

# Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP

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## Introduction

In 2005 Medicaid will turn 40, a momentous event in the life of the largest and most complex of all means-tested public entitlement programs.<sup>1</sup> Since 1997, Medicaid has co-existed with the State Children's Health Insurance Program (SCHIP), a small program which covers a fraction of the number of Medicaid enrolled children but whose legislative structure looms large against its much-beleaguered companion.<sup>2</sup> To the unpracticed eye, SCHIP and Medicaid appear to be quite similar in design; in reality however, their differences could not be more profound, and it is in these differences that clear directions for Medicaid's possible future become visible.<sup>3</sup> It is these differences and their meaning for U.S. child health policy which are the subject of this article.

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<sup>1</sup> Sara Rosenbaum & David Rousseau, *Medicaid at Thirty Five*, 45 ST. LOUIS U. L.J. 7, 7-51 (2001); Sara Rosenbaum *Health Policy Report: Medicaid*, 346 NEW ENG. J. MED. 8, 635-640 (2002).

<sup>2</sup> Sara Rosenbaum et al., *Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals an Impact on Low Income Children*, 1 HOUS. J. HEALTH L. POL'Y 33, 33-61 (2002).

<sup>3</sup> *Id.*; Sara Rosenbaum, Barbara Smith, Colleen Sonosky, Lee Repasch & Anne Markus *SCHIP Policy Brief #1: State SCHIP Design and the Right to Coverage* (The George Washington University Medical Center, Washington, D.C.), at [http://www.gwhealthpolicy.org/downloads/SCHIP\\_brief1.pdf](http://www.gwhealthpolicy.org/downloads/SCHIP_brief1.pdf) (Mar. 2001) [hereinafter Policy Brief]; Sara Rosenbaum et al., *SCHIP Policy Brief #2: State Benefit Design Choices under SCHIP-Implications for Pediatric Health Care* (The George Washington University Medical Center, Washington, D.C.), at [http://www.gwhealthpolicy.org/downloads/SCHIP\\_brief2.pdf](http://www.gwhealthpolicy.org/downloads/SCHIP_brief2.pdf) (May 2001); Sara Rosenbaum et al., *SCHIP Policy Brief #3: Managed Care Purchasing under SCHIP-A*

This analysis is an outgrowth of a multi-year, multi-funder<sup>4</sup> project whose aim was to gain an in-depth understanding of state SCHIP implementation, and in particular, its implications for Medicaid's extraordinary pediatric coverage design.<sup>5</sup> For nearly four decades, Medicaid's unique coverage rules for children under 21, coupled with its extensive reach into the low-income population, have set the program apart from all other forms of health insurance, public or private. Even as the program has struggled to overcome inadequate provider participation and the critical health care access problems faced by the poor generally, Medicaid's effect on access to pediatric health care has been significant, in no small part because of the singular nature of its coverage.<sup>6</sup> This design has supported not only the provision of comprehensive pediatric medical care but also the health care component of the nation's special education and child welfare systems, both of which serve disproportionate numbers of low-income children with special health needs.<sup>7</sup> Through its sheer reach into the nation's maternity system (today Medicaid covers upwards of 40% of all births in many states), the program essentially supports the national network of services for high-risk pregnant women and newborns.<sup>8</sup> In its long-term support for the children with serious physical and mental disabilities, Medicaid's power for pediatric financing has attracted the attention even of

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*Nationwide Analysis of Freestanding SCHIP Contracts* (The George Washington University Medical Center, Washington, D.C.), at [http://www.gwhhealthpolicy.org/downloads/SCHIP\\_brief3.pdf](http://www.gwhhealthpolicy.org/downloads/SCHIP_brief3.pdf) (Dec. 2001).

<sup>4</sup> The Commonwealth Fund, David and Lucille Packard Foundation, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration.

<sup>5</sup> See cases cited *supra* note 3.

<sup>6</sup> Andy Schneider, Rachel Garfield, Risa Elias, David Rousseau & Victoria Wachino, The Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, (2002) at <http://www.kff.org/medicaid/2236-index.cfm> (last visited September 30, 2004).

<sup>7</sup> Victoria Wachino, Andy Schneider & David Rousseau, The Kaiser Commission on Medicaid and the Uninsured, *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*, (2004) at <http://www.kff.org/medicaid/index.cfm> (last visited Oct. 4, 2004); Sara Rosenbaum, et. al., *supra* note 1; Alan Weil, *There's Something About Medicaid*, HEALTH AFFAIRS, 22:1, (Feb. 2003 13-31).

<sup>8</sup> *The Medicaid Program at a Glance*, Kaiser Commission on Medicaid and the Uninsured (The Henry J. Kaiser Family Foundation, February 2003), available at <http://www.kff.org/content/2003/200403/200403.pdf>; *Medicaid: Fiscal Challenges to Coverage*, Kaiser Commission on Medicaid and the Uninsured (The Henry J. Kaiser Family Foundation, May 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm>; National Governor's Association *Making Medicaid Better: Options to Allow States to Continue to Participate and to Bring the Program up to Date in Today's Health Care Marketplace* (March 15, 2002) at <http://www.nga.org/cda/files/MAKINGMEDICAIDBETTER.pdf>.

Presidents, as witnessed by President Reagan's 1982 intervention to ensure Medicaid home coverage for a young, respirator dependent Iowa child named Katie Beckett.<sup>9</sup> At the same time, the pediatric component of Medicaid has proven to be quite controversial, triggering demands for reform by Governors and extensive litigation testing the limits of the legal entitlement.<sup>10</sup>

SCHIP shares Medicaid's mission in its coverage of low-income uninsured children but its coverage, as formulated in federal and state policy, represents a dramatic departure from Medicaid rules and principles.<sup>11</sup> This departure was the result of a legislative strategy, supported by some of the nation's best known children's advocacy organizations, which culminated in the enactment of a "not-Medicaid" pediatric health care financing scheme offering a financially generous alternative to the Medicaid legal entitlement.<sup>12</sup> The strategy was brilliantly successful; states responded to the lure of good money with few strings attached by rapidly implementing SCHIP and extending assistance to several million additional uninsured low-income children ineligible for Medicaid because of state coverage limits.<sup>13</sup>

Yet even as this expansion strategy succeeded, it has left many questions in its wake, not merely because of the aggregate limitations placed on federal SCHIP funding, which in turn have led to enrollment caps and waiting lists, but also because of the implications of its program design for children whose health needs exceed the norm and who are heavily dependent on state health care and social supports.<sup>14</sup>

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<sup>9</sup> Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248.

<sup>10</sup> Fact Sheet: *Medicaid Early and Periodic Screening, Diagnosis, and Treatment: Recent Case Developments*. (National Health Law Program, Washington, D.C.) Feb. 2004 at [www.healthlaw.org/pubs/200402.EPSDT.cases.pdf](http://www.healthlaw.org/pubs/200402.EPSDT.cases.pdf).

<sup>11</sup> See cases cited *supra* note 3.

<sup>12</sup> Sara Rosenbaum & Colleen Sonosky, *Who Speaks for America's Children: The Role of Child Advocates in Public Policy in Medicaid Reforms and SCHIP: Health Care Coverage and the Changing Policy Environment* 81-104 (DeVita and Mosher-Williams ed., Urban Institute Press, 2001).

<sup>13</sup> *Id.*

<sup>14</sup> Genevieve Kenney & Debbie Chang, *The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges*, 23 HEALTH AFFAIRS 5:51-62, at 57; Anne Markus et al., Kaiser Commission on Medicaid and the Uninsured, *SCHIP-Enrolled Children with Special Health Care Needs: An Assessment of Coordination Efforts Between State SCHIP and Title V Programs* (2004); Sara Rosenbaum et al., (2002) State Insurance Design Choices Under Separately Administered SCHIP Programs: Implications for Pediatric Health Care (abstract) 2002 Annual Research Meeting, Academy for Health Services Research and Health Policy, Washington D.C., June 2002.

Two groups of children in particular merit focus. The first group consists of children with moderate to serious physical and mental disabilities, whose health care needs for both “acute” and “long-term care” services transcend what typically would be found in a commercial insurance plan. Some of these children are eligible for Supplemental Security Income on the basis of their severe disability, but the majority actually qualifies for Medicaid on the basis of low family income.<sup>15</sup>

The second group consists of low-income infants, toddlers and young children who face an elevated risk of developmental disability and delay, and whose health circumstances dictate a cluster of services known in the pediatric literature as “early intervention.”<sup>16</sup> These services consist of a range of physical and mental health therapies and stimulation services, preventive counseling and supports for parents and caregivers, and close developmental monitoring by appropriately trained health care specialists in child development.<sup>17</sup> Early intervention is considered by child health experts to be a preventive health intervention.<sup>18</sup> Strictly speaking however, the early intervention process is not necessarily “treatment” for a “diagnosed” condition, and the location of the intervention may be in settings that have both an educational and preventive health mission (e.g., specialized child development settings).<sup>19</sup>

As a result, early intervention is a care process which, like long-term care for chronic conditions, may lie beyond the reach of commercial insurance norms.<sup>20</sup>

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<sup>15</sup> Sara Rosenbaum, *Report: Olmstead v. LC: Analysis and Implications for Medicaid Policy 12* (Center for Health Care Strategy, Inc., NJ, May, 2000).

<sup>16</sup> MICHAEL REGALADO & NEIL HALFON, PRIMARY CARE SERVICES: PROMOTING OPTIMAL CHILD DEVELOPMENT FROM BIRTH TO THREE YEARS, (The Commonwealth Fund, NY, 2002); Neil Halfon, Michael Regalado, Kathryn Taaffe McLearn, Alice Kuo & Kynna Wright, *Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children*, at [http://www.cmwf.org/programs/child/halfon\\_bridge\\_bn\\_564.pdf](http://www.cmwf.org/programs/child/halfon_bridge_bn_564.pdf) (May 2003) (last accessed October 20, 2003).

<sup>17</sup> *Id.*

<sup>18</sup> BARBARA STARFIELD, PRIMARY CARE: CONCEPT, EVALUATION AND POLICY (Oxford University Press, New York, NY, 1974); Halfon, et. al. *supra* note 16.

<sup>19</sup> Sara Rosenbaum et al., *Health Policy and Early Child Development: An Overview* (New York, NY: The Commonwealth Fund, 2001).

<sup>20</sup> *Id.*

We focused our research on these two groups of children, not simply because of their elevated health care needs, but also because it is in the context of these needs that Medicaid's singular coverage design comes into evidence.<sup>21</sup> We viewed state SCHIP implementation – undertaken during an exceptionally strong period of economic growth and strength – as a natural experiment of sorts, a test of how states would design health care assistance for lower income children in the absence of a federal legal entitlement to comprehensive coverage.

This question – namely, what happens when state governments and health care markets are freed from the structural constraints of Medicaid – is a critical one in national health policy. As one of Medicaid's best analysts has observed, the program has been a “strongman” in the U.S. health system in ways which are not always fully appreciated.<sup>22</sup> The press for fundamental Medicaid reforms has been presaged by the passage of SCHIP, a large collection of ongoing federally sanctioned Medicaid demonstrations conducted under the legal authority of §1115 of the Social Security Act, and most recently, the Medicaid provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003,<sup>23</sup> which eliminated federally assisted Medicaid prescription drug coverage for millions of dually enrolled Medicare beneficiaries.<sup>24</sup> Observers anticipate that the press for reform will reach a legislative crescendo as early as the 109<sup>th</sup> Congress, which convenes in 2005, in view of the program's perceived financial unsustainability and its fundamental

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<sup>21</sup> Sara Rosenbaum et. al., *SCHIP Policy Brief #2: State Benefit Design Choices Under SCHIP-Implications for Pediatric Health Care* (The George Washington University Medical Center, Washington D.C.), at [http://www.gwhealthpolicy.org/downloads/SCHIP-\\_brief2.pdf](http://www.gwhealthpolicy.org/downloads/SCHIP-_brief2.pdf) (May 2001).

<sup>22</sup> Weil, *supra* note 7 at 57.

<sup>23</sup> 42 U.S.C. §1395w-101 through §1395w-152.

<sup>24</sup> Cindy Mann, Georgetown University Institute for Health Care Research and Policy, *The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal* (February 2003); Cindy Mann, et. al., Center on Budget and Policy Priorities, *Administration's Medicaid Proposal Would Shift Fiscal Risks to States* (April 2003) at <http://www.cbpp.org/4-1-03health.htm>; Kaiser Commission on Medicaid and the Uninsured, 2004. *The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabilities and Serious Conditions* (July 1, 2004) [hereinafter New Drug Law] at <http://www.kff.org/medicaid/7119.cfm> (last visited October 2004).

incompatibility with modern notions of federalism and market regulation.<sup>25</sup> For this reason, the course of SCHIP implementation, along with these other policy developments, may offer critical lessons for Medicaid reform.

The study of SCHIP design takes on importance for other reasons as well. Across the spectrum of preventive, routine, and long-term and extended care, the fact that coverage matters for children is a well established one.<sup>26</sup> Where coverage shifts from rich and deep to more limited and narrow, the ability to finance the level and depth of health care necessary to reach an appropriate standard of care for children, particularly those with lower incomes and serious illnesses and disabilities may diminish.<sup>27</sup> For this reason, understanding shifts in benefit design, which have implications for the range of health services that can be supported, is of the utmost importance. In an era of constricting concepts of standard health insurance design, it becomes especially important to examine coverage design in depth, in terms of the classes of services and benefits offered, the services, treatments, and conditions that are excluded, the service definitions used, and the standard of medical necessity governing the provision of covered services.<sup>28</sup> Understanding how variations in coverage design, at both the macro and individual level, ultimately influence access to and use of health care is actually not particularly well researched, because of the difficulties inherent in using large population and coverage data sets to analyze

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<sup>25</sup> John K. Iglehart, *The Dilemma of Medicaid*, 348(21) NEW ENG. J. OF MED. 2140 (2003); Weil *supra* note 7; John Holahan & Alan Weil, *Medicaid moving in the wrong direction?* (Urban Institute, Washington, D.C., June 18, 2003), available at <http://www.urban.org/urlprint.cfm?ID=8453>; John Holahan & Alan Weil, *Block Grants are the Wrong Prescription for Medicaid*, HEALTH POLICY ONLINE (Urban Institute, Washington, D.C.), at <http://www.urban.org/UploadedPDF/900624-HPOnline-6.pdf>.

<sup>26</sup> The David and Lucille Packard Foundation, Health Insurance for Children, *Future of Children* (Spring 2003) available at <http://www.futureofchildren.org> (last modified Spring 2003); *Children's Health – Why Health Insurance Matters*, Kaiser Commission on Medicaid and the Uninsured (The Henry J. Kaiser Family Foundation, May 2002) ,available at <http://www.kff.org/uninsured/loader.cfm>; Lisa Dubay & Genevieve M. Kenney, *Health Care Access and Use Among Low-Income Children: Who Fares Best?*, HEALTH AFFAIRS 20:1, 112 (2001); Paul W. Newacheck, Jeffrey J. Stoddard, Dana Hughes, & Michelle Pearl, *Health Insurance and Access to Primary Care for Children*, 338 NEW ENG. J. MED. No. 8, 513-19 (February 19, 1998); Paul W. Newacheck, Michelle Pearl, Dana Hughes, and Neal Halfon, 1998b. *The Role of Medicaid in Ensuring Children's Access to Care*, JAMA 280:8 J. AM. MED. ASS'N 927-933; Alan C. Monheit & Peter J. Cunningham, *Children Without Health Insurance*, 2 U.S. HEALTH CARE FOR CHILD No. 2, 154-170 (Winter 1992).

<sup>27</sup> Rosenbaum et al., *supra* note 21; Rosenbaum et. al., *supra* note 2.

<sup>28</sup> *Id.*

health care access and utilization for low prevalence conditions.<sup>29</sup> At the same time, the relationship between coverage and access is sufficiently strong to suggest that the issue of coverage, particularly for persons with limited means, must be understood well beyond the threshold question of whether *any* coverage exists.<sup>30</sup> To that end, studies of the intricacies of coverage become the starting point for this type of research.

The first part of this article lays out the context for our study by examining Medicaid and SCHIP in their legislative structure and detail. Part Two presents the key findings from our research. Part Three discusses the implications of our findings for the future of Medicaid for children.

## **Bedfellows: Medicaid and SCHIP**

The starting point for this study is an overview of Medicaid and SCHIP, existing side-by-side in the Social Security Act, but which in many respects are as different as the more famous Medicare/Medicaid duo.

### **Medicaid**

Codified at Title XIX, Medicaid is the nation's single largest source of health insurance, covering some 51 million persons as of 2002 at a total cost of more than \$200 billion.<sup>31</sup> Despite its more limited popularity than Medicare, Medicaid is in some respects the most extraordinary surviving statutory legacy of the Great Society, enacted in 1965 as an "afterthought" to Medicare, and a "relegation" to states of responsibility for insuring the poor.<sup>32</sup> Medicaid is the largest surviving public means-tested legal entitlement. The Medicaid entitlement is three-fold. First, the law entitles states to open-ended federal financial assistance for the cost of dozens of classes of federally recognized health services furnished to eligible and enrolled

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<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> Diane Rowland, House Commerce Committee, *Challenges Facing the Medicaid Program in the 21<sup>st</sup> Century*, (October 8, 2003) at <http://www.kff.org/content/testimony/cfm> (last visited September 24, 2004).

<sup>32</sup> RASHI FEIN, *MEDICAL CARE, MEDICAL COSTS: THE SEARCH FOR A HEALTH INSURANCE POLICY* (Harvard University Press, Cambridge, MA) (1998).

persons by qualified and participating health care providers. Second, the program entitles qualified providers to payment for furnishing covered services to enrolled persons, although the terms of payment are left in most cases to state discretion.<sup>33</sup>

Third, Medicaid entitles beneficiaries to a federally defined set of “medical assistance” benefits and services which fall within the federal definition. The federal definition of what constitutes “medical assistance” is exceptionally broad, extending to routine, primary, acute, and long-term services. Many forms of “medical assistance” are mandatory while others are optional. There is no particular logic to coverage mandates and options. For example, “rural health clinic” services are mandatory while prescription drug coverage is optional. In 2002, close to two-thirds of all federal and state Medicaid expenditures were for services classified as “optional.”<sup>34</sup>

Unlike Medicare, Medicaid contains no explicit provisions allowing beneficiaries to bring legal actions to enforce their federal legal entitlement.<sup>35</sup> At the same time however, the courts have recognized the legal entitlement as individually enforceable since the program’s inception, despite serious erosion of enforcement rights in the case of other Social Security Act benefits in recent years.<sup>36</sup>

Medicaid has a special relationship to children. Children comprise half of all Medicaid enrollees; in 2002, the program financed one third of all U.S. births and by 2003, covered 25% of all children.<sup>37</sup> Between 1980 and 2002, the proportion

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<sup>33</sup> RAND ROSENBLATT, SYLVIA LAW, & SARA ROSENBAUM, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* (Foundation Press, New York, NY, 1997); RAND ROSENBLATT, SARA ROSENBAUM & DAVID M. FRANKFORD, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* (Foundation Press, New York, NY) (1997 & Supp. 2002).

<sup>34</sup> Kaiser Commission, *supra* note 8.

<sup>35</sup> TIMOTHY S. JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHT-BASED RESPONSE* (Oxford University Press, New York, NY, 2003); Rosenblatt, et. al., *supra* note 33.

<sup>36</sup> Rosenblatt, Law & Rosenbaum, *supra* note 8; Jost, *supra* note 35; John Holahan, Alan Weil & Joshua M. Weiner, *Which Way for Federalism and Health Policy?* HEALTH AFFAIRS WEB EXCLUSIVE, July 16, 2003, at <http://www.healthaffairs.org/WebExclusives/2205Holahan.pdf> (accessed October 13, 2003); Weil, *supra* note 7; Rosenbaum, *supra* note 1.

<sup>37</sup> National Governor’s Association *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents* (June 10, 2003) available at <http://www.nga.org/cda/files/MCHUPDATE02.pdf>; Census Bureau, *Income, Poverty, and Health Insurance Coverage: 2003* (2004) available at <http://www.census.gov/Press-Release/www/2004/IncPov04slides1-3.pdf>.



of children covered by Medicaid more than doubled, from approximately 10 million to 25 million, as a result of coverage expansions either mandated by Congress or adopted by states, sustained high levels of childhood poverty, and the long-term erosion of employment-based health insurance coverage for lower wage workers and their families.<sup>38</sup>

Children eligible for Medicaid on a mandatory basis are those who live in families with countable family incomes at 133% of the federal poverty level in the case of infants and children under age 6 and 100% of the federal poverty level for children ages 6-18.<sup>39</sup> Children for whom Medicaid is mandatory are also those who receive Supplemental Security Income (SSI) benefits on the basis of blindness or disability, and children in families whose categorical and financial characteristics leave them “related to” states’ 1996 eligibility standards for Aid to Families with Dependent Children (which was repealed by the Welfare Reform Act of 1996).<sup>40</sup>

The official poverty level figure is misleadingly low in the case of children enrolled in Medicaid on the basis of income.<sup>41</sup> In Medicaid, as in other public welfare entitlements, financial eligibility is calculated on the basis of “countable” or “net” income following the application of numerous financial disregards and adjustments to household income required under law. Work and shelter expenses qualify for certain deductions, certain family income - such as SSI benefits received by a sibling or a parent are disregarded, and a portion of child support payments also is disregarded.<sup>42</sup> In the case of lower income children who live in large households with extended family members, only parental income, rather than total household income is counted. As a result of these financial adjustments (which in

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<sup>38</sup> Peter J. Cunningham, Jack Hadley, & James D. Reschovsky, *The Effects of SCHIP on Children's Health Insurance Coverage*, MED. CARE RESEARCH & REVIEW 59:4, 359 (Dec. 2002).

<sup>39</sup> Schneider et al., *supra* note 6; Kaiser Commission, *supra* note 8; Cindy Mann, Diane Rowland, & Rachel Garfield, *Historical Overview of Children's Health Care Coverage*, 13 HEALTH INS. FOR CHILD. NO. 1, 36.

<sup>40</sup> Garfield et al., *supra* note 6.

<sup>41</sup> Sara Rosenbaum & Anne Markus, 2002 SCHIP Policy Brief #4: State Eligibility Rules under Separate State SCHIP Programs-Implications for Children's Access to Care (Geo. Washington Univ. Med. Ctr., Washington, DC) [http://www.gwhealthpolicy.org/downloads/SCHIP-\\_brief4.pdf](http://www.gwhealthpolicy.org/downloads/SCHIP-_brief4.pdf).

<sup>42</sup> *Id.*

concept parallel the income adjustments in the Internal Revenue Code) children may qualify for Medicaid as poverty level recipients when in fact their incomes considerably surpass the federal poverty level.<sup>43</sup>

Furthermore, Medicaid's financial eligibility options where children and pregnant women are concerned are virtually limitless as a result of a provision added to the program by the (subsequently repealed) Medicare Catastrophic Coverage Act of 1988.<sup>44</sup> This provision (which survived repeal) permits states to extend Medicaid to any child through the use of more generous income and asset "disregards" used to calculate financial eligibility for Medicaid. For example, a state might double the shelter allowance and treble the earned income deduction, thereby counting as "poverty level" children, those whose families' gross incomes actually reach or exceed twice the federal poverty level. As of 1997, the year of SCHIP's enactment, a few states had taken advantage of this option either through the state plan amendment process or as part of a broader Medicaid demonstration.<sup>45</sup> Most states however eschewed this option; indeed by 1997, Medicaid had undergone the "near death" experience of being block granted as part of the 1996 welfare reform legislation and states were in no mood to extend legal entitlements to millions of children, particularly in a booming period of economic recovery.<sup>46</sup>

It is also worth noting that Medicaid eligibility can begin up to 3 months prior to the date of application in cases in which the individual would have satisfied program eligibility standards had application occurred at an earlier point.<sup>47</sup> This provision plays a particularly important role for both children and adults who may be uninsured at the time of a major health event and whose application comes only after the fact. The retroactivity aspect of Medicaid underscores its role as a program which operates outside the norms of conventional insurance, without pre-existing condition exclusions, waiting periods, or other barriers to enrollment essential to the proper functioning of a risk pool.<sup>48</sup>

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<sup>43</sup> *Id.*

<sup>44</sup> §303(d) and §303(e) (5) of Pub. L. 100-360. The Act, which added prescription drug coverage to Medicare, was subsequently repealed, but this Medicaid provision survived.

<sup>45</sup> Mann et al., *supra* note 39, at 37.

<sup>46</sup> Rosenbaum & Sonosky, *supra* note 12, at 100.

<sup>47</sup> Schneider et al., *supra* note 6.

<sup>48</sup> Rosenbaum, *supra* note 1; Weil, *supra* note 7; Schneider et al., *supra* note 6.

Where children are concerned, Medicaid is particularly important, not only because of its unusually generous eligibility standards, but also because of its singular coverage rules. Children's Medicaid legal entitlement to coverage encompasses an extraordinary range and depth of benefits and services, and the rules of coverage are found nowhere else in insurance law. These rules survive even when children are enrolled in managed care systems which furnish less than all covered benefits, because they are part of the federal legal entitlement to coverage itself.<sup>49</sup> As a result of legislative amendments enacted in 1967, revised in 1981 and again in 1989,<sup>50</sup> Medicaid coverage requirements extend far beyond the standards applicable to adults. With the exception of the small number of "medically needy" children who "spend down" to eligibility by incurring high health care costs, all Medicaid enrolled children under age 21 are entitled to Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.<sup>51</sup> These services consist of comprehensive periodic and "as needed" health exams to identify physical, mental, and developmental conditions, complete vision, dental and hearing care, all immunizations recommended by the Advisory Committee on Immunization Practices (an advisory body to the CDC), and all medically necessary diagnoses and treatments, which fall within the federal definition of "medical assistance," determined to be necessary to treat or "ameliorate" children's physical and mental health conditions disclosed through screens.<sup>52</sup> Thus, while many forms of medical assistance are optional for adults, all benefits and services falling within the federal definition of medical assistance are mandatory for children. (See Figure 1 pg. 12).

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<sup>49</sup> Rosenblatt, Law & Rosenbaum, *supra* note 33, at 110.

<sup>50</sup> 42 U.S.C.A. §19 (2004).

<sup>51</sup> Sara Rosenbaum et al., *Room to Grow: Promoting Child Development through Medicaid and SCHIP* (Commonwealth Fund, NY, NY) at [http://www.cmf.org/programs/child/rosenbaum\\_room\\_451.pdf](http://www.cmf.org/programs/child/rosenbaum_room_451.pdf) (June 2001); Rosenbaum, et. al., *supra* note 21.

<sup>52</sup> Sara Rosenbaum, Michelle Proser, Andy Schneider & Colleen Sonosky, *Room to Grow: Promoting Child Development through Medicaid and SCHIP* (Commonwealth Fund, NY, NY) at [http://www.cmf.org/programs/child/rosenbaum\\_room\\_451.pdf](http://www.cmf.org/programs/child/rosenbaum_room_451.pdf) (June 2001); Rosenbaum, et. al., *supra* note 21.

**Figure 1. The EPSDT Benefit<sup>53</sup>****1. PERIODIC AND “AS NEEDED” SCREENING SERVICES THAT INCLUDE:**

- An unclothed physical examination
- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations recommended by the CDC Advisory Committee on immunization practices
- Laboratory tests (including blood lead level assessment appropriate for age and risk factors)
- Health education

**2. VISION SERVICES (ASSESSMENT, DIAGNOSIS AND TREATMENT INCLUDING EYEGLASSES)****3. HEARING SERVICES (ASSESSMENT, DIAGNOSIS AND TREATMENT INCLUDING HEARING AIDS)****4. DENTAL SERVICES WHICH INCLUDE AT A MINIMUM RELIEF OF PAIN AND INFECTIONS, RESTORATION OF TEETH AND MAINTENANCE OF DENTAL HEALTH****5. SUCH NECESSARY HEALTH CARE, DIAGNOSTIC SERVICES, TREATMENT AND OTHER MEASURES CLASSIFIED AS MEDICAL ASSISTANCE 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.****6. A “PREVENTIVE” STANDARD OF MEDICAL NECESSITY, RECOGNIZED IN AGENCY IMPLEMENTING GUIDELINES AND JUDICIAL DECISIONS**

<sup>53</sup> §1905(r) of the Soc.Sec.Act, 42 U.S.C. §1396d(r); Part 5, Section 5122 of the State Medicaid Manual, *available at*: [http://www.cms.hhs.gov/manuals/pub45/pub\\_45.asp](http://www.cms.hhs.gov/manuals/pub45/pub_45.asp).

In some respects, the rules of coverage where children are concerned are even more notable than the broad classes of coverage themselves. Federal law prohibits application to children under 18 of even nominal co-payments for covered benefits and services.<sup>54</sup> Even more dramatic is the framework applicable to medical necessity determinations under the program. Medicaid does not explicitly define medical necessity for any covered population, including children, requiring instead that state definitions be reasonable, consistent with the program's overall purposes, and not discriminate in the provision of mandated services against particular conditions or illnesses.<sup>55</sup> Where children are concerned, the federal legal principles of reasonableness applicable to state coverage standards, as construed under a nearly 40 year-old judicial and administrative interpretive "gloss," coupled with the terms "early" and "ameliorate" in the EPSDT statute itself, and the program's fabled legislative history,<sup>56</sup> underscore the preventive nature of the EPSDT legal entitlement and reject arbitrary limits on coverage (such as fixed day, treatment or dollar limits) unrelated to the medical need for treatment.<sup>57</sup> These judicial rulings and agency interpretations were powerfully reinforced by the 1989 EPSDT legislative amendments, which broadly expanded the diagnosis and treatment mandate to include all forms of medical assistance, added mandatory coverage for "as needed" examinations, and tied the concept of medical necessity to the recommendations of treating health professionals.<sup>58</sup> While the 1984 regulations have never been updated to reflect the amendments (a sure sign of the program's controversial

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<sup>54</sup> Rosenbaum & Rousseau, *supra* note 1; Schneider et al., *supra* note 6.

<sup>55</sup> 42 C.F.R. §440.230(b0, 42 C.F.R. §440.230(c). For a discussion of the special Medicaid principles that govern coverage of children, see Sara Rosenbaum & Colleen Sonosky, *Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts* (2002) at [http://www.gwhealthpolicy.org/medicaid\\_publications\\_epsdt.htm](http://www.gwhealthpolicy.org/medicaid_publications_epsdt.htm).

<sup>56</sup> More specifically, the statute was modified in response to two seminal pieces of health services research, which examined the diminished health status of the first young children enrolled in Head Start, as well as the very serious disabling conditions affecting low-income young adults rejected for Selective Service. *EPSDT Does it Spell Health Care for Poor Children* (Children's Defense Fund, Washington, D.C.); ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* (Free Press, New York, NY 1974); *Better Health for Our Children: A National Strategy*, Select Panel for the Promotion of Child Health (Public Health Service, Department of Health and Human Services, Washington D.C. 1981); A.M. FOLTZ, *AN OUNCE OF PREVENTION: CHILD HEALTH POLITICS UNDER MEDICAID* (MIT Press, 1982); Rosenbaum & Rousseau, *supra* note 1; Rosenblatt & Rosenbaum, *supra* note 33.

<sup>57</sup> Sara Rosenbaum & David Rousseau, *Medicaid at Thirty Five*, 45 ST. LOUIS U. L.J. 7, 7-51 (2001); Sara Rosenbaum *Health Policy Report: Medicaid*, 346 NEW ENG. J. MED. 8, 635-640 (2002).

<sup>58</sup> Omnibus Budget Reconciliation Act of 1989 (OBRA 89) Pub. L. 101-239.

nature), the most recent federal guidelines reinforce its scope and reach.<sup>59</sup> As a result, diagnosis and treatment must be furnished at the earliest possible point in the progression of a condition, and the recommendations of treating clinicians are considered to carry especially great weight.<sup>60</sup>

In sum, both historically and legally, the term “medical necessity” in a Medicaid child health context is grounded in concepts of early intervention to ameliorate physical and health conditions, and is a bar against arbitrary limits on diagnosis and treatment unrelated to the recommendations of treating conditions.<sup>61</sup> Furthermore, when read in the context of Medicaid’s general prohibition against discrimination in the provision of mandatory treatments and services based on an individual’s diagnosis or condition, these special coverage rules result in a form of third party financing which, simply stated, has no counterpart in the commercial insurance market.<sup>62</sup> For Medicaid enrolled children, virtually any form of health care is covered from the time that its clinical need is first suspected; treatments range from medical interventions necessary to diagnose and treat conditions to clinically recommended preventive therapies furnished by “licensed practitioners of the healing arts.”<sup>63</sup> Covered treatments must be furnished without the types of “macro” exclusions and limitations which tend to characterize the commercial market.<sup>64</sup> As a result, Medicaid treatments for children encompass not only treatment necessary for “recovery” or “improvement” from “illness or injury” but also treatments necessary to avoid or ameliorate the long-term effects of chronic illness and disability from which there may never be recovery or improvement in the narrow sense of the terms.<sup>65</sup> In the case of Medicaid coverage for children, there is no need to show that a recommended treatment will allow a child to “recover normal functioning” following an “illness or injury” as there typically would be in the case of commercial insurance.<sup>66</sup> Nor does Medicaid contain the typical pediatric

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<sup>59</sup> Centers for Medicare and Medicaid Services, *State Medicaid Manual* (2004), available at [http://www.cms.hhs.gov/manuals/pub45/pub\\_45asp](http://www.cms.hhs.gov/manuals/pub45/pub_45asp).

<sup>60</sup> Sara Rosenbaum & Colleen Sonosky, *Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts*, Chapter 1, p. 2, at [http://www.gwhealthpolicy.org/medicaid\\_publications\\_epsdt.htm](http://www.gwhealthpolicy.org/medicaid_publications_epsdt.htm); Rosenbaum et. al., *supra* note 21, at 3.

<sup>61</sup> *Id.* at 7.

<sup>62</sup> 42 U.S.C. §1396(a)(17); 42 C.F.R. §440.230.

<sup>63</sup> Medicaid Manual, *supra* note 59.

<sup>64</sup> Rosenbaum, *supra* note 1, at 636.

<sup>65</sup> *Id.*; Rosenbaum & Sonosky, *supra* note 60, at 2.

<sup>66</sup> Rosenbaum, *supra* note 64.

exclusions found in commercial plans, such as “educational” exclusions; indeed, Medicaid specifically mandates coverage of all otherwise covered items and services listed in special educational or early intervention plans developed for children with disabilities under the Individuals with Disabilities Education Act (IDEA).<sup>67</sup>

To be sure, an expanded notion of coverage is one of Medicaid’s most essential attributes for adults as well, which accounts for the fact that more than two-thirds of all Medicaid expenditures are for the elderly and persons with severe disabilities.<sup>68</sup> But in the case of adults, much of this coverage is optional with state programs, whereas it is required for children.<sup>69</sup> Indeed, so broad is Medicaid coverage for children that although its coverage is classified as “insurance” for purposes of statistical population coverage estimates, its “legal operating system” follows absolutely none of the conventions of insurance, particularly where children are concerned.<sup>70</sup> Medicaid in a child health context is best thought of as a legal entitlement among eligible children to comprehensive health care financing.

It should come as no surprise that the EPSDT program – and the 1989 EPSDT amendments in particular, which radically expanded the rules of coverage – have proven to be politically unpopular.<sup>71</sup> States have repeatedly called for relaxation of federal standards, and EPSDT requirements have consistently ranked at the top of lists compiled by Governors and state legislators when asked to identify unreasonable Medicaid standards.<sup>72</sup> When asked to explain the opposition, state Medicaid officials point to examples of what they consider to be wildly unreasonable service requests, such as dance therapy for children with disabilities or horseback riding therapy. There exists, however, no systematic evidence of the extent to which non-traditional therapeutic services aimed at improving emotional and physical health dominate EPSDT spending; indeed, federal expenditure data underscore

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<sup>67</sup> 20 U.S.C. §1400 et. seq.

<sup>68</sup> Kaiser Commission *supra* note 8; Rosenbaum, *supra* note 64, at 637.

<sup>69</sup> Rosenbaum, *supra* note 64, at 637; Rosenbaum & Rousseau, *supra* note 1; Schneider et. al., *supra* note 6.

<sup>70</sup> Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL’Y & L. (2):287-317 (Summer 1993).

<sup>71</sup> Rosenbaum & Sonosky, *supra* note 12, at 85-86.

<sup>72</sup> *Id.* at 86; National Governor’s Association, *supra* note 8.

the extent to which spending on children is for entirely traditional forms of medical care such as physician and hospital services, prescription drugs, medical equipment, and diagnostic services.<sup>73</sup>

### **SCHIP**

SCHIP is a grant-in-aid statute which entitles participating states to an annual aggregate payment toward the cost of “child health assistance” furnished by participating providers to enrolled children.<sup>74</sup> Unlike Medicaid which is perpetual, SCHIP was authorized for a 10-year term.<sup>75</sup>

In popular lore, SCHIP had its genesis in the desire of Congress and the President to find common ground following the failure of national health reform.<sup>76</sup> In the wake of the 1996 Health Insurance Portability and Accountability Act (HIPAA), which provided for greater “portability” of employee health benefits, SCHIP was presented as a bipartisan consensus regarding the appropriate role of the federal government in subsidizing health care for lower income uninsured children without access to Medicaid.<sup>77</sup> The legislation received heavy support from traditional children’s advocacy groups.<sup>78</sup>

The reality regarding SCHIP’s origins is far more complicated. In its policy aims, the legislation may have had roots in expansive concepts. In its statutory structure however, SCHIP was the child of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform).<sup>79</sup> Until the threat of a Presidential veto resulted in its removal, the 1996 legislation contained a successor program to Medicaid, which would have replaced the law with an aggregate, capped federal grant-in-aid program which entitled states to assistance but removed the individual legal entitlement as well as virtually all coverage, payment, and detailed

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<sup>73</sup> Centers for Medicare and Medicaid Services, *2003 Data Compendium*, available at <http://www.cms.hhs.gov/researchers/pubs/datacompendium/current>.

<sup>74</sup> Rosenbaum et al., *supra* note 2; Sara Rosenbaum et al., “*The Children’s Hour: The State Children’s Health Insurance Program*,” 17 HEALTH AFF. 1:75-89, 76 (January-February, 1989).

<sup>75</sup> *Id.*

<sup>76</sup> Rosenbaum & Sonosky, *supra* note 12, at 86-87.

<sup>77</sup> *Id.*

<sup>78</sup> Rosenbaum & Sonosky, *supra* note 12, at 82, 94-96.

<sup>79</sup> *Id.* at 91.



administration requirements.<sup>80</sup> These characteristics also constitute a near-perfect description of the SCHIP statutory structure.<sup>81</sup>

Even more strikingly, SCHIP does not merely permit states to augment Medicaid coverage: it allows them to use SCHIP *as an alternative* to Medicaid coverage.<sup>82</sup> That is, states can either combine approaches or choose *either* to operate SCHIP as a separate program *or* to allocate their payments toward Medicaid expansions.<sup>83</sup> The children covered under a state's separate SCHIP would be Medicaid-ineligible children with family incomes at or below 200% of the federal poverty level, or at a slightly higher eligibility level in states which had generous Medicaid programs already reaching SCHIP's 200% threshold.<sup>84</sup> Children with incomes exceeding the SCHIP upper limit could qualify for Medicaid either as medically needy or through the use of the special 1989 legislative authority to extend coverage to all children who might require Medicaid as either a primary or supplemental insurer.<sup>85</sup> The bottom line is that states could effectively substitute SCHIP for Medicaid in the case of uninsured children with incomes above mandatory Medicaid eligibility levels. (See figure 2 pg. 19).

On the face of it then, SCHIP would seem like a particularly loopy legislative initiative. Why would Congress, which hardly can be said to spend excessively on public welfare programs for low-income families, allocate \$40 billion in scarce federal resources over a 10 year time period (the SCHIP price tag) for a program which appears to be utterly duplicative of what Medicaid already permits where children are concerned? The answer, of course, lays in SCHIP's coverage design rules. It is true that SCHIP also provides for a more generous federal subsidy than the level allowed states under Medicaid; but when Senators Rockefeller and Chafee attempted to offer an amendment during the 1997 Senate Finance Committee's consideration

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<sup>80</sup> *Id.*

<sup>81</sup> Rosenbaum et al., *supra* note 2; Sara Rosenbaum et al., "*The Children's Hour: The State Children's Health Insurance Program*," 17 HEALTH AFF. 1:75-89, 76 (January-February, 1989).

<sup>82</sup> Rosenbaum, et. al., *supra* note 81.

<sup>83</sup> Title XXI of the Social Security Act, §2101 [hereinafter Title XXI]; 42 U.S.C. 1397aa.

<sup>84</sup> R. Andrew Allison & Robert F. St. Peter, *Children's Enrollment in HealthWave and Medicaid: Where Do We Stand?* Kansas HealthWave Evaluation Project (2001), available at <http://www.khi.org/transfers/IssueBrief12.AA1.pdf>; R. Andrew Allison, Barbara LaClair & Robert F. St. Peter, *Children's Enrollment in Kansas Public Health Insurance Programs Since the Introduction of HealthWave*, Kansas HealthWave Evaluation Project (2001b), at <http://www.khi.org/transfers/Issuebrief2001.pdf>.

<sup>85</sup> Omnibus Budget Reconciliation Act of 1989 (OBRA) Pub. L. 101-239.

of the legislation to increase federal matching rates for certain optional children in lieu of establishing a new program, their proposal was rejected in the face of opposition by other Members of the Committee and the Governor's Association.<sup>86</sup> It is in the area of coverage design where SCHIP's "not-Medicaid" character and strength (at least from a state perspective) can be seen.<sup>87</sup>

SCHIP departs utterly from Medicaid in virtually every key respect where coverage is concerned. First, the legislation expressly eliminates the individual legal entitlement which lies at the heart of Medicaid, while simultaneously creating a legal entitlement to allotments in participating states.<sup>88</sup> Second, SCHIP replaces Medicaid's defined benefit medical assistance structure with a "premium support" model using the "basic services" covered in the law's actuarial benchmarks to calibrate the coverage obligations of approved state plans.<sup>89</sup> The SCHIP "benchmarks" from which states can choose are the Federal Employee Health Benefit Plan, the health benefit plan offered state employees in a participating state, or the best selling HMO product in the state.<sup>90</sup> In other words, the "child health assistance" extended to eligible children under SCHIP consists of subsidization of enrollment into a participating plan offering "benchmark" coverage.<sup>91</sup> Thus, coverage, as conceptualized in SCHIP, was a direct legislative precursor to the premium support approach to coverage of prescription drug benefits, which was taken in the 2003 Medicare legislation; unlike the Medicare legislation however, SCHIP specifies no statutory standards for participating plans, although implementing federal regulations do contain certain enrollment and other safeguards.<sup>92</sup>

While the SCHIP statute enumerates benefits which in their terms parallel the Medicaid definition of "medical assistance," this enumeration identifies what states *may* spend money on, not what they must cover.<sup>93</sup> For all practical purposes,

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<sup>87</sup> *Id.* at 87.

<sup>88</sup> Title XXI, §2101 (c); 42 U.S.C. 1397aa (c); Policy Brief, *supra* note 3; Rosenbaum et al., *supra* note 2.

<sup>89</sup> Rosenbaum et al., *supra* note 21, at 7-8; Rosenbaum et al., *supra* note 2.

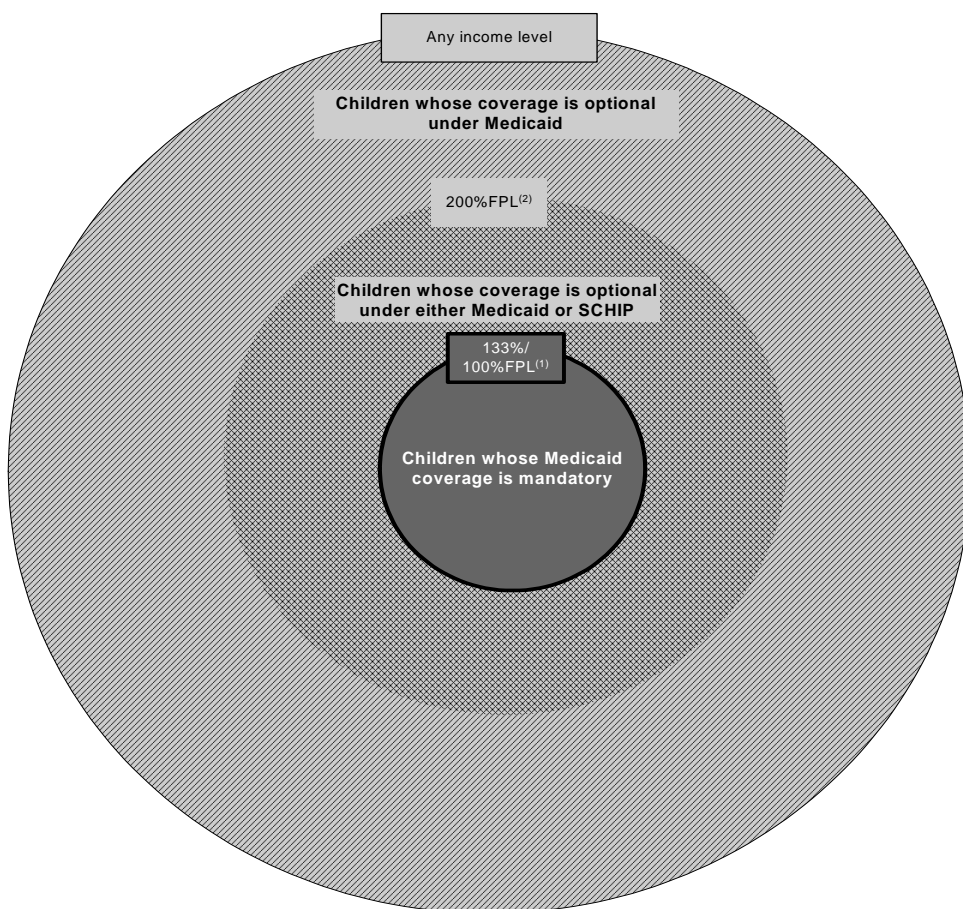
<sup>90</sup> Title XXI, §2103 (b); 42 U.S.C. 1397cc (b).

<sup>91</sup> Rosenbaum et al., *supra* note 21, at 7-8; Rosenbaum et al., *supra* note 2.

<sup>92</sup> 42 CFR Parts 457 et. seq.

<sup>93</sup> Title XXI, §2103; 42 U.S.C. 1397cc; Rosenbaum et al., *supra* note 21, at 8.

**Figure 2. SCHIP as a Coverage Alternative to Medicaid**



(1) Under Medicaid, mandatory groups are children ages 0-6 under 133%FPL and children ages 6-19 under 100%FPL.  
 (2) Targeted children under SCHIP are children with incomes between the upper Medicaid eligibility level in the state and 200%FPL (with some exceptions in states with Medicaid eligibility levels already above 200%FPL where SCHIP eligibility can be extended up to 50 percentage points over the maximum Medicaid level). This means that the SCHIP population represented by the middle circle shrinks and grows depending on Medicaid policy in the state. These children are also optional children under Medicaid and were so before SCHIP was enacted.

the only standard which counts is the actuarial “basic benefit” benchmark; if a state selects a benchmark which includes “additional” services other than those considered “basic,” then it must offer those services at a “substantial actuarial value.”<sup>94</sup> The SCHIP statute contains no rules of coverage other than a bar against the imposition of pre-existing condition exclusions.<sup>95</sup> Basic benefits consist of “inpatient and outpatient hospital services, physicians’ surgical and medical services, laboratory and x-ray services, well-baby and well-child care (as defined by the state), and age appropriate immunizations.”<sup>96</sup> “Additional” service “categories” consist of “prescription drugs, mental health services, vision services, and hearing services.”<sup>97</sup>

Within the categories of “basic” and “additional” service, no standards exist with respect to tests of reasonableness, definitions of benefits, medical necessity standards, or non-discrimination in coverage.<sup>98</sup> The law does prohibit the imposition of pre-existing condition exclusions and specifies the applicability of HIPAA portability and mental health parity standards.<sup>99</sup> Implementing regulations interpreted these provisions slightly more explicitly (for example, the rules define the term “age appropriate immunizations” to cover all ACIP-approved vaccines and specify coverage of “emergency” care).<sup>100</sup> But for all practical purposes, the rules adhere to the vagaries of the statute, leaving states and their plan contractors with immense discretion over benefit design.

A clear example of the discretion enjoyed by states can be seen in the definition of an EPSDT examination compared to a SCHIP well-baby exam. The Medicaid statute defines an EPSDT “periodic screen” as an assessment which

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<sup>94</sup> *Id.*

<sup>95</sup> Title XXI, §2103 (f) (1); 42 U.S.C. 1397cc (f) (1).

<sup>96</sup> Title XXI, §2103 (c); 42 U.S.C. 1397cc (c); Rosenbaum et al., *supra* note 21.

<sup>97</sup> *Id.*

<sup>98</sup> Rosenbaum et al., *supra* note 21, at 8.

<sup>99</sup> Title XXI, *supra* note 93.

<sup>100</sup> 42 CFR Parts 457.520 (b)(4) and 457.10.

encompasses specified procedures: a health history, an unclothed physical examination, an assessment of growth and development, appropriate laboratory tests (including tests for elevated blood lead exposure), ACIP-required immunizations, assessments of vision and hearing in accordance with professional standards, and a referral to a dentist for preventive, restorative and emergency treatment.<sup>101</sup> The SCHIP statute, in contrast, contains no specifications regarding well-baby or well-child exams, and implementing regulations clarify that the content is defined by a state.<sup>102</sup>

It is also important to note that unlike Medicaid, SCHIP cannot supplement inadequate coverage; the statute's health insurance "anti-crowd-out" provisions explicitly prohibit its use to enhance existing coverage.<sup>103</sup>

In sum, as Figure 3 shows, SCHIP is a variation on a state block grant, not a public legal entitlement. The statute was deliberately structured to operate as a *substitute* for Medicaid expansions into the near-poor child population, a vastly more palatable approach from a state policy perspective.<sup>104</sup> SCHIP creates a legal entitlement (albeit capped) in states but bars comparable treatment of children.<sup>105</sup> The statute uses a premium support approach to coverage, eliminates virtually all coverage design requirements applicable to children, not only in terms of classes of benefits and services but equally as importantly, in terms of the rules of coverage themselves.<sup>106</sup> In addition, the statute permits premiums and patient cost sharing.<sup>107</sup> (See Figure 3 pg. 22-23).

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<sup>101</sup> Title XXI, §1905(r); 42 U.S.C. §1396d(r).

<sup>102</sup> Title XXI, §2110 (a); 42 U.S.C. §1397jj(a); 42 CFR Parts 457.10.

<sup>103</sup> Title XXI, §2110 (b) (1)(c); 42 U.S.C. §1397jj (b)(1)(c); Cunningham, et. al., *supra* note 38.

<sup>104</sup> Rosenbaum et al., *supra* note 12, at 90.

<sup>105</sup> Title XXI, §2101(c), §2102(b)(4); 42 U.S.C. §1397aa (c), §1397bb(b)(4).

<sup>106</sup> Title XXI, §2103(a-d); 42 U.S.C. §1397cc(a-d); Rosenbaum, et. al., *supra* note 21, at 7-8.

<sup>107</sup> Title XXI, §2103(e); 42 U.S.C. §1397cc(e).

**Figure 3. A Broad Comparison of Benefit Design Requirements Under Medicaid and SCHIP**

<b>MEDICAID</b>	<b>SCHIP</b>
<p>Participating states must entitle eligible children to a broad range of required classes of “medical assistance”. Required coverage for children is federally defined and nationally uniform in scope:</p> <ul style="list-style-type: none"> <li>• The EPSDT benefit encompasses detailed statutory assessment procedures, vision, dental and hearing services, and all forms of treatment that fall within the federal definition of “medical assistance.”</li> <li>• No distinctions are drawn between physical and mental conditions.</li> </ul>	<p>Participating states must furnish “child health assistance,” which is subject to certain basic design rules but is not a legal entitlement in eligible children. States’ coverage design flexibility is subject to certain rules:</p> <ul style="list-style-type: none"> <li>• Coverage must be “equivalent to,” and must have an “aggregate actuarial value that is at least actuarially equivalent” to, a “benchmark benefit package” selected by the state.</li> <li>• Required categories of “basic services” must be included in the benchmark (inpatient and outpatient hospital care, physician surgical and medical services, laboratory and x-ray services, “well baby and well child” care (undefined) and age appropriate immunizations.</li> <li>• States have the option of covering prescription drugs, mental health services, vision services, hearing services, and other services recognized as “child health assistance.”</li> </ul>

**Figure 3. A Broad Comparison of Benefit Design Requirements Under Medicaid and SCHIP (continued)**

<b>MEDICAID</b>	<b>SCHIP</b>
<p>The concept of medical necessity is subject to federal rules. States must use a “preventive” standard of medical necessity in accordance with the benefit and federal standards of reasonableness and prohibitions against discrimination on the basis of condition or illness.</p> <p>Cost-sharing is prohibited for all categorically needy children.</p> <p>Children are legally entitled to a defined group of benefits. States remain directly obligated to cover all benefits that exceed limits of MCO contracts.</p>	<p>There is no federal definition of medical necessity, tests of reasonableness, or non-discrimination in coverage provisions. HIPAA prohibitions against preexisting condition exclusions apply to insurance products however.</p> <p>Cost-sharing is permitted subject to certain limits but is prohibited for well baby and well child care including immunizations.</p> <p>Benefits are not a federal legal entitlement. States are not obligated to furnish defined benefits beyond the benchmark.</p>

In terms of the proportion of children receiving *any level* of publicly supported health care financing assistance, the SCHIP approach definitely has worked; indeed, the program's impact was immediate.<sup>108</sup> Whereas states' response to the 1988 Medicaid option to reach all children in need of health insurance could be described as lethargic at best, within 3 years, all states had implemented at least some level of expanded coverage under SCHIP.<sup>109</sup> Figure 4 shows states' implementation choices and 2002 eligibility levels. Figure 4 clusters states into three separate tiers. At the top are the 15 states and the District of Columbia that invested their SCHIP allotments solely into Medicaid expansions. The middle tier shows states that implemented SCHIP as a hybrid, expanding Medicaid somewhat and filling in the rest with a separately-administered program at somewhat higher income levels, in an attempt to balance the two main issues of entitling the poorest children and smoothing out the age bands (so that older poor children would be equitably treated compared to younger poor children) on the one hand, and providing less generous treatment for the near poor, on the other hand. The third tier shows states that used their allotments solely to establish a separately-administered program; this tier includes Pennsylvania, one of three states with Florida and New York, whose separate children's insurance programs was already in place at the time of SCHIP's enactment and was grandfathered into the new law by statute. (See Figure 4 pg. 25).

There have been no published studies on the politics of state implementation, but the wealth of contemporary publicity, meetings, and anecdotal evidence that have accompanied implementation suggest that two related factors have tended to influence which tier a state ultimately fell into. The first factor was the issue of legal entitlements. State officials reported that the ability to avoid an entitlement and the relatively uncontrollable expenditure vulnerability that goes along with it heavily influenced their decisions regarding whether to implement SCHIP fully or partially as a separate program.<sup>110</sup> In fact, no state that established a separate SCHIP program did so as a state legal entitlement.<sup>111</sup> It is therefore ironic, perhaps, that implementation of SCHIP was accompanied by an explosion

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<sup>108</sup> Debbie Chang & Genevieve Kenney, *The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges* 23:5 HEALTH AFFAIRS 51-62 (2004).

<sup>109</sup> *Id.*

<sup>110</sup> Chang & Kenney, *op. cit.*, *supra* note 108, at p. 52.

<sup>111</sup> Policy Brief, *supra* note 3, at 1.



**Figure 4. State Implementation Choices and  
Eligibility Levels under SCHIP  
(2002 Upper SCHIP Income Eligibility Limit)**

**MEDICAID EXPANSION ONLY**

Alaska (200%FPL), Arkansas (200%FPL), District of Columbia (200%FPL), Hawaii (200%FPL), Idaho (150%FPL), Louisiana (200%FPL), Minnesota (280%FPL, ages 0-2), Missouri (300%FPL), Nebraska (185%FPL), New Mexico (235%FPL), Ohio (200%FPL), Oklahoma (185%FPL), Rhode Island (250% FPL), South Carolina (150%FPL, ages 1-18), Tennessee (200%FPL), Wisconsin (200%FPL)

**MEDICAID EXPANSION AND SEPARATELY-ADMINISTERED SCHIP PLAN**

Alabama (200%FPL), California (250%FPL), Connecticut (300%FPL), Florida (200%FPL, ages 1-18), Illinois (185%FPL), Indiana (200%FPL), Iowa (200%FPL), Kentucky (200%FPL), Maine (200%FPL), Maryland (300%FPL), Massachusetts (200%FPL, ages 1-18), Michigan (200%FPL), Mississippi (200%FPL), New Hampshire (300%FPL, ages 1-18), New Jersey (350%FPL), New York (250%FPL), North Dakota (140%FPL), South Dakota (200%FPL), Texas (200%FPL), Virginia (200%FPL)

**SEPARATELY-ADMINISTERED SCHIP PLAN ONLY**

Arizona (200%FPL), Colorado (185%FPL), Delaware (200%FPL), Georgia (235%FPL), Kansas (200%FPL), Montana (150%FPL), Nevada (200%FPL), North Carolina (200%FPL), Oregon (170%FPL), Pennsylvania (235%FPL), Utah (200%FPL), Vermont (300%FPL), Washington (250%FPL), Wyoming (133%FPL), West Virginia (200%FPL)

of children's enrollment into Medicaid, even in states that administered SCHIP as a separate program.<sup>112</sup> The cause of this rapid run-up in children's Medicaid enrollment was that many - and in some states most - of the children identified through aggressive outreach were poor enough to be enrolled in Medicaid and therefore barred by federal law in enrollment into SCHIP, since SCHIP is limited to children who are ineligible for other forms of coverage<sup>113</sup>

The second issue frequently reported by state officials was the politics of Medicaid's coverage design for children. Numerous officials suggested strong political objections to such broad coverage for near-poor children in terms of both the comprehensiveness of benefits and the prohibitions against cost-sharing.<sup>114</sup> One study for the United States Department of Health and Human Services that was published in the early years of implementation suggested that while states with separately-administered programs were pursuing cost-sharing, the actual level of cost-sharing requirements imposed was well below the level permitted under federal law.<sup>115</sup> At the same time, the ability to impose cost-sharing (in particular, premiums at higher levels of family income, a practice pursued by 29 states as of 2000) was viewed as politically important.<sup>116</sup>

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<sup>112</sup> Chang & Kenney, *op. cit. supra*, at p. 55.

<sup>113</sup> 42 U.S.C. §1397jj(b)(1)(C); 42 CFR §457.310(b)(2); Rosenbaum & Markus, *supra* note 41, at 6.

<sup>114</sup> Office of the Secretary Assistant Secretary for Planning and Evaluation, *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. Pg. XV. February 26, 2003 Executive Summary at <http://www.aspe.os.dhhs.gov/health/schip/interimrpt/Interim.pdf>

<sup>115</sup> Sara Rosenbaum, Anne Markus & Dylan Roby, *An Analysis of Implementation Issues Relating to CHIP Cost-Sharing Provisions for Certain Targeted Low Income Children*, Health Resources and Services Administration and the Health Care Financing Administration, Department of Health and Human Services, Baltimore and Bethesda, MD, at [http://www.gwhealthpolicy.org/downloads/cs\\_finalreport\\_edt.pdf](http://www.gwhealthpolicy.org/downloads/cs_finalreport_edt.pdf) (June 1999); Anne Markus, Sara Rosenbaum & Dylan Roby, Center For Health Policy, George Washington University, *CHIP, Health Insurance Premiums and Cost-Sharing: Lessons from the Literature* (October 1998) at [http://www.gwhealthpolicy.org/downloads/cost\\_sharing\\_litreview\\_overview.pdf](http://www.gwhealthpolicy.org/downloads/cost_sharing_litreview_overview.pdf).

<sup>116</sup> Office of the Secretary, *supra* note 114; National Conference of State Legislatures (2000) State Children's Health Insurance Program (SCHIP): Cost Sharing at <http://www.ncsl.org/programs/health/chipcost.htm>.

## **Findings from the SCHIP Design Studies**

Given the potential importance of benefit design flexibility accorded under the SCHIP statute, as well as its potential to allow states broad latitude in benefit design, a group of researchers at George Washington University (GWU) with extensive experience in health insurance generally, and children's insurance coverage under Medicaid in particular, carried out a series of detailed descriptive studies over the 1998-2002 time period which collectively sought to measure variations in Medicaid and SCHIP design.<sup>117</sup>

### **Study methods**

The study we report on here is a nationwide, point-in-time descriptive study of coverage under Medicaid and SCHIP, which considers both the coverage offered under states' Medicaid and separately administered SCHIP plans, as well as the coverage which is available through managed care contracts covering children eligible for assistance. Both Medicaid and SCHIP agencies effectuate coverage either wholly or partially through the compulsory enrollment of children in purchased managed care arrangements.<sup>118</sup> As a result, children may derive coverage from two sources: the state plans for the program in which they are enrolled; and their managed care contracts. For this reason, the studies had to be conducted in two phases. In the first phase, researchers compared the details of coverage under state Medicaid and SCHIP plans, as reported by participating Medicaid and SCHIP agencies to the federal government. Such comparisons were once relatively easy, but for more than a decade the federal government has maintained no centralized repository of

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<sup>117</sup> Rosenbaum & Smith, *supra* note 3; Rosenbaum et al., *supra* note 2; Rosenbaum et al., *supra* note 21; Rosenbaum et al., *supra* note 3; Rosenbaum & Markus, *supra* note 41.

<sup>118</sup> Rosenbaum et al., *supra* note 3, at 3-5; Office of the Secretary, *supra* note 114; Sara Rosenbaum, Colleen Sonosky, Karen Shaw & Marcie Zakheim, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (K. Johnson ed., Center for Health Services Research and Policy, The George Washington University Medical Center, Washington, DC) (1 ed. 1997) [hereinafter 1997 Nationwide Study] at [http://www.gwhealthpolicy.org/managed\\_care.htm](http://www.gwhealthpolicy.org/managed_care.htm).

detailed state plan information. For this reason, the task of determining what, precisely, participating states cover under Medicaid and SCHIP has become a major chore. Our previous research has reported on critical differences in SCHIP and Medicaid state plans, the most important of which are silence in SCHIP plans on the definition of medical necessity, as well as more limited coverage of chronic care services, dental and mental health coverage.<sup>119</sup>

In the second phase of the study, managed care contracts had to be collected and analyzed in order to compare their scope of coverage to the coverage offered under their respective state plans. This step was important for two reasons. First, states' Medicaid and SCHIP contracts actually may go beyond the state plan in their coverage specifications. That is, a state plan may not identify certain services as covered for federal reporting purposes but nonetheless, the service is contractually specified.

Second, in a study of trends in public insurance design, understanding which benefits are included in the managed care contract and which remain as a direct financial and performance obligation of a state agency, helps shed light on the practical and political limits of the "marketization" of public insurance. The close study of contracts written by Medicaid agencies reveals certain definite patterns regarding which benefits are regarded as financially or administratively and medically manageable in the private sector.<sup>120</sup> For example, Medicaid contracts routinely exempt certain classes of benefits (e.g., intermediate care facilities for persons with mental retardation and home health services).<sup>121</sup> Similarly, some of the benefits covered in a Medicaid managed care contract may be subject to specified limits that do not apply under the state plan. For example, a contract may place a limit on psychiatric care of 26 mental health visits annually, but under EPSDT and Medicaid's general anti-discrimination rules, no such limit could be imposed by the state; that is, the contractual benefit would have to be supplemented by direct state payments were a child to need additional services.

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<sup>119</sup> Rosenbaum et al., *supra* note 21.

<sup>120</sup> Sara Rosenbaum et al., Center for Health Service Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, (June 1999) [hereinafter 1999 Nationwide Study], at [http://www.gwhealthpolicy.org/managed\\_care.htm](http://www.gwhealthpolicy.org/managed_care.htm) (last visited September 2004); 1997 Nationwide Study, *supra* note 118.

<sup>121</sup> *Id.*

Similarly, some but not all prescription drugs covered under a state Medicaid plan might be included in its managed care contracts, with the remaining drugs in the state formulary covered under the state plan as a form of supplemental coverage. Medicaid beneficiaries enrolled in managed care effectively would be dually insured.<sup>122</sup>

Most interestingly perhaps, public contracts might be silent with respect to certain critical definitional matters which undergird Medicaid benefits but that tend to have no counterpart in privately sold managed care products.<sup>123</sup> Two prime examples are the medical necessity standard or explicit prohibitions against arbitrarily limiting covered benefits based on an enrollee's condition. In the absence of explicit state policy (typically embodied in detailed contractual specifications), silence in the contract would leave contractors with considerable discretion that state Medicaid agencies themselves would not enjoy.<sup>124</sup> Once again, Medicaid agencies would be in the position of supplementing contractual services; non-contractual services would be covered on an extra-contractual basis.<sup>125</sup> (At the same time of course, unless and until a beneficiary or her provider pursues a claim for residual benefits, which necessitates a high degree of knowledge and sophistication about the inner workings of Medicaid, a state presumably would be able to curb their financial exposure for this penumbra of supplemental coverage surrounding the contractual obligation.)

A classic and easy example of this coverage penumbra flowing from this residual benefit phenomenon (which includes non-contractual benefits as well as additional benefits flowing from EPSDT's very liberal definition of medical necessity) can be seen in the case of physical therapy for adults recovering from stroke and a child with a developmental disability emanating from cerebral palsy. A managed care contract which is silent on medical necessity would permit the contractor to use a traditional insurance definition of medical necessity, which limits coverage to covered diagnostic and treatment services which either restore or improve functioning following an illness or injury.<sup>126</sup> The child would need therapy, not to recover from an illness (as would be the case for the patient recovering from

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<sup>122</sup> 1997 Nationwide Study, *supra* note 118.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> Rosenbaum et al., *supra* note 21, at 14, 15-18.

a stroke), but in order to develop physical movement. Traditional insurance principles would deny this coverage, a reality borne out by cases challenging the limits of commercial insurance for children with developmental disabilities.<sup>127</sup> The Medicaid EPSDT benefit would mandate this coverage at the earliest point of diagnosis, and coverage would be ongoing as long as clinically necessary.<sup>128</sup> Were a Medicaid managed care contract not to cover the service, the Medicaid agency would be obligated to finance it directly and supplementally.<sup>129</sup>

For this reason, a close read of Medicaid and SCHIP coverage agreements against the global provisions of state plans becomes essential when attempting to understand the fine points of coverage differentials in the two programs. The contract research phase of the project was conducted through the development of a special data base created by George Washington University in 1994 and updated three times over the ensuing time period.<sup>130</sup> The data base for this study consists of contract documents between contractors and Medicaid and SCHIP agencies covering the 2001-2002 time period, and these contract provisions can be viewed online.<sup>131</sup>

For this particular study, we focused on a subset of all states using managed care in Medicaid and SCHIP as of 2002. Of the 27 state SCHIP programs using managed care as of the study date, 12 State SCHIP agencies effectuated their purchasing by “piggybacking” onto the state Medicaid contract; that is, these state SCHIP agencies used the Medicaid contract, with variations essentially limited to coverage, payment rates, and certain business terms.<sup>132</sup> Medicaid enrolled children in these 12 states would be entitled to supplemental or residual coverage, while SCHIP-enrolled children would receive supplemental benefits only to the extent covered in the separately administered SCHIP plan. With respect to contractual

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<sup>127</sup> See e.g., *Bedrick v. Travelers* 93 F.3d 149 (1996); Rosenbaum et al., *supra* note 120; Rosenbaum et al., *supra* note 33.

<sup>128</sup> Rosenbaum & Sonosky, *supra* note 60, at 2.

<sup>129</sup> 1997 Nationwide Study, *supra* note 118.

<sup>130</sup> Sara Rosenbaum et al., Center for Health Service Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, (June 1999) [hereinafter 1999 Nationwide Study], at [http://www.gwhealthpolicy.org/managed\\_care.htm](http://www.gwhealthpolicy.org/managed_care.htm) (last visited September 2004); 1997 Nationwide Study, *supra* note 118.

<sup>131</sup> *Id.*

<sup>132</sup> Rosenbaum, *supra* note 3, at 6-7.

benefits however, children in these states would receive identical – or nearly identical – coverage unless expressly stated in the agreement.<sup>133</sup>

In 15 states however (approximately 60% of all SCHIP states using managed care products), the state SCHIP agency utilized a completely separate agreement with its contractors at the time of the study.<sup>134</sup> These separate agreements might therefore vary considerably from their Medicaid counterparts with respect to coverage.<sup>135</sup> We focused on these states, because we concluded that they would most clearly illustrate the degree of contractual distinctions drawn between the two forms of managed care products.

We knew from our previous work that state SCHIP plans offered lesser benefits in certain key areas than the scope of coverage found in state Medicaid plans. We then examined the two sets of contracts in these 15 separate-contract states and compared their terms to the information on state plan coverage under both programs which we already had gleaned from our review of the state plans. Where relevant, we have summarized the underlying state plan information in order to aid understanding of the extent to which the contracts follow or depart from their respective state plans.

SCHIP and Medicaid contracts tend to be exhaustive and detailed and are far more prescriptive than most privately purchased agreements. This tendency to tightly manage contractors is undoubtedly an outgrowth of the limited budgets under which states operate and the low-income of their beneficiaries.<sup>136</sup> State agencies cannot afford “point-of-service” network options, and enrollees cannot afford to augment their managed care benefits with out of pocket expenditures for the services of balance billing, non-network providers.<sup>137</sup> With tighter networks come greater concerns over access to covered benefits, and as a result, SCHIP and Medicaid agencies pay particular attention to how care is organized and delivered.<sup>138</sup>

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<sup>133</sup> *Id.*

<sup>134</sup> *Id.* at 7.

<sup>135</sup> *Id.* at 9.

<sup>136</sup> Sara Rosenbaum, *Approaches to Assuring Quality Health Care Through State Contracts with Managed Care Plans*, in *ACCESS TO HEALTH CARE: PROMISES AND PROSPECTS FOR LOW INCOME AMERICANS 223-250, 226-227* (Lillie-Blanton, et al., eds., 1999).

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

Because health care is so vast, perhaps the best way to understand how these contracts operate, as well as their limitations, is to select treatments for one or more specific conditions and view the agreements from a particular sub-population or condition-specific vantage point.

For this article we selected early childhood development as the frame through which the contracts would be analyzed. Early childhood development has become a particular focus of our work for several reasons. First, it is a fascinating topic from an insurance perspective because as noted earlier, the vast bulk of early intervention health services fall within the scope of Medicaid but outside the more conventional insurance norms reflected in the premium-support approach to SCHIP coverage. Second, a great deal of attention has been focused on early child development in recent years as a result of the Bush Administration's No Child Left Behind education reform legislation, which has reinforced Congressional interest in early childhood.<sup>139</sup> Since the federal Individuals with Disabilities Education Act prohibits the use of federal funds to finance health therapies for infants and toddlers receiving early intervention services, the extent to which health services promoting development are found in Medicaid and SCHIP becomes highly important to low-income children.<sup>140</sup>

A third reason to consider early intervention as the candidate treatment for this study was that as research into early childhood development has intensified in recent years, experts have been able to more clearly articulate the standard of care that would be appropriate to the earliest possible identification of developmental delays, as well as the types of health interventions that the evidence suggests would be effective in reducing the potential for delay and ensure early access to treatment.<sup>141</sup>

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<sup>139</sup> The No Child Left Behind Act of 2001, Pub. L. No. 107-110.

<sup>140</sup> §1903(c) of the Social Security Act, 42 U.S.C. §1396b(c).

<sup>141</sup> See MICHAEL REGALADO & NEIL HALFON, PRIMARY CARE SERVICES: PROMOTING OPTIMAL CHILD DEVELOPMENT FROM BIRTH TO THREE YEARS, (The Commonwealth Fund, NY, 2002); Neil Halfon et al., *Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children*, at [http://www.cmwf.org/programs/child/halfon\\_bridge\\_bn\\_564.pdf](http://www.cmwf.org/programs/child/halfon_bridge_bn_564.pdf) (May 2003) (last accessed October 20, 2003).



Figure 5 lists interventions found in the literature. (See Figure 5 pg. 35). These interventions were used to create a taxonomy for contractual specification purposes, so that findings could be presented regarding the relationship between these interventions and specification of terms. The fact that a contract might be silent on a specific intervention does not necessarily signify that an intervention is not furnished by the contractor, only that the intervention is not a clear specification of the agreement.<sup>142</sup> A managed care contractor obviously has discretion to furnish comprehensive childhood development services; however, research into managed care industry custom and practice suggests that few managed care companies specialize in comprehensive child development and consider the intervention to be of limited relevance unless specified in the contract and/or specifically “incentivized” through payment structure.<sup>143</sup>

Using the childhood development intervention, we fashioned the following series of queries to the contract database in order to assess the relationship between early intervention standards and contract specifications:

- 1) Coverage of preventive services: Whether contracts list specific elements of coverage for preventive services for young children, including a comprehensive medical and developmental screen, lead assessments (in view of the impact of elevated lead exposure on childhood growth and development) and anticipatory guidance.
- 2) Continuity of care: Whether contracts require contractors to ensure continuity of care between health care arrangements predating children’s enrollment and post-enrollment care.
- 3) Medical necessity standard: Whether contracts define the standard of medical necessity to be used by contractors and, if so, whether the standard followed the commercial standard of “restoring an individual to normal functioning” or the “growth and development” standard used for children in Medicaid.

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<sup>142</sup> 1997 Nationwide Study, *supra* note 118.

<sup>143</sup> Carolyn Berry, Pamela Butler, Linda Perloff, and Peter Budetti, *Child Development Services in Medicaid Managed Care Organizations: What Does It Take?* 106 PEDIATRICS 191-8 (July 2000).

- 4) Provider network composition: Whether contracts require the contractor to include child development specialists (e.g., pediatricians specializing in child development, lactation counselors, social workers, etc.) in their network of participating providers.
- 5) Supportive child development activities: Whether contracts require contractors to undertake special child development activities such as health education, and outreach efforts.
- 6) Care coordination with other key child development programs: Whether contracts require contractors to coordinate care with early intervention services for infants and toddlers under the Individuals with Disabilities Education Act, which includes early intervention services for infants and toddlers at risk of developmental delay.
- 7) Compensation linked to the quality of early childhood care: Whether contracts provide for financial incentives (positive, such as bonuses, or negative, such as penalties) for the contractor to ensure health care access and/or quality of care for young children.

**Figure 5. Pediatric Interventions Related to Early Childhood Development<sup>144</sup>**

**ASSESSMENT:** ASSESSMENT SERVICES INCLUDE EVALUATION OF INFORMATION FROM PARENTS, DEVELOPMENTAL MONITORING (INCLUDING SCREENING FOR DEVELOPMENTAL PROBLEMS WHEN INDICATED), PSYCHOSOCIAL ASSESSMENT, PARENT-CHILD OBSERVATION, AND ASSESSMENTS OF CHILD BEHAVIOR.

**EDUCATION:** EDUCATION SERVICES INCLUDE ANTICIPATORY GUIDANCE ABOUT THE PARENT-INFANT RELATIONSHIP, CHILD BEHAVIOR, AND VARIOUS DEVELOPMENTAL ISSUES (E.G., PROMOTING HEALTHY SLEEP HABITS AND DISCIPLINE PRACTICES) AS WELL AS PARENTING EDUCATION IN DIFFERENT FORMATS, SUCH AS CLASSES, SUPPORT GROUPS, AND INSTRUCTION BY A PHYSICIAN OR NURSE.

**INTERVENTION:** INTERVENTION SERVICES INCLUDE COUNSELING IN THE OFFICE SETTING, TELEPHONE INFORMATION LINES, AND HOME VISITATION.

**CARE COORDINATION:** CARE COORDINATION REFERS TO THE MANAGEMENT OF SERVICE NEEDS SUCH AS REFERRALS FOR DIAGNOSTIC ASSESSMENTS OR SPECIALISTS.

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<sup>144</sup> Halfon et al., *supra* note 16.

### **SCHIP Plans versus SCHIP Contracts**

The findings are presented on Tables 1 and 2. Table 1 shows the extent of childhood development-related coverage in states with both separately-administered SCHIP plans and separately-administered SCHIP contracts. Because coverage of all services shown in Table 1 are mandatory in Medicaid, no similar comparison is necessary: whatever might be excluded from the Medicaid contract is covered as a residual service.<sup>145</sup> But the same is not true with SCHIP, since supplemental, Medicaid-level coverage is an option but is not required. (See Table I Appendix).

Table 1 shows that states that administer separate SCHIP programs do not report specific coverage of certain aspects of child development services that would be considered required in Medicaid. For example, only 7 states report coverage of developmental assessments, only 2, lead screening, and only 1, anticipatory guidance. In all states, well-baby and well-child care would be covered as a basic SCHIP benefit, and presumably at least a threshold level of anticipatory guidance would be part of any well-child encounter between a pediatric health professional and a parent or caretaker. This same assumption, however, cannot be made about comprehensive developmental assessments and assessment of elevated levels of lead in children's blood, since both interventions are relatively resource intensive, and in the case of developmental assessments, time consuming. Table 1 also shows that only 2 state SCHIP plans provide for the type of preventive standard of medical necessity that is required in the case of Medicaid.

Of great interest however, Table 1 also shows that unlike Medicaid, SCHIP contracts actually can be broader than states' SCHIP plans. That is, certain aspects of developmental interventions that are not covered in a state's SCHIP plan nonetheless show up in a contract as an expectation of the managed care organization. Thus, for example, 7 of the 15 states whose plan and contract elements are displayed show coverage of developmental assessments in their state plans, yet 10 list developmental assessments as an expectation of their contractors. The same is true for vision care, immunizations and lead screening, and for medical necessity.

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<sup>145</sup> Sara Rosenbaum et al., Center for Health Service Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, (June 1999) [hereinafter 1999 Nationwide Study], at [http://www.gwhealthpolicy.org/managed\\_care.htm](http://www.gwhealthpolicy.org/managed_care.htm) (last visited September 2004); 1997 Nationwide Study, *supra* note 118.

## **SCHIP Contracts versus Medicaid Contracts**

Table 2 shows that while SCHIP contracts are more expansive than state SCHIP plans in certain respects, the contracts are less expansive than Medicaid. Not only is Medicaid coverage broader than SCHIP from a state plan perspective, but Medicaid agencies are willing to hold their contractors to broader coverage and management duties than is the case with SCHIP agencies. For example, several states whose SCHIP contracts specify well-child care nonetheless do not specify developmental assessments. Very few SCHIP contracts specify lead screening compared to the Medicaid contracts. Whereas 11 Medicaid contracts build the program's preventive definition of medical necessity into the documents, this level of coverage is specified in only 6 SCHIP contracts. (See Table 2 Appendix).

Connecticut's and Colorado's SCHIP contracts show the contrast between a preventive standard of medical necessity that captures the thrust of the Medicaid standard, and one that is more consistent with traditional commercial insurance principles that focus coverage on treatment of defined medical conditions:

*Connecticut: "Medically necessary/Medical necessity: Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or prevent a medical condition from occurring. . ."*<sup>146</sup>

*Colorado: "'Medically Necessary,' or 'Medical Necessity: A Covered Service shall be deemed Medically Necessary if, in a manner consistent with accepted standards of medical practice, it is: 1. consistent with the symptom, diagnosis and treatment of a Member's medical condition; 2. widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence; 3. not Experimental or Investigational; 4. not solely for cosmetic purposes; 5. not solely for the convenience of the Member, Subscriber, physician or other provider; 6. the most appropriate level of care that can be safely provided to the Member; 7. failure to provide the Covered Service would adversely affect the Member's health."*<sup>147</sup>

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<sup>146</sup> Sara Rosenbaum, Colleen Sonosky, Karen Shaw, and Marcie Zakheim, Center for Health Service Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, (4<sup>th</sup> Ed. 2000 at p. 11-14) [hereinafter 2000 Nationwide Study], at [http://www.gwhealthpolicy.org/managed\\_care.htm](http://www.gwhealthpolicy.org/managed_care.htm) (last visited September 2004).

<sup>147</sup> *Id.* at 7-8.

In the case of Connecticut's contract, a treatment is considered medically necessary for SCHIP children if (as is the case with Medicaid) the intervention is aimed at assisting an individual to attain and maintain growth and development or is designed to prevent a medical condition from occurring.<sup>148</sup> In the case of Colorado, a treatment is considered medically necessary only if aimed at a diagnosable medical condition (which is not always the case with slowed or delayed development in children). Furthermore, treatment will be considered necessary only if failure to furnish the treatment would adversely affect health.<sup>149</sup> Failure to respond to a developmental delay in a child has many adverse consequences, but adverse health may not be one of them.

Differences between Medicaid and SCHIP contracts go beyond coverage. Anticipatory care is significantly less common as a specific performance requirement in SCHIP contracts, as are expectations of continuity of care (related to situations in which children enrolling in a plan are already under treatment and must be integrated into a potentially new network), coordination with early intervention services offered by other public agencies such as state maternal and child health agencies, and other outreach and child development activities.<sup>150</sup> Most strikingly perhaps, "incentivization" of access and quality is a universal feature of Medicaid managed care contracts in the case of treatment and management of young children, but this is not the case in SCHIP contracts.<sup>151</sup>

## **Discussion**

The SCHIP legislation had two parents. One was widely hailed at the time of enactment, while the other remained obscured in the face of back patting and accolades of bipartisanship and health reform. President Clinton, who signed the 1996 welfare law once the Medicaid block grant was removed, extravagantly proclaimed SCHIP the largest expansion in coverage for children since the original

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<sup>148</sup> *Id.* at 11-14.

<sup>149</sup> *Id.* at 7-8.

<sup>150</sup> *See* Table 2.

<sup>151</sup> *Id.*

enactment of Medicaid.<sup>152</sup> This claim, of course, overlooked the doubling of Medicaid's pediatric rolls as a result of the legislative expansions during the 1980s. Praise for SCHIP also helped gloss over the legislation's more sobering dimensions, including the loss of the legal entitlement and the elimination of nearly all coverage rules.<sup>153</sup>

Indeed, in our view it is not too harsh to argue that in the long run, SCHIP may do less to help children and families than harm them by helping to further destabilize the already shaky Medicaid picture. If total destabilization occurs, and if SCHIP (along with the Bush Administration's Section 1115 demonstrations) is any indicator of what the successor program will look like, then there is indeed much to think about, particularly where the welfare of children and adults with significant health needs is concerned. With its ability to act as a substitute for Medicaid even where its benefits are essentially unknown and market-dictated, SCHIP has been, in some key ways, a warm-up for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which completely eliminated Medicaid prescription drug coverage for so-called "dual enrollees" (arguably Medicaid's most sick and most disabled beneficiaries) in favor of a new Medicare premium support system, whose benefit design is essentially unknown and virtually entirely in the hands of participating plans.<sup>154</sup> Like EPSDT, Medicaid prescription drug benefits are one of the law's most comprehensive aspects. With supplemental Medicaid prescription drug benefits eliminated for dual enrollees, they are, like SCHIP children with physical and mental disabilities, essentially reliant on the market's willingness to customize its products to their needs.<sup>155</sup>

Of course one critical issue delineates SCHIP from the Medicaid prescription drug situation. States could have used their authority under SCHIP to duplicate

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<sup>152</sup> Rosenbaum et al., *supra* note 2, at 33. "U.S. Budget: Clinton Signs Bill Adding Kid's Coverage, Changing Medicare, Medicaid Programs," 5 Health Care Pol'y Rep., (BNA) (commenting on the twenty-four billion dollar health insurance program established for uninsured children) at 32 d3 (Aug. 11, 1997); The White House Office of the Press Secretary (September 29, 2000) *President Clinton Announces Approximately 2.5 Million Children Have Enrolled in the State Children's Health Insurance Program* at <http://www.ed.gov/PressReleases/09-2000/wh-0929a.html>; See also, e.g., Michael Levin-Epstein, (2000) "How We Got it Anyway: The Clinton Health Plan Never Died," *Managed Care* (on-line) at <http://www.managedcaremag.com/archives/0010/0010.clinton.html>.

<sup>153</sup> See Policy Brief, *supra* note 3; Rosenbaum, et. al., *supra* note 2, at 36-37; Rosenbaum & Sonosky, *supra* note 12, at 87; Rosenbaum et al., *supra* note 21.

<sup>154</sup> See New Drug Law, *supra* note 24.

<sup>155</sup> *Id.*

Medicaid although at a higher federal match rate.<sup>156</sup> Indeed, a number of states did exactly this rather than establish a separate program.<sup>157</sup> But a separate SCHIP program was the norm, and the states which pursued separate programs did so to avoid not only legal entitlements, but also, as this study shows, Medicaid-level comprehensive coverage. Once states were freed of Medicaid's conditions for children – an enforceable legal entitlement, defined benefits that extend beyond the limits of actuarial coverage norms, and the legal obligation to supplement coverage of managed care plan benefits and services – they expanded coverage rapidly, but on their terms, and only up to the limits of the federal contributions they received.<sup>158</sup> Indeed, waiting lists have become a feature of state SCHIP programs.<sup>159</sup> Furthermore, in terms of benefit design, separately administered SCHIP expansions followed the specifications of the actuarial benchmarks specified in the statute, not the broad concept of coverage envisioned in Medicaid.<sup>160</sup> The difference between the two approaches to pediatric coverage is considerable and shows up clearly when one examines SCHIP and Medicaid limits using the standards of care applicable to early intervention programs for young children at risk of developmental delay.

Much is written in the law and in political and policy essays about “legislative intent.” There are many instances in which a law must be placed in context before its textual meaning becomes truly discernible.<sup>161</sup> SCHIP is not one of those laws; its true intent shows up on the face of the text itself, from the explicit assertion that “nothing in this title shall be construed as providing an individual with an entitlement to child health assistance,” to the use of a premium support approach to coverage.<sup>162</sup>

A detailed inspection of both the law and subsequent state implementation of its provisions confirms what one may have hypothesized might occur during an era notable for its rush to abandon social welfare entitlements for the poor: in the

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<sup>156</sup> See cases cited *supra* note 83; Title XXI of the Social Security Act §2105(b); 42 U.S.C. §1397ee (b).

<sup>157</sup> See Figure 4.

<sup>158</sup> Chang & Kenney, *supra* note 108, at 52.

<sup>159</sup> *Id.* at 57.

<sup>160</sup> Rosenbaum et al., *supra* note 21.

<sup>161</sup> See cases cited *supra* note 33.

<sup>162</sup> Rosenbaum et al., *supra* note 74, at 77.



main, states used their SCHIP allotments to extend to low-income children a far more conventional and limited form of coverage than is possible under Medicaid.

Medicaid reflects an era of public policy support for legal entitlements for the poor and disenfranchised.<sup>163</sup> Medicaid not only established what ultimately has been interpreted as a federal legal entitlement, but did so in remarkably clear and broad terms in the case of children. For children, Medicaid coverage operates at a level which has virtually no parallel in the insurance market. There is no “actuarial benchmark” for Medicaid.<sup>164</sup>

SCHIP is a product of a different era. Under programs such as SCHIP, low-income persons no longer are legally entitled to benefits.<sup>165</sup> They receive what Charles Reich termed “largesse,” up to the limits of fixed aggregate expenditure caps, and without regard to individual need.<sup>166</sup> Furthermore, the design of this largesse is what the market will bear. As the actuarial benchmark shifts ever downward in the face of a declining willingness on the part of insurers and group purchasers to invest in comprehensive coverage, so too, presumably, will SCHIP and similar benefits for the poor, since their terms of coverage are pegged to the market rather than objective tests of reasonableness.

At the same time, it is important not to wax overly poetic about Medicaid. It is essential to remember that the very aspects of Medicaid that make it so substantively strong for children also have served as its political Achilles Heel. So disliked is its individually enforceable legal entitlement and the comprehensiveness of its entitlement terms that states simply refused to take advantage of the program’s pediatric coverage options.<sup>167</sup> Over the past generation, some of the most intense litigation involving enforcement of federal Medicaid rights has involved children

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<sup>163</sup> Stevens & Stevens, *supra* note 56; Charles Reich, *The New Property*, 73 YALE L. J. 733, 786 (1964); RAND ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM (Foundation Press, New York, NY) (1997 & Supp. 2002); Jost, *supra* note 35.

<sup>164</sup> Rosenbaum et al., *supra* note 21, at 6-8.

<sup>165</sup> *Id.*; See cases cited *supra* 105; Rosenbaum et al., *supra* note 74, at 77; See Policy Brief, *supra* note 3, at 5.

<sup>166</sup> Reich, *supra* note 163.

<sup>167</sup> Sara Rosenbaum & Sonosky, *supra* note 12, at 85.

and EPSDT; no wonder states have a strong dislike for the program.<sup>168</sup> Thus, while one can mourn the lack of political support for heavily enriched health benefits for the nation's poorest children, undifferentiated mourning is not particularly helpful to the 20-plus million children who stand to lose their Medicaid entitlement if the program structure is substantially and fundamentally altered, an increasingly likely reality.<sup>169</sup>

It is clear that the pediatric health system needs a source of funding with the flexibility and depth displayed by Medicaid. The evidence regarding the standard of care for children during early child development and later in life as they develop special health needs, underscores the need to finance the range of health services that help achieve optimal growth and development among children.<sup>170</sup> There is a need for child health financing that is unbound by insurance norms and that can respond to health problems in infancy and childhood which require long-term interventions in schools and community settings. It is possible to conceptualize a financing scheme that can supplement what is offered in the private market; indeed, such an approach can serve as a backstop and a form of "stop loss" by supplementing the very benefits and services that the insurance market will never realistically confer on enrollees. This ability to undergird and support insurance products can be seen in Medicaid supplementation of managed care products for children, and the absence of such a feature in SCHIP is as serious a problem as SCHIP's potential to experience enrollment caps because of under-financing.<sup>171</sup>

The real question is whether the fundamental mission of Medicaid to support a broad range of health services for uninsurable populations of all ages can be met only through an individually enforceable legal entitlement. Clearly the answer to this question is "no." In his analysis of health systems in other nations, Timothy Stoltzfus Jost points out that individually enforceable, legal entitlements are peculiarly American and that other nations use global budgeting, system support, and

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<sup>168</sup> Jane Perkins et al. (2004) *Early and Periodic Screening, Diagnosis & Treatment Case Docket* Chapel Hill, NC: National Health Law Program (NHelp) at <http://www.healthlaw.org/pubs/200407.EPSDTdocket.pdf>.

<sup>169</sup> National Governor's Association, *supra* note 8; Rosenbaum, *supra* note 64.

<sup>170</sup> See cases cited *supra* note 16.

<sup>171</sup> 1997 Nationwide Study, *supra* note 118; Chang & Kenney, *supra* note 108, at 57-58.

investments on a population level to achieve adequate levels of resource allocation.<sup>172</sup> The key of course is universality.

Thus, at least where children are concerned, a plausible policy option would be a universal child health insurance program with standard benefits and coverage rules, coupled with a comprehensive program of state grants to develop and support systems of care capable of furnishing supplemental child development and family support services in community settings where they are needed and where they rightfully should be furnished. Many of the services most needed by children with nascent – or actual – physical and mental disabilities (and their adult counterparts) are as much educational or social as they are health care in nature, and optimally the service is woven into the normal daily life of children in school and at play.<sup>173</sup>

The critical issue in this plausible option is the universality of the model. Where only poor children are relegated to benchmark coverage and grant supplementation, the inevitable result appears to be under-financing.<sup>174</sup> Another way to say this is that, were all children to be covered by SCHIP rather than merely a slice of low-income uninsured children, mental health benefits never would have been classified as an “additional” service, dental care would not be non-existent, and there would not be waiting lists for coverage.<sup>175</sup>

Perhaps it seems foolish to consider universality at a time of retrenchment in social policy. On the other hand, the crisis in health care finance now leaves one in four children dependent on public insurance and fewer than two in five with employer coverage. If Medicaid is to be fully debated, then there may in fact be no more appropriate time to abandon backsliding and futile incrementalism in favor of bold reform, and no more appropriate population on whose behalf to do so.

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<sup>172</sup> Jost, *supra* note 35.

<sup>173</sup> Sara Rosenbaum et al. *Health Policy and Early Childhood Development: An Overview* New York, NY: The Commonwealth Fund (2001).

<sup>174</sup> Rosenbaum et al., *supra* note 2, at 55.

<sup>175</sup> *Id.*

Table 1. Coverage Under SCHIP in States With Separate SCHIP Plans and Separate SCHIP Contracts\*

	Separately-administered SCHIP plans										SCHIP managed care contracts																				
	CA	CO	CT	FL	IA	KS	MI	MS	MT	NH	NY	PA	TX	UT	VA	CA	CO	CT	FL	IA	KS	MI	MS	MT	NH	NY	PA	TX	UT	VA	
<b>I. Coverage of preventive services:</b> Contractor must provide well-child care, including:					•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Medical/Developmental Screens	•				•		•			•				•								•									
Immunizations	•	•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Vision Services		•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Hearing Services	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Dental Services	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Lead Screening	•																														
Anticipatory Guidance					•																										
<b>II. Other activities:</b> Contractor must undertake child development activities, health education and outreach efforts					•																										
<b>III. Medical necessity standard:</b> Contractor must use one of two defined medical necessity standards:																															
Standard definition					•																										
Preventive definition			•																												

\*Source: GW analysis of *Negotiating the New Health System*, 4<sup>th</sup> Ed. [http://www.gwu.edu/~chsrrp/Fourth\\_Edition/](http://www.gwu.edu/~chsrrp/Fourth_Edition/); GW analysis of *CHIRI Searchable Database of State SCHIP Plans, 2000* <http://www.gwhealthpolicy.org/chiri.htm>

- (1) Kansas and Virginia refer to EPSDT. Montana, New York, and Utah explicitly mention the AAP periodicity schedule, and Mississippi the recommendations of the U.S. Preventive Services Task Force.
- (2) The Mississippi and Utah SCHIP plans refer to the ACIP guidelines, the Montana SCHIP plan to the AAP periodicity schedule, and the New York SCHIP plan to the guidelines developed by the state Department of Health. The California, Mississippi and Virginia contracts refer the contractor to the ACIP guidelines, and the New York contract uses the guidelines developed by the state Department of Health.
- (3) The Iowa state plan's attachments include contractors' policies, which provide for anticipatory guidance. New Hampshire requires the provision of health education.

- (4) Under its SCHIP program, Florida uses a contract integrated with the Medicaid contract for its youngest, non-Medicaid eligible children (ages birth through 4 years old) and a separate contract for the school-aged, non-Medicaid eligible children (ages 5 through 18 years old).
- (5) In Kansas, contractors are not responsible for providing immunizations but are encouraged to coordinate that care with Kansas Immunization Program Providers.
- (6) Michigan contractors are not responsible for the provision of dental care, which is carved out from the managed care contract and provided by the SCHIP agency on a fee-for-service basis.
- (7) Mississippi references the AAPD guidelines on pediatric dental care.
- (8) Dental services other than hospital and related medical charges associated with dental care are carved out. However, contractor may provide extended dental benefits at no additional cost.
- (9) Pennsylvania requires plans to follow CDC guidelines for both Medicaid and SCHIP enrollees.
- (10) Virginia's separate SCHIP contract refers to the Medicaid medical necessity definition without providing it. A definition was found in the state's Medicaid contract but is too vague to determine whether it is preventive.



	Medicaid managed care contracts													SCHIP managed care contracts																
	CA	CO	CT	FL	IA	KS	MI	MS	MT	NH	NY	PA	TX	UT	VA	CA	CO	CT	FL	IA	KS	MI	MS	MT	NH	NY	PA	TX	UT	VA
<b>V. Other activities:</b> Contractor must undertake child development activities, health education and outreach efforts	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>VI. Care coordination:</b> Contractor must coordinate activities with early intervention and Title V programs	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>VII. Quality of care:</b> Contractor may receive financial incentives to improve access and quality for young children. <sup>33</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

\*Source: GW analysis of *Negotiating the New Health System*, 4<sup>th</sup> Ed. [http://www.gwu.edu/~chsrf/Fourth\\_Edition/](http://www.gwu.edu/~chsrf/Fourth_Edition/) \*\* Mississippi no longer uses managed care in its Medicaid program.

- (1) All of these contracts refer to EPSDT. In addition, California, Iowa, Kansas, Michigan, Pennsylvania and Texas explicitly mention the AAP periodicity schedule, and New York the schedule developed by the state Department of Health.
- (2) These contracts refer the contractor to the ACIP guidelines. In addition, California Medicaid, Florida, and Texas explicitly mention the AAP periodicity schedule.
- (3) New York uses the guidelines developed by the state Department of Health.
- (4) California references the AAP policy on pediatric dental care.
- (5) Mississippi references the AAPD guidelines on pediatric dental care.
- (6) Pennsylvania requires plans to follow CDC guidelines for both Medicaid and SCHIP enrollees.
- (7) Dental care is carved-out. Contractor must cover screens and referrals to DentiCal, MediCal's network of dental providers. Medical services related to dental problems are covered under the contract.
- (8) Childhood lead poisoning case management is excluded from the contract and provided by the Local Health Department.
- (9) PCP requirement.
- (10) Dental care is not covered in the contract but in fee-for-service.
- (11) Dental care is carved out of the contract. Contractor is responsible for screening and referral only.
- (12) PCP requirement.
- (13) Dental care is carved out of the managed care contract. However, referrals to dentists are covered under EPSDT, which is a capitated service. Similarly, audiology and hearing aids, and eye examinations and eyeglasses are carved out but hearing and vision screening are covered under capitated EPSDT.
- (14) PCP requirement.
- (15) Dental services are non-capitated services, i.e. they are excluded from the services included in the calculation of the HMO capitation rate.
- (16) Virginia's separate SCHIP contract refers to the Medicaid medical necessity definition without providing it. A definition was found in the state's Medicaid contract but is too vague to determine whether it is preventive.
- (17) Under its SCHIP program, Florida uses a contract integrated with the Medicaid contract for its youngest, non-Medicaid eligible children (ages birth through 4 years old) and a separate contract for the school-aged, non-Medicaid eligible children (ages 5 through 18 years old).
- (18) In Kansas, contractors are not responsible for providing immunizations but are encouraged to coordinate that care with Kansas Immunization Program Providers.
- (19) Michigan contractors are not responsible for the provision of dental care, which is carved out from the managed care contract and provided by the SCHIP agency on a fee-for-service basis.
- (20) The New York SCHIP contract requires contractors to coordinate care between the SCHIP and Medicaid programs.
- (21) Dental services other than hospital and related medical charges associated with dental care are carved out. However, contractor may provide extended dental benefits at no additional cost.
- (22) Delinquent reports.
- (23) Review of the contracts was broad and inclusive, in that states received a dot if their contract allowed states to use financial incentives—whether they are positive (e.g., bonuses) or negative (e.g., penalties)—for plan performance in accordance with, or better than, the contractual standards, which include quality assurance, or for failure to perform up to the standards. Provisions linking performance measures with service duties and spelling out the availability of bonuses if the plan performs well are rare and were found in two states' Medicaid contracts (Minnesota and Massachusetts) not included in this review.