



CREATIVE FINANCING

By Sue McLaurin, M.Ed., PT

Jennifer was a 6-year-old with a diagnosis of cerebral palsy. She had been receiving physical therapy since shortly after birth. Jennifer was also a Medicaid recipient.

When her physical therapist prescribed a prone stander for Jennifer and submitted the request to Medicaid for approval, the prone stander on the Medicaid list was approved. Although the stander on the list was medically necessary and would have been appropriate for other children with cerebral palsy, it was not appropriate for Jennifer.

Because Medicaid would only fund items on the list Jennifer was denied appropriate equipment for her clinical needs.

That's the kind of situation that led North Carolina to develop an innovative arrangement for evaluating and funding children's assistive technology needs through Medicaid.

Working With Medicaid

In recent years, Medicaid has emerged as the reimbursement agent for thousands of children in North Carolina who need occupational, physical and speech therapy and other rehab services, as well as for in-patient hospitalizations. In most states, therefore, Medicaid makes the

assurance through the prior approval process, and Medicaid is responsible for paying the claim.

This arrangement has allowed for hundreds of children with developmental disabilities and chronic illnesses to receive clinically appropriate equipment and specialized therapies for their needs.

Before implementing its current program, CSHS was, like most other state agencies, grappling with the issue of how to use shrinking funds to serve children on Medicaid. How could it develop a system to expand Medicaid services? Insurance companies have generally asserted that special types of adaptive equipment are not medically necessary. And Medicaid has not funded equipment that fills a clinical, rather than a medical, need.

CSHS approached North Carolina Medicaid with the ideas that clinical services are at the core of what children need in order to advance and that those services would expand the children's abilities to function in schools, child care centers and in other aspects of daily living.

From that concept, CSHS developed a specific proposal whereby it, not Medicaid, would determine not only what is

at the core of what children need in order to advance

decision to fund, or not to fund, assistive technology equipment for children with special needs. In North Carolina, however, that decision is made by the state Children's Special Health Services program, and Medicaid reimburses.

Under a special agreement, CSHS and Medicaid have worked together to fund special therapies and assistive technology devices for eligible children. CSHS provides quality

medically necessary, but what is clinically appropriate.

CSHS staff felt strongly that a clinical review of equipment recommendations was necessary in addition to the administrative review to determine the clinical appropriateness of the equipment. Clinicians provide the clinical review as part of the approval process.

The result is that Medicaid relinquishes approval to CSHS and funds based on its approval.

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From the beginning, the program has reimbursed medical specialists for services provided to eligible children. These services are supplied through a network of community-based specialty clinics and major medical centers that offer comprehensive services for this population.

In addition, CSHS approves requests for assistive technology devices and special therapies, including speech, occupational, physical and respiratory therapies, and audiology.

Funds for operating the CSHS Program are appropriated directly from the General

Assembly of North Carolina (the legislative body) and the Maternal and Child Health Block Grant (Title V of the Social Security Act). These funds are channeled through the Division of Women's and Children's Health of the North Carolina Department of Health and Human Services.

Children who are eligible for these funds must be enrolled in the Medicaid program, must have a medical diagnosis that is on the CSHS diagnostic entity list and must be under 21 years of age. In addition, assistive technology requests are reviewed for clinical appropriateness by clinicians with pediatric experience.

In North Carolina, CSHS's role has shifted over the years. Initially, the program responded to the shortages of trained medical staff by providing a network of circuit-riding clinics staffed by orthopedists to provide services throughout the state.

This system of clinics expanded to other specialists, and soon children were receiving care in orthopedic, cardiology, neurology, myelodysplasia, neuromuscular, and speech and hearing

Changing Role

The CSHS program has provided medical services for children with chronic health care problems and developmental disabilities since it began in 1936 as a part of the Social Security Act

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clinics. CSHS also reimbursed for in-patient hospitalization, medications, supplies, ambulatory physicians, special therapies, including occupational therapy, physical therapy and speech therapy, and durable medical equipment.

Growth in Assistive Technology

Since the emergence of the Tech Act of 1988, assistive technology has evolved from the traditional durable medical equipment (DME) definition to high and low tech equipment.

In North Carolina, assistive technology has long been a part of an array of services that children with special needs receive. In recent years, funding for devices has commanded the lion's share of CSHS allocations. Much of this increase in spending is attributed to the escalating costs for assistive technology.

In 1988, 20 percent of the CSHS budget was expended for durable medical equipment/assistive technology equipment. Today, that portion has grown to 50 percent.

This increase is mostly because of the shift of expenditures from CSHS to Medicaid. Because of the CSHS-Medicaid agreement, Medicaid will increasingly fund more assistive technology.

To improve quality assurance, to ensure appropriateness of services and to contain costs of assistive technology devices, CSHS has developed processes to improve the outcome of services for eligible children. A number of protocols have been instituted for high tech equipment. These include protocols for the following:

- Funding pediatric mobility systems.
- Funding augmentative communication services and devices.
- Installing home ramps.

In addition, CSHS is contracting with several institutions to conduct outcome studies on equipment utilization by its clients.

A Program Year

Approximately 1,600 children with special needs received assistive technology devices funded through CSHS for fiscal year 1998. Of this number, approximately 1,200 children (75 percent) had diseases of the central nervous system and sense organs with an ICD-9 code of 320.0 - 389.0. CSHS expended approximately \$2 million for assistive technology devices for these children.

Twenty percent or 320 children had congenital anomalies, including spinal bifida, with an ICD-9 code of 740.0-759.0. Approximately \$525,000 was authorized and approved for these children.

Other conditions for which CSHS funds were expended included motor delay, chromosomal abnormalities, and musculoskeletal problems.


Approximately 50 percent of funds were expended for pediatric mobility systems in fiscal year 1998. These included wheelchairs, transporter chairs, scooters, strollers and accessories. Forty percent of the funds were spent on adapted equipment and communication devices, with the remaining 10 percent spent on orthotic/prosthetic devices and self-care devices.

Children with special needs, birth to 3 years of age, who are not eligible for Medicaid can receive funds for assistive technology devices through the North Carolina Assistive Technology Funds. The state

General Assembly appropriates these to provide services for children enrolled in early intervention under the Individuals with Disabilities Education Act (IDEA).

Approximately 106 children received assistive technology devices in fiscal year 1998. Expenditures for these devices was approximately \$250,000.

CSHS has long been recognized in North Carolina as a program that provides quality care for children with developmental disabilities and chronic illnesses. With changes in

health care reimbursement, the program will continue to face challenges as it seeks to respond to the needs of its clients and to advocate for the most appropriate services. 

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