

PROJECT THRIVE



Linking Policies for Child Health,
Early Learning, and Family Support

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Project THRIVE *Short Takes* highlight topics of interest and importance to state maternal and child health leaders and their partners building State Early Childhood Comprehensive Systems (ECCS). Each *Short Take* summarizes the issue, relevant research, and related resources. Project THRIVE is a public policy analysis and education initiative for infants and young children at the National Center for Children in Poverty (NCCP) funded through a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, of the U.S. Department of Health and Human Services.

The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

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SHORT TAKE NO. 1

The Deficit Reduction Act of 2005 Opportunities and Challenges for ECCS Initiatives

The Issue

This Project THRIVE *Short Take* examines the potential impact of the Deficit Reduction Act of 2005 (DRA) on health access and coverage for young children ages birth to 5 years. The core provisions of the DRA are described in contrast to existing law, and opportunities and threats are discussed. The last section offers recommendations and resources for further study.

Each state's Early Childhood Comprehensive System (ECCS) initiative has a component focused on assuring health access and a medical home for every child. The DRA changes to Medicaid have important implications for assuring health coverage and access and will potentially have their greatest impact on young children who are more likely to be covered through Medicaid than older children. These new options and requirements in Medicaid should be considered both in states developing ECCS plans and those implementing early childhood system changes.

What Research Says About Medicaid and Young Children

- Young children are more likely than older children to have Medicaid as their source of health coverage. An estimated 35-40 percent of U.S. births are financed by Medicaid, with continuing coverage throughout the first year of life for most infants. In addition, approximately one-third of children ages 1-5 years are covered by Medicaid.¹
- Medicaid is important to both low-income white and minority children. In 2004, an estimated 80 percent of poor black children under age 6 were covered by Medicaid.²
- Children make up half of all Medicaid enrollees, but represent less than 20 percent of the total spending—primarily because they use less expensive primary and preventive services.³
- Millions of uninsured children are eligible for but not enrolled in publicly financed health coverage through Medicaid and SCHIP (the State Children's Health Insurance Program). Effective outreach and enrollment policies can make a difference in coverage levels, and states have adopted promising practices.⁴

Eligibility Options for Children with Special Health Care Needs and Disabilities

What Research Says About Coverage for Children with Disabilities

- Families of children with special health care needs (CSHCN) face barriers in securing health coverage, and some reach coverage limits in private insurance plans.⁵
- Some families have been forced to enroll their children in institutional care or spend-down family income and savings to qualify for Medicaid in the “medically needy” category.⁶

What DRA Changes

Opportunity for States

The Family Opportunity Act of 2006 was designed to give states the option to enroll low- and middle-income families to access appropriate health care for their child with a disability through the Medicaid program. As enacted within the DRA, the Family Opportunity Act provisions could help many families secure affordable health care for their children with severe disabilities.⁷

- The DRA creates a new, optional Medicaid eligibility group that consists of children with disabilities under age 19 who meet the Supplemental Security Income (SSI) program rules for severity of disability but not the income rules (effective January 1, 2007). Under this option, states may extend eligibility to such children in families with income up to 300 percent of the federal poverty level (FPL)—currently set at \$58,500 for a family of four. States also may extend coverage to families above 300 percent FPL without federal matching funds.
- For ECCS planning, it is important to note that this coverage will be phased in, with the youngest children covered first. This option will take effect in January 2007 for children birth to age 6 years (those born on or after January 1, 2001).

The legislation also requires states to establish **Family-to-Family Health Information Centers** providing services to families with children that have special health care needs or disabilities. Centers would offer assistance in securing health care resources, outreach, training and guidance, and service coordination. Similar to some existing centers sponsored by Family Voices in Florida, Massachusetts, and other states, these Family-to-Family Health Information Centers can be a hub for family support to those with CSHCN. They also employ and train parents to provide support to their peers. The legislation requires that such centers be established in at least 25 states in 2007, in 40 states in 2008, and in all 50 states and the District of Columbia by 2009. Funding may come from the Title V Maternal and Child Health Services Block Grant and other sources. This is an opportunity for ECCS initiatives to assist their state in developing a new family support center.

Family Cost Sharing

What Research Says About Family Cost Sharing

Research has demonstrated that if costs are too high relative to family income, they can create barriers to obtaining and maintaining health care coverage, as well as reducing use of needed health services.

- Low-income families already spend a disproportionate share of their income on out-of-pocket health expenses (not including premiums). One recent study found that poor families with incomes less than 100 percent FPL had out-of-pocket costs for health care averaging \$120 per \$1,000 of family income, compared with \$38 per \$1,000 for affluent families with incomes above 400 percent FPL.⁸
- Medicaid policies for keeping cost sharing low have made a difference. Low-income families (those with income up to 200 percent FPL) with full-year public coverage had significantly (700 percent) lower out-of-pocket costs than those with full-year private insurance.⁹
- A small number of states have experimented with premiums for low-income children and family coverage. Increased premiums under Medicaid/SCHIP led to an 11 percent decline in the first month alone in Vermont, disenrollment for failure to pay of nearly one in

five families in Rhode Island, and a drop in enrollment of nearly half in Oregon. Surveys and focus groups indicate that a majority cited problems with increased costs and inability to pay as primary factors leading to lost coverage.¹⁰

What DRA Changes

Prior to the DRA, children (and to a large extent pregnant women) were exempt from premiums and cost sharing—co-payments and co-insurance. Under the DRA, states will have new authority to charge for coverage and care received by low-income children (and adults) enrolled in Medicaid. States may disenroll families that have not paid premiums for longer than 60 days, and may permit providers to require that patients pay before care is rendered.¹¹

Protections for Children and Families

- Certain services are exempt from cost-sharing. These include but are not limited to preventive services, such as well child care, pregnancy-related services, family planning services, and emergency services.
- No premiums or cost-sharing may be imposed for children who fall within mandatory eligibility categories. This includes children who are: receiving TANF cash assistance; are under age 6 and have income less than 133 percent FPL; are ages 6 to 18 and have income less than 100 percent FPL; in federally subsidized foster care or adoption placements; in certain institutions, and/or receiving SSI. Similarly, no premiums may be imposed for pregnant women.
- DRA also includes protections based on income status. No premiums may be imposed for children in optional eligibility categories with family income at or below 150 percent FPL. For those with incomes above 150 percent FPL, aggregate limits, such as 5 or 10 percent of income, are set in federal law.

Cautions for States

While some protections were adopted, the complex details about who can be charged, when, and how much may be difficult for low-income families and providers to understand. Most difficult may be for low-income families to understand that they need only pay premiums and

cost sharing to a certain limit (for example, 5 or 10 percent of their income). State and local agencies concerned with child health will likely need to provide additional educational materials and assistance to families affected by any changes in Medicaid cost sharing.

Benefits and Benchmark Plans

What Research Says About Benefits and Benchmarking

Under the system now in place, the same standards of pediatric care govern all states' Medicaid programs.

- For decades, the child health benefits under Medicaid have been guided by the standards of care set by the American Academy of Pediatrics and have been designed to offer those services deemed medically necessary for a child.¹²
- Many EPSDT-financed services (Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program) are aimed at prevention and early intervention. For example, young children have access to treatment for lead poisoning, dental care starting at age 1 year, early treatment for hearing impairments detected in newborns, and developmental services for young children.¹³

What DRA Changes

Prior Medicaid law required that child health benefits, as defined in the EPSDT benefit, include all of the services available under Medicaid, even if these services were not covered for adults in the state. The DRA gives states the option to restructure their approach to benefits under Medicaid without a federal waiver, using the state plan amendment process (which may or may not require legislative action).¹⁴ The most significant change is that DRA permits use of "benchmark" benefit plans in lieu of the full Medicaid benefit package.

The details for states using benchmark coverage are intricate and can be studied in the resources listed below. The core concept is this: A benchmark benefit is defined in comparison to a typical commercial insurance plan.

- Similar to SCHIP, benchmark plans may be modeled after the standard Blue Cross/Blue Shield preferred

provider option offered under the Federal Employees Health Benefits Program (FEHBP), the state employee plan, or the state's largest federally qualified HMO—health maintenance organization. With federal approval, states may structure other benefit plans.

- For children, benchmark plan coverage would be less than EPSDT requires, but states are required to finance EPSDT services not covered through the benchmark plan as “wraparound” services.¹⁵ This would be similar to some states' Medicaid managed care approaches, which pay on a fee-for-service basis for services outside the managed care contract. Examples include financing eyeglasses, dental care, and developmental services.

Protections for States

States may not require enrollment in benchmark or benchmark-equivalent coverage if the beneficiary is covered in certain categories. This includes, but is not limited to:

- Pregnant women required to be covered under the state plan
- Children who qualify for SSI based on disability
- Children in foster care
- Children and adults qualifying for TANF
- Beneficiaries who are institutionalized, terminally ill, medically frail, and in long-term care facilities

Cautions for States

As with premiums and cost sharing, it may be difficult for low-income families and providers to understand how the full range of EPSDT child health benefits will be covered. If states adopt a benchmark benefits approach for children, families will need educational materials and assistance.

Case Management

What Research Says About Case Management

- In Florida, Maryland, New Jersey, North Carolina, South Carolina, Virginia, Washington State, and elsewhere across the country outreach, care coordination, and case management have been used to identify pregnant women, link them to appropriate care, and provide preventive health education. The results have typically been reductions in low birthweight and infant mortality, as well as savings from reduced hospital days for mothers and babies.¹⁶
- Research and family reports indicate that children with special health care needs require care coordination to assure that they receive the full range of services they need, that services are not duplicated, and that the multiple providers involved communicate effectively with families and each other.¹⁷

What DRA Changes

Under prior law, states were employing various types of case management. The DRA retains the definition of medical case management services (services that assist Medicaid-eligible individuals to gain access to “medical, social, educational, and other services needed by the eligible individual”), but clarifies the definition specifically to include:

- Assessment of an eligible individual to determine service needs
- Development of a specific care plan based on the information collected
- Referrals and related activities to help an individual obtain needed services
- Monitoring activities to ensure that an individual's care plan is effectively implemented and adequately addresses individuals' needs

Nonreimbursable case management activities include any direct delivery of medical, educational, social, or other service to which an individual is referred.¹⁸

Cautions for States

Many states have used case management or targeted case management funding to cover services that have direct impact on young children and their families. Examples include: prenatal care coordination, home visiting, care coordination for children with special health care needs, and mental health wraparound services. If your state uses Medicaid as a major source of financing for care coordination or case management for young children, you should watch for federal guidance and undertake a review of the case management activities underway.

Proof of Citizenship

Medicaid eligibility requires citizenship or legal status for all but emergency care. Prior to enactment of the DRA, no formal written proof or documentation of citizenship was required at the time of application. Under the DRA, states are prohibited from receiving Medicaid reimbursement for any individual who has not provided documentation as proof of citizenship (effective on and after July 1, 2006).¹⁹ This requirement applies to new eligibility determinations, as well as redeterminations.

Cautions for States

These provisions are expected to result in fewer applications among both adults and children.²⁰ For example, parents who are themselves undocumented residents may be reluctant to apply for Medicaid for their children who were born in the United States and are citizens. In addition, collecting the necessary documents can be expected to create financial and logistical barriers even for families in which all members are citizens.

Conclusion

State policymakers and family advocates have an opportunity to use their tools and knowledge to fulfill the positive potential of the DRA. State policy decisions can:

- Cover more parents of low-income children to foster a family approach.
- Extend coverage to more children with disabilities and special health needs, and, in turn, help families to stay intact and parents to continue employment.
- Protect families from excessive premiums and cost-sharing. Greater continuity also depends on using longstanding options to extend annual enrollment periods to children and on making a seamless connection between Medicaid and SCHIP.
- Determine that child health benefits are administered effectively and efficiently and that all eligible children continue to have access to the full range of benefits guaranteed under EPSDT.
- Structure effective case management and care coordination to families and children with social and medical risks and conditions, using other sources of funding where necessary to continue such services.
- Make effective use of Family-to-Family Support Centers (operated through State Title V Maternal and Child Health Agencies) to employ and support parents of children with special health care needs.
- Help to assure that low-income children who are citizens have an opportunity to enroll for the health benefits to which they are entitled by providing families with information and education about Medicaid requirements for citizens and noncitizen residents.²¹

Endnotes

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10. Artiga, S. & O'Mally, M. (2005). *Increasing premiums and cost sharing in Medicaid and SCHIP: Recent state experiences*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
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14. DRA Section 6043-6044, redesignating Section 1937 of the Social Security Act as Section 1938 and adding new Section 1937.
15. Smith, D. (2006, March 31). *Dear State Medicaid Director Letter* (SMDL #06-008). Baltimore, MD: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services <www.cms.hhs.gov/smdl/downloads/SMD06008.pdf>. This letter clarifies the DRA intent that enrolled mandatory and optional categorically needy children under age 19 must receive "wraparound" benefits to the benchmark or benchmark-equivalent plan to assure that in combination with the plan, these children receive the full range of EPSDT benefits.
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Additional Resources

The **Bazelon Center for Mental Health Law** has a special issue of their *Mental Health Reporter* as well as other publications and presentations related to children's mental health coverage under Medicaid. Go to: <www.bazelon.org>.

The **Center on Medicare and Medicaid Services (CMS)** of the U.S. Department of Health and Human Services is the federal agency charged with oversight, regulation, and management of Medicaid. CMS is the administrative partner to states. For updates, visit: <www.cms.gov>.

Health policy is one of several areas of focus for the **Center on Budget and Policy Priorities**, a national policy organization working on fiscal policy that affects low- and moderate-income families and individuals. Visit: <www.cbpp.org> or <www.cbpp.org/pubs/health.htm>.

The **Center for Children and Families at the Georgetown University Health Policy Institute** has published an issue brief—*The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families*—that addresses DRA and its implications for children and families. The report is available at: <jonesd.ihcrp.georgetown.edu/~jonesd3/reconbrief013006.pdf>.

The **George Washington University, Department of Health Policy**, has an array of resources regarding Medicaid and child health policy. Of note is a series of issue briefs on SCHIP, written by Anne Markus and colleagues, as well as analyses on Medicaid and EPSDT authored by Department Chair, Sara Rosenbaum. Go to: <www.gwumc.edu/sphhs/healthpolicy>.

The **Kaiser Family Foundation (KFF)** has several web sites devoted to Medicaid, including state-by-state data and reports from their Commission on Medicaid and the Uninsured. Several recent reports focus on DRA, including an overall summary and documents on EPSDT and SCHIP, and the impact of increasing premiums and cost sharing. Visit: <www.kff.org>.

Medicaid Matters is a web site developed through a joint effort by a number of groups, including Community Catalyst, Georgetown University Health Policy Institute, the Center on Budget and Policy Priorities, and Families USA. See it at: <www.medicaidmatters2005.org>.

The **National Academy for State Health Policy (NASHP)** is dedicated to helping states achieve excellence in health policy and practice. NASHP has in-depth resources for state health policymakers working on children's health issues, including topics such as Medicaid, SCHIP, and promoting healthy mental development. To view publications, go to: <www.nashp.org>.

The **National Health Law Program (NHLP)** has a library of resources on EPSDT, including analyses of state Medicaid plans, federal statutes, and related lawsuits and court decisions. For more, go to: <www.healthlaw.org> and choose child health/EPSDT.

The **National Health Policy Forum** is a research and public policy organization located at the George Washington University. Senior Research Associate, Jennifer Ryan, has written a special issue brief (No. 810) on the potential impact of the DRA. View at: <www.nhp.org>.

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