THE DEFICIT REDUCTION ACT OF 2005: AN OVERVIEW OF KEY MEDICAID PROVISIONS AND THEIR IMPLICATIONS FOR EARLY CHILDHOOD DEVELOPMENT SERVICES

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ABSTRACT: This report analyzes the provisions of the Deficit Reduction Act of 2005 (DRA) and assesses their implications for the provision of early childhood preventive and developmental services in Medicaid. The DRA may have significant effects, given the high proportion of young children enrolled in Medicaid—28 percent of all children under age 6 in 2001—and the broad range of services covered. The law imposes citizenship documentation requirements on applicants and recipients, including children. It gives states broad powers to restructure coverage through the use of a "benchmark" option but also retains Early and Periodic Screening, Diagnostic, and Treatment services as the coverage standard for children under age 19. The law gives states greater authority to impose cost-sharing for Medicaid-covered benefits and services. Finally, it redefines the federal role in financing targeted case management services, which have assumed a central role in child development programs for vulnerable children and families.

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EXECUTIVE SUMMARY

The Deficit Reduction Act of 2005 (DRA) grants states flexibility to modify their Medicaid programs in ways that could negatively affect children and families' access to care. On the other hand, some of the provisions allow states to expand eligibility and thus access to services. This report analyzes key provisions of the DRA, including the latest guidance from the Centers for Medicare and Medicaid Services (CMS), and discusses their implications for early childhood developmental services.

The core provisions of the DRA that could affect young children's health and development are related to eligibility, cost-sharing, premiums, the benefit package, and targeted case management (Table ES-1).

Table ES-1. Summary of Key Provisions Pre- and Post-DRA

Provision	Pre-DRA	Post-DRA
Eligibility: Citizenship Documentation Requirements	Oral affirmation of citizenship status was sufficient. Legal residents required to provide written proof of legal status.	U.S. citizens must show primary documents of citizenship.
Eligibility: Disabled Children with Low and Moderate Family Incomes	Coverage options for disabled children with low and moderate family incomes exceeding SSI eligibility thresholds included special rules for children in need of institutional care, medically needy coverage, and the use of general program flexibility to vary financial eligibility rules in order to recognize extraordinary costs of care for children with disabilities.	Optional eligibility for children with disabilities under age 19 who meet SSI program rules for severity of disability but do not meet income requirements.
Premiums	Except for very limited circumstances, states prohibited from charging premiums and enrollment fees.	States can impose premiums on non-exempt children and parents if their family income is above 150% of FPL.

Provision	**Pre-DRA**	**Post-DRA**
Cost-Sharing	Cost-sharing prohibited for children and, for parents, capped at $3 copayments for prescriptions.	Cost-sharing allowed for non-exempt persons with family income above 100% of FPL but at or below 150% of FPL. Cost-sharing may not exceed 10% of the cost of the service or item, and total cost-sharing (including prescription drugs and non-emergency use of emergency departments) may not exceed 5% of family income. Cost-sharing allowed for non-exempt persons with family income above 150% of FPL. Cost-sharing may not exceed 20% of the cost of the service or item, and the combined total cost of premiums and cost-sharing (including prescription drugs and non-emergent use of emergency departments) may not exceed 5% of family income.
Benefit Standards	States required to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21.	States have a benefit option that is tied to a "benchmark" or "benchmark-equivalent" plan in use in the state. Individuals under age 19 with mandatory coverage must receive the full EPSDT benefit. If the benchmark plan or benchmark-equivalent plan does not provide the full benefit, the state must provide wraparound benefits.

Provision	**Pre-DRA**	**Post-DRA**
Targeted Case Management	*Medical assistance case management.* Services assist eligible individuals in gaining access to needed medical, social, educational, and other services. All federal rules applicable to medical assistance access, coverage, claims, and payment apply. *Case management billed as an administrative service.* Federal guidelines recognize the following as costs directly related to state plan administration: EPSDT administrative services linked to outreach, scheduling, transportation, service coordination, and care arrangement; Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services and utilization review; and Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system). Separate federal financial participation rates and claims payment and billing procedures apply.	*Medical assistance case management.* Case management is more narrowly defined and the scope of permissible case management services in a medical assistance context may be limited. *Case management billed as an administrative service.* Certain case management functions will not be recognized with respect to certain individuals, such as foster care children. The availability of federal Medicaid matching funds in cases where "third-party liability" exists, i.e., if another entity has primary responsibility for payment, appears to be reduced.

Citizenship Documentation Requirements

Prior to DRA, U.S. citizens were not required to provide written proof of citizenship at the time of their application or eligibility review for Medicaid. Oral affirmation of citizenship status was sufficient. Legal residents were required to provide written proof of their residency status at the time of application. While DRA does not change documentation requirements for legal residents, it makes significant changes in these requirements for U.S. citizens.

- In general, eligible individual must show primary documents (i.e., a U.S. passport or certificate of naturalization or citizenship) or documents of citizenship (e.g., a birth record, American Indian card, health insurance record showing U.S. place of birth, census record, or written affidavit), plus documents of identity (e.g., driver's license, school identity card, or draft record).

- For children ages 16 and younger, other documents may suffice (e.g., a school identification card with a photograph, medical record with date of birth, or parental affidavit).
- Title IV Part E children (those in foster care) must have either: a declaration of citizenship; satisfactory immigration status and documentary evidence of the citizenship; or satisfactory immigration status claimed on the declaration.
- Supplementary Security Income (SSI) and Medicare enrollees who are also enrolled in Medicaid are exempted from the above requirements, as their enrollment in SSI and Medicare already require citizenship documentation. Enrollees in state programs that require citizenship documentation, including those receiving food stamps or child protective services, are also exempt.

Disabled Children with Low or Moderate Family Incomes

Prior to DRA, there were special rules for coverage of disabled children in families with low or moderate incomes that nonetheless exceeded SSI eligibility thresholds. The rules pertained to children in need of institutional care, medically needy coverage, and the use of general program flexibility to vary financial eligibility rules in order to recognize extraordinary costs of care. The DRA establishes a new eligibility category for such children.

- This new and explicit option is targeted to disabled children under age 19 with family incomes up to 300 percent of the federal poverty level (FPL). Federal financial participation phases in, beginning with children born on or after January 1, 2001.
- States may impose income-related premiums, capped at 5 percent of income for families below 200 percent of the FPL and 7.5 percent for families between 200 and 300 percent of the FPL. States have the right to terminate coverage for failure to pay premiums for more than 60 days and to waive premiums if they would create an "undue hardship."
- Children must enroll in employer-sponsored coverage for which they are eligible if the employer pays 50 percent of the premium. States must pay the remainder of the premium and treat employer coverage as third-party liability (TPL).

Premiums and Cost-Sharing

Prior to DRA, state Medicaid agencies were prohibited from charging premiums and enrollment fees, with very few exceptions. Cost-sharing was prohibited for children and limited to $3 copayments for prescription drugs for parents. Under the DRA, states may impose premiums, cost-sharing, or both. CMS guidance clarifies that the poorest children and parents (below 100% of the federal poverty level in the case of cost-sharing and below 150% of the poverty level in the case of premiums) should be exempt from these new options.

Premiums

- States can impose premiums on children and parents if their family income is above 150 percent of the FPL.
- Populations exempt from premium charges include: children under age 18 with mandatory coverage, Title IV Part B and E individuals (children in foster care or individuals to whom adoption or foster care assistance is made available), and pregnant women.
- Prepayment of premiums can be a requirement prior to Medicaid enrollment, and Medicaid coverage can be terminated (even for children) if premiums are not paid within 60 days of the due date. Payment can be waived if the state determines that it constitutes an "undue hardship."

Cost-Sharing

- Cost-sharing is allowed for non-exempt persons with family income above 100 percent of the FPL but at or below 150 percent of FPL. Cost-sharing may not exceed 10 percent of the cost of the service or item, and total cost-sharing, including prescription drugs and non-emergency use of emergency departments (EDs), may not exceed 5 percent of family income.
- Cost-sharing is allowed for non-exempt persons with family income above 150 percent of FPL, but may not exceed 20 percent of the cost of the service or item. The combined total costs of premiums and cost-sharing, including prescription drugs and non-emergency use of EDs, may not exceed 5 percent of family income.
- Services exempt from cost-sharing include: those provided to children under age 18 with mandatory coverage; services provided to Title IV Part B and E individuals; preventive services for all children under age 18, regardless of family income; services for pregnant women related to the pregnancy or to a medical

condition that could complicate the pregnancy; family planning services; and emergent use of the ED.

- States can decide to exempt other services from cost-sharing and premiums or to reduce the amount of cost-sharing.

Benefit Standards

Under Medicaid law, health benefits are either mandatory or optional, and states determine their amount, duration, and scope. Benefits must be reasonable, medically necessary, comparable among different "categorically needy" groups (i.e., groups eligible for the program based on federally defined categories), non-discriminatory in terms of the types of conditions covered, and available on a statewide basis. States are required to cover EPSDT services for individuals under age 21.

The DRA gives states a new benefit option tied to a "benchmark" or "benchmark-equivalent" plan in use in the state.

- Parents and children may be enrolled in "benchmark" or "benchmark-equivalent" plans, except for Title IV Part B and E individuals, those receiving Temporary Assistance for Needy Families (TANF), and those whose Medicaid eligibility is based upon a disability. States are permitted to automatically enroll all beneficiaries in benchmark coverage, as long as they are informed of their right to opt out of benchmark plans into traditional Medicaid coverage. States can do so even for beneficiaries who were originally exempt under the statute.
- Benchmark plans include: the Federal Employees Health Benefits Program (FEHBP) Blue Cross/Blue Shield preferred provider organization (PPO); a state's employee coverage plan; the health maintenance organization (HMO) with the largest number of non-Medicaid enrollees in a state; or any other plan approved by the secretary of the U.S. Department of Health and Human Services (HHS).
- Benchmark-equivalent plans (BEPs) must have the equivalent or higher of the aggregate actuarial value of one of the above plans. BEPs must cover: 1) inpatient and outpatient hospital services; 2) physician surgical and medical services; 3) laboratory and X-ray services; 4) well-baby and well-child care, including age-appropriate immunizations, and 5) other appropriate preventive services, as determined by the HHS secretary.
- If the benchmark plan offers the optional services of prescription coverage, mental health services, vision services, or hearing services, then for each category of service the BEP must offer at least 75 percent of the actuarial value of the coverage

offered in the benchmark plan. If the benchmark plan does not cover these optional services, the BEP is not required to cover them, though states may choose to do so.

- Individuals under age 19 with mandatory coverage must receive the full EPSDT benefit. If the benchmark plan or BEP does not provide the full benefit, the state must provide wraparound benefits.
- States have great flexibility in deciding whom to enroll in each plan. They can have multiple plans in a state, and their plans can vary by region within the state.
- States cannot use the benchmark option to expand coverage. It can be applied only to groups that were eligible for coverage prior to DRA enactment.

Targeted Case Management

EPSDT covers medical case management, including targeted case management (e.g., for people with HIV/AIDS or children with special needs) as well as administrative case management. The DRA makes several changes to the definition of targeted case management and the availability of federal funding for such services. While CMS has provided some guidance about these provisions, the modifications are confusing and require further clarification.

- The scope of permissible targeted case management services in a medical assistance context may be limited.
- Case management will and will not be recognized with respect to certain individuals. (For example, certain case management functions are no longer recognized for children in foster care.)
- The availability of federal financial participation in cases where third-party liability exists, i.e., when another entity has primary responsibility for payment, appears reduced.

IMPLICATIONS AND CONCLUSION

The DRA makes a number of significant changes in federal Medicaid policy. Some provisions only codify and formalize ongoing practice—a step that, while perhaps not significant in and of itself, nonetheless demands that we closely monitor how states go about implementing these choices that are now recognized in federal law. Some of the changes could negatively affect children and families' access to care, while others enable states to expand access to services. As the provisions of the DRA are implemented, it will be important to focus on how they affect the quality and availability of developmental services for young children and families. The following policy issues deserve particular attention:

- Safeguarding children's eligibility for coverage during and after the transition to Medicaid's new citizenship verification requirements.
- Configuring Medicaid coverage for children in states that opt to create benchmark plans so that the EPSDT guarantee, including access to developmental services, is preserved.
- Applying new cost-sharing flexibility to ensure that the exemption applicable to preventive services includes developmental services.
- Interpreting and applying the case management amendments through the development of a list of case management activities permitted and excluded by the legislation, to ensure that child welfare claims against Medicaid adhere to the new standards.

The DRA adds a new layer of complexity to state Medicaid program design, and there are many areas of uncertainty about its potential impacts. Federal guidance issued to date has helped to clarify some issues, but many require further clarification. Unresolved questions—such as the ambiguity in targeted case management provisions—will be answered by states as they implement the new provisions and decide how to modify and adjust their programs.

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INTRODUCTION

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law.[1] The most significant set of changes to Medicaid's coverage structure since its 1965 enactment, the DRA redefines the minimum coverage rules that state programs must satisfy in order to qualify for federal payments. Most Medicaid beneficiaries, and in particular low-income families and children, could be affected by these changes, depending on how states respond to this new flexibility. In addition, the legislation gives states the ability to increase the share of the costs of covered services borne by beneficiaries, significantly alters the conditions under which federal funding is available for targeted case management services, and imposes new citizenship verification requirements on applicants.

States are now able to revise the structure of "medical assistance," the legal term of art that defines the covered benefits and services to which Medicaid beneficiaries are entitled. States that opt to use this new flexibility must adhere to certain minimum standards, including continuation of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services as the standard of coverage for "categorically needy" Medicaid-enrolled children under age 19 (i.e., those eligible for the program based on federally defined categories). At the same time, the flexibility created by the law marks a new chapter in the life of Medicaid, permitting states to begin to align coverage principles for certain beneficiaries with the concept of "premium support," which has been a dominant feature of national health policy reform proposals since the early 1990s.

In this report, we provide a brief overview of Medicaid coverage principles prior to enactment of the DRA. We then describe the policy landscape surrounding the legislation's passage—an important consideration given the act's relatively limited legislative history—and the speed with which passage occurred, as well as a number of ambiguities that appear in the legislative text. We then summarize the key elements of the legislation, including changes in eligibility, medical assistance coverage, premiums and cost-sharing, and federal financial support for targeted case management. We conclude with a discussion of the implications of DRA for the provision of early childhood development services to Medicaid beneficiaries, identifying issues that will be important to follow during what is expected to be a fairly lengthy period of legislative implementation.

Like most health insurance legislation, the text of the DRA is dense and includes a number of ambiguities that cannot be clarified by the law's legislative history. In some cases, these ambiguities appear to be the result of a deliberate choice on the part of Congress to move the program in certain directions, while giving the secretary of the Department of Health and Human Services (HHS) considerable latitude to interpret and implement the law. In other cases, the ambiguities appear to be products of the vagaries of legislative drafting—a common occurrence when legislative activity occurs within a compressed time frame. The task of clarifying the DRA is expected to continue for some time; as a result, the analysis offered in this report should be considered preliminary.

OVERVIEW OF PRE-DRA MEDICAID STANDARDS

In order to understand the reforms, it is important to review Medicaid policy before the passage of DRA in the areas of eligibility, benefits and coverage, premiums and cost-sharing, and case management.

Eligibility

Medicaid eligibility depends on a complex combination of factors related to financial status, categories describing certain defined populations (e.g., children, parents and caretaker relatives, pregnant women, elderly persons, and persons with disabilities), state residence, U.S. citizenship or legal status, and other matters.[2] Some populations are considered "categorically needy" because they fall into certain classification categories and meet certain financial rules described in the statute. Categorically needy persons can be both mandatory and optional. For example, children under age 6 with family incomes at or below 133 percent of the federal poverty level (FPL) are classified as mandatory categorically needy, while children with countable family incomes above this standard are considered optional categorically needy. Ninety-four percent of all Medicaid children fall into a categorically needy eligibility grouping.[3]

Proof of Citizenship

Medicaid law requires individuals to be U.S. citizens or have legal residency status of a minimum duration to be eligible for all but emergency care.[4] Prior to the DRA, individuals were required to provide an oral affirmation of citizenship on behalf of themselves and their children at the time of application or re-determination of program eligibility. Legal residents were required to submit written proof of legal status.[5]

Disabled Children in Families with Low to Moderate Incomes

Medicaid law mandates coverage of all disabled children who receive Supplemental Security Income (SSI). In addition, with the exception of states that use eligibility standards for disabled children and adults that differ from those for SSI, and states that use separate enrollment procedures to determine eligibility based on disability and income, Medicaid coverage is automatically conferred on any child found to be eligible for SSI by the Social Security Administration.

Federal law accorded states several options for children with disabilities whose family incomes and assets exceeded levels permitted under a state Medicaid plan. These included coverage for such children as medically needy "spend-down" beneficiaries, coverage of certain institutionalized children as well as children at risk of institutionalization, and financial flexibility to adjust family income in the case of children with disabilities whose families incur high medical costs.[6]

Benefits and Coverage Rules

Prior to the DRA, a detailed series of standards governed Medicaid coverage principles. These standards defined the classes of benefits and services that either must or could be covered, as well as the amount, duration, and scope of coverage within each benefit and service class. Some of these rules applied to categorically needy as well as medically needy beneficiaries, while others applied only to categorically needy persons.[7]

Benefit Classes. In the case of categorically needy persons, Medicaid covers a set of required and optional benefit and service classes (Figure 1). These classifications have been expanded many times over Medicaid's 40-year existence and result in a coverage structure that can best be described as a "defined benefit" entitlement. That is, enrollees are entitled to coverage for certain classes of benefits that are defined with relative precision (e.g., inpatient hospital care, family planning services and supplies, outpatient hospital care, federally qualified health center services, and other services).

Figure 1. Medicaid Benefits

"Mandatory" Benefits	**"Optional" Benefits**
• Physician services • Hospital services • Rural and federally-qualified health center services • Family planning • Certified pediatric and family nurse practitioners • Nurse mid-wives • Laboratory and x-ray services • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21 • Pregnancy-related services • Medical and surgical services by a dentist • Nursing facility services for individuals age 21 or older	• Prescription drugs • Home health care • PT/ST/OT • Dental services & dentures • Optometrist & eyeglasses • Other prosthetic devices • Mental health services • Intermediate care facility for mental retardation • Nursing facility for individuals under age 21 • Private duty nursing • Personal care services • Case management, including targeted case management and primary care case management • Hospice care • Medical transportation

Source: CMS, Medicaid at a glance: 2005.

Amount, Duration, and Scope of Coverage. The "amount, duration, and scope" principles that govern Medicaid date back to the program's 1965 enactment. These principles were designed to ensure that coverage would be reasonable and adequate, comparable among sub-populations, non-discriminatory in terms of the types of conditions covered, and available on a statewide basis.[8]

The extensive classes of covered benefits and the amount, duration, and scope rules, along with rules that permit enrollment during times of great medical need, set the program apart from commercial insurance.[9] The commercial insurance market is governed by principles aimed at avoiding risk (for example, limiting enrollment to certain time periods in order to avoid entry "at the point of service") as well as concepts of "moral hazard" and "fair discrimination" that result in benefit designs that exclude many chronic and high-cost conditions. Commercial insurers vary coverage by condition and population sub-group in order to reflect perceived differences in actuarial risk and anticipated rates of health care utilization.[10] Because Medicaid rests on principles of social insurance rather than actuarial risk, the program is structured as a financing entitlement rather than a risk insurer. Indeed, the hallmark of Medicaid is coverage of populations, services, and benefits that lie well outside actuarial coverage norms.[11]

Medicaid's amount, duration, and scope rules reflect this tradition. Before the passage of the DRA, Medicaid coverage of categorically needy persons was governed by concepts of statewide availability of coverage, comparability, reasonableness, non-discrimination, and medical necessity. These concepts have been extensively interpreted over the years in federal regulations and judicial policy. The concepts can be summarized as follows:

- *Statewide availability of coverage:* Medical assistance had to be available on a statewide basis; that is, medical assistance could not be in effect in one part of the state and not in another.[12]
- *Comparability:* Medical assistance had to be comparable in "amount, duration, and scope" among categorically needy groups.[13] Under this rule, states could not vary the range of benefits for sub-groups of categorically needy persons. For example, a state could not provide psychiatric coverage only to disabled adult enrollees and not to children. Of course, because Medicaid, like health insurance, covers only medically necessary care, an adult with a serious mental disability would make extensive use of his or her psychiatric coverage, while a child might use few or no mental health services in any year.
- *Reasonableness:* Coverage levels for any benefit or service—required or optional—had to be reasonable.[14] This reasonableness test has been subject to longstanding federal agency interpretation requiring that coverage be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[15] In applying this rule to specific cases, judicial policy further refined the standard. For example, one court held that a state cannot limit physician visits to three visits per month unless it also provided an emergency exception.[16]
- *Non-Discrimination:* States could not "arbitrarily discriminate" on the basis of a patient's condition in the provision of required benefits and were instead limited to reasonable standards linked to medical necessity.[17] By contrast, condition-based discrimination is common in commercial insurance, which frequently varies coverage levels based on specific diagnoses. Examples of this type of condition-based coverage distinction within the private health insurance market can be found in the areas of mental illness, HIV/AIDS, and rehabilitative therapies for children with developmental disabilities and adults with chronic and degenerative diseases who are judged to be incapable of making a recovery, even if treatment prevents further deterioration or maintains or improves functioning.[18]
- *Medical necessity:* States were required to ensure that across-the-board coverage limits, as well as decision-making standards in individual cases, were governed

> by concepts of medical necessity. While the definition of medical necessity was left to states, it was understood that, as with other coverage rules, it would have to be consistent with the purpose of the benefit, reasonable, comparable, and non-discriminatory.[19]

EPSDT and Standards of Reasonableness. Since 1967, states have been required to furnish Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for beneficiaries under age 21.[20] With this federal mandate, Congress moved beyond the already-strong Medicaid coverage standards for adults to ensure broader and deeper coverage for children and adolescents, guided by principles of prevention, growth, and development.[21]

EPSDT grew out of a strong evidentiary base: evaluations of the health status of young children enrolled in early Head Start demonstrations, which found that providing education and health services to preschool children from disadvantaged backgrounds helped them achieve better outcomes later in life, and a pre-Medicaid study of rejection rates of young military draftees, many of whom were found to suffer from chronic conditions and disabilities that might have been prevented or ameliorated in early childhood.[22] Since its inception, EPSDT has provided comprehensive health exams aimed at identifying physical or mental health conditions; vision, dental, and hearing care; and treatment needed to correct or ameliorate physical and mental health conditions. In 1989, the treatment rules were amended to require coverage of all medically necessary treatments that fall within any covered service or benefit class, even if the service class is optional for persons ages 21 and older (e.g., speech and physical therapy, medical equipment) (Figure 2).[23]

Figure 2. Core EPSDT Elements

Benefits and Services

- Periodic and "as needed" screening services
- Vision, hearing, and dental care
- All medically necessary "medical assistance," diagnosis and treatment needed to "ameliorate" conditions, including covered treatments identified in IEPs and IFSPs under the IDEA and child welfare case plans
- A "preventive" standard of medical necessity

Administrative Services

- Informing families
- Transportation, scheduling and other assistance
- Linkages to other agencies (special education, Title V, WIC, child welfare, other agencies)
- Reporting

Because federal EPSDT guidelines and extensive judicial rulings have concluded that EPSDT's fundamental purpose is to provide preventive health services and services to promote healthy growth development, the program is governed by a medical necessity test that, unlike that for adults, requires coverage of preventive and developmental treatments—not just treatments that restore "normal" functioning following illness or injury.[24]

Premiums and Cost-Sharing. Pre-DRA, states had little flexibility in regard to premium and cost-sharing. The federal law prohibited any form of cost-sharing for children under 18, family planning services and supplies, pregnant women, institutional residents, and hospice recipients.[25] For adults, only nominal cost-sharing (under $5 for most services) was permissible, although copayments of twice the nominal amount were allowed in certain efforts to curb unnecessary hospital outpatient department service utilization. Medicaid law pre-DRA permitted the use of premiums and enrollment fees under very limited circumstances.[26]

Targeted Case Management. Since 1986, federal Medicaid law has recognized case management services as an administrative activity aimed at managing service utilization, as well as a form of medical assistance. The statute defines medical assistance case management as services that "assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."[27] Many public programs for children and adults with special needs, including child welfare programs, school health clinical programs, special education programs, and programs administered by Title V agencies, provide case management services. Typically, those public health clinics and agencies and private institutions and health professionals that participate in both Medicaid and these special needs programs bill Medicaid for provision of case management services. Case management is also a basic service offered by the nation's health centers, in which 40 percent of the patients are children. The health clinics' participation in Medicaid is required in order to conserve federal grant funds to subsidize care for uninsured persons.

THE POLICY LANDSCAPE FOR MEDICAID REFORM

The reforms included in the DRA grew out of policy debates over the costs and structure of Medicaid. For many years, state officials have raised concerns about Medicaid's broad coverage standards. Their concerns related not only to the classes of required benefits but also to the program's amount, duration, and scope standards and tests of reasonableness. Beginning in 1993 with the Clinton Administration's approval of Oregon's health care rationing demonstration program under Section 1115 of the Social Security Act (also known as a Section 1115 waiver program), the Health and Human Services Department began to permit changes in Medicaid's coverage standards for both demonstration and traditional beneficiary populations.[28] Such changes have been particularly notable in the case of demonstration populations—typically, low-income women and children and low-income uninsured adults—whose coverage increasingly reflects private insurance norms rather than the rules that historically governed Medicaid.[29] As states' use of Medicaid managed care arrangements grew throughout the 1990s, the pressure to move toward coverage standards similar to those in commercial insurance also grew—particularly because states remained legally obligated to adhere to Medicaid coverage standards and principles, even if their contracts with managed care entities were limited to the scope of benefits found in a commercial insurance policy.[30]

The State Children's Health Insurance Program (SCHIP), enacted in 1997, was the first federal legislative attempt to more closely align public health insurance coverage standards for low-income children with private health insurance principles. SCHIP is not a legal entitlement for children, and coverage rules are expressed as an insurance premium "benchmark" bounded by actuarial value rather than defined benefits. Although SCHIP permits coverage of nearly as broad a range of services and benefits as those found in Medicaid, its minimum coverage requirements are quite limited; coverage standards are expressed as broad categories rather than defined benefits. Furthermore, coverage adequacy is tied to the value of a premium rather than to specific coverage rules. In this regard, SCHIP moved public financing for low-income families closer to the concept of "premium support," under which a group health insurance sponsor offers competing insurers a defined contribution toward the cost of enrollee coverage, with covered benefits and covered services broadly defined.[31]

The concept of premium support was first outlined by Alain Enthoven and has been prominent in federal health policy since the early 1990s.[32] The theory is that the use of a defined contribution approach to health care costs, coupled with broadly delegated powers to insurers to hold down costs, will foster competition among insurers while holding down spending. Although the notion of a fixed contribution tends to receive more attention than the delegation of benefit design powers, premium support in fact turns on both principles. Sponsors broadly outline coverage and give insurers considerable leeway to "fill in" the specifics of benefit design. As a result, insurers can potentially slow the growth of sponsors' premium costs, not only by introducing purchasing efficiencies but also by shrinking what types of services they will cover in the event that funding from the sponsor falls short.

In this respect, the SCHIP statute is similar to premium support: the law requires states administering SCHIP programs separate from Medicaid to offer coverage possessing a minimum actuarial value. Very few classes of services are enumerated in the statute, and the legislation eliminates the underlying tests of coverage reasonableness and non-discrimination that are the hallmark of Medicaid coverage requirements. For example, SCHIP requires coverage of "well-baby" care, not detailed screening requirements. SCHIP requires "physician" services and "hospital" services, but does not specify minimum standards for how much care is to be provided or medical necessity standards by which the adequacy of care is to be measured. Because SCHIP does not include an EPSDT coverage mandate, the statute eliminates EPSDT's rules of coverage and medical necessity requirements. Although some states with separately administered SCHIP programs have elected to maintain an EPSDT coverage standard, many have not. Research indicates that numerous state SCHIP plans offer a narrower benefit range and use a narrower definition of medical necessity than Medicaid.[33]

By 2005, there was growing state demand for expanded Medicaid coverage flexibility and higher cost-sharing responsibilities for beneficiaries. State demands grew from the rising costs of Medicaid, yet 30 percent of Medicaid expenditures are attributable to optional, rather than required, benefits, and the top 10 percent of Medicaid beneficiaries—high-cost patients with serious disabilities or in poor health—account for 72 percent of all Medicaid expenditures.[34] Thus, greater flexibility and cost-sharing might not address the source of high costs.

The states' interest in flexible benefit designs and higher cost-sharing coincided with a broader interest on the part of the Administration and congressional leadership in reducing the extent of public and private insurance coverage by limiting benefits and increasing direct patient responsibility for financing health care. This interest can be seen in the Administration's fiscal year 2007 budget proposal to expand the use of health savings accounts coupled with high-deductible health plans.[35] Indeed, the Medicare Part D prescription drug program entitles Medicare beneficiaries to premium subsidies rather than a defined set of pharmaceutical benefits, with control over the details of coverage design delegated to Part D plans operating under broad standards.

Like the DRA's cost-sharing and benefit design reforms, the citizenship and targeted case management provisions also reflect broader policy contexts. Some policymakers in the 109th Congress have focused on curbing use of Medicaid and other public services by individuals who are not U.S. citizens. And a series of recent investigations by Congress and the Clinton and Bush Administrations suggested that there were several problems with Medicaid's provision of case management services. These include: 1) the use of Medicaid case management funds to pay for public activities falling outside of the service definition for case management; 2) the use of Medicaid funds to pay for case management services furnished to ineligible children and adults; and 3) failure on the part of a number of public agencies to adhere to Medicaid claims payment and administrative cost rules and documentation requirements.[36]

In addition, the DRA's coverage expansion option for disabled children from low- and moderate-income families, known as the Family Opportunity Act, was the result of ongoing concerns on the part of a number of lawmakers over the serious health care barriers faced by low- and moderate-income families whose children experienced high health care costs.

KEY PROVISIONS OF THE DRA RELATING TO CHILD DEVELOPMENT

Tables 1 through 7 set forth the key elements of the DRA relating to changes in Medicaid eligibility, benefits, premiums and cost-sharing, and targeted case management. Figure 3 summarizes the cost estimates prepared by the Congressional Budget Office (CBO) for each set of reforms. Overall, CBO projects that the reductions in Medicaid spending will yield $4.8 billion in net savings over 2006–2010.[37]

Figure 3. Net Costs and Savings from Medicaid Changes in 2005 DRA (in millions)

Net Savings and Costs in Millions (total savings of $4.8 billion over five years)	**2006**	**2006–2010**
Savings		
• Evidence of citizenship	–5	–220
• Alternative benefit packages	–30	–1,250
• Increase premiums and cost-sharing	–10	–960
• Additional cost-sharing for drugs	–20	–960
• Targeted case management	–30	–760
Costs		
• Coverage of certain disabled children	0	1,380
• Health opportunity accounts	0	56
• Cost-sharing non-emergency care provisions	5	10

Source: CBO, Cost Estimate S. 1932 Deficit Reduction Act of 2005, January 27, 2005.

Documentation of Citizenship

The DRA modifies current law by requiring individuals seeking Medicaid coverage to furnish written documentation of citizenship. This modification is expected to have a significant effect on enrollment of adults and children because of the practical and financial difficulties families might face in obtaining necessary documentation. Although this provision received relatively little attention during the DRA debate itself, it has received significant scrutiny since then. Numerous states have indicated that they are not in a position to implement the statute, owing to the administrative burden; litigation has been filed to prevent its implementation; and studies have suggested that implementation will create widespread barriers to care and delays.[38]

Interim final regulations issued on July 12, 2006, exempt two groups from the new citizenship documentation requirements: dual Medicare and Medicaid enrollees, including a small number of children with end-stage renal disease, and SSI recipients, including approximately 1 million children.[39] These exemptions are based on the fact that citizenship for both groups is confirmed by the Social Security Administration. All other Medicaid applicants and recipients are covered by the requirements, which set forth the types of documents needed as well as general standards regarding the time frames in which applicants and recipients must produce them.[40]

Analyses of the potential effects of the citizenship regulations suggest that children may bear the heaviest burden, representing three-quarters of the estimated 2 million citizens who may lose coverage because of their inability to produce documentation.[41] Families may have problems providing citizenship and identity verification documentation for their children, particularly in states that do not institute automatic data matching between the vital records system and Medicaid enrollment process. Children covered through "presumptive eligibility" will be exempt from the documentation requirements, but their families will have to comply with them for them to receive permanent coverage.[42] Children whose Medicaid eligibility is linked to entry into foster care—even on an emergency basis—do not appear to be exempt from the requirements.[43]

In addition, there are concerns that the documentation rules might negatively affect safety net providers such as health centers, children's hospitals, public hospitals, health departments, and pediatric practices that serve large Medicaid populations. If many of their patients lose coverage, these providers might experience revenue declines large enough to affect their ability to provide services in general. The loss of coverage also might impinge on health care providers' ability to arrange for specialty care and other services that require referrals.

Table 1. Eligibility: Documentation of Citizenship
(effective July 1, 2006)

	Pre-DRA	**Deficit Reduction Act**
U.S. Citizens	No written proof of citizenship at time of application; oral affirmation of citizenship status sufficient	Written proof of citizenship at application or eligibility re-determination: 1. U.S. passport, certificate of naturalization, certificate of U.S. citizenship, valid driver's license, or other identification document deemed valid; or 2. birth certificate or other identification document deemed appropriate Certain groups exempt (SSI recipients, dual enrollees) as a result of alternative verification pathways through the Social Security Administration
Legal Residents	Written proof of legal status for legal residents at time of application	No change

Source: Authors' analysis of Deficit Reduction Act of 2005, February 2006.

Coverage of Disabled Children in Families with Low to Moderate Incomes

Effective January 1, 2007, under the Family Opportunity Act (part of the DRA), states will have an explicit option to extend Medicaid coverage under certain circumstances to disabled children under age 19 in low- to moderate-income families (Table 2).[44] This eligibility is for children with disabilities who meet SSI program rules for severity of disability but do not meet that program's income requirements.

Table 2. Family Opportunity Act:
Eligibility Expansion Options for Children with Disabilities
(effective July 1, 2007)

	Pre-DRA	**Deficit Reduction Act**
Disabled Children with Low and Moderate Family Incomes	Coverage options for disabled children in families with low and moderate incomes that exceed SSI eligibility thresholds included: special rules for children in need of institutional care, medically needy coverage, and the use of general program flexibility to vary financial eligibility rules in order to recognize extraordinary costs of care for children with disabilities.	New and explicit option for disabled children with family incomes up to 300% of the federal poverty level (FPL), with federal financial participation phased in by age: • *Age:* For children under age 19, states have option to phase in coverage beginning with children born on or after January 1, 2001. • *Family income:* Up to 300% FPL • *Income-related premiums:* States have options to charge premiums, capped at 5% for families with incomes <200% FPL and 7.5% for families with incomes at 200%–300% FPL. States have right to terminate coverage for failure to pay after 60 days and waive payment if it would create "undue hardship." • *Employer-sponsored coverage:* Families must enroll if eligible and 50% of premiums are paid by employer. States must pay remainder of premium and treat employer coverage as third-party liability.

Source: Authors' analysis of Deficit Reduction Act of 2005, February 2006.

"Benchmark" Coverage

Section 6044 of the DRA adds a new Section 1937 to Medicaid law, permitting states to revise and restructure the medical assistance as "benchmark" coverage as a state plan option without special waivers. This section is complex and applies only to certain population groups, including all categorically needy children. States that choose this option must meet certain minimum coverage standards, including the provision of EPSDT benefits. Section 1937 became effective March 31, 2006.

Section 1937(a) sets forth the state option as follows:

> Sec. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—
>
> (1) AUTHORITY.—
>
> (A) IN GENERAL.—*Notwithstanding any other provision of this title* [emphasis added], a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals specified by the State through enrollment in coverage that provides—
>
> (i) benchmark coverage . . . or benchmark equivalent coverage . . .; and
>
> (ii) for any child under 19 years of age who is covered under the State plan . . ., wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r)[45]

The language of the amendment is not clear—the use of the term "may provide" leaves open the possibility that the terms of benchmark coverage are themselves optional, and the sweeping introductory language, "Notwithstanding any other provision of this title," raises many questions about the amendment's full impact. But the legislative history, the CBO cost estimates, a letter to members of Congress from CMS Administrator Mark McClellan, and a Congressional Record Statement from Congressman Joe Barton, chair of the House Commerce Committee, all suggest that there are important limitations on states' flexibility where application of the benchmark standard to children is concerned.

As with SCHIP coverage, the benchmark standard is expressed in terms of commercial insurance norms and actuarial equivalence. The language of equivalence resembles SCHIP, permitting states to fashion their "benchmark benefit packages" in relation to the Federal Employees Health Benefits Program (FEHBP), state employee coverage, coverage offered by the health maintenance organization (HMO) with the largest number of non-Medicaid enrollees in a state, or any other benchmark approved by the HHS secretary. A state also may offer "benchmark-equivalent" coverage, or coverage that includes certain basic services as well as "substantial actuarial value" for certain additional services offered at state option.

Although a state can choose a to model their plans on one of the benchmark plans, as a practical matter, benchmark equivalency operates as the minimum standard of coverage. The minimum services for benchmark equivalency, as well as the additional services for which substantial actuarial value must be shown through a formal actuarial determination, are shown in Figure 4.

Figure 4. Benchmarks and Benchmark Equivalency

Benchmarks

- Federal Employees Health Benefits Program
- State employee plan
- Largest-selling federally qualified HMO

Benchmark Equivalency

Required (full actuarial value)

- Inpatient and outpatient hospital services
- Physician surgical and medical services
- Laboratory and X-ray services
- Well-baby and well-child care, including age-appropriate immunizations
- Other appropriate preventive services, as designated by the secretary

Optional (75% of actuarial value)

- Prescription drugs
- Mental health services
- Vision services
- Hearing services

Table 3 illustrates important differences between EPSDT benefits and benchmark-equivalent coverage in terms of preventive, diagnostic, and treatment services as well as the standard that governs the amount, duration, and scope of services.

Table 3. A Comparison of EPSDT and Benchmark Benefits

EPSDT	Benchmark-Equivalent Coverage
Screening services (periodic and as needed) • Unclothed physical examination • Comprehensive health and developmental history (including assessment of both physical and mental health development) • Immunizations recommended by the Centers for Disease Control and Prevention advisory committee on immunization practices • Laboratory tests including assessment of blood lead levels • Health education and anticipatory guidance	**Well-baby and well-child care, including age-appropriate immunizations** • Required at full actuarial equivalence • Undefined in content • Undefined in frequency
Vision services (periodic and as needed) • Assessment • Diagnosis • Treatment, including eyeglasses	**Vision services** • Not required • Undefined in content • If furnished, 75% of actuarial value
Hearing services (periodic and as needed) • Assessment • Diagnosis • Treatment, including hearing aids and speech therapy	**Hearing Services** • Not required • Undefined in content • If furnished, 75% of actuarial value
Dental services (periodic and as needed) • Preventive beginning no later than age 3 or earlier if medically indicated • Restorative beginning no later than age 3 or earlier if medically indicated • Emergency care beginning no later than age 3 or earlier if medically indicated	**Other appropriate preventive services as designated by HHS** • Required, but only at the HHS secretary's discretion • Undefined in frequency or content • If required by secretary, full actuarial value

EPSDT	Benchmark-Equivalent Coverage
Diagnostic and treatment services that are medically necessary and the need for which is disclosed by a periodic or interperiodic screen *Standard of coverage: early, to correct or ameliorate defects and physical and mental health conditions discovered by screening services, whether or not such services are covered under the state medical assistance plan. These services include:* • Physician services • Hospital Services (outpatient and inpatient) • Federally qualified health center services • Rural health clinic services • Family planning services and supplies • Medical care or any other type of remedial care recognized under state law or furnished by licensed practitioners within the scope of their practice, as defined by state law • Home-based care • Private duty nursing services • Dental services • Clinic services • Physical therapy and related services • Prescribed drugs • Dentures • Prosthetic devices • Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21 • Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law • Case management • Respiratory care • Personal care services • Any other medical or remedial care recognized by the secretary of Health and Human Services	**Hospital, physician, and laboratory services** • Required • Undefined in frequency and standard of coverage • Full actuarial value **Prescription drugs** • Optional • Undefined • 75% actuarial value **Laboratory and X-ray services** • Required • Undefined • Full actuarial value **Mental health services** • Optional • Undefined • 75% actuarial value

Source: Authors' analysis, 2005.

Table 4 assesses EPSDT in relation to a standard PPO in the FEHBP to further demonstrate differences between EPSDT and the coverage provided under what a state might choose as a benchmark plan.

Table 4. A Comparison of EPSDT and the FEHBP Standard PPO

Benefit	EPSDT	FEHBP Standard PPO (Blue Cross/Blue Shield Plan)
Comprehensive assessment of physical and mental growth and development (developmental assessments)	Covered	Limited to "healthy newborn visits," "routine screening," "routine physical examinations," "neurological testing," and initial examination of a newborn needing "definitive treatment," when the infant is covered under a family enrollment.
Anticipatory guidance	Covered	Silent (Not covered)
Physical, speech, and related therapies	Covered without limitations other than medical necessity; no requirements for therapy to be for purposes of recovery from developmental delay or incident; therapy covered for conditions identified through early intervention and child care programs.	Limited to inpatient coverage. "Maintenance therapy" expressly excluded. Also excluded are "recreational and educational" therapy and "any related diagnostic testing except as provided by a hospital as part of a covered inpatient basis." All services billed by schools or a member of school staffs are excluded.
Hearing services	Covered without limitations, including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development.	Testing covered only when "related to illness or injury." Routine hearing tests excluded other than as standard part of "routine" screening for children; hearing aids excluded along with testing and examinations for the prescribing or fitting of hearing aids.
Eye examinations and eyeglasses	Covered without limitations, as medically necessary.	One pair of eyeglass replacement lenses or contact lenses to "correct an impairment directly caused by a single instance of accidental ocular injury or intraocular injury;" eye examinations for specific medical conditions; nonsurgical treatment for amblyopia and strabismus from birth through age 12. Eyeglasses and routine eye examinations specifically excluded, as are eye exercises, visual training, and orthoptics except in connection with the specific diagnosis of amblyopia or strabismus.

Benefit	**EPSDT**	**FEHBP Standard PPO (Blue Cross/Blue Shield Plan)**
Durable medical equipment (DME)	Covered without limitations, as medically necessary.	Certain DME covered but only if prescribed for the treatment of "illness or injury."
Home nursing	Covered without limitations, as medically necessary; home visits can cover health educators, therapists, health aides, and others.	Covered for 2 hours per day, 25 visits per year, when furnished by a nurse or licensed practical nurse and under a physician's orders.
Other medically necessary care	Covered (and covered in greater amount, duration, and scope) if recognized under §1905a of the Social Security Act	No supplemental coverage
Medical necessity standard	Early care to correct or ameliorate conditions	Blue Cross/Blue Shield determines "whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are: 1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury; 2. Consistent with standards of good medical practice in the United States; 3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider; 4. Not part of or associated with scholastic education or vocational training of the patient; and 5. In the case of inpatient care, cannot be provided safely on an outpatient basis. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan."

Sources: S. 1905(r) of the Social Security Act, 42 U.S.C. 1396d(r); Part 5, Section 5122 of the State Medicaid Manual; OPM, FEHBP Blue Cross and Blue Shield Service Benefit Plan, 2005. Comparisons by authors.

Another way of thinking about differences between EPSDT and the benchmark standard is to examine both in relation to enrollment in a managed care arrangement (Table 5). Most state Medicaid programs use managed care arrangements for children. Under Medicaid managed care, regardless of how the contractual coverage rules are specified, the actual standard of coverage is the full EPSDT benefit, which would "wraparound" the contractual plan. In a benchmark arrangement, such as those used in many states that administer separate SCHIP programs, the benchmark coverage offered by the plan represents full coverage.

Table 5. EPSDT and Benchmark Coverage in a Managed Care Context

Benefit	EPSDT/Current Law Managed Care Standards	Deficit Reduction Act
Contractual benefits	Benefits defined in Section 1905(r) of the Social Security Act Managed care performance standards described in Section 1932 of the Social Security Act or under terms of a waiver	Defined contribution to a benchmark-equivalent set of basic benefits at an actuarial rate that does not have to be reasonably sound Applicability of Section 1932 is unclear
Supplemental or extra-contractual benefits	Benefits defined in Section 1905(r) of the Social Security Act Managed care standards described in Section 1932 of the Social Security Act or under terms of a waiver	At state option

Source: Authors' analysis, 2005.

Section 1937(a) as added by the DRA mandates that, for children under age 19, the state must provide:

> enrollment in coverage that provides . . . wrap around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services described in section 1905(r).

This sub-section suggests that, as is the case with many state Medicaid managed care plans today, the conferees envisioned that EPSDT benefits, to a greater or lesser degree, would supplement benchmark benefits, effectively giving children two tiers of coverage. Because EPSDT is so extensive, few, if any, states attempt to purchase the entire benefit from managed care entities and instead leave certain services (or certain services in amount, duration, and scope) as a supplement to the benefits directly furnished by the state itself. Other states use specialized managed care entities (e.g., behavioral health organizations or other special purpose contractors) to furnish the more extensive level of EPSDT coverage not found in managed care contracts.

Interim guidance issued by CMS on March 31, 2006, provides a general description of the benchmark option and its relationship to EPSDT, but details are lacking.[46] The guidance does not clarify which elements of EPSDT, such as the developmental assessment, will be considered part of a benchmark well-child exam. It is therefore possible that developmental assessments could be furnished only as wraparound services, which would be subject to special prior authorization rules, rather than as basic and routine parts of periodic or as-needed health examinations. The guidance sheds no light on: the expected level of state outreach to families with regard to accessing wraparound services; the minimum level of preventive, acute, and other EPSDT services that should be considered part of the benchmark; how vision and hearing services should be treated; or how states should handle EPSDT support services such as information, scheduling, and transportation assistance. Early experience with approvals of benchmark coverage, limited to the state of Virginia, suggests that the CMS approval process is relatively rapid, with virtually no "look behind" to assess state implementation plans related to adoption of the benchmark against EPSDT coverage and service standards.[47]

In addition to the special EPSDT wraparound rule, Section 1937 provides for coverage of services in federally qualified health centers and rural health clinics, as follows:

> Notwithstanding the previous provisions of this section, a state may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless (A) the individual has access through such coverage or otherwise to [FQHC and rural health clinic services]; and (B) payment for such services is made in accordance with [the prospective payment system].

This provision appears to require continued coverage of services provided in federally qualified health centers and rural health clinics at the statutory payment rate specified under the prospective payment system.

Section 1937, while appearing to extend the benchmark option to all categorically needy children, also contains numerous exemptions (Figure 5).

Figure 5. Benchmark-Exempt Medicaid Beneficiaries

- Persons who qualify for Medicaid under the state plan on the basis of being blind or disabled (or being treated as blind or disabled) without regard to whether the individual is eligible for SSI, including an individual who is eligible as an institutionalized person
- Mandatory pregnant women
- Persons who are dually eligible for Medicare and Medicaid
- Hospice patients
- Residents of medical facilities
- Medical frail or special needs individuals (to be defined by the secretary)
- Beneficiaries qualifying for long term care services
- Children receiving foster care and adoption services under title IV-B or title IV-E
- Individuals whose coverage is based on their eligibility for assistance under title IV-A (TANF recipients)
- Women whose coverage is based on eligibility under the breast and cervical cancer program
- Certain other limited services beneficiaries

Given these exemptions, it appears that the benchmark option applies to categorically needy children other than children who are: in families who receive Temporary Assistance for Needy Families (TANF) or SSI (or who are SSI related); in foster care or adoption placements; residents of institutions; or fall into a special need status recognized by the HHS secretary. In the case of parents and caretakers, persons who receive TANF are exempt. However, the CMS benchmark guidance issued on March 31 permits states to default enroll all beneficiaries in benchmark coverage, even if they are exempt, as long as they are informed of their right to opt out into traditional Medicaid coverage.[48] Thus, children in foster care or those with significant disabilities could be automatically enrolled in a benchmark plan once eligible, so long as a parent was informed of their right to retain traditional coverage. No guidelines explain the minimum information process or procedures to be instituted to ensure that parental choice is informed and voluntary.

In essence, the groups subject to the new benchmark option appear to be non-exempt poverty-level children, parents, and caretakers who receive Medicaid but not TANF. Section 1937 appears to respond to the interest expressed by a number of states in waivers that would permit them to substitute SCHIP's general approach for Medicaid's more detailed coverage standards. States could apparently establish benchmark plans that would combine SCHIP enrollees and non-exempt, poverty-level Medicaid-enrolled children and their non-exempt parents and caretakers into larger purchasing pools. For Medicaid-enrolled poverty-level children, EPSDT would continue as a required wraparound. For both children and their poverty-level parents and caretakers, coverage for federally qualified health center and rural health clinic benefits would continue.

It is important to note that, although Section 1937 permits adjustment of medical assistance coverage, it does not alter beneficiaries' entitlement to medical assistance. Thus, although children eligible for separately administered SCHIP plans are not entitled to coverage, children covered by the Section 1937 benchmark provisions remain entitled to assistance, even if the nature of the assistance changes. At the same time, however, until the HHS secretary interprets seemingly sweeping "notwithstanding" clause that introduces Section 1937, it is not possible to know with certainty how Medicaid coverage will be altered, if at all.

Premiums and Cost-Sharing

Sections 6041 through 6043 of the DRA modify pre-enactment rules on premiums and cost-sharing, providing states with additional flexibility with respect to certain populations and services. Notably, the amendments fail to address directly the treatment of persons with incomes below the FPL (as determined by a state). The legislative history of the DRA, as well as statements from Congressman Barton, suggest that pre-DRA rules related to premiums and cost-sharing remain applicable. Yet, the precise interaction between pre-DRA and post-DRA standards—in terms of the amount of cost-sharing permitted, covered and exempt services, and provider flexibility to deny care in the case of persons who cannot pay—is unclear, so that following discussion must be considered preliminary. At the same time, the provisions are relatively clear with respect to poverty-level children.

The DRA adds a new section 1916A, which became effective March 31, 2006. Special rules on the use of cost-sharing for emergency department services will go into effect on January 1, 2007. The law creates new options for instituting cost-sharing and premiums for children's coverage—options not available to states prior to the DRA (Table 6). In the case of children whose coverage is mandatory (e.g., TANF children, poverty-level children, children in federally assisted foster care or adoption placements, certain institutionalized children, and children receiving SSI), prior protections continue to apply. But premium and cost-sharing options are considerably expanded for children whose coverage is optional. States may continue to exempt all children or take advantage of these new options, either in part or in whole.

Table 6. State Options for Premiums and Cost-Sharing for Children's Coverage

Pre-DRA	**Deficit Reduction Act**
Premiums: No premiums for categorically needy children; premiums permitted for other children *Cost-sharing:* Cost-sharing prohibited	**Mandatory Children** *Premiums:* No premiums allowed in the case of children whose coverage is mandatory (including children in foster care and adoption placements under Titles IV B and E) *Cost-sharing:* No cost-sharing on most services for children whose coverage is mandatory, including children in foster care and adoption placements. **Optional Children** *Premiums:* Families with incomes at or below 150% of FPL cannot be charged premiums. Families with state-defined countable incomes over 150% may be charged premiums. *Cost-sharing:* No cost-sharing (at any income level) for preventive services and family planning, services furnished to terminally ill or institutionalized persons, or emergent use of the emergency department. Cost-sharing allowed for non-preferred prescriptions and non-emergent use of emergency department and other non-exempt services. Provider enforceability of cost-sharing permitted States permitted to define family income for purposes of applicable copayment and coinsurance levels and aggregate permissible exposure to premiums and coinsurance Certain variations in permissible coinsurance (10%–20%) and permissible aggregate limits apply, depending on state-defined income family income levels. Families below 150% of FPL have a 5% aggregate limit on cost-sharing and families above 150% of FPL have a 5% aggregate limit on both premiums and cost-sharing.

Source: Authors' analysis of the Deficit Reduction Act of 2005.

Section 1916A recognizes explicitly the use of premiums, copayments, and co-insurance. Allowable coinsurance can be up to 10 percent of the cost of services for families with incomes between 100 percent and 150 percent of the FPL, and up to 20 percent for families with incomes over 150 percent of the FPL.

Section 1916A permits states to set standards for the post-eligibility valuation of family income. It permits recognition (or disallowance) of deductions and disregards that determine whether a family's gross income falls below or above the countable income levels, which in turn triggers cost-sharing responsibilities or exemptions under the state plan. For example, in determining eligibility for Medicaid, states are required to disregard work-related expenses. However, once applicants have been determined to be eligible for

Medicaid, Section1916A appears to permit states to eliminate this disregard, thereby potentially raising family income from below-poverty to above-poverty levels.

In addition to giving states new flexibility over premiums and cost-sharing, the DRA gives states the option to permit providers to make premiums and cost-sharing requirements "enforceable." Prior to the DRA, participating physicians and hospitals were obligated to furnish care to patients, regardless of their ability to satisfy applicable cost-sharing rules. The DRA makes it possible for providers to require payment of any allowable cost-sharing before providing care, including payments for services sought in emergency departments. It also authorizes providers to waive advance payments on a case-by-case basis.[49]

Although the act appears to maintain applicable Emergency Medical Treatment and Active Labor Act (EMTALA) standards, it also gives states flexibility to permit cost-sharing in hospital emergency department situations.[50] The law appears to permit hospital personnel to make *a priori* determinations that services sought by patients are not in fact services they are obligated to furnish under EMTALA (i.e., appropriate screening to determine the existence of emergency medical conditions and stabilization or medically appropriate transfers when emergency medical conditions are identified) and to impose cost-sharing. How hospital personnel's new authority to impose cost-sharing based on the judgment of emergency department staff is to be reconciled with their duty to furnish care without prior discussion of the costs under the EMTALA statute remains unclear.

Section 1916A also gives states the option to terminate coverage if beneficiaries fail to make premium payments for more than 60 days. States may waive this penalty in cases where it would impose "undue hardship."[51]

The DRA requires the HHS secretary to adjust "nominal" cost-sharing levels allowed for non-preferred prescription drugs and non-emergent use of the emergency department for the rate of medical inflation on an annual basis.[52]

Section 1916A establishes aggregate limits on the amount of permissible premiums and cost-sharing in relation to family income. Families with countable incomes from 100 percent through 150 percent of the FPL cannot be charged premiums, but can be charged cost-sharing up to 5 percent of aggregate family income on a quarterly or monthly basis. Families with countable incomes over 150 percent of the FPL can be charged premiums and cost-sharing, but the combined aggregate of premiums and cost-sharing may not exceed 5 percent of family income. This means that, while lower-income families are exempt from premiums, they can face higher point-of-service cost-sharing than families with higher incomes, because the 5 percent would only be made up through cost-sharing, not premiums.

These rules allow states to define what is counted as family income. This may result in cost-sharing limits in relation to families' gross income, rather than income adjusted to take into account certain housing and work expenses. As noted above, for families with state-defined poverty-level income, the permissible levels of payments and the enforcement rules are unclear.

Targeted Case Management

The DRA appears to limit the scope of permissible targeted case management services as the term is used in the context of medical assistance (Table 7). How this will affect states' ability to bill for case management services as administrative activities is unclear.

In addition, the DRA amends the definition of third-party liability. According to the amendments, certain public programs can be considered "first dollar" (i.e., the primary payer) in situations involving the provision of covered case management services to children and adults who are enrolled in Medicaid and other public programs. These amendments are ambiguous, especially with respect to the extent to which other public programs will be considered liable under federal and state law and whether these third-party liabilities should be applied for both medical assistance and administrative payments for case management. Thus, this analysis should be considered preliminary.

Table 7. Targeted Case Management

Pre-DRA	**Deficit Reduction Act (§6052)**
Case management defined	
Medical assistance case management: Medical assistance case management: services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (42 U.S.C. §1396n(g) (2)). All federal rules applicable to medical assistance access, coverage, claims, and payment would apply. **Case management billed as an administrative service:** no single definition, but federal guidelines recognize the following activities as costs directly related to state plan administration: EPSDT administrative services linked to outreach, scheduling, transportation, service coordination, and care arrangement; Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services and utilization review; and Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system). Separate federal financial participation rates and claims payment and billing procedures apply.	**Expands on the definition by amplifying its meaning:** Amends §1396n(g)(2) to retain the existing definition but also to provide the following clarification of what is meant by case management in the context of the medical assistance definition. **May or may not carry over to the definition of case management in the context of administrative services.** (I) assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following: taking client history; identifying the needs of the individual and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual. (II) development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual. (III) referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual. (IV) monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with an individual's care plan; whether the services in the care plan are adequate; whether there are changes in the needs or status of the eligible individual and if so, making necessary adjustments in the care plan and service arrangements with providers.

Pre-DRA	Deficit Reduction Act (§6052)
	Specifically excludes from the definition: "the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including with respect to the direct delivery of foster care services, services such as (but not limited to) the following: (I) research gathering and completion of documentation required by the foster care program. (II) assessing adoption placements. (III) recruiting or interviewing potential foster care parents. (IV) serving legal papers. (V) home investigations. (VI) administering foster care subsidies. (VII) making placement arrangements." Clarifies that case management services need not comply with comparability or statewideness requirements.
Types of case management and conditions for FFP	
Medical assistance case management services (payable at the state medical assistance rate) may be targeted to particular subgroups as a state plan matter (no freedom of choice waiver required). Case management services must be billed as medical assistance and must comply with conditions of payment for medical assistance (e.g., free choice of providers, furnished by a qualified provider, be considered medically necessary, and be billed in accordance with Medicaid claims principles) (SMM §4302) Case management also may be furnished as an integral part of another billable service, in which case it is not separately reimbursable (SMM §4302) Case management may be furnished as an administrative service (paid at the federal matching rate for administrative services). Case management services must be directly related to state plan administration. When case management is furnished as an administrative service, federal requirements regarding administration costs must be followed (use of time studies, allocation of costs among programs, related to administration of state Medicaid plan). (SMM §4302) Case management may be furnished as an integral part of EPSDT medical assistance services or as an EPSDT administrative service.	**Specifies when case management will and will not be recognized with respect to certain individuals.** With respect to contacts with "individuals who are not eligible for medical assistance under the state plan" or who, if eligible "are not part of the target population specified in the state plan," such contacts are considered allowable case management "when the purpose of the contact is directly related to the management of the eligible individual's care." Contacts are NOT considered allowable case management activity if such contacts relate "directly to the identification and management of the noneligible or nontargeted individual's needs and care." In the case of case management services that are reimbursable under another federally funded program as third-party liability, state cost allocation systems must adhere to OMB Circular 87 or successor circulars

Pre-DRA	**Deficit Reduction Act (§6052)**
Third-party liability recovery for case management services	
General third-party liability recovery principles apply to "care and services available under the plan" 42 U.S.C. §1396a(a)(25)(A). Where [third party] legal liability is found to exist, states must make recovery efforts "after medical assistance has been made available" 42 U.S.C. §1396a(a)(25)(B). States must have in place subrogation laws that apply "to the extent that payment has been made under the state plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance." 42 U.S.C. §1396a(a)(25)(H).	Specifies that "in accordance with 42 U.S.C. §1396a(a)(25), federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, *including as reimbursement under a medical, social, educational, or other program*." [emphasis added] Exempts activities carried out under the Indian Health Service and the Ryan White Care Act from the meaning of federal programs.

Source: Authors' analysis of the Deficit Reduction Act of 2005.

DISCUSSION AND IMPLICATIONS

In a number of respects, the DRA makes significant changes in federal Medicaid policy for young children and their families. In others, the legislation codifies and formalizes ongoing practice— a step that, while perhaps not significant in and of itself, nonetheless demands that we closely monitor how states go about implementing these choices that are now recognized in federal law. As the provisions of the DRA are implemented, it is important to focus on ensuring the quality and availability of developmental health care for young children.

Safeguarding Eligibility for Coverage

Children enrolled in Medicaid and scheduled for eligibility redeterminations, as well as children filing initial applications, are required by statue, as of July 1, 2006, to furnish proof of citizenship. Available evidence suggests that many families will have difficulty gaining access to such proof; indeed, a January 2006 survey of low-income families conducted by the Center on Budget and Policy Priorities found that as many as 2.9 million children could lack the required proof of citizenship.[53]

There are two possible consequences of this provision. First, many young children might be terminated from or denied coverage. Second, states could experience an unanticipated swell in SCHIP enrollment because that program does not require written proof of citizenship. Children from families whose incomes are low enough to qualify for Medicaid but who are unable to demonstrate their citizenship may thus migrate to SCHIP.

Ensuring that welfare agencies have full online access to birth certificates may be the most expeditious means of averting a widespread loss in coverage among children. Hospitals, clinics, and community health providers might be recruited to help families access necessary documentation. Since newborns of Medicaid-enrolled women are automatically eligible for and enrolled in the program, this provides time to assure that families have proper documentation until time of renewal. Lessons from New York State Medicaid program, which has had a citizenship documentation requirement in place for years, suggest that giving families time and flexibility to secure the documentation as well as support services are crucial.[54]

This type of assistance, as well as assistance with fees required to secure copies of documents, would appear to be eligible for federal matching funds to states at the Medicaid administration rate.

Configuring Benchmark Coverage

Many states will likely pursue the new benchmark coverage option for Medicaid-enrolled children and their families. This option is only available for groups who were already eligible for Medicaid at the time of DRA enactment. That is, the benchmark option cannot be used to expand coverage to previously ineligible populations—an option that federal policymakers explicitly blocked out of concern that Medicaid expenditures might rise rather than fall as a result of the legislation.

In the case of children, the DRA requires a configuration of benchmark coverage to preserve EPSDT services as defined in federal law prior to the DRA. This means that benchmark plans need to cover all classes of preventive, diagnostic, and treatment services and benefits recognized under EPSDT. In addition, they need to provide coverage with two fundamental standards:

- a preventive standard of medical necessity that evaluates medical need in light of children's healthy growth and development (rather than the more traditional "recovery" standard found in private insurance); and
- protection against the types of arbitrary coverage limits commonly found in insurance arrangements but prohibited under Medicaid.

States' experiences with Medicaid managed care arrangements over the past decade shed considerable light on how agencies currently approach the concepts of benchmark and wraparound coverage for children. State experiences can be classified into several basic categories:

- Purchase of a "typical" benchmark plan using benchmark classes of services and a benchmark medical necessity standard, with supplementary coverage, through fee-for-service payments, for all EPSDT preventive, diagnostic, and treatment services that lie outside of the benchmark. The supplementary coverage can involve complete categories of services as well as services that are excluded by the plan as unnecessary but that meet EPSDT's more expansive medical necessity test.
- Purchase of a plan that contains all classes of EPSDT preventive and treatment services except for very specific classes of care (e.g., long-term institutional placement), with use of a medical necessity standard that parallels that required under EPSDT (i.e., a healthy development standard of medical necessity and prohibition against arbitrary limits in treatment).
- A basic plan, supplemented by specialty service arrangements (e.g., special behavioral plans serving children at significant risk for lifelong serious mental illness as a result of severe emotional disorders) and potentially additional fee-for-service coverage of services and benefits that remain the direct responsibility of the state.

Yet, there is little information on which of these benefit designs result in high-quality developmental care and early intervention. Many factors could affect the success of the coverage arrangements within particular states, including the organization of health services and managed care markets.

All of these purchasing options are available under the law's EPSDT requirements. Which options states take, and whether certain options result in the growth of Medicaid managed care markets capable of providing high-quality developmental care, are critical issues that bear careful attention in the coming years.

Applying Cost-Sharing Flexibility

Under the DRA, states have expanded options to impose cost-sharing for children whose coverage is optional and for most adults. The legislation exempts preventive services for children from cost-sharing, although the term preventive is not defined. Because so much is known about how cost-sharing causes parents to forgo preventive care for their children, how states define preventive care in the context of early child development context will be crucial. Should the cost-sharing exemption be applied only to the periodic or interperiodic EPSDT screenings and immunizations? Should vision, dental, and hearing services be exempt? Should follow-up treatments for children at risk of developmental delays also be exempt? These choices could have a significant impact on access to early childhood development services and should be made with full understanding of the relationship between cost-sharing and utilization of services available in the community.

Another issue for states to consider will be the DRA's cost-sharing enforcement clause, including enforcement in the context of emergency department services. Whether to permit health care providers to make any form of treatment for children conditional on a family's prior payment of copayments or coinsurance is a major policy decision in its own right. Presumably, most providers would waive cost-sharing on ethical grounds when confronted with a sick child, even if the location of care might be inappropriate (e.g., the use of an emergency department when a clinic would have sufficed). Other providers might waive the cost-sharing out of concern over legal exposure over violations of EMTALA or other forms of medical liability. (In spite of DRA's ambiguity, the DRA reiterates EMTALA's applicability to emergency care situations.) At the same time, clear Medicaid policy will be important where children's access to health care is concerned.

Interpreting Case Management Amendments

Perhaps the most confusing issue concerns how to interpret and apply the case management amendments. The DRA tightens the standards applicable to Medicaid's intersection with the child welfare system in terms of the child welfare agency practices that can and cannot be cost-allocated to Medicaid. The list of practices permitted and excluded by the DRA will need to be compared with current agency relationships, so that child welfare claims against Medicaid adhere to the new standard.

But the more confusing aspect of the amendment relates to the third-party liability recovery provisions. Typically, third-party liability is used in the context of medical assistance, not administrative costs. To the extent that public programs serving Medicaid-enrolled children perform program administration functions that, in the context of Medicaid, are also classifiable as administrative case management, should the third-party liability provisions be read as extending to these administrative arrangements? For example, would EPSDT scheduling and transportation be paid for as an EPSDT administrative service even when performed for a child who is also receiving special education or child welfare services?

Equally important, should public programs that explicitly require funded providers to bill Medicaid be classified as programs whose terms permit reimbursement for case management services? For example, health centers and family planning programs explicitly require grantees to bill Medicaid for all covered services furnished to eligible persons. Should this explicit direction to bill Medicaid for all covered services be interpreted as prohibiting reimbursement for case management for patients with Medicaid? Such important issues await interpretation from CMS.

The administrative relationships between Medicaid and the broad array of public programs with limited budgets that furnish or arrange health care for children as part of their statutory duties are critical to the accessibility and quality of pediatric care. So, too, is the ability of publicly funded health care providers to properly bill for Medicaid-covered services. In both cases, extensive clarification of the DRA is necessary to fully understand what may and may not be claimed as a permissible Medicaid expense, either as medical assistance or case management.

CONCLUSION

This report provides an overview of the main provisions of the Deficit Reduction Act of 2005 that affect the benefits and coverage of children enrolled in Medicaid. The DRA adds a new layer of complexity to state Medicaid program design and there are many areas of uncertainty about its potential impacts. Federal guidance issued to date has lifted some uncertainty, but much remains. The remaining questions will be answered by states as they implement the new provisions and make decisions on how to modify and adjust their programs.

NOTES

[1] P.L. 109-362.

[2] A. Schneider, R. Elias, R. Garfield et al., *The Medicaid Resource Book,* Washington D.C.: Kaiser Commission on Medicaid and the Uninsured, 2003, http://www.kff.org/medicaid/2236-index.cfm (accessed Feb. 18, 2006).

[3] A. Sommers, A. Ghosh, and D. Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories,* Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005.

[4] Undocumented persons and recent legal residents are eligible for emergency coverage only.

[5] L. Ku, D. Cohen Ross, and M. Broaddus, *Survey Indicates Budget Reconciliation Bill Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens,* Washington, D.C.: Center on Budget and Policy Priorities, 2006, http://www.cbpp.org/1-26-06health.pdf (Accessed Feb. 12, 2006).

[6] 42 U.S.C. §1396a(e); Section 1902(r)(2) grants states flexibility to recognize income deductions and disregards that extend beyond those normally applicable under federal cash welfare programs.

[7] The principal categorically needy eligibility groups involving children are as follows: 1) children who meet welfare requirements in effect in the state at the time of TANF's effective date; 2) poverty-level children under age 18 who meet applicable financial tests (incomes or below 133 percent of FPL in the case of children under 6 and 100 percent of FPL for children ages 6 to 18); 3) children receiving SSI benefits; 4) children receiving federally assisted adoption or foster care assistance under Title IV of the Social Security Act; 5) children in families receiving transitional medical assistance because they return to work and increase their earnings and as a result lose their cash assistance, or because their Social Security benefits increase; and 6) certain institutionalized children. In general, medically needy beneficiaries "spend down" to Medicaid eligibility levels, although there are limited spend-down provisions applicable to categorically needy persons at risk for institutional care. 42 U.S.C. §1396a(a)(10)(A) and (C); only 6 percent of all Medicaid children are medically needy. Rules applicable to medically needy beneficiaries are not reviewed here. See A. Sommers, A. Ghosh, and D. Rousseau, 2005, above.

[8] The *Handbook of Public Administration, Supplement D,* a 1966 document issued by the U.S. Department of Health, Education and Welfare that interpreted the 1965 legislation contains an extensive discussion of Medicaid's original coverage standards. The interpretation of coverage rules found in *Supplement D* was codified as original program regulations.

[9] S. Rosenbaum, "Health Policy Report: Medicaid," *New England Journal of Medicine,* 2002 346(8): 635–640.

[10] R. Rosenblatt, S. Law, and S. Rosenbaum, *Law and the American Health Care System,* New York: Foundation Press, 1997.

[11] S. Rosenbaum, 2002.

[12] 42 U.S.C. §1396a(a)(3).

[13] 42 U.S.C. §1396a(a)(10).

[14] 42 U.S.C. §1396a(a)(17).

[15] *Handbook of Public Administration, Supplement D,* 42 C.F.R. §440.230.

[16] Curtis v. Taylor 648 F. 2d 946 (5th Cir., 1980).

[17] Beal v Doe 432 U.S. 438 (1977).

[18] The Mental Health Parity Act, P.L. 107-147, is designed to alleviate at least some forms of discriminatory coverage in the case of persons with mental illness; Doe v Mutual of Omaha 179 F. 3d 557 (7th Cir., 1999); cert. den. 528 U.S. 1106; Bedrick v. Travelers Health Insurance 93 F. 3d 149 (4th Cir., 1996); McGraw v. Prudential Ins. Co. 137 F. 3d 1253 (10th Cir., 1998).

[19] Beal v. Doe, *supra.*

[20] S. Rosenbaum, A. Markus, and C. Sonosky, "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP," *Suffolk Journal of Health & Biomedical Law,* 2004 1: 1–47.

[21] S. Rosenbaum, D. R. Mauery, P. Shin et al., *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT,* Washington, D.C.: The George Washington University School of Public Health and Health Services, Department of Health Policy, 2005, available at http://www.gwumc.edu/sphhs/healthpolicy/new_publications.html.

[22] Children's Defense Fund, *EPSDT: Does It Spell Health Care for Poor Children?* Washington D.C., 1977.; S. Rosenbaum, D. R. Mauery, P. Shin et al., 2005.

[23] S. Rosenbaum, A. Markus, and C. Sonosky, 2004.

[24] S. Rosenbaum, D. R. Mauery, P. Shin et al., 2005; Rosie D v. Romney (Jan. 26, 2005); http://www.masslegalservices.org/docs/RosieD.pdf.

[25] Section 1916 of the Social Security Act.

[26] Ibid.

[27] 42 U.S.C. §1396a(a)(19).

[28] S. Rosenbaum, "Mothers and Children Last: The Oregon Cost Sharing Experiment," *American Journal of Law and Medicine,* 1993.

[29] J. Alker, *Premium Assistance Programs: How Are They Financed and Do States Save Money?* Washington, D.C.: Kaiser Family Foundation, 2005, http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf; S. Artiga and C. Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* Washington, D.C: Henry J. Kaiser Family Foundation, 2005, http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf.

[30] Wadley v. Daniels v. Wadley, 926 F. Supp. 1305 (M.D. Tenn., 1996). Federal regulations, 42 C.F.R. §438.210 also clarify that states that utilize managed care arrangements must specify which state plan services are covered under the contract and require states and managed care entities to inform members regarding state plan services that they may continue to obtain directly from the state.

[31] See, e.g., M. Moon, *Restructuring Medicare: Impact on Beneficiaries,* New York: The Commonwealth Fund, 1999; M. Moon, *Competition with Constraints: Challenges Facing Medicare Reform.* Washington, D.C.: The Urban Institute, 2000.

[32] See, e.g., A. Enthoven, "The History and Principles of Managed Competition," *Health Affairs,* 1993 12 Suppl: 24–48; A. Enthoven and R. Kronick. "A Consumer-Choice Health Plan for the 1990s. Universal Health Insurance in a System Designed to Promote Quality and Economy." *New England Journal of Medicine,* 1989 320(1): 29–37; A. Enthoven, "Managed Competition: An Agenda for Action," *Health Affairs,* Summer 1988 7(3): 25–47.

[33] S. Rosenbaum, A. Markus, and C. Sonosky, 2004.

[34] A. Sommers, A. Ghosh, and D. Rousseau, 2005; A. Schneider, J. Lambrew, and Y. Shanouda, *Medicaid Cost-Containment: The Reality of High-Cost Cases,* Washington, D.C.: Center for American Progress, 2005.

[35] Office of Management and Budget, *Budget of the United States Government Fiscal Year 2007,* Washington, D.C., 2007, http://www.whitehouse.gov/omb/budget/fy2007/.

[36] Office of Inspector General, *Audit Review of the Oklahoma Department of Human Service's Medicaid Administrative Costs* (A-06-03-00046) Washington, D.C.: Department of Health and Human Services, 2005; Government Accountability Office, *Medicaid Financing: States' Use of Contingency-Fee to Maximize Federal Reimbursement Highlights Need for Improved Federal Oversight* (GAO-06-748) Washington, D.C.: Government Accountability Office, 2005.

[37] Congressional Budget Office, Cost Estimate-S.1932 Budget Deficit Reduction Act of 2005. Jan. 27, 2005. Available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

[38] L. Ku, *Revised Medicaid Documentation Requirement Jeopardizes Coverage for 1 to 2 Million Citizens,* Washington, D.C.: Center on Budget and Policy Priorities, July 13, 2006, Available at http://www.cbpp.org/7-13-06health2.htm.

[39] 71 Fed. Reg. 39214-39229; in states that do not automatically furnish Medicaid to all SSI recipients, separate data submission requirements will apply but states will be able to affirm citizenship through a data exchange with the Social Security Administration.

[40] L. Ku, op. cit.; Henry J. Kaiser Family Foundation, *Fact Sheet on Citizenship Documentation Requirements,* Washington D.C., July 2006. http://www.kff.org/medicaid/7533.cfm; J. Solomon and A. Schneider, *New Citizenship Requirements focus Medicaid Documentation Requirements on Citizen Families,* Washington D.C. Center on Budget and Policy Priorities, July 2006, http://www.cbpp.org/7-13-06health.htm.

[41] L. Ku. op. cit.

[42] Presumptive eligibility is a mechanism authorized in law to allow states to enroll children in Medicaid at the point of service based on the family's declaration that its income is below the state's Medicaid income eligibility guidelines. No verification of income is needed at the time the presumptive eligibility determination is made. The child's parent or other adult caring for the child has until the end of the following month to submit a full Medicaid application on behalf of the child.

[43] P. Redmond, *Children in Foster Care May Have to Delay Health Care Because of Federal Regulations on Citizenship Requirement,* Washington, D.C.: Center on Budget and Policy Priorities, 2005, http://www.cbpp.org/7-7-06health.htm.

[44] Sec. 6061 of the Deficit Reduction Act of 2005.

[45] Sec. 6044 of the Deficit Reduction Act of 2005.

[46] State Medicaid Director Letter, March 31 2006, Section 6044 of the Deficit Reduction Act of 2005. Available at http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=date&filterValue=180|d&filterByDID=1&sortByDID=1&sortOrder=ascending&itemID=CMS061241.

[47] J. Solomon, *West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries' Health,* Washington, D.C.: Center on Budget and Policy Priorities, 2006, http://www.cbpp.org/5-31-06health.htm.

[48] State Medicaid Director Letter, Mar. 31 2006.

[49] Sec. 1916A(d)(2) of the Social Security Act.

[50] Sec. 1916A(e) as added by §6043.

[51] Sec. 1916A(d)(1) of the Social Security Act.

[52] Sec. 1916A(d)(2)(b) of the Social Security Act.

[53] L. Ku, D. Cohen Ross, and M. Broaddus, 2006.

[54] P. Boozang, M. Dutton, and J. Hudman, *Citizenship Documentation Requirements in the Deficit Reduction Act of 2005: Lessons from New York,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2006, http://www.kff.org/medicaid/7534.cfm.

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