Medicaid Policy Statement

Committee on Child Health Financing

The American Academy of Pediatrics recognizes the achievements of the Medicaid program in improving access to health care services for poor children. Despite recent legislative expansions to extend eligibility to more poor and disabled children and to broaden the scope of preventive and treatment services in all states, several additional program improvements are needed to eliminate the following barriers to access:

1. Federal and state fiscal crises are creating major roadblocks to Medicaid program implementation and expansion.
2. Thousands of poor children will not be eligible for Medicaid until October 1, 2001.[1]
3. Only a portion of those who are potentially eligible for Medicaid apply for coverage, and many eligible children do not utilize services.
4. Fewer Medicaid funds are available for primary and preventive care because of the increasing need for long-term care services.
5. Early and periodic screening, diagnosis and treatment (EPSDT)/preventive health services are being received by too few children and the implementation of expanded service coverage under EPSDT, granted in 1989, is subject to a great deal of inconsistent state interpretation.
6. Inadequate provider reimbursement reduces children's access to health care services.

The Academy has developed the "Children First" proposal which calls for the elimination of Medicaid and replaces it with a one-class, private insurance system of universal access to health care for all children through age 21 and for all pregnant women.[2] However, until the "Children First" proposal, or a similar health care reform initiative is implemented, the Academy recommends the following policy actions to improve the current Medicaid program.

I. Eligibility

A. At a minimum all children through age 21 whose family incomes are at or below 185% of the federal poverty level (FPL) should immediately be eligible for Medicaid.

B. All children should be continuously enrolled for a minimum of 1 year regardless of changes in family structure, income, and resources or because of administrative sanctions, and should remain eligible for continuous enrollment for an additional 6 months after an increase in family income if it is less than 300% of the FPL.

C. Presumptive eligibility, currently available only to pregnant women, should be extended to all children so that immediate and temporary Medicaid coverage can be provided until a formal eligibility determination can be made.

D. States should be encouraged to extend coverage to uninsured children by using more generous income and resource methodologies to determine Medicaid eligibility for children allowed under section 1902 (r)(2) of the Medicaid statute.[3]

E. A "buy-in" program in which individuals can purchase health insurance premiums on an income-adjusted basis through Medicaid should be established for children living in families whose income is between current eligibility standards and 300% of the FPL.

II. Benefits

A. EPSDT-expanded benefit policies in combination with other mandatory and optional benefits should be consistent with the American Academy of Pediatrics' "Scope of Health Care Benefits for Infants, Children and Adolescents Through Age 21 Years"[4] in amount, duration, and scope. Federal and state efforts to assure consistency in the implementation of expanded coverage of diagnostic and treatment services under EPSDT should be strengthened,[5] particularly among managed care providers.

B. EPSDT services should be delivered by a continuing care provider, preferably a pediatrician, according to the American Academy of Pediatrics' "Recommendations for Preventive Pediatric Health Care."[6] If partial screens are performed, arrangements should be made for the patient to receive continuing care.

III. Financing

A. Entitlement funding should be continued.

B. Financing safeguards should be implemented to assure that funding levels are sufficient to meet children's health care needs under Medicaid. Serious consideration should be given to an alternative financing arrangement to avoid the financial pitfalls associated with Medicaid which relies so heavily on federal and state funding. This could include (1) creating a children's trust similar to the federal trust funds currently used to finance Medicare and Social Security, and (2) dedicating tax revenues as is done with the Presidential Election Campaign fund.

C. States should be given maximum flexibility to raise funds for their portion of the federal-state match.

IV. Administration

A. States should designate all hospitals, federally qualified health centers, public health clinics, Title V services, Head Start programs, WIC clinics, and, if feasible, other appropriate health care delivery sites as mandatory "outstationing" sites for processing Medicaid applications.

B. Enrollment in managed care arrangements should be carefully designed to assure access to physicians and other health care providers with expertise in delivering preventive, primary, and specialty services for infants, children, and adolescents.

C. Monitoring requirements should be strengthened to evaluate enrollment experience in managed care arrangements as well as access to appropriate pediatric specialists and treatment modalities.
D. Freedom of choice and other regulation waivers should be approved based on their potential to promote increased access and quality of care, and not be determined solely on the basis of their cost containment potential. In addition, in states where enrollment in managed care plans is mandatory, Medicaid beneficiaries should have the freedom to choose among two or more managed health care plans or between managed care plans and participating private and public providers. In areas where only one managed care plan is available, particularly rural areas, families should be able to choose their individual physicians.
E. Reporting burdens and claim form complexity should be minimized through the development of federal claims payment performance standards that promote prompt provider payment, uniform claims billing, and electronic on-line eligibility verification, as well as minimize retroactive claims denials.
F. Uniformly collected claims data, including age, diagnosis, eligibility category, and recipient identification number, should be encouraged.
G. Simplified enrollment procedures and forms, including the development of culturally appropriate materials, should be implemented to increase beneficiary participation.
H. The number of services requiring prior state approval should be minimized.
I. Enforceable federal sanctions should be imposed on those states found to be out of compliance with Medicaid guidelines set by the Omnibus Reconciliation Acts (OBRA) of 1989 and 1990.
J. Each state should develop a Children's Medicaid Action Plan that will define goals to be achieved and establish outcome objectives for access and health status. These plans should be developed in consultation with pediatricians and other primary health care providers, maternal and child health experts, and Medicaid beneficiaries.

V. Provider Reimbursement

A. 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.
B. Medicaid physician fees for pediatric care should be at least 90% of the usual, customary, or reasonable (UCR) rates or equivalent to those in Medicare, whichever is higher.
C. To alleviate the states' inappropriate use of the Medicare resource-based relative value scale (RBRVS) to pay for pediatric care, an RBRVS for children's services should be approved by the Health Care Financing Administration (HCFA) that takes into account the physical, developmental, and behavioral differences unique to children. It should be similar in scope and detail to the resource-based relative value scale developed for Medicare.

VI. Cost Containment and Quality Improvement

A. Cost containment is essential, but should not impede access or compromise the quality of care.
B. Quality assurance standards for children's services covered by Medicaid should be developed and monitored by pediatricians. In addition, qualification standards for nonphysicians who are Medicaid providers should be developed.
C. Preventive care for children through health supervision delivered by a continuing care provider, preferably a pediatrician, is the best approach to containing costs.
D. Utilization management programs should not impede access to health care and must include input from pediatricians.
E. The program should encourage delivery of services in the setting that provides quality care at the lowest cost, eg, treatment in the office as opposed to the emergency department.
F. State financial incentives should be structured to minimize fraud and abuse by providers and beneficiaries, and to recover funds from other liable third parties.

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3. Fox HB. *The Section 1902 (R) (2) Option to Provide Medicaid Eligibility to Additional Children and Pregnant Women*. Washington, DC: Fox Health Policy Consultants; July 1992
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