

Appendix One
DRAFT

**Iowa's ABCD II PROJECT:
Medicaid Barriers to Interventions Work group**

**November 16th
Conference Call**

M i n u t e s

Members Present: Cheryll Jones, Laurie Nash, Dave Stout, Molly Schulte, Renee Wallace, Chaney Yeast, Dr. Rizwan Shah, and Dann Stevens

Members Absent: Beth Troutman Ph.D., and Shanell Wagler

ABCD II Staff Present: Kay DeGarmo, Carrie Fitzgerald, and Sally Nadolsky, Facilitator

Opening Comments:

- Sally Nadolsky welcomed participants and described the focus of the meeting – discussing and reviewing the barriers within Medicaid for providers, other than physicians, to bill for services.

Review of Topics from the “Preliminary ABCDII Interventions For Families Work Group Report”

- Anticipatory guidance (A/G)-
 - Well-child codes include A/G, but if it's provided as a separate service, the Feds say to use a series of codes that aren't open to anyone here (99401). Those codes are for “counseling and risk-factor reduction”.
 - How much of an issue is this?
 - Laurie Nash – Currently in Iowa A/G is only reimbursable though the well-child exam, but home visiting includes a lot of A/G. Their Home visitors use the Bright Futures Pocket guides. A/G is not the purpose of the home visit, but is part of the service that is received. These services are often provided by social service agencies who employ BWs and MSWs. Also, in their agency Laurie has a PNP who does home visits with teenagers.
 - Dave Stout asked to what extent physicians would be willing to pass off A/G? Kay DeGarmo will explore that issue with a few physicians.
 - Cheryll Jones commented that A/G is “part and parcel” of the well-child exam, and that a child with risk factors would be referred to Early ACCESS, or the Parent Education Connection (they work with kids 0-3).
- Parent Information and Support Services-

Appendix One
DRAFT

- CPT guidance says to use E and M codes for these services
- When provided, how has this worked, or how has it been coded?
 - Dave Stout said that at the Community Mental Health Center they have not billed for it, as it is not under their Magellan contract. They use a limited amount of county dollars to pay for it. They are unfamiliar with the fee-for-service side of this. Sally Nadolsky said this is part of the impact of having a carve-out for managed care.
 - Dave Stout said that this is a barrier in that when they could use it, funding is a problem and thus they are do provide on a smaller basis than they would like.
 - Sally asked that Dave explore what diagnostic codes they usually use and where they fall in or out of the managed care area. Dave will do a test case to see what would happen.
 - Molly Schulte said that they use grants to pay for these services, sometimes Prevent Child Abuse Iowa money, but they have never used an E and M code. Sometimes they can carve out some time from Care Coordination through EPSDT to pay.
 - Renee Wallace said that bill Care Coordination for referrals, but it seems the E and M codes have to be used in a clinical setting. “We could use it a whole lot more if we could use it on our home visits.”
 - Kay DeGarmo asked if physicians have problems getting paid for this. Chaney Yeast answered that for the majority of visits they don’t bill for this at all, unless the child is right there.”
- Parenting Education-
 - Standardized programs - the guidance is to use E and M codes.
 - Cheryll Jones said that parenting education is “more intense and focused, a follow-up to information and support. Doesn’t lend itself it a primary care office visit.”
 - Dave Stout agreed that they could use this code when the kids have a diagnosis, and the education is very focused on the issue at hand for that family. There is no funding for it through Medicaid.
 - A discussion began with Laurie Nash stating that there is a need for topic specific parenting education, not just a generic program. For example, parents with mental illness or substance abuse issues need tailored education. (Mid- East Iowa Community Mental Health Center provides parenting education for parents with depression.)
 - Dave Stout mentioned that Child Care Resource and referral provides training programs for providers, but that funding is not sustainable.
 - Cheryll Jones said that childcare centers often deal with children with behavior issues. Behavior specialist should be available to work with centers.

Appendix One

DRAFT

- Chaney Yeast said that family therapy is often needed, especially for families with drug-exposed children. DHS won't pay for those services, though.
 - Kay DeGarmo said, "Funding is the issue", and "is there a chance Medicaid can help?" Also, screening centers should provide this, there are enough codes open, if they have the staff available.
 - If services, like specific family counseling or parenting education, are available to families involved with a DHS court case, could those services be made available to all families? Cheryll Jones replied that families typically do have to be in DHS system to get the services, and that most families won't go on their own. They don't identify it as a need for them.
 - Dave Stout talked about foster and adopted kids who deal with the whole overlay of attachment. Few practitioners have the experience to deal with the issues and look only at the child and not the parent/family issues.
 - Cheryll Jones stated that there is a "new morbidity" in early childhood and our workforce is not prepared to deal with it.
 - Molly Schulte said that the Early ACCESS liaisons and coordinators need more training to deal with social/emotional issues of young children.
 - Dave Stout said that the Community Mental Health Centers should be major players in this issue, but many won't do it.
 - Cheryll Jones said that recruiting staff to provide these services to families and young children is very hard. Training and funding issues go hand-in-hand. Also, we should consider the restrictive licensing and scope of services for PNPs.
 - Dr. Shah said that training must be provided; the AAP is looking at mental health training. There are barriers to reimbursement within Pediatrics for diagnosing mental health issues with children. We need to also work with private insurers. There are behavioral issues that Pediatricians can and should take care of, and they should be reimbursed.
 - Laurie Nash said that training on mental health should be given to all providers within early childhood. (The Dept. of Education at the University of Iowa just eliminated the large majority of their early childhood courses.)
 - Dr. Shah said that the incoming Iowa AAP president, Dr. Jody Murph, holds this as a special area of interest, and she is also very involved with residency education.
- Problem Focused Counseling and Behavioral Intervention-
 - Clinicians can bill under an E and M code. Do other providers want to use this but can't?
 - Dr. Shah said that for at-risk kids you can use professional for in-home, but reimbursement is the main issue.

Appendix One
DRAFT

- Dave Stout said that for families with behavioral concerns, if the diagnosis falls into mental health carve-out in-home work requires all the hops of certification and is very hard to get through Medicaid.
 - Cheryll Jones said that families who are not in the DHS system (juvenile court) may have a plan of care with a home health agency, but not through DHS.
 - Sally Nadolsky asked if we went in to change these rules, who should monitor the families' services? The doctor? Yes, from Cheryll.
 - Sally stated that studies show that doctors typically don't read home health plans, and they are not closely monitored. Cheryll Jones said that no one closely monitors home health plans.
 - Discussion started about kids without a mental health diagnosis, and that young children (0-3) maybe never have a diagnosis. Dave Stout stated that when there's no DSMIV diagnosis, there's no funder for services, "we're out of the picture." It would be good, though, to partner with a home health agency to provide the mental health slant.
 - Sally Nadolsky asked if we should eliminate the DHS monitoring of care? Cheryll Jones replied yes, because home health agencies don't always have any expertise in behavioral health care.
 - Carrie Fitzgerald asked about if someone like Dave Stout's agency could be in the consultative/supportive role to in-home providers. Dave replied that makes a lot of sense.
 - Kay DeGarmo asked if we should consider changing the home health requirement? Laurie Nash said that in Johnson Ocutny, home health does very little with very young kids. They do newborn visits and CSHCN visits, but nothing for behavioral interventions.
 - Molly Schulte and Renee Wallace said that their home health agencies work with the elderly, medically-needy kids, but are not trained to do work with young children and behavioral issues. Without a diagnosis, getting through the medical referral process is very difficult and there is never enough money.
 - Jennifer Stater asked what ICD9 odes are used for drug exposed children? 99559 for meth exposure and testing. V-7189 is used for a meth bust, but the child is negative for meth.
- Sally Nadolsky asked what other licensed practitioners should Medicaid look at?
 - Cheryll Jones said private psychologists, LSW's. If they (CHSC) want to make a referral to them, if it isn't a DHS case, they can't see them.
 - Dave Stout said it makes a difference what contracts are with the private practitioners.

Appendix One
DRAFT

- Sally Nadolsky said that Medicaid does not have LSW's open. Magellan allows Social Workers, but Medicaid doesn't reimburse Social Workers. Medicaid will pay independent psychologists.
 - Dave Stout said that it makes sense for independent Social Workers to be able to be reimbursed through Medicaid.
 - Sally Nadolsky asked how would we know if a provider had specialized expertise in providing services to young children? Dave Stout answered that we wouldn't. The Licensing Board uses the "assumption of confidence." Laurie Nash said that unless someone specializes in early childhood, they don't have the expertise.
 - Several people thought the idea of opening reimbursement up to Social Workers was a good idea.
 - Kay DeGarmo will look into the licensing issues regarding psychologists.
- Independent Family Therapy
 - What else should we consider?
 - Cheryll Jones said we need to keep looking at which providers are open to bill?
 - Case Management - outside of MR/BI/DD
 - Provided by EPSDT Care Coordinators and CHSC – what should change?
 - The 99000 (E and M case management) codes are for the physician management of the case – medical conferences, telephone calls, and lengthy contacts with the patient or providers.
 - Molly Schulte said these codes are not open in Iowa but that the local providers would love to be able to bill for this. There is no other funding for this work.
 - Cheryll Jones asked if we could open it to "qualified healthcare providers" for the exact codes we need for case management. Often PNs are the Primary Care Providers.
 - Would the group like to open these? Yes.

Next Meeting to be scheduled in January 2006.