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Children Not the Target of Major Medicaid Cuts But Still Affected by States' Fiscal Decisions

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Confronting the economic downturn that has increased both the number of Medicaid recipients and the program's rate of growth, most states have taken steps to reduce, or at least contain, their Medicaid program costs. Because children are already a low-cost population and are protected by statutory provisions governing EPSDT and cost sharing, they have been largely protected from major cuts. Still, a few states have made reductions in children's income or categorical eligibility, a few have sought waiver approval to impose cost-sharing requirements applicable to children, and a handful have tightened their home- and community-based waiver programs serving children with disabilities. The more common cost-saving strategies, such as lowering or freezing provider payments and imposing greater controls on service authorization, are ones that have not targeted children specifically but are nevertheless likely to have an impact on their access to care.

This fact sheet provides new information on the extent of state Medicaid policy changes affecting children in states' fiscal years 2003 and 2004. It includes only changes affecting regular Medicaid programs and not those affecting Medicaid SCHIP programs exclusively.[1] The policy areas we examined include eligibility, managed care enrollment, benefits, authorization, cost sharing, fee-for-service provider payments, and home- and community-based waivers. To obtain current information, we examined managed care contracts, provider bulletins, and Medicaid state plan amendments submitted to CMS. In addition, we conducted extensive telephone interviews with senior Medicaid staff. Despite multiple telephone and e-mail contacts, we were unable to obtain complete information from 8 states.[2]

Eligibility and Enrollment

Only a few states have revised their eligibility policies to lower income eligibility levels or eliminate optional coverage groups -- in large part because states in 2003 and 2004 were able to rely on enhanced federal matching funds and meet the September 2003 maintenance of effort requirement[3] -- although more states appear to have adopted policies that made children's enrollment more difficult. Tennessee, which under its 1115 waiver had no upper income limit for uninsured children, has frozen enrollment for infants in families with incomes above 185% of poverty and for other children in families with incomes above the federal mandatory income levels (133% of poverty for those age 1 to 6 and 100% of poverty for those ages 6 to 18).[4] Three other states, prior to September 2003, had eliminated optional eligibility groups that include or are specifically for children. Nebraska discontinued coverage for 19- and 20-year olds, and 2 other states (Oklahoma and Oregon) eliminated

coverage for the medically needy. Importantly, though, one state increased eligibility for children. Virginia raised its income eligibility ceiling for children ages 6 to 19 from 100% to 133% of poverty to ensure that all children in a family are able to qualify for Medicaid.

Strategies affecting Medicaid program enrollment -- including eliminating 12-month continuous and presumptive eligibility, reducing outreach, and changing the way income is calculated -- appear more common. According to the Center on Budget and Policy Priorities and the Kaiser Family Foundation,[5] for example, 5 states, (Arizona, Connecticut, Indiana, Nebraska, and Washington) eliminated 12-month continuous eligibility for children. Two states tightened the income disregards they use in calculating eligibility: Minnesota eliminated its 21% earned income disregard for children ages 2 to 5, and Nebraska reduced its income disregard from 20% to a flat $100. At the same time, 2 other states (California and Missouri) chose to adopt presumptive eligibility policies for children.

Managed Care Enrollment

Although it seems that states might rely more heavily on capitation as a means of reducing or containing Medicaid program costs, we found that budget difficulties rarely contributed to states' increased use of capitated arrangements. Of the 9 states modifying their managed care enrollment policies for children, we found only 2 that reportedly had done so for budgetary reasons, and both of these states switched from using capitated managed care organizations (MCOs) to fee-for-service arrangements. New Hampshire now pays all providers under a traditional fee-for-service program, while Oklahoma has implemented a statewide primary care case management system. Interestingly, 2 states (Tennessee and Utah) switched from capitating MCOs to contracting with them on a no-risk basis, and 5 states expanded MCO enrollment, but not for reasons related to fiscal concerns. Four of these states (Nevada, North Dakota, South Carolina, and Virginia) expanded their MCOs into additional geographic areas of the state, while Rhode Island began enrolling the SSI population into MCOs on a non-risk basis.

Benefits, Authorization, and Cost Sharing

Cost-saving strategies for many states have involved tightening of authorization policies for particular services and, in a few states, have included increased cost-sharing requirements applicable to certain children. Many states also eliminated or reduced optional Medicaid benefits, but they report that, because of the EPSDT mandate, these changes do not affect children. Presumably participating managed care plans have been properly informed of this protection; yet, whether providers and families have been able to rely on EPSDT to access all benefits that have been eliminated or reduced is not known. In the 15 states cutting back on benefits,[6] changes were made most frequently to dental coverage, with 3 states eliminating the entire benefit and 5 reducing the scope of coverage. Coverage for audiology services or hearing aids was also eliminated in 3 states, as was coverage for psychologists' services. Other benefits that children might need -- including inpatient and outpatient mental health services, case management, vision services, orthotics and prosthetics, and private duty nursing -- were reduced or eliminated in no more than a single state. Of the 15 states making benefit changes, however, one state was able to restore eliminated benefits in July 2003. (There is an additional state with an approved state plan amendment to eliminate certain benefits but, as a result of litigation, the state has been unable to proceed with implementation.)

More significant for children is the fact that 15 of the 45 states for which we have information imposed new authorization policies for selected services or strengthened policies already in effect. The majority of these states[7] chose to require greater oversight of prescription drug coverage, with all but 2 of these adopting a preferred drug list (PDL) that requires providers to obtain prior approval before writing prescriptions for medications not included on the list.[8,9] Four states (Maine, Massachusetts, Montana, and New Mexico) adopted initial authorization requirements for

restorative dental services, ancillary therapies, circumcision, and high-cost durable medical equipment, such as power wheelchairs. Two states began requiring earlier prior authorization -- in Georgia for ancillary therapies, and in Virginia for ancillary therapies, outpatient mental health services, and home health services. One state (Alaska) adopted requirements for more frequent review of inpatient mental health treatment and more stringent medical necessity criteria for residential treatment. We also heard from a few states that, although they have not changed their authorization policies, they have been more rigorously enforcing them, resulting in the perception among providers that policies have changed.

In addition, a few states chose to address budget problems by pursuing new or expanded cost-sharing requirements for Medicaid children in higher income families. Vermont amended its 1115 waiver to charge SSI-eligible children ages 18 to 21 copayments for hospital-based services. The state also increased premiums for children in families with incomes between 185% and 225% of poverty by $5 to $25 and for children in families with incomes between 226% and 300% of poverty by $11 to $35.[10] Minnesota has received approval to move children in families with incomes between 150% and 170% of poverty into its 1115 waiver program where they will be required to pay monthly premiums ranging from $28 to $55, depending on family size, beginning in July 2004. Washington received approval for an 1115 waiver to charge $10 monthly premiums for children in families with incomes between 151% and 200% of poverty, but will not impose premium charges until July 2005.[11] Maine submitted an amendment to its HIFA waiver (covering childless adults) to require monthly premiums for children covered under the TEFRA (Katie Beckett) eligibility option.[12] If approved by CMS, the state will begin charging monthly premiums ranging from $92 to $1,200 to families with incomes above 200% of poverty.[13] (Two other states -- Colorado and Georgia -- submitted cost-sharing proposals but subsequently withdrew them.)

Fee-for-Service Provider Payments

Although the majority of states left Medicaid reimbursement rates for some or all pediatric providers unchanged in fiscal years 2003 and 2004, among those that made changes, decreases were less likely than increases, and freezes were reportedly instituted for budgetary reasons in only a handful of states. States recognized that providers were discontented and that access might be compromised -- particularly for dentists, mental health providers, surgical specialists, and neurologists. Still, 9 states elected to decrease rates for pediatric providers during fiscal years 2003 or 2004. Four of these (Georgia,[14] Massachusetts, Montana, and Texas) reduced payments across the board for participating providers, in Montana by as much as 7%, although the state has subsequently restored rates to pre-reduction levels. (Across-the-board rate reductions in California had also been approved by the legislature but are on hold, pending the outcome of litigation.) In the other 5 states (Louisiana, Maine, Maryland, Minnesota, and Oregon), rates were reduced for specific types of providers or services and frozen for all others. Depending on the state, the affected providers have included hospitals, home- and community-based waiver providers, anesthesiologists, residential treatment centers, federally qualified health centers and rural health clinics that received enhanced reimbursement for completion of special EPSDT forms, and providers of DME and mental health rehabilitation services.

In addition, 20 states froze their reimbursement rates for all pediatric providers over this 2-year period, but of these, only 6 states reported that rates were kept at their 2002 levels because of fiscal constraints that prevented potential increases.[15] The other 14 states generally reported that their Medicaid reimbursement rates were not routinely adjusted.

At the same time, however, a significant number of states chose to increase their rates for at least some pediatric providers. Sixteen states adopted more generous rates, with 3 (Nebraska, Oklahoma, and Wisconsin) making rate increases for all

providers. The amount of these increases ranged significantly and was as high as 45% for some provider types and services in Oklahoma. Among the 13 states making targeted rate increases,[16] 5 (the District of Columbia, Louisiana, Idaho, Nevada, and South Carolina) were states that moved to align Medicaid reimbursement rates with a percentage of those paid by Medicare, resulting in payment increases for at least some pediatric providers.[17] Targeted rate increases primarily benefited hospitals and dentists[18] but also affected pediatric subspecialists, personal care providers, emergency transport providers, and home health agencies and outpatient hospital departments providing ancillary therapies to children up to age 3, as well as providers of lead screening services, some disposable medical supplies, and spacers. Many of these 13 states reportedly would have increased rates for more provider types if they were not constrained fiscally.

Home- and Community-Based Waivers

Of the 43 states for which we have information, all operate home- and community-based waivers serving children. States generally report that waivers are effective cost-saving strategies for persons who would otherwise be in institutions, yet we found that 6 states took steps to reduce waiver costs, while 4 chose to expand their use of the waiver option.[19] Of those making cuts, Alaska and North Carolina both reduced available benefits: Alaska tightened coverage of environmental modifications and special equipment in its waiver for children who are technology dependent or medically fragile, and North Carolina eliminated daily respite coverage and coverage of live-in support services in its waiver for individuals with mental retardation and developmental disabilities. New Mexico tightened authorization of services in its waiver for children with disabilities. Washington restructured its single waiver for individuals with mental retardation and developmental disabilities so that it now operates 4 separate waivers, each serving children requiring different levels of services and subject to different expenditure limits for certain services. Michigan and Vermont, rather than containing costs through benefit modifications, elected to cap enrollment under waivers for children (Michigan) or individuals (Vermont) with mental retardation and developmental disabilities.

Of the states expanding their home- and community-based waivers for children, Georgia made children needing ongoing skilled nursing care eligible for its waiver serving individuals requiring respiratory therapy, and New Jersey increased the number of slots available in its community care waiver for disabled individuals. Iowa added a transportation benefit to its waiver that includes children with mental retardation and developmental disabilities. Most significantly, Wisconsin created new waivers exclusively for 3 different categories of children -- those with physical disabilities, developmental disabilities, and severe emotional disturbances.

Conclusions and Future Directions

Although children have not been the primary focus of state efforts to curtail Medicaid costs, children's access to care is likely to be affected by many of these changes nevertheless. Nearly all states appear to have pursued some Medicaid cost containment strategy during fiscal years 2003 and 2004. Among the states for which we have complete information, the majority either cut or, for budgetary reasons, froze payments for at least some pediatric providers, which might cause providers to refuse new Medicaid patients or to drop out of the program entirely. Also, many states have introduced benefit reductions that, if not implemented in accordance with EPSDT, could result in more limited benefit packages for children, while about the same proportion have adopted stricter prior authorization requirements that are almost certain to leave families and providers spending more time obtaining approval for necessary care. The cost containment strategies affecting children most directly -- changing income or categorical eligibility, imposing new cost-sharing requirements, and cutting participation in home- and community-based waivers -- have been used by states far less often, but their impact is more immediate and significant.

Overall, 3 states appear to have pursued the most dramatic changes in their Medicaid programs

for children. Maine and Washington have both sought to require cost sharing for at least some children in the Medicaid program. Both states also froze or lowered fee-for-service provider payments; one eliminated benefits; and the other imposed more restrictive authorization policies. Tennessee's Medicaid program closed enrollment to any child with a family income above federally mandated minimum levels and sought other benefit and cost-sharing changes, although these are on hold pending litigation.

Of course, children may also be affected by Medicaid changes targeted at parents alone, particularly those concerning eligibility. Researchers have shown that reductions in eligibility for parents are associated with lower enrollment for children.[20] Four states have lowered income eligibility for parents or pregnant women and 5 states reduced transitional Medicaid coverage for women leaving welfare, while another 5 states adopted policies making Medicaid enrollment more burdensome.[21]

Although recent reports suggest that states' fiscal situations are improving and that children are a high priority population, there is still cause for concern. One reason is the termination in July 2004 of Congressional authorization for enhanced Medicaid matching rates. Another is the movement in several states[22] to contain program costs by seeking 1115 waivers that in effect would block grant their programs.

State Medicaid agency officials for the most part were uncertain about future cost containment actions that might be necessary in the coming year. Still, about a third of the states are reportedly considering specific program changes, and while a handful have reported that all cost containment options are on the table, only one state expects "draconian cuts." Most of the cost-saving strategies that states reportedly are considering center around tightening authorization requirements and reducing provider payments, although a few are also examining options pertaining to managed care expansions, cost-sharing requirements, and home- and community-based waiver restructuring. Importantly, however, there are a few states that are anticipating pediatric provider rate increases or home- and community-based waiver expansions for children.

Several states are examining the possibility of making more fundamental changes to their Medicaid programs. Colorado, for example, is discussing a HIFA waiver application that would offer a standard commercial benefit package to poverty-related Medicaid- and SCHIP-enrolled children, with wraparound benefits available to children with special health care needs, although the process by which children would access such benefits has not yet been defined. Tennessee also intends to seek waiver approval to make a variety of changes to its Medicaid program, including eliminating brand-name drug coverage, limiting off-label prescription drug use, and significantly restricting its definition of medical necessity.[23]

STATE MEDICAID COST-CUTTING MEASURES AFFECTING CHILDREN, SFY 2003 AND 2004						
States	**Eligibility Reductions**	**Managed Care Expansions[1]**	**Increased Authorization Requirements**	**Increased Cost-Sharing Requirements**	**FFS Payment Freezes[2] or Reductions**	**HCBS Waiver Reductions**
AK		na	X			X
AL		na				
AR		na	ni		ni	ni
DE					X (f)	
GA		na	X		X (r)	
IA					X (f)	
ID		na				
IN			ni		ni	ni
KS			X			
KY			ni		ni	ni
LA		na	ni	ni	X (r)	ni
MA			X		X (r)	
MD					X (r)	
ME		na	X	X[3]	X (r)	
MI						X
MN			X	X[4]	X (r)	
MS		na			X (f)	
MT		na	X		X (r)	
NC						X
ND					X (f)	
NE	X					
NH			X			
NJ			X			
NM			X			X
NY			ni		ni	ni
OK	X					
OR	X		X		X (r)	
SD		na	ni	ni	ni	ni
TN	X		X		na	
TX					X (r)	ni
UT					X (f)	
VA			X			
VT		na		X		X
WA			X	X[5]	X (f)	X
WI			X			
WV	ni		ni	ni		ni
WY		na				
Total	4/51 (8%)	0/37 (0%)	15/45 (33%)	4/48 (8%)	15/45 (33%)	6/43 (14%)

Source: Information obtained by the Maternal and Child Health Policy Research Center through interviews with senior Medicaid staff and reviews of state plan amendments submitted to CMS, managed care contracts, and provider bulletins during the winter and spring of 2004.

na = not applicable
ni = no information provided
f = freeze
r = reduction
HCBS = home- and community-based services waiver

[1] This table only identifies states that expanded their use of capitated managed care as a cost containment measure.
[2] This table only identifies states that froze rates for all providers as a cost containment measure.
[3] Maine has submitted an 1115 waiver application and is awaiting CMS approval.
[4] Minnesota will require cost sharing in July 2004, which is actually fiscal year 2005.
[5] Washington has an approved 1115 application but has elected not to implement cost-sharing requirements until July 2005.

Endnotes

[1] For information on SCHIP program changes, please see Fox HB and Limb SJ. *SCHIP Programs More Likely to Increase Children's Cost Sharing than Reduce Their Eligibility or Benefits to Control Costs.* Washington, DC: Maternal and Child Health Policy Research Center, April 2004.

[2] These states are Arkansas, Indiana, Kentucky, Louisiana, New York, South Dakota, Texas, and West Virginia.

[3] The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided $10 billion in federal funds to increase the Medicaid matching rate through June 2004. States whose match rate for 2003 was lower than for 2002 could use the higher rate from April through September 2003 and states whose match rate for 2004 was lower than for 2003 could use the higher rate from October 2003 through June 2004. Each state also received a 2.95 point increase in its matching rate from April 2003 through June 2004.

[4] Tennessee also accepts new enrollees who are determined to be medically eligible because they have specified conditions and who have incomes up to 100% of poverty.

[5] Cohen Ross D and Cox L. *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge*. Washington, DC: Kaiser Family Foundation, July 2003. Ku L and Nimalendran S. *Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs*. Washington, DC: Center on Budget and Policy Priorities, December 2003.

[6] These 15 states are Colorado, Connecticut, Florida, Georgia, Idaho, Michigan, Minnesota, Montana, Nebraska, New Jersey, New Mexico, Ohio, Texas, Utah, and Washington.

[7] These 10 states are Kansas, Maine, Minnesota, New Hampshire, New Jersey, Oregon, Tennessee, Virginia, Washington, and Wisconsin.

[8] In Tennessee, MCOs, which are not at risk for services, must abide by the state's PDL.

[9] In Oregon, the Oregon Evidence-Based Practice Center is conducting research into the clinical effectiveness of particular classes of drugs to identify which drugs will be included in the state's PDL. None of the 12 drug class reviews to date have included pediatric patients, however, one scheduled later this year on inhaled corticosteroids (for asthma) will include children.

[10] In Vermont, children in families with incomes between 226% and 300% of poverty who are underinsured are eligible for Medicaid (rather than SCHIP), which provides them coverage supplemental to their basic insurance.

[11] Washington had until recently intended to begin charging premiums in July 2004. In addition, it had earlier proposed higher monthly premiums of $15 for children in families with incomes between 100% and 150% of poverty and $20 for children in families with incomes between 151% and 200% of poverty.

[12] Arkansas already has 1115 waiver authority, obtained in 2002, to charge monthly premiums to this population. The state charges premiums ranging from $42 to $458 for families with incomes above $25,000.

[13] In Maine, families with more than one child in the program will pay one premium.

[14] In Georgia, this reduction does not affect dentists.

[15] These 6 states are Delaware, Iowa, Mississippi, North Dakota, Utah, and Washington.

[16] These 13 states are the District of Columbia, Hawaii, Idaho, Louisiana, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oregon, and South Carolina.

[17] In the District of Columbia, all codes below 48% of Medicare were increased to this threshold. In Idaho, rates were increased to equal Medicare rates, while in Nevada, evaluation and management codes and medicine codes were raised to 85% of Medicare rates. Louisiana revised rates for some services provided by orthopedists to be 80% of Medicare rates, cardiology and maternal and fetal medicine specialists to be 84% of Medicare rates, and surgeons performing surgeries on children up to age 10 to be equal to Medicare rates. In South Carolina, pediatric subspecialist reimbursement rates were increased to 120% of Medicare rates, compared to 75% of Medicare rates for adult specialists.

[18] In the District of Columbia, rates for dentists were increased by 300%.

[19] Respondents sometimes lacked sufficient details about these waivers since waivers are often administered by other state agencies, such as those serving persons with mental retardation and developmental disabilities.

[20] See, for example, Lin CJ, Lave JR, Chang CC, Marsh GM, LaVallee CP, Jovanovic Z. Factors associated with Medicaid enrollment for low-income children in the United States. *Journal of Health and Social Policy*. 2003;16(3):35-51.

[21] Cohen Ross D and Cox L. *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge*. Washington, DC: Kaiser Family Foundation, July 2003.

[22] There are at least 4 states are considering these waivers. These states are California, Connecticut, Florida, and New Hampshire.

[23] In Tennessee, a medically necessary service would be limited to that which is required in order to diagnose or treat an enrollee's medical condition; is safe and effective; is the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee; and is not experimental or investigational.

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