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# The Applicability of the Life Care Plan for Adopted Children with Disabilities: What Will Medicaid Pay?

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**Introduction**

At the end of 2006, there were approximately 126,000 children in the United States' foster care system awaiting adoption (U.S. Department of Health, Children's Bureau, 2008). Of these children, 60% were diagnosed with emotional, mental, or physical disabilities—conditions collectively referred to as "special needs." Despite the disproportionate number of children with special needs, potential parents are more likely to adopt a child without a known disability (U.S. Department of Health, Children's Bureau, 2008).

Adoption of a child is considered a legal process, which involves first terminating the birth parents' rights and obligation, and then bestowing these rights and obligation onto the adoptive parents (Zamostny, O'Brien, Baden, & Wiley, 2003). The adoption process is managed through a variety of public and private agencies responsible for matching the child with an adoptive family and then helping the family complete the adoption process. The process of adoption varies depending upon the type of agency. Each agency has adoption case managers who maintain a caseload of children available for adoption. The case managers identify families whose needs match those of the children awaiting adoption. One of the main difficulties with this process occurs when the case manager does not completely understand the child's needs and is unable to provide adequate information to the potential parents. This problem is often seen when the adoption agency is handling special needs adoptions, and often

creates a barrier towards placing a child with a disability. However, very little research has focused on the exploration of barriers to the adoption of children with special needs.

In an effort to explore practicing adoption case manager's views regarding barriers towards special needs adoptions, the primary author conducted a pilot study to explore these views. By employing a qualitative research methodology, semi-structured interviews were held with five adoption case managers. Each participant was actively working within the adoption field and had both past and present experience with special needs adoptions. A number of themes emerged from the interviews that addressed barriers that limited the adoption of children with disabilities. These primary themes included:

1. lack of information regarding disabilities
2. uncertainty of the child's future, and
3. fear of caring for the child

The first theme, lack of knowledge about and understanding of disabilities the potential adoptive parents had, resulted in an inability to grasp a realistic picture of the needs of the child. This theme, or adoption barrier, appeared to be exacerbated by the case managers' own lack of understanding regarding disabilities; therefore the case managers were unable to answer potential parent's questions regarding the child's disability related needs. Another theme that emerged which is barrier related to the lack of knowledge is the assumed uncertainty of the child's future. The case managers stated that potential parents often expressed concerns regarding the quality of the future of a child with a disability. Finally, the case managers stated that the lack of information and understanding of the child's needs created fear and insecurities about potential parents' abilities to adequately manage the care of the child. Life care planning is a tool that can address all these themes that were identified by the case managers, thus reducing the barriers associated with special needs adoptions.

***Provision of Healthcare for Adopted Children with Disabilities***

Financial support for meeting the disability-related needs of an adopted child is most often provided by state Medicaid. Therefore, the purpose of this study was to determine the feasibility of applying the life care plan methodology to a child with special needs within the adoption system based on the Florida Medicaid benefits system.

The Medicaid program was enacted in 1965 under Title XIX of the Social Security Act and is funded through a state and federal partnership (Centers for Medicare and Medicaid Services, 2008). According to the legislation, the Medicaid plan is administered by each state in accordance with its individual state plan. The goal of the Medicaid program is to improve the health coverage of recipients who otherwise might not be able to afford their medical care. Each recipient must meet specific eligibility requirements to be covered under Medicaid, which are determined by federal and state legislation (Center for Medicaid Services, 2008).

Like most insurance policies, Medicaid has limitations on the type and amount of services that are covered by the plan. The limitations of benefits are determined by state legislation; therefore vary between states (Center for Medicaid Services, 2008). Some states have also developed supplementary plans that can cover additional services for people who have extraordinary medical needs. The two supplementary plans that specifically apply to this study are Children's Medical Services (Children's Medical Services, 2008) and the Developmental Disability Waiver (Agency for Health Care Administration, 2007).

Children's Medical Services (CMS) is under Florida's Title V and serves the state's children with special health care needs. The program is a supplementary managed care plan under the state of Florida's Medicaid program and is designed to provide eligible children with

integrated medical services. Eligible children are those who are under the age of 21, who qualify for state Medicaid, and who have serious or chronic physical, developmental or behavioral conditions that require extensive preventive and maintenance care beyond that required by typically healthy children (CMS, 2008).

The other supplementary plan that was applied to this study is the Developmental Disabilities Waiver (DDW) program. The waiver is a Medicaid program that is designed to provide home and community-based services to people with developmental disabilities, including cerebral palsy. The goal of the program is to promote, maintain, and restore the health of recipients in order to minimize the effects of the disability and promote optimal independent functioning (Agency for Health Care Administration, 2007). According to the agency that administers the program, participants must be covered under the state Medicaid benefits in order to be eligible for the DDW program.

***Methods***

In order to complete this study, the primary author reviewed a life care plan that had been prepared by and was obtained from an experienced life care planner who maintains a nationwide life care planning practice out of Florida. The life care plan describes the current and future needs of a five-year-old child whose primary disability is developmental delays and hydrocephalus as a result of cerebral palsy. The child is a Caucasian female who is one of a set of quadruplets. She was born with hydrocephalus and a cleft palate and currently has a ventriculoperitoneal (VP) shunt in place. Previous surgeries include shunt and shunt revisions, tonsillectomy, tubes in ears, gastrostomy, strabismus surgery, and cleft palate surgery. The life care plan was developed to help the family determine the impact of the child's disability on independent functioning throughout her lifetime (Deutsch, 2004). Specifically, this primary author examined the life care plan and determined if the recommendations would be financially covered by Florida Medicaid, CMS or DDW programs.

***Life Care Plan Comparison***

Overall, the comparison between the example life care plan and the services provided by Florida Medicaid showed that the majority of the child's needs were covered by at least one of three Medicaid programs. The primary author reviewed all sections of the life care plan and specifically identified the similarities and differences of services, which are as follows:

*Projected Evaluations*

The majority of the projected evaluations and their frequencies were covered under the state Medicaid plan. However, Medicaid financial support was not provided for evaluations that would promote independent functioning such as vocational and disabled driver evaluation. Additionally, nutritional evaluations were not covered under Florida Medicaid. However, nutritional evaluations would be covered under the DDW, but DDW would only reimburse at a frequency of once per year and the recommendations for the child were to receive nutritional evaluations twice per year (Figure 1, see Page 116).

*Projected Therapeutic Modalities*

The projected therapeutic modalities outlined in Figure 2 would be reimbursed under state Medicaid along with supplemental coverage via CMS and the federal Individuals with Disabilities Education Act/I.D.E.A. (U.S. Department of Education, 2008). It should be noted that, although services may not appear to be covered under Medicaid for certain therapeutic

modalities, such services may be covered when provided by similar practitioners. For example, behavioral services are covered if provided by a behavioral analyst as opposed to a developmental psychologist. The behavioral analyst in this instance could provide the same services as a developmental psychologist, thus meeting the needs of the client as well as being reimbursed by Medicaid.

Although therapeutic modalities are covered under Medicaid, the frequency with which the services are provided is limited. Specifically Medicaid guidelines cover speech, physical, and occupational therapy reimbursed at a frequency of once per week; however, this conflicts with the recommendations of twice per week outlined for the child in the life care plan. Yet, due to the supplementary services the child would be eligible for through CMS, CMS would reimburse the additional sessions that are required. Finally, although most projected therapeutic modalities are covered either through Medicaid or Medicaid supplemental coverage, disabled driver training is not reimbursed under any of these social programs (Figure 2, see Page 117).

*Diagnostic/Educational Testing*

In the case analyzed for this study, the life care plan recommended educational testing and a special education program for the child as depicted in Figure 3. Educational testing at a frequency of once per year is covered by state Medicaid and CMS programs and all special education services are provided by the public school system under the federal I.D.E.A. with costs reimbursed by the county, state, or federal government (U.S. Department of Education, 2008). (Figure 3, see Page 118)

*Home Equipment and Medications*

The life care plan recommends a nebulizer to treat the child's bronchial pulmonary dysplasia (Figure 4). A review of the Florida Medicaid program reveals that Medicaid covers the purchase and regular replacement of this medical device. Furthermore, Albuterol, used with the nebulizer, would also be reimbursed under the Medicaid prescription program. (Figure 4 and Figure 5, see Page 119)

*Home Care*

The life care plan recommends respite care for the family in order to prevent caregiver burnout. Although respite care is not covered under state Medicaid, the CMS program will cover 720 hours of care per year. Since the life care plan recommendation includes 640 hours per year for respite care, the CMS program will more than cover the hours anticipated in the life care plan. Furthermore, it was noted in this section that a case manager will be necessary in order to organize and facilitate the child's care as well as help the parents identify and apply for any additional programs for which the child may be eligible. Under state Medicaid and CMS, specialized case management services are covered at a frequency of 32 minutes per day. (Figure 6, see Page 120)

*Future Medical Care Routine*

The majority of services and necessary frequency under routine future medical care are reimbursable through state Medicaid and supplementary programs. The first limitation noted in this section is frequency for eye exams under the Medicaid program. State Medicaid reimburses at a frequency of once a year; however the plan suggests two to five times per year. Additional limitations were noted with the frequency of auditory screenings. Medicaid

reimburses screening once every three years; however the plan suggests screenings once per year. The last limitation noted was in the frequency of an electrocardiogram (EKG) recommended for the child. State Medicaid programs cover an EKG once per year; however, for this case, it is recommended twice a year. (Figure 7, see Pages 121-122)

*Sections Not Covered by Medicaid or Supplemental Programs*

There were two essential sections of the life care plan where none of the recommendations were covered by Medicaid programs. This included leisure time and aids for independent functioning. Under each of these sections, recommendations for adaptive toys, assistive computers, and summer camp were included; however, none were reimbursable under the Medicaid programs.

**Unique Issues**

There are several issues related to the comparison of life care plan recommendations to Medicaid reimbursable services. The first issue is that Medicaid plans vary among states and this study is specifically designed around the availability, eligibility, and covered services of Florida's Medicaid programs. Life care planners who may examine Medicaid reimbursable services for a particular situation should consult their state public assistance programs (or the program requirements in the state in which the client lives). Additionally, Medicaid supplemental programs such as the DDW vary across states as well. Appendix A identifies the comparable programs available in each state.

The next issue relates to the continuous changes that occur in the Medicaid program. As a result, the life care planner must consistently keep abreast of such changes and, as such, should routinely re-evaluate the system coverages to ensure what needs and services may be financially supported.

The final issue relates to the process involved in applying for and seeking out services under the Medicaid program. As stated above, the Medicaid program is constantly changing and varies across states. Therefore, families needing to rely on the Medicaid system (such as is common with adoption of special needs children) must have an individual case manager to assist them in understanding, advocating, and applying for the necessary Medicaid programs.

**Conclusions**

Based on the results of this study, many areas within the life care plan were covered under Medicaid and/or supplemental programs. However, other important goods and services also were not covered. For example, aids and services to promote independent functioning generally were not covered. Lack of a provision for such a vital need could limit the quality of life of an individual with a disability and create a lifetime of barriers to independence. In this particular case, without a disabled driving evaluation or training, the client potentially would be dependent on friends and family members or public transportation. Limitations such as this in the meeting of independent living needs would most likely negatively impact the opportunity for a client to build peer social interactions which is essential for normal development and to help the child learn appropriate social skills.

Life care plans hold great potential for parents of adopted children with special needs regardless of the available funding source. Specifically, a Medicaid life care plan model can serve as a valuable educational tool for adoptive parents. Not only does the life care plan educate the parents about the lifetime disability-related needs, but it can also help parents identify the financial support programs that are available to meet the child's medical needs.

Often parents are unaware of the financial resources that exist and therefore are not able to access full medical coverage for their child. Having an understanding of future needs of a child with a disability would help ease some of the parent's fears about adopting such a child. Education pertaining to the lifetime disability-related needs of a child, knowledge that funding exists to meet such needs, and reduction of fear regarding caring for a child with disability should increase the likelihood that a potential parent would adopt a child with a disability.

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**Appendix A**

| State | SM | DD | CMS | Title V Websites |
|---|---|---|---|---|
| Alabama | X | X | X | http://www.rehab.state.al.us/Home/default.aspx?url=/Home/Services/CRS/Main |
| Alaska | X | X | X | http://www.hss.state.ak.us/dph/wcfh/default.htm |
| Arizona | X | - | X | http://www.azdhs.gov/phs/ocshcn/crs/crs_az.htm |
| Arkansas | X | X | X | http://www.medicalhomear.org/about.html |
| California | X | X | X | http://www.dhs.ca.gov/pcfh/cms |
| Colorado | X | X | X | http://www.cdphe.state.co.us/ps/hcp/ |
| Connecticut | X | X | X | http://www.ct.gov/dph/cwp/view.asp?a=3138&Q=387702&PM=1 |
| Delaware | X | X | X | http://dhss.delaware.gov/dhss/dph/chca/dphcshcn.html |
| District of Columbia | X | X | X | http://www.childrensnational.org/DepartmentsandPrograms |
| Florida | X | X | X | http://www.cms-kids.com |
| Georgia | X | X | X | http://health.state.ga.us/programs/cms/index.asp |
| Hawaii | X | X | X | http://hawaii.gov/health/family-child-health/cshcn/cshnppage.html |
| Idaho | X | X | X | http://www.healthandwelfare.idaho.gov |
| Illinois | X | X | X | http://www.uic.edu/hsc/dscc/ |
| Indiana | X | X | X | http://www.in.gov/isdh/19613.htm |
| Iowa | X | X | X | http://www.uihealthcare.com/depts/state/chsc/index.html |
| Kansas | X | X | X | http://www.kdheks.gov/shs/ |
| Kentucky | X | X | X | http://chfs.ky.gov/ccshcn/ |
| Louisiana | X | X | X | http://www.dhh.louisiana.gov/offices/?ID=256 |
| Maine | X | X | X | http://www.maine.gov/dhhs/boh/cshn/home.html |
| Maryland | X | X | X | http://www.fha.state.md.us/genetics/html/specialcare.cfm |
| Massachusetts | X | X | X | http://www.mass.gov/ |
| Michigan | X | X | X | http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-15087--,00.html |
| Minnesota | X | X | X | http://www.health.state.mn.us/divs/fh/mcshn/mcshn.html |
| Mississippi | X | X | X | http://www.msdh.state.ms.us/msdhsite/_static/41,0,163.html |

SM – State Medicaid Program
DD – 1915(c) Comparable programs to Developmental Disabled Waiver
CMS – Title V programs which are comparable to Florida's CMS

**Appendix A Cont.**

| | | | | |
|---|---|---|---|---|
| Missouri | X | X | X | http://www.dhss.mo.gov/SHCN/CSHCN.html |
| Montana | X | X | X | http://www.dphhs.mt.gov/PHSD/family-health/cshs/cshs-index.shtml |
| Nebraska | X | - | X | http://www.dhhs.ne.gov/HCS/Programs/DCP.htm |
| Nevada | X | X | X | http://health2k.state.nv.us/cshcn/CSHCN.htm |
| New Hampshire | X | X | X | http://www.dhhs.state.nh.us/dhhs/specialmedsrvcs/default.htm |
| New Jersey | X | X | X | http://www.state.nj.us/health/fhs/sch/index.shtml |
| New Mexico | X | X | X | http://www.health.state.nm.us/mch.html |
| New York | X | X | X | http://www.health.state.ny.us/community/special_needs/index.htm |
| North Carolina | X | X | X | http://wch.dhhs.state.nc.us/cay.htm |
| North Dakota | X | X | X | http://www.ndhealth.gov/cshs/ |
| Ohio | X | X | X | http://www.odh.ohio.gov/odhPrograms/cmh/bcmh/cmh1.aspx |
| Oklahoma | X | X | X | http://www.okdhs.org/programsandservices/health/cshcn/ |
| Oregon | X | X | X | http://www.ohsu.edu/outreach/cdrc/occyshn/community/team1.php |
| Pennsylvania | X | X | - | |
| Rhode Island | X | X | X | http://www.dhs.ri.gov/dhs/famchild/kids_connect_app.pdf |
| South Carolina | X | X | X | http://www.dhec.sc.gov/health/mch/cshcn/index.htm |
| South Dakota | X | X | X | http://doh.sd.gov/FamilyHealth/child.aspx |
| Tennessee | X | X | X | http://health.state.tn.us/MCH/css.htm |
| Texas | X | X | X | http://www.dshs.state.tx.us/cshcn/ |
| Utah | X | X | X | http://health.utah.gov/cshcn/ |
| Vermont | X | - | X | http://healthvermont.gov/family/cshn/cshn.aspx |
| Virginia | X | X | X | http://www.vahealth.org/specialchildren/ |
| Washington | X | X | X | http://www.doh.wa.gov/cfh/mch/CSHCNhome2.htm |
| West Virginia | X | - | X | http://www.wvdhhr.org/cshcn/ |
| Wisconsin | X | X | X | http://www.dhfs.state.wi.us/dph_bfch/cshcn/index.HTM |
| Wyoming | X | X | X | http://wdh.state.wy.us/familyhealth/csh/index.html |

SM – State Medicaid Program
DD – 1915(c) Comparable programs to Developmental Disabled Waiver
CMS – Title V programs which are comparable to Florida's CMS

**Figure 1** **Medicaid Coverages for a Child with Cerebral Palsy**
**Projected Evaluations**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Developmental Psychology | Beginning 5 6/9/04<br>Ending 21 2020 | 1 X/ 2-3 years to age 21 | Evaluate developmental levels and monitor for behavioral problems | • Covered under the Developmental Disability Waiver (DDW) |
| Psychological Evaluation | Beginning 5 2004<br>Ending 5 2004 | 1 X Only | Assess family's needs and formulate a counseling program to address them | • Covered by State Medicaid Plan |
| Physical Therapy | Beginning 5 2004<br>Ending Life exp. | 2X/Year through age 21; thereafter 1X/year | Assess physical therapy program | • Covered by State Medicaid Plan<br>• IDEA will provide evaluation for school related tasks |
| Occupational Therapy | Beginning 5 2004<br>Ending Life exp. | 2X/Year through age 21; thereafter 1X/ 3 year | Assess occupational therapy program | • Covered by State Medicaid Plan<br>• IDEA will provide evaluation for school related tasks |
| Speech Therapy | Beginning 5 2004<br>Ending 21 2020 | 2X / Year | Assess speech therapy program | • Covered by State Medicaid Plan<br>• IDEA will provide evaluation for school related tasks |
| Nutritional Evaluation | Beginning 5 2004<br>Ending Life exp. | 2 X/ Year through age 18; then 1 X / year thereafter | Monitor nutritional needs and make recommendations | • Covered under the DDW for 1 X year evaluation only |

- Services not covered under projected evaluations include vocational evaluation and disabled driver evaluation.

**Figure 2**

**Medicaid Model for a Child with Cerebral Palsy**
**Projected Therapeutic Modalities**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Behavioral Analysis Services* | Beginning 5<br>Life Exp. | 1 X/ week for 3 months now, 2X / month for 3 months at ages 6, 8, 10, 12, 14, 16, 18, and 21 | Implement a developmental stimulation and behavioral modification program for caregivers to follow. | • Covered under the Developmental Disability Waiver<br>• Covered by CMS |
| Family Counseling | Beginning 5 2004<br>Ending 21 2020 | 1 X/ week for 3 months now, 2X / month for 3 months at ages 6, 8, 10, 12, 14, 16, 18, and 21 | To help the family cope with the situation and becoming stronger advocates | • Covered by State Medicaid |
| Physical Therapy | Beginning 5 2004<br>Ending Life exp. | 2X/week through age 21 (48 weeks / year); thereafter 4 - 6 X / year | Enhance muscular development and prevent contractures | • 1X / week limit under State covered Medicaid. CMS covers the overage on services. |
| Occupational Therapy | Beginning 5 2004<br>Ending Life exp. | 2X/week through age 21 (48 weeks / year); thereafter 4 - 6 X / year | Cognitive and visual stimulation and introduce adaptive technology to enhance functioning | • 1X / week limit under State covered Medicaid. CMS covers the overage on services. |
| Speech Therapy | Beginning 5 2004<br>Ending 21 2020 | 2X/week through age 21 (48 weeks / year); thereafter 4 - 6 X / year | Address speech, language, and cognitive deficits | • 1X / week limit under State covered Medicaid. CMS covers the overage on services. |

*Instead of Developmental Psychologist, Medicaid covers Behavioral Analyst. Behavioral Analyst can address the same behavioral modification issues as a developmental psychologist. Services not covered under therapeutic modalities would be disabled driver training.

**Figure 3**

**Medicaid Model for a Child with Cerebral Palsy**
**Diagnostic/Educational Testing**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Educational Testing | Beginning 5 2004<br>Ending 21 2020 | 1 X / year | To assist supplemental therapist in coordinating with school sponsored program | • Covered by CMS<br>• Some educational related testing is covered by IDEA |
| Special Education Program | Beginning 5 2004<br>Ending 21 2020 | Weekly educational program | Educational and therapeutic program | • Special education programs provided at the cost of county, state, and federal government under IDEA |

**Figure 4** **Medicaid Model for a Child with Cerebral Palsy**
**Home Furnishings and Accessories**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Nebulizer | Beginning 5 2004<br>Ending 21 2020 | 1 X / 3-4 years | Treatment for Bronchial Pulmonary Dysplasia | • Covered by State Medicaid<br>• Covered by CMS |

**Figure 5** **Medicaid Model for a Child with Cerebral Palsy**
**Medication**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Prescription Medication* | Beginning 5 2004<br>Ending 21 2020 | Annual | As prescribed by physician for breathing treatments | • Current medications are Albuterol and antibiotics needed prior to dental visits secondary to heart condition |

*Generic prescription medication is covered under Medicaid insurance as needed and prescribed.

**Figure 6** **Medicaid Model for a Child with Cerebral Palsy**

**Home Care / Facility Care**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Pre - Age 21<br>Respite Care (HHA) * | Beginning 5 2004<br>Ending 21 2020 | 1 night per week for 4 hours; 1 weekend / month for 36 hours (640 hours / year) | Prevent parental burnout | • Covered under the Developmental Disability Waiver<br>• Covered by CMS |
| Pre - Age 21<br>Case Management ** | Beginning 5 2004<br>Ending 21 2004 | 3 - 4 hours / month (36 - 48 hours / year) | Coordinate and oversee care | • Covered by State Medicaid Plan<br>• Covered by CMS |

* Limited to 8 hours in one 24 hour period and a total of 720 hours per year

** Limited to 32 minutes per day

**Figure 7** **Medicaid Model for a Child with Cerebral Palsy**
**Future Medical Care Routine**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Pediatrician / Internist | Beginning 5 2004<br>Ending Life Exp. | 4 X / year for 15 years; 2 X / year thereafter | Care required in addition to the routine care all children required | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Neurologist | Beginning 5 2004<br>Ending Life Exp. | 1-2 X / year | Monitor for seizure disorder and other neurological problems | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Orthopedics | Beginning 5 2004<br>Ending Life exp. | 2-4 X / year through age 15; thereafter 1X/year | Monitor bone development and contractures | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Physiatrist | Beginning 5 2004<br>Ending Life exp. | 1-2 X / year | Monitor habilitation plan, need for treatment of spasticity, orthotics | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Ophthalmologist * | Beginning 5 2004<br>Ending Life exp. | 2-5 X / year through age 10; thereafter 1X/year | Monitor eyes, vision, and strabismus | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Cardiologist | Beginning 5 2004<br>Ending Life exp. | 1-2 X / year | Monitor heart condition | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Pulmonologist | Beginning 5 6/9/04<br>Ending Life Exp. | 2 X / year | Monitor bronchial pulmonary dysplasia and pulmonary insufficiency | • Covered by State Medicaid Plan<br>• Covered by CMS |

* Vision Exam is restricted to once per year; however follow up visits are covered

**Figure 7 cont.** **Medicaid Model for Cerebral Palsy**

**Future Medical Care Routine**

| Item/Service | Age/ Year | Frequency/ Replacement | Purpose | Comment |
|---|---|---|---|---|
| Otolaryngologist/ENT * | Beginning 5 2004<br>Ending 21 2020 | 2 X / year through age 14; then 1X / 2-3 year through age 21 | Monitor for seizure disorder and other neurological problems | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Neurosurgeon | Beginning 5 2004<br>Ending Life exp. | 2 X / year through age 20; thereafter 1X / year | Monitor VP shunt | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Pathology lab work | Beginning 5 2004<br>Ending Life exp. | 2-3 X / year | Monitor functions with a CBC, Metabolic panel | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Neurological diagnostics | Beginning 5 2004<br>Ending Life exp. | 1 X / year | Monitor Shunt with Shunt Series, EEG, CT of head, MRI of Brain | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Cardiac Diagnostics ** | Beginning 5 2004<br>Ending Life exp. | See individual test for frequency | Monitor heart functioning with Chest X-ray, EKG (1X / year), Echocardiogram (1X/year), stress tests | • Covered by State Medicaid Plan<br>• Covered by CMS |
| Pulmonary Function testing | Beginning 6 2005<br>Ending Life exp. | 1 X / year | Monitor pulmonary functions | • Covered by State Medicaid Plan<br>• Covered by CMS |

* Hearing Exams are limited to 1 every 3 years; follow up visits to address tubes are covered at the same rate

** EKG was recommended twice per year; however is only covered for one per year