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# Options and Considerations When Accessing Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) for Part C Services



# Table of Contents

Purpose and Anticipated Outcome of this Document.....	3
Approaches to Medicaid Utilization .....	3
Finding Common Ground with Your State Medicaid Program.....	5
Essential Elements of Readiness to Facilitate the Dialogue with Medicaid .....	6
Political Will and Competing Factors.....	7
Exploring a Part C Medicaid EPSDT State Plan Amendment.....	7
Procedures to Define Operational Detail .....	9
Qualified Providers.....	13
Reimbursement/Rate Considerations.....	15
State Medicaid Match.....	19
In Summary.....	20

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**Purpose and Anticipated Outcome of this Document**

The challenges of implementing and maintaining valuable Part C services through a blended funding mechanism have escalated for Part C administrators and stakeholders in the current economic recession. Budget reductions, realignments and curtailments compound proportionally for the Part C system, which is reliant upon a variety of partner resources and fund sources.

This paper is intended for Part C administrators and stakeholders as they contemplate Medicaid EPSDT as a source of reimbursement for any or all of the Part C services within their state. States may be using Medicaid to fund Part C services to some degree but now face a reduction or loss of these funds due to competing needs and challenges within the state. More states who may not be accessing Medicaid funds realize that this is a potential resource, particularly in light of growing enrollments and declining resources from other partners.

This paper provides specific guidance to state Part C leaders including ways of finding common ground with your state Medicaid agency, identifying the essential elements of readiness to facilitate the dialogue, and providing some procedures to define operational details of a new partnership, or creating the opportunity to change your current Medicaid partnership.

**Approaches to Medicaid Utilization**

The majority of state Part C systems utilize Medicaid as a partner in funding services to enrolled infants, toddlers and their families. The degree to which these partnerships exist varies substantially, and ranges from formal, Part C cultivated initiatives to other arrangements which are informal and largely depend upon provider capacity and knowledge. The latter typically “piggy-back” upon existing methods of reimbursement and are not constructed specifically for the Part C target population.

The variety of ways states access Medicaid for early identification and the

provision of services and supports for very young children and their families include the following:

- Outreach/Enrollment Partnerships that recognize the system's ability to collect documentation to support enrollment into Medicaid.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management (TCM)
- Medicaid State Plan services, particularly physical, occupational, and speech/language therapies
- Development of a State Plan Amendment for uncovered services, such as special instruction/developmental therapy, social work services, family therapy etc.
- Waivers including 1915(c) Home and Community Based Waivers targeted to a specific population(s) and/or service(s). The intent of waiver services is to reduce the frequency of institutionalism, promote self-determination and to permit a state to provide targeted programs for individuals based on need which often reflects services not otherwise available under Medicaid to the population.
- Katie Beckett/TEFRA (Tax Equity and Financial Responsibility Act of 1988) which permits states to enroll children with disabilities who live at home and need extensive care but who would not otherwise qualify for Medicaid due to their family income and resources
- Managed Care Initiatives
- Medicaid Administrative Claiming (MAC) to include system activities at the state and local levels required to assure the delivery of quality services to children and families.
- Title V and State Rehabilitation Agency Interagency Agreements that represent the unique Federal requirement for state Medicaid agencies to partner with "sister" agencies in the planning and delivery of services to targeted populations, such as child with special health care needs (CSHCN), pregnant women, low birth-weight babies, children with sensory losses, etc.

**Finding  
Common  
Ground with  
Your State  
Medicaid  
Program**

Rarely do states utilize only one avenue to access Medicaid to support programs and services to very young children and their families. Most states report multiple avenues such as Administrative Claiming, TCM and some type of direct service reimbursement. When making these decisions, the state's structure should be considered. For example, a state with a significant managed care system within its Medicaid program will operate differently than a state without a significant managed care system.

In planning system improvements related to Medicaid financing for early childhood and family supports and services, there are multiple issues to be considered before initiating exploratory or formal discussions. In order to ensure that all resources are effectively utilized, supports and services to eligible children and families should:

- Be cultivated or improved in terms of accessibility and utilization for families, including considerations related to travel to homes and community settings, the nature of pediatric-oriented practitioners (or medical treatment model), and the importance of families as key participants in service planning, delivery and evaluation;
- "Match" or conform to the population to be served- specifically issues related to pediatric trained personnel and variations of service delivery models appropriate to the target population;
- Be consistent with the method or desired approach(es) to providing services consistent with evidence-based practices and the requirement for individualized family service plans developed by multidisciplinary teams;
- Expand and support the variety and availability of appropriately trained and qualified providers by understanding current Medicaid provider enrollment requirements and establishing personnel development supports that will assist new providers to engage in pediatric service delivery;
- Be compatible with data collection and verification; and
- Facilitate service monitoring and supervision to ensure timeliness,

quality and compliance.

The way in which Part C services are available and provided to families is individualized – defining service limits are inconsistent with the Part C regulatory requirements. Service definitions across multiple resources should be the same, provider qualifications should be the same, reimbursement should be the same and methods for service delivery, particularly in terms of site of service should be the same.

There are a variety of additional challenges that contribute to the Part C funding “quilt.” Resources have varying eligibility criteria, and come with their own service descriptions, provider qualifications and methods of payment. The Part C requirement to utilize existing resources first coupled with the Medicaid “payor of last resort” requirement can further exacerbate the access to other important federal and state resources.

As state planners review their options and move to access or refine the resources utilized to support Part C services, it is imperative that they have clearly defined the system of services to their potential partners that reflects both their philosophy and the available evidence about effective early intervention services. – e.g., home and community settings, the essential involvement of families and other caregivers in service planning and delivery, and the identification of qualified providers – is clearly defined as discussions are initiated and before negotiations are conducted.

There are several options to consider as one reconfigures Medicaid for any population. Key considerations from a public policy perspective that includes:

- Ease of management at state, local and provider levels, particularly in terms of accessibility, documentation and monitoring/surveillance;
- Cost projections – figuring out the potential impact (human and

**Essential  
Elements of  
Readiness to  
Facilitate the  
Dialogue with  
Medicaid**

fiscal) for state consideration;

- Continuity of care for individuals as they “ age” from one public system to another, or when eligibility changes and service needs continue; and
- Adequate capacity or availability of appropriately qualified providers.

## **Political Will and Competing Factors**

Key to any state reconfiguration of Medicaid is the state’s will to pursue these avenues of opportunity. Considerable collaboration and coordination across and within state departments is essential to ensure that initiatives successfully respond to the local needs and are in alignment with the individual IDEA program requirements.

During economic recessions, state budgets are tight – many are in decline. State “match” necessary to access Medicaid federal funds is a key challenge for all services, for all populations. There is a balance between ensuring that Medicaid is responsible to continue their “match” requirement for the state share of reimbursement for services already established, and the Part C agency’s use of state funds as “match” for specific Part C services only.

## **Exploring a Part C Medicaid EPSDT State Plan Amendment**

There are several avenues through which states access Medicaid financing for some or all of their Part C system. These are discussed in detail in an earlier publication available at the ITCA website ([http://www.ideainfanttoddler.org/pdf/Medicaid\\_Paper05.pdf](http://www.ideainfanttoddler.org/pdf/Medicaid_Paper05.pdf)). This article focuses on one approach that has been successful in creating a strong partnership that benefits all Part C system participants as well as the state Medicaid agency.

EPSDT – Early Periodic Screening, Diagnosis and Treatment – is a separate program under Medicaid that offers coverage to children from birth to age 18 (or older in a few states). It was established in 1967 to ensure that

appropriate screening, evaluation and needed service(s) were provided to children to ensure 1) earliest identification of child needs, 2) the timely provision of needed services, and 3) the prevention or reduction of disability amongst young children. It is a voluntary program on the part of parents. Eligible children may enroll in Medicaid regardless of whether they are enrolled in EPSDT. However, EPSDT provides additional benefits for the child and family primarily in assuring the availability of routine and periodic exams and screenings, and facilitates the rapid referral to identified services for EPSDT enrolled children regardless of whether the service is currently a “covered” service in the state.

EPSDT was enacted soon after the implementation of Medicaid, and was further refined in 1989 by the Omnibus Budget Reconciliation Act (OBRA 1989). As a result of this legislation, many of the improvements to EPSDT were to ensure that states made a direct and concerted effort to locate and identify children with medical and health care needs earlier, and that children received proactive and preventative screening and identification services according to the periodicity table. Prior to this legislation, many states were woefully low in the overall numbers and percentage of children screened. This legislation established a minimum penetration threshold for states with respect to the implementation of EPSDT nationally.

OBRA 1989 also made several changes to EPSDT that were supportive of the newly emerging Part C systems nationally. Specifically, these changes included:

- Requiring a comprehensive listing of screenings, including mental health, to be provided to enrolled children according to the periodicity schedule of the American Academy of Pediatrics. This was an effort to ensure that children in EPSDT received timely and ongoing screenings designed to identify developmental or health problems as early as possible.
- The “unbundling” of the EPSDT screening to permit a variety of

approved providers to conduct domain-specific screenings and assessments as children needed them, in addition to the periodicity schedule. This helped to ensure that timely screening was provided to children and that the efforts of state Part C systems in Child Find were eligible for reimbursement and that these services would be included in the state Medicaid reports.

- Mandating that if a need was identified, the service would be provided for the child even if it was an uncovered service by the state.
- OBRA 1989 further promoted the concept of a “medical home” for each enrolled child.

Efforts continue nationally to ensure that appropriate and timely screenings, diagnostic and treatment services are provided to children by qualified providers. The federal requirement related to provider choice assists families to ensure that they are able to identify and utilize a qualified pediatric provider to serve their child’s specific needs, and has effectively expanded options and opportunities for families and providers alike to serve this high risk population through high quality, evidenced based interventions.

EPSDT is an ideal portal for states to access reimbursement for a variety of already covered services, by identifying and enrolling qualified providers in their state’s Medicaid program, as well as through the expansion of EPSDT services to include uncovered early intervention services. The remainder of this section of the document describes one successful state approach that has national implications and application.

In this model, the state creates a new service entitled “Early Intervention Services” (EIS) as a new EPSDT service, available for children who meet the State’s eligibility criteria for Part C services (both those children at risk for and those identified as having a developmental delays or diagnosed

medical condition) and who have an Individualized Family Service Plan (IFSP). This is achieved through the development and approval at the Federal level of a State Plan Amendment (SPA).

Access to these services is through the Part C program, and conforms to the Part C regulations, policies and procedures. In this model, the SPA is framed around five (5) consolidated, functional components and is a modification of the traditional service unit approach used by Medicaid and reflects the variety of highly qualified practitioners performing functions for Part C and the individualized nature of Part C services themselves.

The following five (5) service categories could be implemented utilizing this reimbursement structure:

1. **Screening, Evaluation and Assessment:** A rate is developed for both 1) the newborn screening service, and for 2) evaluation/assessment services provided by individual practitioners for children in the Part C program. In order to control for costs, an allowable “not to exceed” number of evaluation/assessment services would be defined for a given period and only exceeded with state-level approval. Reimbursement includes costs for preparation, administration, family discussion/explanation, and report development
2. **Multidisciplinary Team Services:** Teaming is essential in the planning and delivery of appropriate services for an enrolled child and family. Reimbursement for teaming is based upon two types of contact. One, a team meeting—either for the purpose of IFSP development, review or evaluation. The second reimbursement would be for collateral contact encouraging team consultations through phone, e-mail, report sharing, and one-to-one consultations as set forth in the IFSP. This reimbursement effectively supports a primary provider method of delivering

services that is often a philosophical foundation of many state Part C systems, but is not limited to this model and does accommodate a variety of approaches to providing early intervention services.

3. **Early Intervention Services** (EIS) would include but not be limited to, family training, counseling, home visits and team consultation that promote the competency of the family and designated caregiver(s) to respond to the developmental needs of the infant or toddler through the delivery of:
  - Assistive technology devices and services
  - Health services necessary to enable the child to benefit from early intervention services
  - *Home visiting services including family training and counseling*
  - Medical services for diagnostic or evaluation purposes only
  - Nursing services
  - Nutrition/dietician services
  - Occupational therapy
  - *Parenting education*
  - Physical therapy
  - Psychological services
  - *Sign language and cued language services*
  - *Social work services*
  - *Special instruction/developmental therapy*
  - Speech-language pathology and audiology services
  - Vision services.

The services in *italics* are not typically covered in many current Medicaid state plans. Additional discussion is also warranted regarding Assistive Technology services and devices, primarily related to the inclusion of AT under “durable medical equipment” and current funding mechanisms established by a state for this category of service.

A common rate is developed for all practitioners for family/caregiver and individual child services. This rate includes consideration of all related costs such as practitioner travel time and cost, preparation and report development. The rate should support the variety of individualized treatment model approaches to service delivery (including but not limited to primary provider) that are emphasized within the state, ensuring the provision of appropriate services for the child and/or family needs.

Early Intervention Services (EIS) are determined by the Multidisciplinary Team based evaluation that is based upon the child's developmental status and unique needs, and upon the family's concerns, priorities and resources. Services are interdisciplinary in nature and focus on the family, and their designated caregivers, as the primary teacher and support person for their very young child.

4. **Transportation and related costs:** Reimbursement at the state rate for transportation when it is required that a family/child travel to a facility or setting in order to receive services, including related costs such as overnight expenses and meals as the travel necessitates.
5. **Service Coordination/case management:** Service coordination requires well prepared practitioners who have appropriate caseloads, and who are provided effective supervision. Careful study or examination is needed to better understand the status of the state's 0-3 service coordination system and how this model(s) "fits" with many of the federal requirements or preferences related to case management services. Fully examining this would assist in identifying current and potential range of provider qualifications, caseload sizes, training and supervision needs.

## Qualified Providers

This dialogue and investigation would assist the state in creating rates that support good practice, establish appropriate caseload sizes and recruiting new service coordinators from the wide range of public and private partner programs and services. Reimbursement for service coordination could be configured by functions (face-to-face client services, team activities, and documentation/administrative services) or could be reimbursement for face-to-face family or team activities which include consideration of documentation requirements, travel, telephone, etc. in the rate.

Children determined to be eligible by Part C would qualify for these services, using the IFSP as the physician's order for service identification to include frequency, intensity, and duration. No service would be reimbursed by either the Part C system or Medicaid if it is not on the IFSP. All services in this SPA would be provided by qualified providers certified as such by the Part C Lead Agency.

All personnel may be required to successfully complete initial and ongoing Part C credentialing requirements **in addition to** the state licensure or certification requirements for specific disciplines. These disciplines typically include specialty therapists/aides (Speech/Language, Physical and Occupational therapies), Audiologists, Social Workers, Developmental Therapists/Special Instruction Providers/Aides/Assistants, Nurses, Physicians, Psychologists, Nutritionists, and mental health specialists.

Part C credentialing or certification typically involves extended professional development requirements related to infant/toddler development, family dynamics and relationships, appropriate pediatric intervention practices, etc. This credentialing or certification is managed through the Part C system and is typically offered through a blend of pre-service, in-service/training and technical assistance opportunities.

State early intervention systems are often diverse in their organization and

who qualifies as a “provider.” This diversity is usually considered a strength, providing choice for families and expanding the ability to recruit a variety of part-time and full-time practitioners in areas where the volume of service need, or service specialty, cannot support a full time practitioner, or where distance or special considerations pose challenges to provider recruitment.

Health, medical and social service sectors provide multiple opportunities for expanding the Part C referral and provider base. These partnerships also meet the Part C requirements for use of existing resources, and maximize the family and child’s opportunities to participate in programs and services that they would typically utilize given their individual circumstances. These partnerships ensure coordination and collaboration, avoiding duplication, and help the state to maximize their collective resources – people, time and money.

Early Head Start Family Support Coordinators provide service coordination, as do most state Title V/CSHCN programs. Parent education and support is provided through a variety of sources (Home Visiting, Community Extension Services, Parents as Teachers, Teen Parenting Programs, Early Head Start, etc.) and can serve as the foundation for special instruction/developmental therapy.

Interagency agreements should be developed to ensure maintenance of effort, conformance with state and federal Part C requirements, including personnel standards, program policies and procedures, confidentiality, participation in training, documentation and data reporting, etc.

The organization of reimbursement is a critical consideration in order to ensure that reimbursement promotes appropriately delivered services, by qualified personnel who respond to the child’s developmental concerns and the family’s concerns, priorities and resources. Reimbursement must take into consideration the following elements:

**Reimbursement  
/ Rate  
Considerations**

- Provider qualifications;
- The state's Part C credentialing requirements, if any;
- Site of service - acknowledging transportation as a cost to ensure that services are provided in the child's typical setting and enhances their daily routines and activities;
- Specific tasks (beyond face-to-face services) that practitioners are expected or required to perform, such as documentation, team meetings, training, collateral contact, etc.;
- Efficient use of all personnel through consultation, collateral service delivery and training the provides the optimal environment for the family's active and engaged participation;
- Overall system administrative costs including monitoring and surveillance, data collection, record maintenance, supervision, training and reasonable personnel costs; and
- Incentives that promote the delivery of services in a manner that is consistent with the vision, policies and procedures of the Lead Agency.

Reimbursement methodologies should consider the ease of administration in documentation, billing and payment reconciliation. Common payment systems, including common rates of reimbursement for all fund sources used to support Part C may assist to streamline fund accessibility, facilitate training, and improve documentation practices and accountability.

Equity across reimbursement sources can also serve to reduce the opportunity for services (type, frequency, location and/or provider) to be "driven" by funding, as well as eliminate bias or the potential for funding to influence services for children based upon their funding source(s). There is anecdotal evidence that funding often drives services—from influencing the frequency, intensity or location of service, to whether the service is available at all. Ideally, the same rates for reimbursement are used for all fund sources that come together to support a state's Part C/IDEA system.

Often states implement common rates using the Medicaid rate as the “standard.” In some states, this rate is “complemented” by an additional amount to support travel considerations in recognition of the requirement for home and community based service delivery. This cost center is often not included in traditional Medicaid rates but is permissible under a Medicaid State Plan Amendment approach.

Traditional options that have been used by states to configure reimbursement are no longer viable under current CMS requirements. This means that individual unit reimbursement, typically a 15 minute unit, is the national standard for Medicaid reimbursement. This unit rate should be based upon cost data and reflect many of the system considerations discussed earlier in this paper.

System infrastructure components (training, monitoring, data collection, etc.) could be an allowable cost center in rate development, as well as consideration for practitioner time spent in direct services, teaming, consultation, documentation and an acknowledgement for reasonable planning, preparation and transportation.

Options to explore related to reimbursement include the following:

**Option 1: Current State Approved Medicaid Rates**

The state’s current rate approach for reimbursement would be the “standard” for Part C service reimbursement. Current Medicaid covered service chapters would be used where they exist, and a new SPA negotiated only for those Part C services which were not covered. New rates would need to be developed for these new services, and a complement could be negotiated to reflect the additional consideration of travel, training, etc. that is not currently included in the Medicaid approved rate cost centers for existing services.

## **Option 2: Cost Reimbursement**

Reimbursement under this option would include the variety of costs that are required to ensure the delivery of quality services to Medicaid eligible and enrolled infants, toddlers and their families. The State Plan Amendment requires that a cost methodology be determined, but not that the rates be stated in the agreement itself. There are a number of ways to configure rates for reimbursement that also support the desired service delivery system. Reimbursement would be clustered to match the five (5) “functions” earlier discussed:

1. Newborn, infant and toddler comprehensive developmental, vision and hearing Screening, Evaluation and Assessment
2. Multidisciplinary Team Services
3. Early Intervention Services
4. Transportation and related costs necessary for the child or family to receive a service
5. Service Coordination/case management

The Part C system typically utilizes a combination of agencies and individual practitioners to provide services to eligible infants, toddlers and families. Many states seek to implement less of a “medical therapy” model of early intervention supports and services and promote a consultative model that is believed to facilitate more active family participation and involvement along with direct therapy intervention. Whatever methods are utilized, the approach to reimbursement should support the model and not work against it.

## **Option 3: Annual Average Cost Per Child**

The average annual cost per child may be estimated for a State Fiscal Year using the December 1 Child Count (point in time). This cost includes consideration of all systems components and provider responsibilities. Ideally, it may be determined through a cost study process in order to reflect increases in actual cost over time.

By agreeing to a managed care model, utilizing the average annual cost per child as the billing basis, invoices could be created based upon the monthly report of children in service and providers would report actual service detail as required for Medicaid 416 EPSDT data reports. This billing would rely upon the adjusted annualized cost per child. These data would include all children referred and in the eligibility determination/IFSP development process, as well as those receiving IFSP services.

A caution when using the annual cost approach is that reimbursement does not take into consideration those children for whom intense services are essential. This would include children with Autism Spectrum Disorder or those with extensive health care needs. It would be possible to create another form of reimbursement specifically for these children. Given that there usually is a wide range of service delivery frequencies and intensities across the total enrolled population, the improved economies of scale and enhanced utilization may more than compensate for costs incurred for children with intense needs. Data would help to inform the state of current enrollment together with planned service intensity in order to determine if things equalize, or if a special initiative for one or both of these populations would be required.

States considering this approach need to understand the organization of their provider community and ensure that using the annual average cost approach doesn't have the unintended consequence of excluding some providers who may not provide the full range of Part C services, but who may provide only one or two of these specialized services.

## **State Medicaid Match**

As previously discussed, Medicaid is a Federal/state partnership requiring that the state provide a level of "match" in the form of state or local dollars in order to draw down the Federal share. Federal funds may not be used as "match." Each state's "match" or Federal Financial Participation (FFP) is based upon the state's relative wealth. For some services, depending upon

who provides the service (e.g., physicians and nurses), the FFP may change pursuant to Federal Medicaid regulations. Additionally, Medicaid FFP for administrative purposes only (administrative claiming) may also be matched at 50%. And, FFP varies if reimbursement is through the Children's Health Insurance Program or CHIP. FFP changes annually and current information on individual state FFP may be obtained at <http://aspe.hhs.gov/health/fmap.htm>.

Many state Part C systems receive state general fund revenue and some use these funds as their state Medicaid match. Regardless of the "match" source, the state Medicaid agency is responsible to ensure the provision of services to Medicaid eligible children. As earlier discussed, several states have recognized this and only employ alternative match arrangements for those services that are "above" the Medicaid covered services and specifically designed to meet Part C requirements. Examples of this are service coordination, teaming requirements including IFSP development, and special instruction or developmental therapy (as it is termed in several states). The costs for services in the "natural environment" may also be seen as "above" the Medicaid standard and could be "matched" by Part C state funds.

If Part C state funds are used for "match" purposes, states may want to consider that this be achieved through "certification of match" whereby these funds do not actually transfer to the state Medicaid agency. Only the FFP is paid upon presentation of a provider invoice for services rendered in this arrangement. This invoice is "backed" through an interagency agreement that routinely certifies that there is sufficient state "match" available to meet the FFP obligation. Some state Medicaid agencies bill the Part C agency for FFP on a routine basis, "after the fact," and pay the provider 100% of the reimbursement.

## **In Summary**

Creating a SPA can expand reimbursement for Part C services that would include all of the required services. The importance of equitable services for all Part C eligible and enrolled children cannot be understated; parallel and equal opportunities for services must be available for all children regardless of the funding source. Some states have pursued a similar enhancement with their private insurance carriers, particularly once a Medicaid SPA has been successfully crafted, approved and implemented.

Uncovered children may be a challenge for some areas of a state where the gap between Medicaid enrollment and private insurance is more pronounced. For these children, IFSP services and supports are dependent upon other Federal, state and local resources. Recent federal advancements to the SCHIP program offer opportunities to cover a more broad group of children under the state's Medicaid program and should be strongly considered for these uncovered children who also participate in Part C services.

There will be children who require both Part C services as well as other medical services reimbursed by Medicaid. Partnerships in data sharing help to check for duplication, protect against fraud, and can truly monitor the total service package for individual children and assist to guide system evaluation and decision making in the future.