

## **Medicaid Benefits for Children and Adults: Issues Raised by the National Governors' Association's Preliminary Recommendations**

Cindy Mann

### **Overview**

The Medicaid benefit package determines which health services a Medicaid beneficiary will be able to receive under the program. It is set by each state through a combination of federal standards and state options. Because federal standards are particularly strong for children, benefits for children are comprehensive in every state. Benefits vary more widely from state to state for adults, depending on the extent to which a state has chosen to cover a service that it is not required to cover. While state variations defy efforts to generalize, particularly for children and even for adults, Medicaid typically covers services that are not covered under commercial insurance plans. This reflects the special role Medicaid plays for children and adults with chronic illnesses and disabilities whose needs are often not met by private insurance plans and for those who cannot afford to pay out-of-pocket for care.

Over the next few months, federal policymakers will be considering changes in federal Medicaid standards in order to achieve federal savings. At the same time, states are looking to Congress to provide them with greater flexibility to help them achieve savings at the state level. In a Preliminary Report on Medicaid Reform issued June 15, 2005, the National Governors Association (NGA) released policy recommendations, which include major changes in the federal benefit standard affecting both children and adults.<sup>1</sup> The NGA proposal recommends that states be permitted to provide different groups of children and adults different benefit plans and would also allow them to cover different benefits in different parts of the state. This Issue Brief summarizes the NGA benefit recommendations and identifies some of the key questions and issues raised by those recommendations.

### **Key Questions and Issues:**

- **“Tiered” or “targeted” benefit plans can achieve savings only by excluding coverage for care that someone needs.** Targeting benefits to those most in need sounds appealing— why spend resources on benefits that people do not need? Medicaid rules, however, already preclude states from covering a service that someone does not need—and most states are aggressive in protecting against inappropriate utilization of services, particularly in these tough economic times.

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<sup>1</sup> The NGA policy report is at <http://www.nga.org/cda/files/0506medicaid.pdf>.

Since Medicaid already limits coverage to necessary care, savings can only be achieved through benefit standard changes by cutting back on coverage for care that people need.

- **Children stand to lose the most under the proposal.** The NGA proposal would end the federal government’s core benefit guarantee to children, known as the Early and Periodic Screening, Diagnostic and Treatment (“EPSDT”) service, at least for some children. Eliminating EPSDT would have far-reaching consequences particularly for children with developmental problems and other special health care needs.
- **By permitting states to have different coverage rules in different parts of the state, access to care could vary without regard to someone’s need for coverage and existing disparities could widen.** How would this new flexibility be implemented? Would some regions be favored over others?
- **Targeting would require new systems to assign different benefit packages to different people and could lead to arbitrary or discriminatory distinctions among beneficiaries.** What standards would be applied to assign people to different medical benefits? Who would decide? How would the process be administered? Would people be reassigned to a different benefit package if their health deteriorated? Would delays occur? The more the system attempts to be responsive to people’s evolving health care needs, the more complicated the system would need to be. Gaps and delays in covering needed care would be inevitable.

#### **Background: What are the current Medicaid benefit rules?**

Medicaid benefit rules are different for children than for adults.

- **Children are guaranteed a comprehensive benefits package,** known as the Early and Periodic Screening, Diagnostic and Treatment service (“EPSDT”). Established by Congress in 1967 soon after the program was created, and expanded in 1989, EPSDT represents Medicaid’s core commitment to children.<sup>2</sup> It assures all children, regardless of the state in which they may live, coverage for preventive care (e.g., regular health, vision, hearing and dental checkups), and for the medical services they might need to treat or ameliorate a health problem.<sup>3</sup>
- **Coverage for adults can be--and typically is--much more limited.** Certain services, such as hospital care and physician services, must be covered, but many others are optional for adults, including vision care, speech or physical therapy, prosthetic devices, and prescription drugs. States can also limit the scope of coverage for a particular benefit within certain parameters. One state, for example, has a 3-drug per month limit for adults.

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<sup>2</sup> EPSDT does not apply to children covered under the “medically needy” portion of the program.

<sup>3</sup> See, Rosenbaum, S., et al, “Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP,” *Journal of Health and Biomedical Law*, 1 (2004); 1-47.

- **States cannot favor one group of adults over another when they establish their benefit package.** When a state covers an optional benefit for adults, it must cover that benefit for all adult beneficiaries (other than the “medically needy” group), and it cannot discriminate among beneficiaries by diagnosis. For example, if physical therapy (an optional benefit) is covered, it cannot be covered just for the elderly, leaving out adults with disabilities. (This rule is known as “comparability.”)
- **States must offer the same Medicaid benefit package in all parts of the state.** Medicaid benefits must be available statewide. For example, a state cannot cover a benefit for people in one county and not cover the benefit for people in another county.
- **For all Medicaid beneficiaries, under current law only necessary services can be covered.** Under federal rules, only services that are medically necessary for that particular Medicaid enrollee can be covered.<sup>4</sup> States must guard against unnecessary utilization, and they have a variety of tools and considerable incentives to do so.<sup>5</sup> They can enroll people in managed care,<sup>6</sup> and they may implement disease management initiatives for people with chronic illnesses. States may also require prior authorization before a service is covered, and they must conduct pharmacy utilization reviews. In addition, they may audit health plans and providers, develop practice guidelines, structure their provider payments to encourage or discourage certain practices, and drop plans and providers when they do not follow program rules or provide quality care. Given these tools and states’ incentives to keep their costs down, it is not surprising that there is little evidence of over utilization in the program.<sup>7</sup>

### **What problem is benefit targeting trying to solve?**

According to the NGA preliminary recommendations, targeting would address what is described as Medicaid’s “one-size-fits-all approach” to benefits. Medicaid beneficiaries are diverse—some are healthy, while others are very sick or have chronic medical problems. Why offer a benefit package that includes home health services or speech therapy to someone who does not need that particular service? *In fact, regardless of what benefits are covered in the Medicaid package, no one should be getting coverage for an*

<sup>4</sup> 42 USC section 1396a (a) (30) (A).

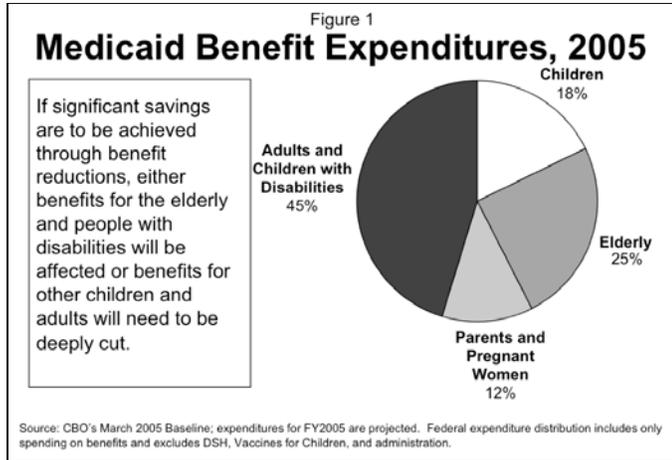
<sup>5</sup> The notable exception is with respect to “dual eligibles” -- individuals who are enrolled in Medicare and Medicaid. States have limited ability to manage care for duals in part because the treating physician is subject to Medicare, not Medicaid rules. States and dual eligible beneficiaries could benefit by a number of reforms that would address this care management disconnect.

<sup>6</sup> In 2003, more than 60 percent of Medicaid beneficiaries were in managed care. CMS Medicaid managed care data at <http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf>.

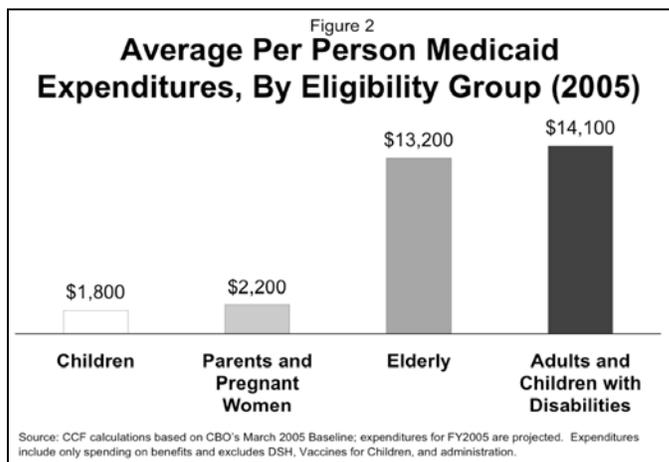
<sup>7</sup> Kuhlthau, K. et al, “Correlates of Use of Specialty Care,” *Pediatrics* Vol. 113 No. 3, March 2004, pp.e249-e255. There is some evidence that Medicaid beneficiaries make higher use of emergency room services, and there are many reasons why this may be the case, including the need to access care after work and greater availability of translation services at most hospital emergency rooms compared to doctors’ offices. In any event, emergency room use is not evidence of over utilization of services, but rather may suggest that strategies are needed to help promote access to care at the most appropriate site.

*unnecessary service under current Medicaid rules.* If they are, it is not because of the design of the benefit package but because management tools (either at the provider, health plan, or state level) are not being applied effectively.

Given the basic rules of the program, targeting can lower program costs only by excluding a benefit for someone who needs the benefit.<sup>8</sup> No funds would be saved, for example, by excluding pregnancy-related services from the benefits provided to men, since men don't use these services, and Medicaid is presumably not paying to provide these services to men under current rules. *Savings can be achieved through benefit targeting only by eliminating a covered benefit for someone who would need that service.*



Nearly 70 percent of the spending on services in Medicaid is for adults and children with disabilities and for the elderly; much less is spent overall and on a per person basis on health services used by other children and adults. (Figures 1 and 2) Given this distribution of spending, if significant savings are to be achieved by reducing benefits, either the benefits provided to people with disabilities and to seniors will have to be affected (that is where the money is) or the benefits provided to other children and adults (mostly very low-income parents and pregnant women) will have to be cut deeply.



**What does the proposal recommend?**

The NGA preliminary policy recommendation with respect to benefits is brief. It reads as follows:

*Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a*

<sup>8</sup> This principle applies in a managed care setting as well as when services are paid for on a fee-for-service basis. Capitated MCO payments are generally based on estimates of utilization of health services given the type of beneficiaries that will be covered, payment history and other factors. Risk-based arrangements vary widely and some states have more experience than others in setting their capitated rates, but the concept that payments to providers can and should be set based on the services needed and used applies throughout.

*traditional health insurance program. This discussion extends beyond the traditional distinction between “mandatory” and optional” populations, which are arbitrary distinctions when it comes to the need for health care services. This would include an improved ability to set benefit limits and cost sharing amounts, do employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations or in different parts of the state. Medicaid can be improved by focusing more on improving health outcomes rather than adhering to a sometimes- arbitrary list of benefits mandates (that are often the result of effective lobbying by provider interest groups).*

**What are the implications of the NGA policy for the EPSDT benefit guarantee for children?**

The NGA policy appears to eliminate the longstanding “EPSDT” guarantee for children; some children would receive less coverage than they are guaranteed today under EPSDT standards. The proposal does not describe which children would lose coverage and what services would continue to be covered for all children.

**Who would have access to a comprehensive benefit package and who would not? Who decides?**

Because it is impossible to predict who will need a particular medical service, some of the most difficult questions arise with respect to how differential benefit packages would be assigned.

While the NGA recommendation does not specifically explain how it would address this issue, the policy does recommend that lines not be drawn based on whether a beneficiary is enrolled in a “mandatory” versus an “optional” eligibility group under the program. (In 2003, the Bush Administration proposed capped allotments and fewer federal standards for so-called optional beneficiaries.) As the NGA report notes, mandatory and optional designations do not differentiate (and were never intended to differentiate) among populations based on their health or need for medical services. Medically fragile individuals can and do fall within either group.

This still leaves open the question of how benefit packages would be assigned. One option would be to divide people by income group, but income is also not a proxy for good health within Medicaid because most beneficiaries have very low incomes and so many have health problems.<sup>9</sup> The NGA policy appears to agree and generally assumes that different people would have access to different benefits and services based on their health status.

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<sup>9</sup> Income eligibility levels for adults in the median state (other than for those who need institutional care in a nursing home) are well *below* the federal poverty line. Partly because they are so poor, more than one out of three (37.3 percent) adults enrolled in Medicaid reported they were in fair or poor health, compared to 11.3 percent of privately insured adults. Children are enrolled at somewhat higher income levels, but still the vast majority (79 percent) has income below or just above the federal poverty line and 20.4 percent reports some health-related limitation. Hadley, J. and Holahan J, Urban Institute, *Inquiry*, Vol. 40, No 4, Winter 2003/2004; Urban Institute analysis of MSIS data for 2001, prepared for the Kaiser Commission on Medicaid and the Uninsured, June 2005.

If health status were the operative criteria, how would assignment of benefits actually work? Would assigned benefit plans be based solely on medical history? Would plans vary by diagnosis or disease? Or by disability or level of disability? Would a child have to be found “disabled” in order to receive speech therapy needed to address a developmental problem? Would teens with no prior history of mental health problems be able to receive mental health intervention services recommended by their physician? Would a previously healthy parent diagnosed with breast cancer be reassigned to a more comprehensive benefit package, and, if so, how quickly would that happen? Would she have coverage for the diagnostic tests? Would any federal rules guide this process or would these questions be left to states’ discretion?

### **How would targeting be administered?**

Currently, most children and about half of the adults who are enrolled in Medicaid qualify based on their income (and age), rather than a disability or medical condition. These individuals may have significant medical conditions (and according to research, many in fact do), but their medical needs are not evaluated as a condition of eligibility. Once they are enrolled, they are able to access the care that is appropriate for them as determined by their provider subject to the rules of the program.

Under a new system that offers different benefits to different people, new systems would be needed to assign people to a benefit package. Assuming that income was not the sole operative criteria, some type of medical review would be needed for each child and adult to determine their benefit category. A review would need to be done at the point of initial application and presumably also when a new medical need or condition arose. If the system were to be even modestly responsive to people’s changing medical needs frequent re-evaluations would be necessary. *The more responsive the system attempted to be, the more complicated it would need to be, making it costly to administer and difficult for providers and beneficiaries to navigate.* And, if a child or adult has to be referred, reevaluated, and reclassified in order to receive needed care, delays accessing care (and potential gaps in provider reimbursements) would be inevitable even in the best-run system. Experience in Oregon and Utah with tiered benefits (approved through section 1115 waivers) has shown that such systems can create “widespread confusion” among providers and beneficiaries and add to administrative burdens.<sup>10</sup>

### **What would be the result of ending the requirement that Medicaid coverage be available on a statewide basis?**

By permitting states to vary coverage by geography, people with similar needs for medical care could end up having vastly different access to care depending on where in the state they might reside. There are already disparities in access for people living in some rural and more remote areas; this change could exacerbate those disparities. Even

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<sup>10</sup> Hines, P. et al, “Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers in Multnomah and Washington Counties,” The Office for Oregon Health Policy and Research, December 2003; Mann, C. and S. Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program,” Kaiser Commission on Medicaid and the Uninsured, June 2004; “A Case Study of the Utah Waiver Experience”, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

people who could get to an appropriate provider might not be able to receive the care they need if payment for that service was not permitted under Medicaid in their part of the state. One possible outcome of this type of flexibility, particularly given that some states require counties to contribute a portion of the state's share of Medicaid costs and counties are looking for fiscal relief, is that people's benefits could depend on the ability and willingness of their county to make that contribution.<sup>11</sup>

## **Conclusion**

As the NGA and Congressional processes move forward, it will be important to identify the many issues that arise from the benefits proposal, particularly for children who stand to lose the most. When Medicaid does not cover necessary health care, some people may still receive care, but uncompensated care will rise along with the potential for higher costs due to delayed care. In many instances, people will not get the care they need. Their health will deteriorate or, as in the case of children, their ability to develop or function at their potential could be compromised. These issues are central to Medicaid's basic mission.

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<sup>11</sup> In New York's recent legislative session the issue of providing counties with some relief from Medicaid financing gained considerable attention-- in New York, counties pay roughly half of the state's share of Medicaid costs. A cap on county spending growth was agreed to. (See "On-Time Budget Heads List of Actions Taken in Legislature's 228th Session," *New York Times*, July 10, 2005). Under current Medicaid rules, the shortfall will be made up by the state. Under rules that allow states to vary benefit plans by county, the risk of a shortfall could be shifted to beneficiaries. The benefit standard could be redesigned so that people who live in counties with a Medicaid shortfall could receive less coverage.