each child's intervention program.

Eligibility and program are reviewed at least annually based on this ongoing evaluation data. Reassessment will be completed at least every three years according to state and federal regulations.

The team shall discontinue Early Childhood Special Education services when:

1. the child is able to function within appropriate developmental expectations without special instruction and services.

OH

2. the child can appropriately be served in a program addressing their primary disability area under categorical guidelines. Eligibility must be determined in accordance with each of the disability areas initial entrance criteria through reassessment, prior to transferring to a school age level of service.

OR

3. the child has reached age seven by September 1.

GLOSSARY OF TERMS

ADAPTIVE BEHAVIORAL SCALES: is an instrument that considers the way a child expresses behaviors in response to diverse environmental demands. It measures the effectiveness or degree with which a child meets the standards of functional independence and social responsibility expected of age and cultural group.

BRONCHOPULMONARY DYSPLASIA (BPD): Chronic lung disorder characterized by coarse cystic-appearing lungs with hyperinfiltration, obstructive bronchiolitis, and pulmonary fibrosis resulting from respiratory distress syndrome with high concentrations of oxygen and positive - pressure ventilation. Infants with BPD often have prolonged hospital stays and most often go home on oxygen.

CEREBRAL PALSY: a group of non-progressive disorders resulting from malfunction of the motor centers and pathways of the brain rendering the child incapable (in varying degrees) of coordinating muscle action and unable to maintain normal postures and balance in performing normal movements and motor functions.

CHROMOSOMAL ABNORMALITY: an abnormality in the number of chromosomes or in their configuration including, but not limited to, Down Syndrome (Trisomy 21), Trisomy 18, Trisomy 13, Cri du Chat Syndrome,

COMMUNICATION: understanding (receptive) and expressing (expressive) needs, ideas and information. Communicative competence includes content, form, and social use components.

COMPOSITE SCORE: An overall test score which represents the collective results from several separate subtests or scales. The General Cognitive Index on the McCarthy Scales of Children's Abilities is a composite score derived from the results on the Verbal, Perceptual-Performance and Quantitative scales.

CONGENITAL MALFORMATIONS: a malformation of all or part of the fetus in utero such as but not limited to, CHARGE syndrome, VATER syndrome, and/or TARR syndrome.

CRITERION REFERENCED INSTRUMENT: tests that measure a child's development of particular skills in terms of levels of mastery. The principal objective of criterion referenced tests is to assess the specific skill a child does or does not have and to relate the assessment to curricular content.

CYTOMEGALOVIRUS (CMV): a virus which has been included in the herpes virus family and is transmitted transplacentally. The most serious form of the disease with resultant CNS deficit, is usually found in the newborn (under 4 months). Neurologic characteristics include microcephaly, spasticity, mental retardation, - delay in developmental areas.

DEVELOPMENTAL AREAS: the developmental areas are cognitive, communication, social/emotional, self help and fine/gross motor domains.

DEVELOPMENTAL CHECKLISTS: a method of measuring commonly recognized levels of achievement at specific ages.

DEVELOPMENTAL HISTORY: considers birth history, medical history, attainment of developmental milestones, characteristics of family and family history, interpersonal skills, adequacy of social learning contexts, educational experiences, and other factors that may be pertinent to understanding the child's present and future functioning. Information about the child's developmental history may be obtained through interviews with primary and secondary caregivers.

FETAL ALCOHOL SYNDROME: a medically diagnosed pattern of malformations characterized by any or all of the following:

1. Prenatal onset and persistence of growth deficiency for length, weight, and head circumference
2. Facial abnormalities including short palpebral fissures, epicanthal fold, maxillary hypoplasia, micrognathia and thin upper lip
3. Cardiac defects, primarily septal defects
4. Joint and limb abnormalities, including some restriction of movement and altered palmar crease patterns
5. Delayed development and mental deficiency varying from borderline to severe.

INTRACRANIAL HEMORRHAGE (ICH): bleeding within the cranial cavity which can be subdivided into four major grades of severity:

- I - subdural - bleeding outside of the ventricles
- II - hemorrhage in one or more ventricles with no ventricular dilation
- III - hemorrhage into the ventricles with dilation
- IV - interventricular hemorrhage with blood also in the white matter of the brain.

KNOWN TO HINDER NORMAL DEVELOPMENT: a medically diagnosed and documented condition or syndrome which, by history and research is associated with mental retardation or substantial delays in development. Not included are those conditions or syndromes suspected by a physician but yet unsubstantiated.

MATERNAL DRUG USE: the medically documented ingestion of class A Narcotics during pregnancy which substantially affects the subsequent development of the child.

METABOLIC DISORDER: an inborn or acquired disorder of metabolism, identified in the newborn period, known to be associated with mental retardation and/or a substantial delay in development.

MOTOR: movement of the body in space including:

1. gross motor: the development of postural stability and independent movement that is smooth and symmetrical and which allows the child to interact actively with his/her environment.
2. fine motor: smooth and efficient use of the smaller muscle groups (i.e. reach, grasp and release, and manipulation of objects).
3. oral-motor: the efficient ability to use and coordinate the oral musculature for speech and feeding.

NEURAL TUBE DEFECTS: a defect in the fusion of the neural folds from which the brain and spinal cord arise including, but not limited to, hydrocephaly, microcephaly, anencephaly, proencephaly, encephalocele, Arnold-Chiari malformations and Dandy-Walker cysts.

NEUROMUSCULAR DISORDERS: a medically diagnosed disorder of muscular control such as, but not limited to, myasthenias, myotonias and/or Wernig-Hoffman.

NORM-REFERENCED INSTRUMENT: instrumenta designed to give the assessor information about an individuals standing in relation to a population of other people with whom s/he presumably shows some important characteristics. The tests yield scores that are distributed along a normal curve. An individual's score on the test indicate that s/he knows more, less or about the same as his/her peers, but it does not necessarily reveal, in detail, what he knows or pattern of error.

STANDARD DEVIATION (SD): a measure of the extent to which scores deviate from the mean. It is the square root of the variance, and is the most important and most commonly used measure of variability. Small standard deviations means the scores are distributed close to the mean. Large standard deviations means the scores are spread over a wider range.

SYNDROME: a group of signs and symptoms that collectively characterize or indicate a particular disease or abnormal condition.

SYSTEMATIC OBSERVATION(S): a plan for observing the child while collecting data on a specific behavior(s) and documenting the results for the purpose of: 1) to confirm or dispute information obtained from objective assessment procedures; 2) to gather information not addressed on objective measures; and 3) to assess the interaction of the child with his/her physical and human environment.

TEAM DECISION: the process of reviewing and determining appropriate needs, placement and services based on relevant medical, family, functional and assessment information gathered by professional staff and parents and families.

TECHNICALLY ADEQUATE INSTRUMENT: refers to test instruments for which the technical characteristics of reliability, validity and norms meet accepted standards, such as The Standards for Educational and Psychological Tests from The American Psychological Association (1979).

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Genetic Counselors in State of MN - (available for phone
consultations)

1. Beth Ann Bloom - St. Paul Ramsey Hospital - 612/221-3456
2. Barb Kunz - United Hospital of St. Paul - 612/298-8416
3. Bonnie Leroy - University of MN Hospitals - 612/624-7193
4. Shari Baldinger - Abbott-Northwestern Hospital,
Minneapolis - 612/863-4502

A P P E N D I X

DEFINITIONS**Family Education and Counseling**

Assisting parents in understanding the special needs of their child and providing parents with information about child development.

Home Visits

Any early intervention services provided in the home of the child with handicapping conditions.

Occupational Therapy

- a. Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- b. Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
- c. Preventing, through early intervention, initial or further impairment or loss of function.

Physical Therapy

Services provided by a qualified physical therapist.

Speech Pathology

- a. Identification of children with speech or language disorders;
- b. Diagnosis and appraisal of specific speech or language disorders;
- c. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
- d. Provision of speech and language services for the habilitation or prevention of communicative disorders; and
- e. Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

A P P E N D I X

SUMMARY OF DIRECTORS' SURVEY

A total of 108 Directors of Special Education in Minnesota were surveyed by a mailed questionnaire. Fifty-five surveys, or 51%, were returned. Eighty percent of the Directors who responded to the survey indicated that they were supportive of establishing a system to access third party reimbursement. The reasons indicated most often included: 1) to disperse costs, 2) to maximize community involvement, 3) to share financial responsibility with other entities, 4) to reduce the drain on the general education fund that is occurring as a result of education picking up the costs of more and more "related services", and 5) to avoid duplication of costs. A concern exists that education has assumed financial responsibility for some services that are medical in nature.

The majority of Directors (93%) stated that they are not accessing third party reimbursement, with the exception of a few (18%) who stated that they access reimbursement for medical diagnosis and evaluation. Districts that are accessing third party reimbursement commonly request that parents submit the claim to their insurance company. The school then pays the deductible and any non-reimbursed expenditures.

The Directors identified three barriers to accessing third party reimbursement: 1) lack of knowledge as to how to access third party reimbursement; 2) difficulty in determining who is fiscally responsible; and 3) difficulty collecting on bills submitted to third party payors for reimbursement.

Eighty-two percent of the Directors favored a centralized claims processing system. The reasons most often given were convenience and efficiency. Forty-five percent of the Directors felt that their districts currently have the capacity to implement a system for collecting third party reimbursement. Those districts that indicated that they did not currently have the capacity to implement a system for collecting third party reimbursement listed clerical assistance and money for start-up costs as resources they would need.

Forty-seven percent of the Directors who responded to the survey indicated that the personnel licensing standards to become eligible for medical assistance reimbursement would prohibit them from accessing reimbursement. Twenty-nine percent indicated that they were unsure as to how the personnel licensing standards would affect their ability to access third party reimbursement.

The following resources were identified as necessary prerequisites to implementing a system for accessing third party reimbursement: 1) technical assistance; 2) manual of guidelines, procedures, forms, and letters; 3) appropriately licensed staff; 4) systems development; and 5) clear State guidance as to what services are eligible for reimbursement.

A P P E N D I X E

APPENDIX E

STATE FORMULA AID

The State of Minnesota administers a state aid formula for special education reimbursement which targets a fixed percentage of state contributions for salaries of essential personnel, instructional supplies and equipment, individual student services under contracts with other agencies, and residential placements.

The aid formula for 198B-89 is as follows:

Salaries	66% of salary expenditures not to exceed \$18,400 in aid. Full-time employees with salaries in excess of \$27,879 are subject to the \$18,400 aid limitation. Part-time salaries are prorated accordingly. Districts are authorized to levy for the difference between the cap of \$18,400 and full 66% of salary.
Personnel Contracts	(not employees of district) 52% of expenditures.
Instructional Supplies and Equipment	47% of the cost of instructional supplies, materials and equipment, not to exceed an average of \$47 of aid per handicapped child as determined by the duplicate child count.
Student Contracts	52% of the difference between contract expenditure and formula allowance attributable to the pupil.
Early Childhood Home Based Travel	50% of expenditure for staff travel.
Special Pupil	(Residential placement of students for whom no district of residence can be determined) 100% of the difference between expenditure and formula allowance and special education aids generated by the child.
Residential Placements	57% of the difference between the expenditure and formula allowance generated by the student.

EDUCATION CHILD COUNT

Six Year History of Unduplicated Child Count:
(All Handicapping Conditions)

	12/82	12/83	12/84	12/85	12/86	12/87
0-2 years	400	408	520	514	756	844
3 years	657	717	705	795	*1440	*1613
4 years	3175	3338	3562	3406	3383	3485
5 years	3628	3813	4036	3945	3908	3836

* The increase reflects the mandate to serve from three years old.

DEFINITIONS

- SPCH - Speech and Language
- MMH - Mild/Moderately Handicapped
- SP - Severe/Profoundly Handicapped
- PI - Physically Impaired
- HI - Hearing Impaired
- VI - Visually Impaired
- LD - Learning Disabled
- EBD - Emotional and Behavioral Disorder
- D&B - Deaf/Blind
- OHI - Other Health Impairment
- AUT - Autism
- ECSE - Early Childhood Special Education

APPENDIX F

Breakdown by Disability Area* (Birth through Two)

	12/82	12/83	12/84	12/85	12/86	12/87
SPCH*	78	95	130	106	188	79
MMH*	66	60	76	76	192	55
SP	32	38	51	46	61	22
PI*	88	68	89	107	130	46
HI	56	59	58	45	54	58
VI	26	23	29	42	38	17
LD*	12	16	21	49	30	5
EBD	2	2	3	3	1	1
DSB	3	2	1	4	5	4
OHI*	37	45	62	35	54	17
AUT	0	0	0	1	3	1
ECSE						539**
TOTAL	400	408	520	514	756	844

* The noncategorical label resulted in fewer children identified in SPCH, MMH, PI, LD, & OHI categories.

** The mandate to serve from birth is not reflected in these figures. The 12/88 child count will reflect a more accurate accounting of the birth to two year olds requiring special education services.

Breakdown by Disability Area For Three Year Olds

	12/82	12/83	12/84	12/85	12/86	12/87
SPCH	380	422	390	416	808	512
MMH	65	69	86	126	250	50
SP	30	36	33	31	99	38
PI	55	53	43	61	105	49
HI	55	54	57	54	47	40
VI	16	12	15	21	9	15
LD	42	52	49	34	35	15
EBD	7	6	10	13	29	8
D&B	0	4	3	1	0	0
OHI	4	9	19	35	53	15
AUT	3	0	0	3	5	2
ECSE						*869
TOTAL	657	717	705	795	**1440	**1613

* The noncategorical label resulted in fewer children identified in SPCH, MMH, SP, PI, LD, EBD, & OHI categories.

** The increase reflects the mandate to serve from three years old.

APPENDIX F

Breakdown by Disability Area For Four Year Olds:

	12/82	12/83	12/84	12/85	12/86	12/87
SPCH	2029	2196	2333	2122	2195	1320
MMH	191	174	219	287	336	79
SP	117	130	151	150	118	53
PI	162	110	145	103	121	58
HI	73	80	77	70	64	44
VI	29	25	18	23	22	9
LD	390	465	425	403	328	148
EBD	151	122	137	152	106	32
D&B 2		0	5	3	2	1
OHI	19	32	59	81	71	24
AUT	12	4	13	12	20	8
ECSE						*1709
TOTAL	3175	3338	3582	3406	3383	3485

* The noncategorical label resulted in fewer children identified in SPCH, MMH, SP, PI, HI, VI, LD, EBD, OHI & AUT categories.

APPENDIX F

Breakdown by Disability Area For Five Year Olds:

	12/82	12/83	12/84	12/85	12/86	12/87
SPCH	2559	2638	2749	2721	2655	2084
MMH	209	234	230	277	263	127
SP	166	128	180	172	180	89
PI	94	95	148	108	98	90
HI	87	84	80	76	84	69
VI	39	21	23	30	29	21
LD	338	448	471	392	389	137
EBD	95	105	84	99	128	76
D&B	2	2	1	0	4	1
OHI	28	31	58	57	69	19
AUT	11	17	12	13	9	17
ECSE						1106
TOTAL	3628	3813	4036	3945	3908	3836

* The noncategorical label resulted in fewer children identified in SPCH, MMH, SP, PI, HI, VI, EBD & OHI categories.