AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Health Financing

Medicaid Policy Statement

ABSTRACT. This policy statement replaces the 1994 Medicaid Policy Statement. The new policy statement incorporates federal legislative changes and policy recommendations related to eligibility, outreach and enrollment, Medicaid managed care, covered benefits, access to pediatric care, and quality improvement plans.

ABBREVIATIONS. AAP, American Academy of Pediatrics; SCHIP, State Children's Health Insurance Program; SSI, Supplement Security Income program; TANF, Temporary Assistance for Needy Families program; PCP, primary care pediatrician; EPSDT, Early and Periodic Screening, Diagnosis, and Treatment program.

The American Academy of Pediatrics (AAP) recognizes the achievements of the Medicaid program's improvement of access to health care services for low-income newborns, infants, children, adolescents, and young adults, hereinafter referred to as children. In fiscal year 1996, Medicaid insured almost 30% of children nationwide younger than 21 years (approximately 23 million children.)[1] This policy statement includes a brief summary of new federal legislative changes and policy recommendations related to eligibility, outreach and enrollment, Medicaid managed care, covered benefits, access to pediatric care, and quality improvement plans.

Because states are able to expand Medicaid coverage under the State Children's Health Insurance Program (SCHIP) (Title XXI of the Social Security Act), a major provision of the Balanced Budget Act of 1997, the proportion of children eligible for Medicaid is likely to increase. In addition, the outreach and enrollment efforts that accompany SCHIP are likely to increase the number of eligible children enrolled in Medicaid. Title XXI of the Social Security Act will make more than $40 billion in federal grants available to states during the next 10 years to provide uninsured children with health insurance coverage, including Medicaid. Although Title XXI does not create universal coverage, the program offers an unprecedented opportunity to expand insurance to a large portion of uninsured children. A companion AAP statement on Title XXI is available that addresses Medicaid and non-Medicaid approaches for extending health insurance to SCHIP-eligible children.[2]

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

ELIGIBILITY

Provisions in the Balanced Budget Act of 1997 (Public Law 105–33) allow states to expand Medicaid eligibility with an enhanced federal match. The Balanced Budget Act of 1997 restores Medicaid to persons who lost the entitlement after the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193) and also grants states greater flexibility when determining eligibility.

The AAP recommends that states implement the following Medicaid eligibility expansions and provisions to ensure enrollment of all children eligible for Medicaid under federal legislation. States should:

1. Immediately extend Medicaid coverage, if they have not already done so, to all children at or below the federal poverty level who are younger than 19 years to take advantage of the enhanced federal match offered under Title XXI.
2. Ensure that Medicaid-eligible children who lose cash benefits under the Supplement Security Income (SSI) program as a result of welfare reform remain enrolled in Medicaid.
3. Eliminate asset testing to determine Medicaid eligibility.
4. Guarantee 12 months of continuous Medicaid eligibility for children younger than 19 years.
5. Adopt presumptive Medicaid eligibility options for children younger than 19 years, similar to the option available for pregnant women.
6. Ensure that a redetermination of eligibility be made before disenrolling any children from Medicaid because of changes in their eligibility for cash assistance under the Temporary Assistance for Needy Families (TANF) program.
7. Ensure that children who are removed from their homes by the state are immediately enrolled in Medicaid.

OUTREACH AND ENROLLMENT

Since Medicaid was delinked from welfare during the mid-1980s, children have benefited from major eligibility expansions. However, children's participation in Medicaid is unacceptably low for a variety of reasons. Enrolling Medicaid-eligible uninsured and underinsured children is a major priority of the AAP. The AAP estimates that in 1997, approximately 4.5 million uninsured children were eligible for Medicaid but were not enrolled. Another 4.6 million privately insured children also were eligible for Medicaid as a supplement to their private insurance but not enrolled.[3] Because employer-sponsored private

coverage for low-wage workers often has gaps in benefits and high cost-sharing obligations, enrolling these children in Medicaid would reduce underinsurance for millions of children of low-wage workers.

Federal and state regulatory and administrative procedures must be reoriented to make optimal outreach and enrollment a high priority for states. Ironically, state eligibility procedures have been shaped by federal rules that penalize states for enrolling ineligible beneficiaries but are silent about the millions of eligible beneficiaries who are not enrolled. Pediatricians, other health care professionals, and child advocates can assist state Medicaid agencies to provide outreach to families whose children are uninsured or underinsured. The following steps should be taken to strengthen national, state, and community outreach and enrollment efforts:

1. Federal legislation should be enacted that creates state enrollment targets and rewards states for exceeding target levels. If states do not respond to these incentives, penalties should be considered for consistent substandard performance.
2. New outreach efforts should be initiated to reach children who are potentially eligible for Medicaid but not enrolled, including but not limited to:
   - legal immigrants;
   - those who lost welfare or SSI eligibility as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, but who may still qualify for Medicaid benefits;
   - SCHIP-eligible children whose family income has changed; and
   - underinsured children.
3. State Medicaid agencies should be encouraged to accept mail-in and phone-in applications.
4. States should expand the use of alternative enrollment sites, including health care centers, child care centers, Head Start programs, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), schools, child care resources and referral agencies, and religious centers.
5. States should expand the use of electronic information systems (eg, fax for documentation and electronic application forms).
6. New eligibility determination for TANF should be linked to Medicaid so children in families deemed eligible for TANF will be enrolled automatically in Medicaid.
7. States should coordinate Medicaid and SCHIP outreach and enrollment, including the use of common application forms. Forms should be short and written in language that is manageable to the average Medicaid applicant.
8. Federal policy should be established to prevent denial of citizenship attributable to prior receipt of Medicaid and all other health care-related services.

MEDICAID MANAGED CARE

States are increasingly turning to managed care in the hope of curtailing rising health care costs, increasing Medicaid beneficiaries' access to health care services, enhancing the coordination of services, and improving the continuum of care. The following are precautions that states must take to ensure that Medicaid managed care initiatives meet the health care needs of Medicaid beneficiaries:

1. At the time of Medicaid enrollment, if applicable, families should receive easily understood information about their choices of managed care plans, primary care physicians, and voluntary enrollment of children with special health care needs. Also, they should receive education on how managed care arrangements work, including the importance of primary and preventive care and the need to obtain most health services directly from or by referrals from their primary care pediatricians (PCPs). Educational materials for families should be culturally sensitive aimed at appropriate literacy levels and available in languages used by Medicaid recipients in each state.
2. States should ensure that every effort is made for Medicaid beneficiaries to make an informed choice when choosing a managed care plan. Such efforts should include the use of face-to-face counselors. When participants do not choose and must be assigned to a plan, the criteria used to assign them should include current and previous relationships with primary care and specialty clinicians, location of clinicians, assignment of other family or household members, choices by other members in the service area, and capacity of managed care organizations to provide special care or services appropriate for the participants. Pediatricians should be considered primary care practitioners in all default enrollment systems and state-based enrollment broker options. Random assignment, without such criteria, should not be allowed. In addition, states should allow individuals to switch plans with reasonable cause at any time.
3. States should implement special planning and oversight of the use of managed care for children with special health care needs and all children who are TANF-, SSI-, or foster care-eligible. This can include examination of benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, quality performance measures for children with various types of chronic conditions, family participation, innovative plan practices, pediatric risk adjustment mechanisms, and other financial incentives for high quality care.
4. State Medicaid agencies should select managed care plans based on the plan's ability and/or demonstrated readiness to provide evidence that Medicaid beneficiaries have received quality cost-effective care that meets expected process and outcome goals.

COVERED BENEFITS

Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, states are required to offer the full scope of mandatory and optional Medicaid benefits to children. Given the comprehensiveness of Medicaid's benefits for children and the financial incentives inherent in managed care

to restrain the use of specialty or high-cost services, it is critical to ensure that plans and health professionals fully understand the benefits they are responsible to provide under Medicaid. The following recommendations are intended to help ensure that children enrolled in Medicaid receive all their entitled benefits:

1. The full scope of pediatric Medicaid benefits distinct from those for adults, including EPSDT, should be clearly specified in all managed care contracts. The EPSDT benefit should include developmental assessment, anticipatory guidance, vision and hearing testing, behavioral health assessment, and age-appropriate laboratory tests, as well as all diagnostic and treatment services that are medically necessary to follow-up on a condition identified during a screening visit.
2. The EPSDT expanded benefit policies in combination with other mandatory and optional benefits should cover, at a minimum, the benefits outlined in the AAP's policy statement "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years."[4]
3. The EPSDT periodicity schedule should be consistent with the AAP's periodicity schedule "Recommendations for Preventive Pediatric Health Care."[5]
4. The EPSDT services should be provided by a pediatric PCP who serves as the child's medical home.
5. State Medicaid agencies and the Health Care Financing Administration should closely monitor access, treatment, and provision of Medicaid benefits, especially expanded coverage of diagnostic and treatment services under EPSDT.
6. Pediatric medical necessity definitions, consistent with EPSDT policy, should be included in all Medicaid managed care contracts. When making any determination about the medical necessity of any item or service to be provided to a person 0 through 21 years of age, state Medicaid agencies and managed care plans should consider whether an item or service: 1) is appropriate for the age and health status of the person; 2) will prevent or ameliorate the effects of a condition, illness, injury, or disability; 3) will aid the overall physical and mental growth and development of the person; 4) will assist to achieve or maintain maximum functional capacity for performing daily activities; and 5) relies on medical practice guidelines that are endorsed or approved by appropriate medical professional societies or governmental public health agencies.[6]
7. States should inform families about Medicaid benefits not included in managed care plan contracts and how to access these carved-out services. Although these services may not be the responsibility of managed care plans, they are still entitlements of the Medicaid program.
8. States that have received or are considering section 1115[a] demonstration waivers should maintain all Medicaid benefits for children 0 through 21 years.

[a]Section 1115 of the Social Security Act allows states to waive compliance with any provision of Medicaid, in addition to other federal programs authorized by the Act, for any experimental, pilot, or demonstration project that would promote the objectives of the Medicaid program.

ACCESS TO PEDIATRIC SERVICES

Increasingly, Medicaid beneficiaries are required to enroll in capitated managed care plans, including children who are eligible under foster care and SSI categories. Ensuring a smooth transition into managed care is a major concern of the AAP, particularly in the light of stringent utilization review procedures.[b] The following recommendations are intended to encourage access to appropriate pediatric care:

1. To comply with the Omnibus Budget Reconciliation Act of 1989, all states must set reimbursement rates at a level "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[7] Strong evidence demonstrates that adequate reimbursement is a prerequisite for states to comply with federal law.
2. All forms of Medicaid reimbursement (eg, capitation, fee-for-service) should be structured to ensure that pediatric services and procedures are available to Medicaid beneficiaries at least to the extent that such services are available to the general population in the same geographic area.
3. Medicaid reimbursement, including capitation arrangements, must account for advances in pediatric care, such as, but not limited to, new vaccines and new technologies. Adjustments to capitation rates reflecting these medical advances should be included in all state managed care contracts.
4. Medicaid physician fees for pediatric care should be at least 90% of the usual, customary, or reasonable rates or equivalent to those in Medicare, whichever is higher.
5. The AAP supports the concept and use of the Medicare Resource-based Relative Value Scale (RBRVS) physician fee schedule as the basis for physician reimbursement. However, the AAP recognizes that the current and proposed methods of implementation still contain inequities as they pertain to pediatrics. A process to modify the Resource-based Relative Value Scale physician fee schedule for children should be initiated. In particular, a system for the ongoing evaluation of expenses for practice overhead, including expenses specific to pediatrics, must be implemented, and universal adoption of a single conversion factor by payers is mandatory.[8]
6. If state Medicaid agencies adopt a capitated system, that system should be adjusted for case-mix differences based on age, modifiers for children with special health care needs, outlier risk-adjusted methods, more rate cells/groups, a pediatric diagnostic classification system, or a combination of these. Because pediatric risk-adjustment techniques are not well-developed, contract provisions about carved-out services,

[b]Certain groups of children with special health care needs, however, are now exempt from mandatory enrollment if they reside in states that are not operating 1115 or 1915(b) waiver programs. These are children younger than 19 years who are eligible for SSI, children with special health care needs eligible for Maternal and Children Health (Title V) services, children who are eligible under the Katie Beckett option, and children receiving foster care otherwise in an out-of-home placement.

outlier payment, reinsurance or shared-risk arrangements for individual children and aggregate plan loss or profits should be included.
7. State Medicaid agencies should explore innovative methods to establish trust funds to support graduate medical education relevant to the provision of care for Medicaid participants and the assurance of a qualified pediatric workforce.
8. The choice of health care clinicians for children must include pediatricians, to the extent that they are available. Efforts should be made by state Medicaid agencies and managed care plans to maintain established relationships of children with their general and specialty pediatricians to avoid disruptions in the continuity of care.
9. The provider network of any managed care plan should include sufficient numbers of appropriately trained and board-eligible or board-certified providers of pediatric care, including primary, medical subspecialty, and surgical specialty pediatric care. These physicians should be accessible or available by referral from the PCP to provide medically necessary services without restraint from the managed care organization. In addition, pediatric providers of health-related services should include children's mental health services, social work services, developmental evaluation services, occupational therapy services, physical therapy services, speech therapy and language services, school-linked clinic services, and other public health services.

QUALITY IMPROVEMENT PLANS

State Medicaid agencies are required to have quality improvement plans for managed care organizations. Most of these requirements address preventive and primary care. Few focus on specialty care or children with special health care needs. The following recommendations are directed at ways to enhance the development and use of comprehensive pediatric quality care measures:

1. Quality improvement plans should include the following: pediatricians in its development, appropriate peer review with pediatric cases reviewed by pediatricians, provider credentialing, random reviews, medical record reviews, focused studies, pediatrician participation in quality improvement committees, and reporting and analysis of health outcome measures.
2. State Medicaid agencies, in consultation with representatives of their respective AAP chapter, should develop appropriate procedures to oversee and ensure the quality of preventive, primary, acute, and chronic care provided to all children served in state-approved managed care plans.
3. State Medicaid agencies should work with all plans and all forms of Medicaid funding to ensure uniform EPSDT and other pediatric service reporting that imposes a minimum paperwork burden on providers, as well as peer review of EPSDT services for utilization and quality by persons specifically trained and practicing in pediatrics. Educational and nonpunitive programs should be implemented to ensure effective and uniform EPSDT. Other pediatric service reporting and payment should be contingent on substantial compliance with graduated quality review processes to ensure completion of all categories of screening as required by the state's Medicaid plan.
4. Quality performance measures for all children should include compliance with the AAP's preventive care and immunization standards and other current pediatric AAP practice parameters.
5. Special performance measures for all children should be adopted, including measures related to risk assessment, early identification, provider capacity and organization (including the use of multidisciplinary teams), specialty referrals, service utilization, care coordination, family satisfaction, and health and functional outcomes.
6. States should incorporate Consumer Assessment of Health Plans survey questions, especially questions for parents of children with special health care needs.
7. States should monitor enrollment patterns and reasons for enrollment changes to ensure that managed care organizations do not encourage "high-cost" persons to switch to other plans or do not underserve Medicaid beneficiaries.
8. Plans should create incentives to promote the early identification of children with special health care needs to provide ongoing links between care coordinators and PCPs.
9. State Medicaid agencies should implement comprehensive administrative review processes to ensure that managed care organizations are prepared to serve children and reimburse providers before Medicaid managed care programs are implemented on annual contract renewals.

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