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OF THE STATE OF WASHINGTON

WASHINGTON STATE DEPARTMENT OF SOCIAL AND
HEALTH SERVICES

Appellant,

v.

SAMANTHA A.,

Respondent.

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BRIEF OF THE ARC OF WASHINGTON STATE, THE
NATIONAL HEALTH LAW PROGRAM, NORTHWEST
HEALTH LAW ADVOCATES AND TEAMCHILD AS AMICI
CURIAE IN SUPPORT OF RESPONDENT

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I. INTRODUCTION

The Department's rules preclude the consideration of a treating physician's opinion in determining the amount of personal care services ("MPC") to which a child Medicaid recipient is entitled.¹ This conflicts with the federal EPSDT mandate requiring States to afford substantial deference to a child's treating physician's determination of what is medically necessary for her patient. The statutory language and history of the EPSDT program² establish the primacy of a child's treating clinician³ in determining what health care services a State must provide to a child receiving Medicaid.

Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be 'medically necessary' to improve or ameliorate a child's

¹ The rules invalidated by the trial court include WAC 388-106-0130(3)(b), -0213, hereinafter referred to as the "Children's MPC rules."

² The portions of the Medicaid statute outlining the unique requirements of the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program are found at 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

³ The terms "physician," "clinician" and "provider" are used mostly interchangeably in much of this brief, except to the extent that the term "physician" is specifically used in a relevant source of law. The EPSDT provisions of Medicaid do not generally impose limits on the types of providers who may provide covered screening services and treatment recommendations in addition to any that might already be required by law. See 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). To this end, the U.S. Department of Health and Human Services has determined that such screenings may be "performed by, or under the supervision of, a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services." U.S. Dep't of Health & Human Serv.'s., State Medicaid Manual, §5123.1(C). Ex. 1.

condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.

Rosie D. v. Romney, 410 F. Supp. 2d 18, 26 (D. Mass. 2006) (collecting cases). Thus, courts have repeatedly held that a treating physician's prescription of medically necessary treatment is entitled to substantial deference by a State Medicaid agency.

The Department asks the Court to depart from this longstanding statutory approach. It asserts that a 1993 amendment to Medicaid's definition of MPC (*see* 42 U.S.C. § 1396a(a)(24)),⁴ permits it to ignore physicians' prescriptions of what is medically necessary for their patients receiving EPSDT services. Appellant's Opening Brief (AB) 21-22. Through the 1993 amendment, Congress expanded Medicaid recipients' ability to receive MPC by giving States the flexibility to authorize MPC services even in the absence of a treating physician's authorization, without changing states' authority to provide MPC on a physician's prescription. This neither facially allows nor evinces an intent to allow states to reduce MPC benefits by ignoring qualified clinicians' prescriptions of such services as medically necessary for children receiving EPSDT. The Department's argument thus fails for two reasons: 1) it is

⁴ *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, Sec. 13601(a)(1), (5). Ex. 2.

not supported by the plain language of the statute on which it relies; and 2) it requires the court to conclude, incorrectly, that the 1993 MPC amendments, which did not in any way mention, much less alter, the EPSDT statute, implicitly partially amended or repealed it to invalidate the EPSDT mandate's application to MPC.

The Trial Court held that the EPSDT statute requires the Department to "meaningfully consider and weigh recommendations from a child's medical providers in the MPC assessment process in determining medical necessity." Clerk's Papers ("CP") 255 at Conclusion of Law ("CL") 6. The Trial Court correctly rejected the Department's claim that it can ignore the opinions of medical providers in determining what level of care is medically necessary for EPSDT recipients. However, the language of related statutes, numerous court decisions, and the EPSDT program's history support a higher standard than articulated by the Trial Court. Specifically, a treating physician's prescriptions of medically necessary treatment, including MPC, are entitled to *substantial deference* by a State in assessing a child's need for and entitlement to covered health care.

As the Children's MPC rules violate the EPSDT mandate, this Court should uphold the lower court's conclusion that they are invalid. In addition, this Court should clarify that the Department must afford

substantial deference to an EPSDT recipient's treating physician in determining what health care, including MPC, the child shall receive.⁵

II. ISSUES PRESENTED

1. Do the Children's MPC rules violate the federal EPSDT mandate by preventing consideration of the treatment recommendations of a child's treating physician as part of the MPC assessment process?

2. Do the Department's Children's MPC rules violate the EPSDT mandate by failing to afford substantial deference to the treatment recommendations of a child's treating clinician in determining whether a prescribed course of treatment will be provided to her?

III. IDENTITY AND INTEREST OF AMICI

As described in more detail in appendix A, *amici curiae* are Washington-based and national organizations representing a broad spectrum of children and adults receiving health care through the Medicaid program. This case is of vital importance to the work *amici* perform on behalf of vulnerable children and youth who rely on EPSDT. Further, *amici* offer the Court a broader perspective on the Medicaid program and

⁵ Samantha A. has challenged, and the superior court below invalidated the Children's MPC rules on the additional grounds that they violate Medicaid's "comparability" requirements and that they are arbitrary and capricious. CP 256-57 at CL 12, 14; Amended Brief of Respondent (SB) 32-39. While *amicus* supports an affirmation of the court's ruling on these grounds, these issues are not the focus of this brief.

EPSDT requirements than may be available from the parties, while simultaneously providing valuable direction in deciding this appeal.

IV. STATEMENT OF THE CASE

Samantha A.'s Statement of the Case accurately discusses the procedural facts at bar and is incorporated by reference. SB 5-13.

V. ARGUMENT

A. History, Intent And Impact Of The Medicaid Program

1. EPSDT is the largest and most important health security program for children in Washington state and nationally.

Medicaid is the primary source of health care for millions of Americans, particularly children, the elderly and people with disabilities. The program insures or provides health care to more people in this country than any other system, public or private, covering more than 58 million Americans. Kaiser Family Foundation, *State Medicaid Fact Sheet – Washington and the US* (hereinafter, “*Fact Sheet*”), at <http://www.statehealthfacts.org/mfs.jsp?rgn=49&rgn=1>. Ex. 3. Over 28 million children were enrolled in Medicaid in 2007 (nearly 30% of all children in our country), including over 630,000 children in Washington State. Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer 2010* (June 22, 2010), 3, 39, Table 2. Ex. 4. Washington State

provides Medicaid services to all children living in families at or below 200% of the Federal Poverty Level (FPL).⁶ *Fact Sheet* at 2. About half of Medicaid enrollees are children, both nationally and in Washington State,⁷ but they account for less than one-fifth of all Medicaid spending.⁸

2. EPSDT - Medicaid Benefits for Children

Medicaid services for children under age 21 are governed by a set of requirements, encompassed in the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT services fall in the mandatory category of Medicaid services that all participating States must provide. *S.A.H. v. Dep't of Soc. & Health Serv.'s*, 136 Wn.App. 342, 348-49, 149 P.3d 410 (Div. III 2006); *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007). By creating EPSDT, Congress and the President recognized that poor children have significantly more illnesses and disabilities than higher-income children and that children's health and developmental

⁶ The federal poverty level is currently, \$22,050 for a family of four in the forty-eight continental United States. 75 Fed. Reg. 45628-45629 (Aug. 3, 2010). Ex. 5.

⁷ Children were found to comprise 49.5% of the persons receiving Medicaid nationally, in FY2007. In Washington state, children comprised 54.4% of the State's recipients of Medicaid services. *Fact Sheet* at 2.

⁸ Center on Budget and Policy Priorities, *Introduction to Medicaid 1* (Dec. 17, 2008) (Ex. 6); *Fact Sheet* at 2.

needs differ from adults'.⁹ In the program's original legislative history, Congress emphasized that the States would be required to make "vigorous efforts to screen and treat children." S. Rep. No. 90-744, (1967), *reprinted in* 1967 U.S.C.C.A.N. 2843, 3032. Ex. 8. Funds expended through EPSDT were also intended to reduce discrepancies in the number of children served from State to State and to help States with the "early identification of children in need of correction" of disabilities. *Id.* Thus, since its origin, EPSDT was envisioned as a complete treatment program to seek out children's health care needs and address them in an expeditious and professional manner.

Congress made the most significant expansion to EPSDT through the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989) ("OBRA 89"). Ex. 9. OBRA 89 established the current definition of services that must be provided under EPSDT: screening services at intervals meeting reasonable standards of medical practice, dental, vision, and hearing care, and

[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and

⁹ See Rosenbaum *et al.*, George Washington School of Public Health and Health Services, *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* 10 (Apr. 2005), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_35A8D671-5056-9D20-3DEFF238AEFA7071.pdf. Ex. 7.

physical and mental illnesses and conditions discovered by the screening services *whether or not such services are covered under the state plan.*

42 U.S.C. § 1396d(r)(emphasis added). During OBRA 89's passage, Congress recognized that "[t]he EPSDT benefit is, in effect, the Nation's largest preventive health program for children." H.R. Rep. No.101-247, at 398 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2124. Ex.10.

B. The EPSDT Statute's Plain Language Requires Medicaid Agencies To Give A Treating Physician's Treatment Recommendations At Least Meaningful Consideration

The EPSDT statute explicitly requires States to furnish health care services to children receiving Medicaid based on "child health screening services" provided by qualified clinicians. Specifically, through its Medicaid state plan, each participating State must provide for

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) *arranging for* (directly or through referral to appropriate agencies, organizations, or individuals) *corrective treatment the need for which is disclosed by such child health screening services, . . .*

42 U.S.C. § 1396a(a)(43)(A)-(C) (emphasis added). Consequently, when an EPSDT recipient's treating clinician conducts a covered screening, in the course of which (s)he identifies "treatment services described in section 1396d(r)" as necessary for her patient, the State must generally arrange for the child to receive such services. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 26 (D. Mass. 2006). To determine the scope of this right, one must then answer the questions what constitutes a covered "child health screening," and what treatment is "described in section 1396d(r)"?

1. Any clinical contact between an EPSDT recipient and a treating clinician is a covered child health screening.

The EPSDT statute specifies that covered health screenings must be provided to children receiving EPSDT with a certain periodicity (42 U.S.C. § 1396d(r)(1)(A)(i); *see also* 42 C.F.R. § 441.56(b), (e)). Ex. 11. These are "periodic screenings." Additionally, the statute provides for coverage of "inter-periodic" screenings -- screenings that occur between required periodic screenings. 42 U.S.C. § 1396d(r)(1)(A)(ii). While periodic screenings must generally be provided at an EPSDT recipient's request (42 C.F.R. § 441.59(a), Ex. 12), States may decline to furnish duplicative periodic screenings under narrow circumstances. 42 C.F.R. § 441.59(b). Conversely, there is no statute or rule explicitly limiting inter-periodic screenings, other than that they be "indicated as medically necessary." 42 U.S.C. § 1396d(r)(1)(A)(ii). In this context, CMS has

stated “we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.” HCFA Dear State Medical Director Letter, Jan. 10, 2001, 10, available at <https://www.cms.gov/smdl/downloads/smd011001a.pdf>. Ex.

13.

2. EPSDT requires the Department to furnish all medically necessary corrective or ameliorative health care that a provider identifies in a screening.

Through 42 U.S.C. § 1396d(r)(5), Congress has specified that the EPSDT treatment services the State is required to provide must include:

[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Read together with the other operative sections of the EPSDT statute, these provisions require a participating State to “arrange for” an EPSDT recipient to receive all health care identified by a child’s treating clinician, in the course of any indicated screening, as medically necessary to correct or ameliorate an eligible child’s “defects, physical and mental illnesses and conditions.” 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B) 1396d(r)(5).

To be clear, the Department need not reflexively rubber stamp a clinician’s statement that a treatment is medically necessary. 42 C.F.R. §

440.230(d) (Ex. 14) allows States to set appropriate limits on EPSDT services based on “medical necessity.”¹⁰ However, to determine if a clinician is (in)correct in finding that a prescribed treatment is medically necessary, the State must give that judgment meaningful consideration. As such, the EPSDT statute plainly bars the State from utterly ignoring a treating clinician’s determination that a prescribed course of treatment is medically necessary for a child receiving EPSDT. *See C.F. v. Dep’t of Children & Families*, 934 So.2d 1, 7 (Fla. Dist. Ct. App. 2005); *Cf. Semerzakis v. Comm’r of Soc. Serv.’s*, 873 A.2d 911, 927 (Conn. 2005).

C. The Department Must Give Substantial Deference To A Treating Physician’s Prescribed Treatment For EPSDT Recipients

Not only must a State Medicaid agency consider the opinion of a treating physician, the Medicaid statute requires States to give it substantial deference when deciding whether a prescribed course of treatment must be provided under EPSDT.

When construing a statute, the court must ascertain and give effect to the Legislature’s intent. *Frank v. Fischer*, 108 Wn.2d 468, 473-74, 739 P.2d 1145 (1987); *U.S. v. Daas*, 198 F.3d 1167, 1169 (9th Cir. 1999).

¹⁰ For example, states do not have to cover treatment that is unsafe or experimental, under the reasoning that such treatments are not medically necessary. *See* U.S. Dep’t of Health & Human Serv.’s., CMS State Medicaid Manual § 5122. Ex. 1.

Congress intended that the treating physician be central in determining utilization of health care in the Medicaid program and that the physician decide for her patient which Medicaid services are appropriate and in what amount. *See* S. Rep. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986. Ex. 15. This is reflected in case after case addressing the role of a treating physician's prescription of medically necessary treatment in the State's decision to provide the treatment to EPSDT recipients.

Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds *specific care* to be 'medically necessary' to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.

Rosie D., 410 F. Supp. 2d at 26 (*emphasis added*, holding that "if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate").¹¹ Indeed, States must not simply give "meaningful consideration" to a treating physician's judgments in deciding whether to provide a Medicaid recipient a form of medical assistance. Rather,

¹¹ *See also Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *S.D. v. Hood*, 2002 U.S. Dist. LEXIS 23535 at **29-33. (E.D. La. Dec. 5, 2002), *aff'd*, 391 F.3d 581 (5th Cir. 2004); *see generally Emily Q v. Bonta*, 208 F. Supp. 2d 1078 (C.D. Cal. 2001).

[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.

Weaver v. Reagen, 886 F.2d 194, 200 (8th Cir. 1989). To this end, courts reverse Medicaid decisions that denied coverage because the agency failed to give proper deference to the treating physician's opinion.¹² This standard not only flows from the statute itself, but from the common sense proposition that a patient's treating physician has a

greater opportunity to examine and observe the patient. Further, as a result of his duty to cure the patient, the treating physician is generally more familiar with the patient's condition than are other physicians.

Connor v. Rudolph, No. 01-A-01-9601-CH-00046, 1996 WL 591176, *5 (Tenn. App. Oct. 11, 1996) (reversing denial of Medicaid benefits).

Although the precise characterization of the level and nature of this deference has varied somewhat (*see infra* fn. 12), the common conclusion

¹² *See, e.g., Urban v. Meconi*, 930 A.2d 860, 865 (Del. S. Ct. 2007) (holding that the administrative decision-maker must give "substantial weight" to the opinions of treating physicians; ... generally should give less probative weight to the opinion of a physician who has never examined the patient; ... and should not substitute its expertise for the competent medical evidence.") (citations omitted); *Hummel v. Ohio Dep't of Job & Fam. Services*, 844 N.E.2d 360, 364 (Ohio App. 2005) (affirming lower court reversal of agency's denial of Medicaid coverage, stating that the "medical opinion and diagnosis of a patient's treating physician are entitled to substantial deference in deciding whether to grant medical benefits"); *Holman v. Ohio Dep't of Human Services*, 757 N.E.2d 382, 388-89 (Ct. App. 2001) (reversing agency's denial of coverage noting "it is well settled that treating physicians' opinions based on objective evidence should be accorded significant weight ... and, if the opinion is uncontradicted, complete deference must be given to such opinions and diagnoses") (citations omitted); *A.M.L. v. Dep't of Health*, 863 P.2d 44, 47-48 (Utah App. 1993) (reversing administrative decision based on agency-hired physician rather than the opinion of the treating physician).

of these cases is that a Medicaid recipient's treating clinician's prescriptions of medically necessary treatment hold a privileged evidentiary position deserving substantial deference from a State Medicaid agency in determining whether to provide the prescribed form of medical assistance to the Medicaid recipient.

In a related context, Justice Kennedy has stated that “[t]he opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.” *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 608 (1999) (Kennedy, J., concurring); see also *Crabtree v. Goetz*, No. Civ.A. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008). In *Olmstead*, the U.S. Supreme Court recognized the “integration mandate” of the Americans With Disabilities Act (“ADA”)¹³ as generally requiring that government services be provided to persons with disabilities in the forum that is most integrated into the community. *Olmstead*, 527 U.S. at 597. This is particularly

¹³ Congress sought to eliminate unjustified segregation and isolation of disabled persons through Title II, among other provisions of, the ADA. *Townsend v. Quasim*, 328 F.3d 511, 515-16 (9th Cir. 2003), citing 42 U.S.C. §§ 12101(a)(2), (5), 12132. Ex. 16. To this end, the Department of Justice adopted regulations implementing this directive, mandating that “[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities.” 28 C.F.R. § 35.130(d). Ex. 17. Additionally, the Department of Justice required public entities to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. § 35.130(b)(7).

relevant in the context of MPC, which enables many Medicaid recipients to be cared for in the community and concomitantly avoid institutionalization. *Olmstead* and its progeny in the lower courts clarified that the integration mandate can require States to expand state benefits programs, including Medicaid, that provide persons who can be properly served in the community the care they need to maintain a community placement.¹⁴ In response, states have expanded the provision of MPC to Medicaid recipients who would otherwise require an institutional level of care. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Service Programs: Data Update* (November 2009), 2, 4, available at <http://www.kff.org/medicaid/upload/7720-03.pdf>. Ex. 18. Samantha A. is just such an individual. She receives Medicaid services through the “Basic Waiver” program, one of four programs operated by the State to provide home and community based services to persons with developmental disabilities who otherwise require the level of

¹⁴ *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1182 (10th Cir. 2003) (termination of medically necessary medication to persons with disabilities living in the community, resulting in risk of their institutionalization, violated the ADA); *Townsend*, 328 F.3d at 520 (denial of community-based Medicaid-funded long term care for “medically needy” persons with disabilities, whose clinical needs entitled them to institutional placement, violated the ADA); see also *Helen L. v. DiDario*, 46 F.3d 325, 337-39 (3d Cir. 1995) (pre-*Olmstead* case in which Pennsylvania was found to have violated the ADA’s integration mandate by not providing state-funded attendant care services for which plaintiff was eligible in her own home, rather than a nursing home).

care provided in an institution. WAC 388-845-0005 – 0030; CP 251 at FF5. Thus, the Department has determined that, without MPC and related services, Samantha A. would require an institutional level of care. *Id.*

Statutes are not interpreted in isolation, but rather must be construed so as to harmonize their application with other relevant statutes. *C.J.C. v. Corp. of the Catholic Bishop of Yakima*, 138 Wn.2d 699, 708-09 (1999); *Jett v. Dallas Indep. Sch. Dist.*, 491 U.S. 701, 739 (Scalia, J., concurring in part and concurring in the judgment). Thus, the ADA, general Medicaid, and EPSDT statutes must be read together to require the Department to afford substantial deference to a child's treating physician's prescription of medically necessary services that ameliorate the functional deficits created by a child's mental and developmental conditions and that give the child the opportunity to live at home, integrated into the community. Consequently, this Court should find that the EPSDT statute requires the Department to give substantial deference to the treating physician's determination of the amount of MPC that a child receiving EPSDT services needs.

D. 42 U.S.C. § 1396a(a)(24)'s Definition Of MPC Does Not Conflict With Or Otherwise Limit The EPSDT Mandate

The Department asserts that the federal statutory definition of MPC creates an exception to the EPSDT mandate, allowing it to ignore a child's treating clinician's recommendation that a prescribed course of MPC is

medically necessary. AB 21. However, there is no conflict between the two statutory provisions, and no exception may be inferred. Congress adopted the EPSDT statutory language broadening coverage to physician-prescribed corrective or ameliorative treatments before it revised the MPC definition on which the Department hinges its arguments.¹⁵ The question thus presented is whether these two statutory sections conflict and, if so, whether the latter partially amends or partially repeals the former by implication. The answer is clear - no conflict exists, and no implicit partial repeal or amendment of the EPSDT mandate can be inferred from 42 U.S.C. § 1396a(a)(24).

Repeal or amendment of a statute by implication is not favored. *Washington State Welfare Rights Org. v. State*, 82 Wn.2d 437, 511 P.2d 990 (1973). Explaining this canon of construction, as applied to federal statutes, the U.S. Supreme Court has stated:

¹⁵ As noted *supra*, the relevant expansion of the EPSDT statute was passed in 1989, as part of OBRA 1989. The section of the Medicaid Act establishing personal care services as an optional service for adult Medicaid recipients and adding language allowing States to authorize such services at their option, even in the absence of a physician's authorization, was added in the Omnibus Budget Reconciliation Act of 1993. Compare Omnibus Budget Reconciliation Act of 1990, Public L. No. 101-508, 104 Stat. 1388, Sec. 4721 (1990) (defining "personal care services" as one of a variety of services falling within the rubric of "home health aide" services, then a mandatory medical service that could only be authorized by a physician) (Ex. 19), with Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, Sec. 13601(a)(1), (5) (establishing personal care services, with its current definition, as a form of medical assistance that States have the option of including in their State plans).

A new statute will not be read as wholly or even partially amending a prior one unless there exists a 'positive repugnancy' between the provisions of the new and those of the old that cannot be reconciled. . . . This principle rests on a sound foundation. Presumably Congress had given serious thought to the earlier statute.... Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end.

Blanchette v. Connecticut General Ins. Corp., 419 U.S. 102, 133-34 (1974).

Here, nothing in the statutory definition of MPC facially limits the Department's duties, established by the EPSDT statute, to meaningfully consider treating physicians' prescriptions of medically necessary health care, including MPC. Through 42 U.S.C. § 1396a(a)(24), Congress expanded Medicaid recipients' ability to receive MPC by giving States the flexibility to authorize MPC services even in the absence of a physician's authorization. That expansion facilitates access to MPC services. It does not even suggest a Congressional intention to allow States to limit services by ignoring qualified clinicians' prescriptions of such services as medically necessary for children receiving EPSDT, much less creates a "positive repugnancy" with EPSDT's mandate that such consideration be given when the Department has a treating clinician's recommendation.

Moreover, even if the statutes arguably conflicted, "where potentially conflicting acts can be harmonized, [courts] construe each to

maintain the integrity of the other.” *Anderson v. State, Dept. of Corrections*, 159 Wn.2d 849, 859, (2007).¹⁶ The overwhelming weight of legislative history, as well as judicial and agency interpretations of the EPSDT statute, all support a conclusion that a State Medicaid agency must accord substantial deference to an EPSDT recipient’s treating physician’s prescription of medically necessary treatment. Thus, even if the Department’s unobvious construction of the definition of MPC had any persuasive force in the abstract, the court would still be required to interpret it so as to harmonize with, rather than partially repeal, the EPSDT statute’s general mandate that meaningful consideration be given to a treating physician’s prescription of medically necessary treatment for an EPSDT recipient. The Department provides no contrary legislative history, case law or other authority for concluding otherwise.

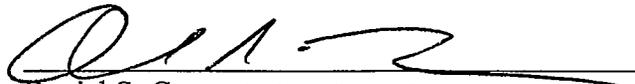
¹⁶ A court determines the plain meaning of a statute “from the ordinary meaning of the language at issue, the context of the statute in which that provision is found, related provisions, and the statutory scheme as a whole.” *Christensen v. Ellsworth*, 162 Wn.2d 365, 372 (2007). The ordinary meaning of 42 U.S.C. § 1396a(a)(24) does not facially alter the Department’s duties under EPSDT; and, the statutory components of the EPSDT program fall within the statute “in which [the MPC definition] is found, related provisions, and the statutory scheme as a whole.” Consequently, the plain meaning of 42 U.S.C. § 1396a(a)(24) should be read as incorporating the EPSDT mandate concerning MPC services authorized by a State Medicaid agency for children. However, “[i]n cases where the question is whether one statute has been impliedly repealed or overruled by another related statute,” courts have sought to harmonize the statutes “without first engaging in a plain language analysis.” *Anderson*, 159 Wn.2d at 859 fn. 6. It is unclear whether this principle applies in circumstances where, as here, a plain meaning analysis reveals no conflict between related statutory provisions passed at different times. Regardless, in either case, the result at bar is the same.

VI. CONCLUSION

The Trial Court correctly rejected the Department's argument that it could ignore the evaluation of Samantha A's physician in assessing how much MPC is medically necessary for her to receive. The plain language, intent, and history of the EPSDT statute permit no other conclusion. This Court should also clarify that the Department must give substantial deference to the statutory screening conducted by qualified clinicians, and that the Department may only depart from those recommendations when it has, and articulates, a reasoned basis for doing so. For these reasons, the superior court's ruling should be *affirmed*.

DATED: October 7, 2010.

NORTHWEST HEALTHLAW ADVOCATES



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APPENDIX A

The Arc of Washington State

The Arc of Washington State (“the Arc”) is a non-profit organization affiliated with the Arc of the United States and eleven local Arc chapters throughout the state. It is comprised of individuals with developmental disabilities, their families, professionals, and other members of the community. The Arc’s mission is to advocate for the rights and full participation of people with developmental disabilities. Since 1936, the Arc has been a leader in the development of services and programs for people with developmental disabilities. The Arc works with parents and self-advocacy groups throughout the state to inform and educate individuals about the legislative process and current developmental disability issues. It also provides support to parents of children with developmental disabilities through its Parent to Parent program, which matches parents with Helping Parent volunteers, provides referrals for services in the community, and education about developmental disabilities.

The Arc has great familiarity with the services required by and programs serving this state’s children with disabilities. Many of the parents the Arc works with through its advocacy and Parent to Parent program have children who are Medicaid recipients, a substantial

percentage of whom receive personal care services (“MPC”) through the Medicaid program. In serving these children with disabilities and their families, the Arc benefits from the expertise and experience of its executive director Sue Elliot, who has served in this capacity for twelve years, before which she served as the Director of the Division of Developmental Disabilities (“DDD”) of the appellant, the Washington State Department of Social and Health Services (“the Department”).

The Arc supports community based services, rather than institutionalization, because it recognizes that separating children with disabilities from their families and unnecessarily placing them in segregated care facilities causes such families avoidable harm, wastes valuable governmental resources, and generally constitutes discrimination. The Arc tries to help parents find the resources and services to be able to meet their children’s needs in the community so that their children can stay home with them. The cuts in MPC services resulting from the Children’s MPC Rules invalidated by the Court below have negatively impacted children and families with whom the Arc has worked, and these families would in turn greatly benefit, should this Court uphold the lower court’s ruling.

The National Health Law Program

The National Health Law Program, Inc. (NHeLP) is a national public interest law firm working to increase and improve access to quality health care on behalf of limited income people – particularly children and youth - by providing legal and policy analysis, advocacy, information and education. Over the 40 years since its inception, NHeLP has developed substantial expertise on Medicaid law and has provided legal interpretation and analysis of complex changes in state implementation of Medicaid, federal Medicaid rules and administrative interpretations, and federal and state court cases. NHeLP shares its expertise with a nationwide network of attorneys and advocates working on Medicaid and other health issues and serves as a national clearinghouse for legal information. As an advocate for civil rights in health care, NHeLP works to promote greater understanding of the barriers to health care faced by low income children and youth. In particular, NHeLP has worked for three decades analyzing, interpreting and enforcing the requirements of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Northwest Health Law Advocates

Northwest Health Law Advocates (“NoHLA”) is a public interest law firm and advocacy organization representing the interests of low- and moderate-income Washington State residents in improved access to health

care. With over twenty-five years of experience, NoHLA's staff are experts in Medicaid and EPSDT law and provide technical assistance to attorneys and community advocates statewide in their representation of Medicaid clients, including children with unmet health care needs. NoHLA provides frequent trainings on Medicaid law, represents clients who are denied coverage of health care services, and is recognized as an effective advocate for improved laws and policies, such as the significant expansion of medical assistance coverage for children in Washington State (known as Apple Health for Kids).

TeamChild

TeamChild is a nationally recognized, non-profit that provides civil legal representation to low income youth who are involved in, or at risk of involvement in, the juvenile justice system in Washington State. TeamChild provides services in seven counties in Washington, including Benton, Franklin, King, Pierce, Snohomish, Spokane and Yakima counties, which have the highest concentrations of low-income or at-risk youth. TeamChild lawyers advocate for youth clients to help them access their basic rights to education, health care, and other social services. TeamChild collaborates with communities and child welfare, educational, mental health and juvenile justice systems, both locally and nationally to develop fair and effective policies and solutions for reform.

TeamChild provides a significant amount of advocacy for Medicaid eligible children in Washington. Publicly funded health care, including Medicaid, is vital to the well-being of many of TeamChild's clients. TeamChild believes that a child's right to medical and mental health treatment is paramount and that an accessible and high-quality public health care system is critical for the success of Washington State's children. Its advocates work to zealously protect this right, with the goal of keeping children healthy.

NO. 84325-2

IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

WASHINGTON STATE DEPARTMENT OF SOCIAL AND
HEALTH SERVICES

Appellant,

v.

SAMANTHA A.,

Respondent.

EXHIBITS TO BRIEF OF THE ARC OF WASHINGTON
STATE, THE NATIONAL HEALTH LAW PROGRAM,
NORTHWEST HEALTH LAW ADVOCATES AND
TEAMCHILD AS AMICI CURIAE IN SUPPORT OF
RESPONDENT

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Exhibit 1

5122. EPSDT SERVICE REQUIREMENTS

The EPSDT benefit, in accordance with §1905(r) of the Act, must include the services set forth below. The frequency with which the services must be provided is discussed in §5140.

A. Screening Services.--Screening services include all of the following services:

- o A comprehensive health and developmental history (including assessment of both physical and mental health development);
 - o A comprehensive unclothed physical exam;
 - o Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);
 - o Laboratory tests (including blood lead level assessment appropriate to age and risk);
- and
- o Health education (including anticipatory guidance).

Immunizations which may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time. The ACIP schedule is included in §5123.2.C.

B. Vision Services.--At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

C. Dental Services.--At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

D. Hearing Services.--At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids.

E. Other Necessary Health Care.--Provide other necessary health care, diagnostic services, treatment, and other measures described in §1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

42 CFR 440.230 allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.

All services must be provided in accordance with both §1905(a) of the Act and any State laws of general applicability that govern the provision of health services. Home and community based services which are authorized by §1915(c) of the Act are not included among the other health care under subsection E because these services are not included under §1905(a) of the Act.

5123. SCREENING SERVICE DELIVERY AND CONTENT

5123.1 Minimum Standards and Requirements.--

A. State Standards.--Set standards and protocols which, at a minimum, meet the standards of §1905(r) of the Act for each component of the EPSDT services, and maintain written evidence of them. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice and be established after consultation with recognized medical and dental organizations involved in child health care. The standards must also provide for EPSDT services at other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions. The intervals at which services must be made available are discussed in §5140.

B. Services.--Provide an eligible individual requesting EPSDT services required screening services listed in §5122. This initial examination(s) may be requested at any time, and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Sound medical practice requires that when children first enter the EPSDT program you encourage and promote that they receive the full panoply of screening services available under EPSDT.

It is desirable that a parent or other responsible adult accompany the child to the examination. When this is not possible or practical, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere.

C. Who Screens/Assesses?--

o Examinations are performed by, or under the supervision of, a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services. These services may be provided within State and local health departments, school health programs, programs for children with special health needs, Maternity and Infant Care projects, Children and Youth programs, Head Start programs, community health centers, medical/dental schools, prepaid health care plans, a private practitioner and any other licensed practitioners in a variety of arrangements.

o The use of all types of providers is encouraged. Recipients should have the greatest possible range and freedom of choice. It is required, in the case of title V, and encouraged, in the case of the primary care projects (i.e., community health centers), that maximum use be made of these providers. Day care centers may provide sites for examination activities. Encourage cooperation when and where other broad-based assessment programs are unavailable.

o Providers may not be limited to those which have an exclusive contract to perform all EPSDT services. Service providers may not be limited to either the private or public sector or because the provider may not offer all EPSDT services or because it offers only one service. Assure maximum utilization of existing resources to more effectively administer and deliver services.

Medicaid providers who offer EPSDT examination services must assure that the services they provide meet the agency's minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

5123.2 Screening Service Content.--

A. Comprehensive Health and Developmental History.--Obtain this information from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

1. Developmental Assessment.--This includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for developmental assessment is a part of every routine initial and periodic examination.

Exhibit 2

**UNITED STATES PUBLIC LAWS
103rd Congress - First Session
Convening January 5, 1993**

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Additions and Deletions are not identified in this document.
For Legislative History of Act, see LH database or Report for
this Public Law in U.S.C.C. & A.N. Legislative History section.

PL 103-66 (HR 2264)
August 10, 1993
OMNIBUS BUDGET RECONCILIATION ACT OF 1993

An Act to provide for reconciliation pursuant to section 7 of the concurrent resolution on the budget for fiscal year 1994.

Be it enacted by the Senate and House of Representatives of the United States
of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1993".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

TITLE I--AGRICULTURE AND RELATED PROVISIONS
TITLE II--ARMED SERVICES PROVISIONS
TITLE III--BANKING AND HOUSING PROVISIONS
TITLE IV--STUDENT LOANS AND ERISA PROVISIONS
TITLE V--TRANSPORTATION AND PUBLIC WORKS PROVISIONS
TITLE VI--COMMUNICATIONS LICENSING AND SPECTRUM ALLOCATION PROVISIONS
TITLE VII--NUCLEAR REGULATORY COMMISSION PROVISIONS
TITLE VIII--PATENT AND TRADEMARK OFFICE PROVISIONS
TITLE IX--MERCHANT MARINE PROVISIONS
TITLE X--NATURAL RESOURCES PROVISIONS
TITLE XI--CIVIL SERVICE AND POST OFFICE PROVISIONS
TITLE XII--VETERANS' AFFAIRS PROVISIONS
TITLE XIII--REVENUE, HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, CUSTOMS AND
TRADE PROVISIONS, FOOD STAMP PROGRAM, AND TIMBER SALE PROVISIONS
TITLE XIV--BUDGET PROCESS PROVISIONS
TITLE I--AGRICULTURAL PROGRAMS

SEC. 13600. REFERENCES IN SUBCHAPTER; TABLE OF CONTENTS OF SUBCHAPTER.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.--Except as otherwise specifically provided, whenever in this subchapter an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

*612 (b) REFERENCES TO OBRA.--In this subchapter, the terms "OBRA-1986", "OBRA-1987", "OBRA-1989", and "OBRA-1990" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), and the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), respectively.

(c) TABLE OF CONTENTS OF SUBCHAPTER.--The table of contents of this subchapter is as follows:

PART I--SERVICES
PART II--ELIGIBILITY
PART III--PAYMENTS
PART IV--IMMUNIZATIONS
PART V--MISCELLANEOUS
PART I--SERVICES

SEC. 13601. PERSONAL CARE SERVICES FURNISHED OUTSIDE THE HOME AS OPTIONAL BENEFIT.

<< 42 USCA § 1396d >>

(a) IN GENERAL.--Section 1905(a) (42 U.S.C. 1396d(a)) is amended--

(1) in paragraph (7), by striking "including personal care services" and all that follows through "nursing facility";

(2) by striking "and" at the end of paragraph (21);

(3) in paragraph (24), by striking the comma at the end and inserting a semicolon;

(4) by redesignating paragraphs (22), (23), and (24) as paragraphs (25), (22), and (23), respectively, by striking the semicolon at the end of paragraph (25), as so redesignated, and inserting a period, and by transferring and inserting paragraph (25) after paragraph (23), as so redesignated; and

*613 (5) by inserting after paragraph (23), as so redesignated, the following new paragraph:

"(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location; and"

<< 42 USCA § 1396a >>

(b) CONFORMING AMENDMENTS.--(1) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking "through (21)" and inserting "through (24)".

(2) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking "through (22)" and inserting "through (25)".

<< 42 USCA §§ 1396a NOTE, 1396d nt >>

(c) EFFECTIVE DATE.--The amendments made by subsections (a) and (b) shall take effect as if included in the enactment of section 4721(a) of OBRA-1990.

SEC. 13602. ADDITIONAL FEDERAL SAVINGS THROUGH MODIFICATIONS TO DRUG REBATE PROGRAM.

<< 42 USCA § 1396r-8 >>

(a) CHANGES IN REBATE PROGRAM.--

(1) IN GENERAL.--Section 1927 (42 U.S.C. 1396r-8) is amended by striking subsection (c) and all that follows through "(2)" in subsection (f)(2) and inserting the following:

"(c) DETERMINATION OF AMOUNT OF REBATE.--

"(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.--

"(A) IN GENERAL.--Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (k)(8)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of--

"(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

"(ii) subject to subparagraph (B)(ii), the greater of--

"(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

"(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,

for the rebate period.

"(B) RANGE OF REBATES REQUIRED.--

"(i) MINIMUM REBATE PERCENTAGE.--For purposes of subparagraph (A)(ii)(II), the 'minimum rebate percentage' for rebate periods beginning--

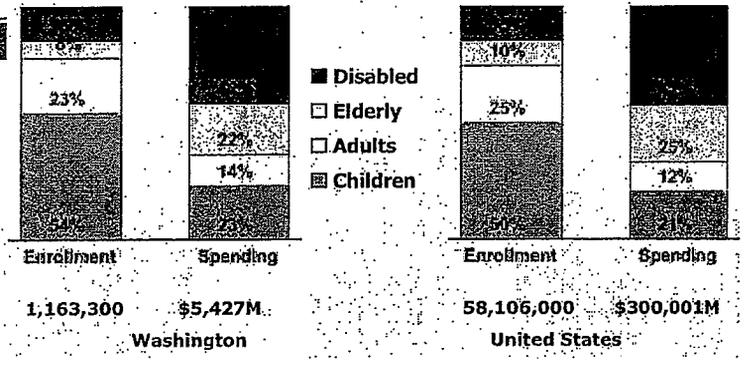
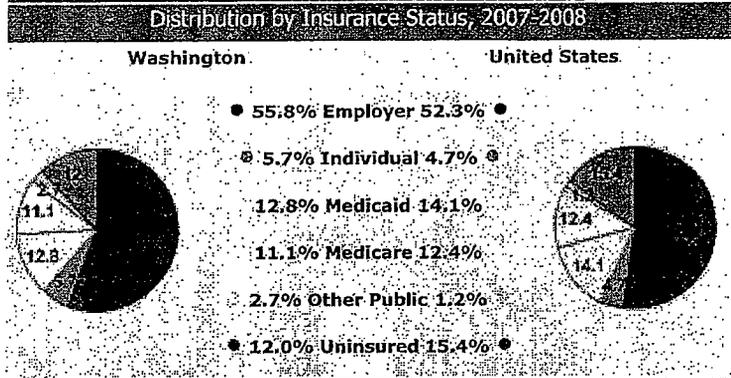
"(I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;

"(II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;

*614 "(III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;

Exhibit 3

Total Residents, 2007-2008		Medicaid Enrollment and Spending by Group, FY2007	
WA: 6,464,700	US: 300,544,200		



	Number		Percent		Notes
	WA	US	WA	US	

Demographic Profile, 2007-2008

	WA	US	WA	US	Notes
Total Residents	6,464,700	300,544,200	-	-	
Income					
Poor Residents (below 100% FPL)	904,500	54,942,500	14.0	18.3	% of total residents
Residents (100-133% FPL)	309,500	19,349,300	4.8	6.4	% of total residents
Median Annual Income	\$58,460	\$51,233	-	-	
Age					
Children (0-18)	1,650,700	78,677,200	26	26	% of total residents
Poor Children	273,900	19,306,600	17	25	% of total children
Adults (19-64)	4,078,000	184,079,200	63	61	% of total residents
Poor Adults	560,800	30,870,100	14	17	% of total adults
Elderly (65+)	736,000	37,787,700	11	13	% of total residents
Poor Elderly	69,900	4,765,800	9	13	% of total elderly
Distribution by Race/Ethnicity					
White	4,894,000	196,505,600	76	65	% of total residents
Black	227,100	36,466,900	4	12	% of total residents
Hispanic	555,900	47,395,400	9	16	% of total residents
Other	787,700	20,176,200	12	7	% of total residents
Non-Citizen	397,100	21,266,400	6	7	% of total residents
Population Living in Non-Metropolitan Areas	520,600	48,950,400	8	16	% of total residents

Health Insurance Coverage of the Nonelderly, 2007-2008

	WA	US	WA	US	Notes
Medicaid	785,800	39,256,200	13.7	14.9	% of nonelderly
Children	429,000	23,397,800	54.6	59.6	% of Medicaid
Adults	356,800	15,858,500	45.4	40.4	% of Medicaid
Uninsured	759,100	45,693,300	13.3	17.4	% of nonelderly
Children	118,200	8,076,400	15.6	17.7	% of uninsured
Adults	640,900	37,616,900	84.4	82.3	% of uninsured
Nonelderly (below 100% FPL)	254,300	17,476,400	33.5	38.2	% of uninsured
Nonelderly (100-133% FPL)	56,700	4,702,800	7.5	10.3	% of uninsured
Nonelderly (134-300% FPL)	295,500	15,950,700	38.9	34.9	% uninsured
Nonelderly (301-400% FPL)	67,000	3,172,100	8.8	6.9	% of uninsured
Nonelderly (above 400% FPL)	85,600	4,391,400	11.3	9.6	% of uninsured
Employer Sponsored Insurance	3,596,700	156,860,100	62.8	59.7	% of nonelderly

	Number		Percent		Notes
	WA	US	WA	US	
Individual Insurance	367,700	13,823,100	6.4	5.3	% of nonelderly
Other Public	219,300	7,123,600	3.8	2.7	% of nonelderly
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2007-2008					
Uninsured	1.2	0.2	-	-	% point change
Medicaid	-	-	1.4	1.0	% point change
Employer-Sponsored	-	-	-2.3	-1.2	% point change
Individually Purchased	-	-	-1.0	-0.2	% point change
Medicaid Enrollment					
Total Enrollment, FY2007	1,163,300	58,106,000	-	-	% of total residents
Children	633,000	28,754,500	54.4	49.5	% of Medicaid enrollees
Adults	269,700	14,627,000	23.2	25.2	% of Medicaid enrollees
Elderly	86,900	5,934,900	7.5	10.2	% of Medicaid enrollees
Disabled	173,700	8,789,500	14.9	15.1	% of Medicaid enrollees
% Enrolled in Managed Care, 2008	-	-	89.3	70.9	% of Medicaid enrollees
Medicaid Expenditures					
Total Medicaid Spending, FY2008	\$6,292,711,500	\$338,791,482,443	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	\$326,316,695	\$17,738,530,492	5.2	5.2	% of total spending
Acute Care	\$3,893,883,722	\$206,255,691,313	61.9	60.9	% of total spending
Rx Drugs	\$272,131,323	\$15,274,195,878	7.0	7.4	% of acute care spending
Long Term Care (LTC)	\$2,072,511,083	\$114,797,260,638	32.9	33.9	% of total spending
Nursing Home	\$570,288,914	\$49,639,456,902	27.5	43.2	% of LTC spending
Home/Personal Care	\$1,299,039,064	\$47,762,519,611	62.7	41.6	% of LTC spending
Per Enrollee Medicaid Spending, FY2007					
Total	\$4,665	\$5,163	-	-	
Children	\$1,927	\$2,135	18.3	18.6	% of total spending
Adults	\$2,741	\$2,541	11.8	11.9	% of total spending
Elderly	\$13,919	\$12,499	18.6	24.3	% of total spending
Disabled	\$12,999	\$14,481	34.7	40.9	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2010	1.70	1.28	62.94	56.20	
General Fund Spending on Medicaid, SFY2008	\$2,954	\$111,711	20.2	16.3	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2009					
Pregnant Women	\$33,874	\$24,352	185	133	% of federal poverty level
Infants	\$36,620	\$24,352	200	133	% of federal poverty level
Children 1-5	\$36,620	\$24,352	200	133	% of federal poverty level
Children 6-19	\$36,620	\$18,310	200	100	% of federal poverty level
Working Parents	\$13,488	\$11,616	77	66	% of federal poverty level
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2005	133,500	8,807,160	100	100	
Total Dual Eligible Spending in Millions, 2005	\$2,154	\$131,864	100	100	
Total Medicare Enrollment, 2010	954,381	46,589,141	14	15	% of total residents
Estimated Annual "Clawback" Payment, 2006	\$131,305,656	\$6,605,675,559	-	-	
CHIP					
Eligibility Income Level for Family of 3, 2009	\$54,930	-	300	-	% of federal poverty level
Change in CHIP Enrollment, June 2008-09	-	-	13.9	2.7	% growth, 2008-2009
Total CHIP Spending, FY2007	\$43,264,003	\$10,046,523,960	-	-	

This fact sheet was last updated on June 25, 2010. Additional Medicaid Fact Sheets available at <http://www.kff.org/MFS/>.



All data are drawn directly from statehealthfacts.org, Kaiser's continuously updated database for state-level health data. More detailed notes and sources are available by following the online links from each topic on the fact sheet.

Demographic Profile

Total Residents, Income, Age, Race/Ethnicity, Citizenship, Population Living in Non-Metropolitan Areas

Source: KCMU and Urban Institute analysis of the Current Population Surveys, March 2008 and 2009.

Notes: These demographic data may differ from Census Bureau figures due to grouping by health insurance unit (HIU) rather than household. A Metropolitan Statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 population. A Non-Metropolitan Statistical Area lacks at least one urbanized area of 50,000 or more inhabitants.

Median Annual Income

Source: U.S. Census Bureau, Current Population Survey, 2007, 2008, and 2009 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2006-2008.

Health Insurance Coverage

Medicaid, Uninsured, Medicaid, Employer-Sponsored Insurance, Individual Insurance, Other Public, Percentage Point Change in the Rate of Coverage of the Nonelderly Population (0-64 years old)

Source: KCMU and Urban Institute analysis of the Current Population Survey (CPS), March 2008 and 2009.

Notes: State figures are based on pooled 2007 and 2008 data; U.S. figures are based on 2008 data.

Medicaid

Total Enrollment

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2007.

% Enrolled in Managed Care

Source: Medicaid Managed Care Penetration Rates by State as of June 2008, CMS, DHHS.

Total Medicaid Spending in Millions

Source: Urban Institute estimates for KCMU based on CMS Form 64 for FY2007.

Notes: All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about \$315.3 billion in FY2006.

Per Enrollee Medicaid Spending and Distribution by Group

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2007.

Multiplier and Federal Matching Rate

Source: KCMU calculations based on the FMAPs as published in the Federal Register, April 30, 2010 (Vol. 75, No. 83), pp. 22807-22809.

Notes: The multiplier is based on the FMAP and represents the amount of federal funds a state receives for every dollar it spends on Medicaid. The rate varies year to year and is based on each state's relative per capita income. It ranges from a low of 50% to 76%, averaging roughly 60% nationally. For FY2007, the rate for Alabama was 1:2.21 (68.85%).

State Medicaid Spending as % of State General Fund

Source: 2008 State Expenditure Report, National Association of State Budget Officers

Notes: A state's general fund is the predominant fund for financing a state's operations.

Medicaid Eligibility Levels

Source: Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, December 2009; and Medicaid Eligibility, DHHS, CMS.

Notes: All dollar figures represent the annual income for a family of three. For Working Parents, the U.S. figures represent the median annual income in dollars and as a percent of the FPL. For other groups, the U.S. figures represent the federal minimum annual income in dollars and as a percent of the FPL. The eligibility thresholds for parents in Arizona, Indiana, Iowa, New Mexico, Oklahoma, and Utah are for Medicaid coverage established through waivers and are higher than for "regular" Medicaid coverage. The coverage offered through these waivers generally provides fewer benefits and has higher levels of cost-sharing than allowed in Medicaid.

Medicaid and Medicare Dual Eligibles

Sources: The Urban Institute and KCMU estimates based on data from MSIS and CMS-64 reports from CMS for 2005.

CMS Statistics: Medicare State Enrollment, CMS. *An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit*, KCMU, March 2006.

CHIP

Eligibility Income Level for a Family of Three

Source: Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2009; and Medicaid Eligibility, DHHS, CMS.

Notes: The levels are for separate SCHIP programs only. The following states do not have a separate SCHIP program: AK, AR, DC, HI, LA, MN, MO, NE, NM, OH, OK, RI, SC, WI.

Current CHIP Enrollment

Source: Collected by Health Management Associates for KCMU. Data as of June 2009.

Notes: Figures represent the current monthly enrollment. TN phased out its Medicaid expansion program in September 2002. In March 2007, the state implemented a new SCHIP program called CoverKids.

Total CHIP Spending

Source: FY2007 CHIP Expenditures (state and federal), CMS, Special Data Request.

Abbreviations

CMS: Centers for Medicare and Medicaid Services

DHHS: U.S. Department of Health and Human Services

FMAP: Federal Medical Assistance Percentage

FPL: Federal Poverty Level (The FPL for 48 states was \$16,090 for a family of 3 in 2005; Alaska \$20,110 and Hawaii \$18,510.)

KCMU: The Kaiser Commission on Medicaid and the Uninsured

MSIS: Medicaid Statistical Information System

CHIP: State Children's Health Insurance Program

Exhibit 4

MEDICAID

A PRIMER

2010



THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

MEDICAID

A PRIMER

Key Information on Our Nation's
Health Coverage Program for Low-Income People

June 2010



THE KAISER COMMISSION ON
Medicaid and the Uninsured

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Over its nearly 45-year history, the Medicaid program has grown increasingly integral to our health care system. Today, it is a primary source of coverage, access, health care financing, and innovation in health care delivery. During the recession, the program has provided a coverage safety-net for millions of Americans, especially children, who would otherwise have joined the uninsured. Under health reform, Medicaid assumes even greater importance as it becomes the national coverage mechanism for low-income people in the new plan for near-universal coverage. With this expanded role for Medicaid on the horizon, basic information about the program is a key resource.

What is Medicaid?.....3

Medicaid is the nation’s publicly funded health coverage program for low-income Americans. Medicaid covers health and long-term care services for specified categories of low-income people currently, but it will be expanded in 2014 to reach nearly everyone under age 65 with income up to 133% of the poverty level. Medicaid fills large gaps in our health insurance system, finances the lion’s share of long-term care, and provides core support for the health centers and safety-net hospitals that serve the nation’s uninsured and millions of others. Within broad federal guidelines, states design their own Medicaid programs.

Who is Covered by Medicaid?.....7

Medicaid covers nearly 60 million low-income Americans, including children and parents, people with severe disabilities, and low-income, elderly and disabled Medicare beneficiaries known as “dual eligibles.” Medicaid is expected to reach another 16 million people over the first five years of health reform, when a national expansion of the program takes place. Most Medicaid beneficiaries have no access to or cannot afford employer-based or individual insurance in the private market. For dual eligibles, Medicaid supplements Medicare, covering services that Medicare excludes or limits – especially, long-term care – and paying Medicare’s premiums and cost-sharing.

What Services Does Medicaid Cover?.....14

Medicaid covers a broad range of health and long-term care services, but program benefits vary by state. Medicaid covers comprehensive services for children. It also covers services that most private insurers and Medicare exclude or limit, including long-term care, mental health care, and services and supports needed by people with disabilities. Transportation, translation, and other services help lower access barriers that many in the low-income population face. Medicaid enrollees obtain most services from providers and managed care plans in the private sector.

How Much Does Medicaid Cost?.....22

Medicaid spending on services totaled about \$339 billion in 2008. Two-thirds of Medicaid benefit spending is attributable to seniors and people with disabilities. Although beneficiaries in these two groups make up just a quarter of all Medicaid enrollees, their extensive needs for health and long-term care translate into high costs to the program. While aggregate Medicaid costs are high, Medicaid’s administrative costs are low and Medicaid acute care spending per capita has been rising more slowly than private insurance premiums.

How is Medicaid Financed?.....27

Medicaid financing is a federal-state partnership in which the federal government matches state Medicaid spending. Under normal rules, the federal match rate is at least 50% in every state but higher in poorer states, reaching 76% in the poorest state, and the federal share of Medicaid spending overall is 57%. In 2008, states on average spent about 16% of their general funds on Medicaid, and Medicaid accounted for about 7% of total federal outlays. In 2009, Congress enacted a temporary increase in federal Medicaid funding to ease recessionary pressures on states and preserve coverage, and currently the federal government funds about 66% of Medicaid spending. Under health reform, the federal-state financing partnership that supports Medicaid will continue. However, the federal government will finance the lion’s share – an estimated 96% -- of the cost of the new Medicaid coverage stemming from health reform over the first decade.

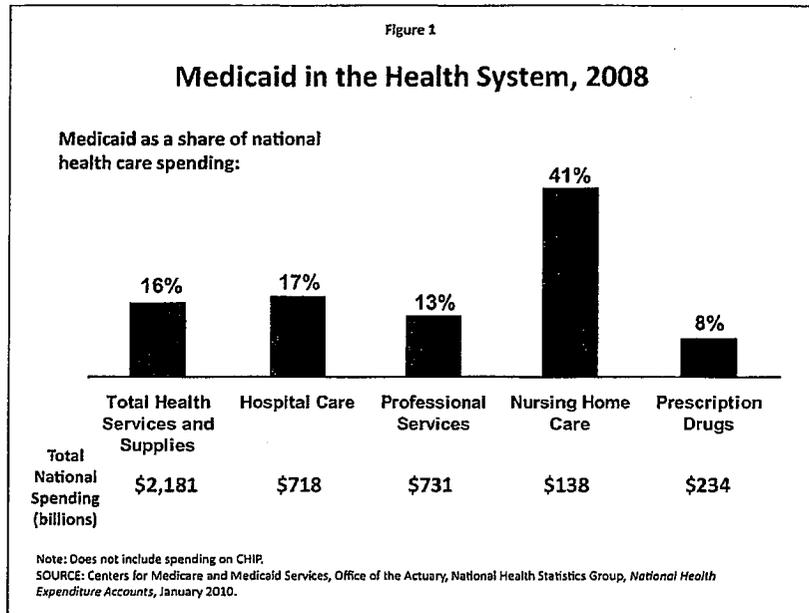
How Does Health Reform Reshape Medicaid for the Future?.....30

A major expansion of the Medicaid program is integral to the national coverage framework established by the health reform law. In the new system, Medicaid will provide the foundation for coverage of the low-income population. Current restrictions on eligibility for non-elderly adults will be removed so that nearly everyone under age 65 with income below a national floor will be eligible. Millions of the uninsured will gain Medicaid coverage as a result, and the federal government will finance the vast majority of increased coverage over the next decade. To prepare Medicaid for its broader, national role, the reform law strengthens the program through provisions and investments to simplify Medicaid enrollment, improve Medicaid access and quality of care, ensure coordination with the new insurance exchanges, and achieve other goals of reform.

Tables.....35

INTRODUCTION

No major health program or issue can be considered today outside the context of the nation's new health care reform law, known as the "Affordable Care Act." The health reform law, the most significant social legislation in the U.S. since 1965, seeks to eliminate large and growing gaps in health insurance by increasing access to affordable coverage and instituting a new legal obligation on the part of individuals to obtain it. To accomplish this reform, the law creates a national framework for near-universal coverage and also outlines a comprehensive set of strategies to improve care and contain costs. Integral to the coverage framework laid out in the reform law is a dramatic expansion of the Medicaid program; half the expected gains in coverage due to health reform will be achieved through this expansion.



The reliance on Medicaid as a platform for wider coverage of the low-income uninsured has a long history. Established in 1965 as part of President Johnson's "Great Society," Medicaid was originally conceived as a health coverage supplement only for those receiving cash welfare assistance. Overtime, Congress has expanded Medicaid substantially to fill growing coverage gaps left by the private insurance system. Many states have expanded eligibility for the program further and Medicaid has been the cornerstone of all state-level initiatives to broaden coverage of the uninsured. In 2007, Medicaid covered health and long-term care services for nearly 60 million people, including more than 1 in 4 children and many of the sickest and poorest in our nation. During the economic recession, Medicaid has provided a safety-net of coverage for millions more Americans affected by loss of work or declining income. Medicaid now provides benefits to more people than any other public or private insurance program, including Medicare.

* Health reform was enacted in two separate pieces of legislation. President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), signed on March 30, 2010, includes changes to new law.

As a mainstay of coverage in the U.S., Medicaid is also a core source of health care financing – it funds almost a sixth of total national spending on personal health care (Figure 1). Medicaid is the main payer of nursing home care and long-term care services overall; it is also the largest source of public funding for mental health care. Health centers and safety-net hospitals that serve low-income and uninsured people rely heavily on Medicaid revenues. Medicaid is an engine in state and local economies, too, supporting millions of jobs.

Looking ahead to the even larger role Medicaid will soon play under health care reform, understanding the program and how it fits into our health care system takes on additional importance. The purpose of this primer is to provide that foundation by explaining the basics of Medicaid and providing key information about the program today.

WHAT IS MEDICAID?

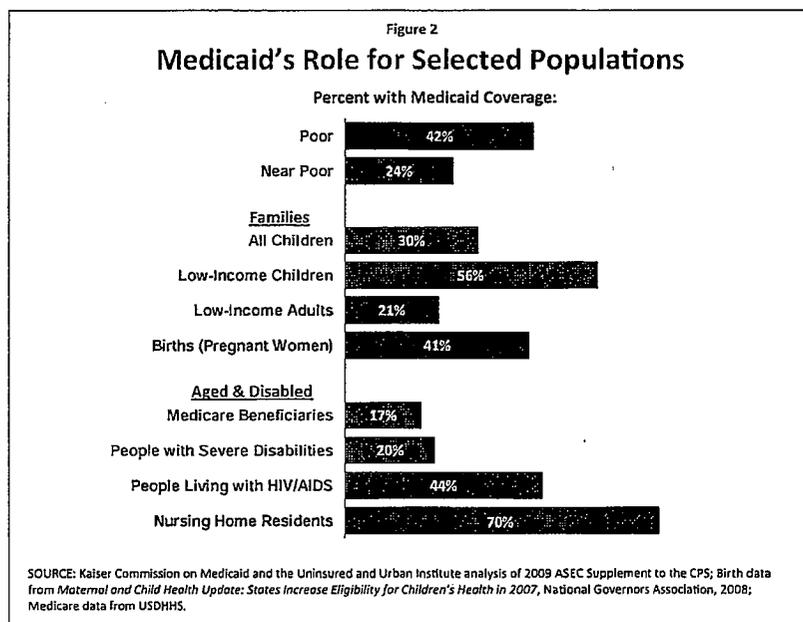
Medicaid is a public health insurance program that fills important gaps in our system today – gaps in coverage, long-term care, and financing for the safety-net delivery system. Under health reform, Medicaid’s role in health coverage and financing will increase substantially. A significant expansion of Medicaid, which will extend health coverage to millions more low-income people, is the foundation of the national coverage system established by the new law. The federal government will finance the lion’s share of the cost of the new coverage. States will continue to shape their own programs, but Medicaid eligibility will be simplified to support coordination between Medicaid and subsidized coverage offered in the new insurance exchanges.

What is Medicaid?

Medicaid is the nation’s publicly financed health and long-term care coverage program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program that was initially established to provide medical assistance to individuals and families receiving cash assistance, or “welfare.” Over the years, Congress has incrementally expanded Medicaid eligibility to reach more Americans living below or near poverty, regardless of their welfare eligibility. Today, Medicaid covers a broad low-income population, including parents and children in both working and jobless families, individuals with diverse physical and mental conditions and disabilities, and seniors. Medicaid’s beneficiaries include many of the poorest and sickest people in the nation.

What is Medicaid’s role in the U.S. health care system?

Medicaid fills large gaps in our health insurance system. Medicaid provides health coverage for millions of low-income children and families who lack access to the private health insurance system that covers most Americans. The program also provides coverage for millions of people with chronic illnesses or disabilities who are excluded from private insurance or for whom such insurance, which is designed for a generally healthy population, is inadequate. Finally, Medicaid provides extra help for millions of low-income Medicare enrollees known as “dual eligibles,” assisting them with Medicare premiums and cost-sharing and covering key services, especially long-term care, that Medicare limits or excludes. Medicaid is the nation’s largest source of coverage for long-term care, covering more than two-thirds of all nursing home residents. (Figure 2)

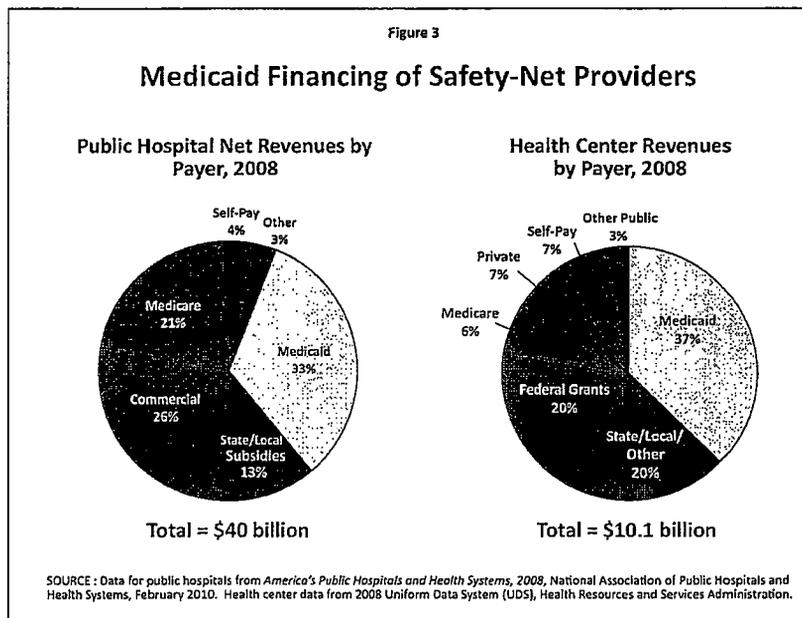


By design, Medicaid expands to cover more people during economic downturns. Because eligibility for Medicaid is tied to having low income, and enrollment cannot be limited or waiting lists kept, the program operates as a safety-net. During economic recessions like the current one, when job loss causes workers and their families to lose health coverage and income, more people become eligible for Medicaid and the program expands to cover many of them, offsetting losses of private health insurance and mitigating increases in the number of uninsured.

It is estimated that for every one percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million.¹ Medicaid enrollment growth has been accelerating in each six-month period since the recession began in December 2007. The largest six-month Medicaid enrollment increase on record occurred from December 2008 to June 2009, when 2.1 million additional individuals obtained Medicaid coverage. Between June 2008 and June 2009, enrollment rose by nearly 3.3 million, or 7.5%.

Medicaid is the main source of long-term care coverage and financing in the U.S. Over 10 million Americans, including about 6 million elderly and 4 million children and working-age adults, need long-term services and supports.² Medicaid covers about 7 of every 10 nursing home residents and finances over 40% of nursing home spending and long-term care spending overall.³ More than half of all Medicaid long-term care spending is for institutional care, but a growing share – 41% in 2006, up from 30% in 2000 and 13% in 1990 – is attributable to home and community-based services.⁴

Medicaid funding supports the safety-net institutions that provide health care to low-income and uninsured people (Figure 3). Medicaid provides 33% of public hospitals' net revenues. Medicaid payments provide an even larger share of health centers' total operating revenues (37%) and is their largest source of third-party payment.⁵



How is Medicaid structured?

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. States are entitled to these federal matching dollars and there is no cap on funding. This financing model supports the federal entitlement to coverage and allows federal funds to flow to states based on actual need. Through the matching arrangement, the federal government and the states share the cost of the program.

The states administer Medicaid within broad federal guidelines and state programs vary widely. State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary but all states participate. Federal law outlines basic minimum requirements that all state Medicaid programs must meet. However, states have broad authority to define eligibility, benefits, provider payment, delivery systems, and other aspects of their programs. As a result, Medicaid operates as more than 50 distinct programs – one in each state, the District of Columbia, and each of the Territories. Due to wide programmatic variation and demographic differences across the country, the proportion of the population covered by Medicaid varies from state to state, ranging from 8% in New Hampshire and Nevada to 22% in the District of Columbia (Figure 4).

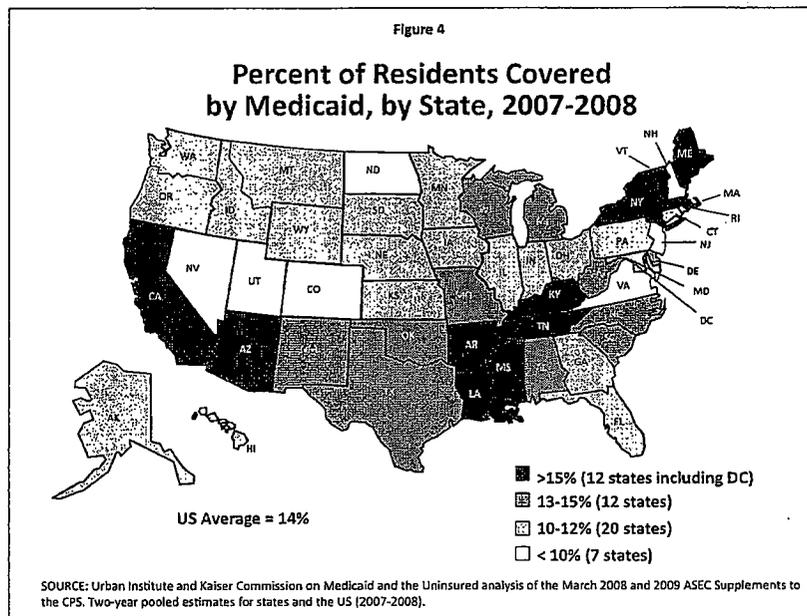


Table 2

Federal Medical Assistance Percentages, FY 2006-2010

State	FY 2006	FY 2007	FY 2008	FY 2009*	FY 2010*	Federal Funds Sent to State for Each Dollar
						In State Medicaid Spending, FY 2010
Alabama	69.5%	68.9%	67.6%	77.5%	77.5%	\$3.45
Alaska	57.6%	57.6%	52.5%	61.1%	62.5%	\$1.66
Arizona	67.0%	66.5%	66.2%	75.9%	75.9%	\$3.15
Arkansas	73.8%	73.4%	72.9%	80.5%	81.2%	\$4.31
California	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Colorado	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Connecticut	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Delaware	50.1%	50.0%	50.0%	61.6%	61.8%	\$1.62
District of Columbia	70.0%	70.0%	70.0%	79.3%	79.3%	\$3.83
Florida	58.9%	58.8%	56.8%	67.6%	67.6%	\$2.09
Georgia	60.6%	62.0%	63.1%	74.4%	75.0%	\$2.99
Hawaii	58.8%	57.6%	56.5%	67.4%	67.4%	\$2.06
Idaho	69.9%	70.4%	69.9%	79.2%	79.2%	\$3.80
Illinois	50.0%	50.0%	50.0%	61.9%	61.9%	\$1.62
Indiana	63.0%	62.6%	62.7%	74.2%	75.7%	\$3.11
Iowa	63.6%	62.0%	61.7%	70.7%	72.6%	\$2.64
Kansas	60.4%	60.3%	59.4%	69.4%	69.7%	\$2.30
Kentucky	69.3%	69.6%	69.8%	79.4%	80.1%	\$4.04
Louisiana	69.8%	69.7%	72.5%	80.8%	81.5%	\$4.40
Maine	62.9%	63.3%	63.3%	74.4%	74.9%	\$2.98
Maryland	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Massachusetts	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Michigan	56.6%	56.4%	58.1%	70.7%	73.3%	\$2.74
Minnesota	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Mississippi	76.0%	75.9%	76.3%	84.2%	84.9%	\$5.61
Missouri	61.9%	61.6%	62.4%	73.3%	74.4%	\$2.91
Montana	70.5%	69.1%	68.5%	77.1%	78.0%	\$3.54
Nebraska	59.7%	57.9%	58.0%	67.8%	68.8%	\$2.20
Nevada	54.8%	53.9%	52.6%	63.9%	63.9%	\$1.77
New Hampshire	50.0%	50.0%	50.0%	60.2%	61.6%	\$1.60
New Jersey	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
New Mexico	71.2%	71.9%	71.0%	79.4%	80.5%	\$4.13
New York	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
North Carolina	63.5%	64.5%	64.1%	74.5%	75.0%	\$3.00
North Dakota	65.9%	64.7%	63.8%	70.0%	70.0%	\$2.33
Ohio	59.9%	59.7%	60.8%	72.3%	73.5%	\$2.77
Oklahoma	67.9%	68.1%	67.1%	75.8%	76.7%	\$3.30
Oregon	61.6%	61.1%	60.9%	72.6%	72.9%	\$2.69
Pennsylvania	55.1%	54.4%	54.1%	65.6%	65.9%	\$1.93
Rhode Island	54.5%	52.4%	52.5%	63.9%	63.9%	\$1.77
South Carolina	69.3%	69.5%	69.8%	79.4%	79.6%	\$3.90
South Dakota	65.1%	62.9%	60.0%	70.6%	70.8%	\$2.42
Tennessee	64.0%	63.7%	63.7%	74.2%	75.4%	\$3.06
Texas	60.7%	60.8%	60.5%	69.9%	70.9%	\$2.44
Utah	70.8%	70.1%	71.6%	80.0%	80.8%	\$4.20
Vermont	58.5%	58.9%	59.0%	70.0%	70.0%	\$2.33
Virginia	50.0%	50.0%	50.0%	61.6%	61.6%	\$1.60
Washington	50.0%	50.1%	51.5%	62.9%	62.9%	\$1.70
West Virginia	73.0%	72.8%	74.3%	83.1%	83.1%	\$4.90
Wisconsin	57.7%	57.5%	57.6%	69.9%	70.6%	\$2.40
Wyoming	54.2%	52.9%	50.0%	58.8%	61.6%	\$1.60

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FFY 2006-2009 FMAPs as published in the Federal Register as follows: FY 2006 FMAP Vol. 69, No. 226, pp. 68370-28373; FY 2007 FMAP Vol. 70, No. 229, pp. 71856-71857; FY 2008 FMAP Vol. 71, No. 230, pp. 69209-69211; FY 2009 FMAP Vol. 74, No. 234, pp. 64697-64700; FY 2010 FMAP Vol. 75, No. 83, pp. 22807-22808.

Note: FY2006 and FY2007 for Alaska are from Federal Register, May 15, 2006 (Vol. 71, No. 93), pp. 28041-28042. FY 2009 and FY2010 FMAPs reflect additional federal Medicaid funding available through the American Recover and Reinvestment Act (ARRA) of 2009, P.L. 111-5.

* FY 2009 FMAPs are for the 4th Quarter of that fiscal year, and FY2010 FMAPs are for the 2nd Quarter of 2010.

Exhibit 5

NOTICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010

Tuesday, August 3, 2010

AGENCY: Department of Health and Human Services.

***45628 ACTION:** Notice.

SUMMARY: This notice provides a delayed update of the Department of Health and Human Services (HHS) poverty guidelines for the remainder of 2010, and until the 2011 poverty guidelines are published, which is expected to occur in late January 2011. HHS is issuing this delayed update due to recent legislation that prohibited the Secretary of HHS from publishing 2010 poverty guidelines before May 31, 2010, and required that the 2009 poverty guidelines remain in effect until the Secretary of HHS published updated guidelines.

DATES: Effective Date: Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690-7507—or visit <http://aspe.hhs.gov/poverty/>.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1-800-375-5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a staff member, please call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You also may visit <http://www.hrsa.gov/hillburton/default.htm>.

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's Web site at <http://www.census.gov/hhes/www/poverty/poverty.html> or contact the

Census Bureau's Demographic Call Center Staff at (301) 763-2422 or 1-866-758-1060 (toll-free).

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of HHS to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses ***45629** to prepare its estimates of the number of individuals and families in poverty.

However, provisions in three recent laws prohibited the Secretary of HHS from publishing updated poverty guidelines for 2010 before May 31, 2010, and required that the poverty guidelines published on January 23, 2009, remain in effect until updated poverty guidelines were published. These provisions were section 1012 of the Department of Defense Appropriations Act, 2010 (Pub. L. 111-118), section 7 of the Temporary Extension Act of 2010 (Pub. L. 111-144), and section 6 of the Continuing Extension Act of 2010 (Pub. L. 111-157).

The provisions included in these laws were in response to a decrease in the annual average CPI-U for 2009. In the absence of a legislative change, this decrease would have required HHS to issue 2010 poverty guidelines that were lower than the 2009 poverty guidelines, resulting in an adverse effect on potential and actual program beneficiaries. An explanatory statement in the December 16, 2009 Congressional Record described the first legislative provision to delay the publication of the 2010 guidelines as a "freeze" of the guidelines at 2009 levels "in order to prevent a reduction in eligibility for certain means-tested programs, including Medicaid, Supplemental Nutrition Assistance Program (SNAP), and child nutrition * * *." (Congressional Record (House), December 16, 2009, p. H15370).

Legislation to further delay the publication of the 2010 poverty guidelines beyond May 31, 2010, did not pass Congress. Accordingly, HHS is publishing poverty guidelines for the remainder of 2010 in this notice. These 2010 guidelines will remain in effect until HHS publishes the 2011 poverty guidelines, which is expected to occur in late January 2011.

If HHS had published the 2010 poverty guidelines in late January 2010, on the normal schedule, the update would have been based on the 2008 Census Bureau poverty thresholds and the percentage change in the annual average CPI-U from calendar year 2008 to calendar year 2009 (the period from January through December 2009). Since the publication of the 2010 poverty guidelines was delayed through May 31, 2010, HHS is basing this update on the 2008 Census Bureau poverty thresholds—which remain the most recent published thresholds available—and the percentage change in the average CPI-U from calendar year 2008 to the period beginning with January 2009 and ending on May 31, 2010. The average CPI-U for the January 2009-May 2010 period was 0.042 percent higher than the annual average CPI-U for calendar year 2008. (The Omnibus Budget Reconciliation Act of 1981 requires that the starting point for the update of the poverty guidelines shall be the latest published Census Bureau poverty thresholds, rather than the previous HHS poverty guidelines.) The percentage increase in the CPI-U was so small that after the rounding procedures used in the guidelines calculation, the guidelines for the remainder of 2010 showed no change from the 2009 guidelines.

The poverty guidelines are calculated each year using the latest published Census Bureau poverty thresholds as the starting point. They are not calculated from the previous year's poverty guidelines. As a result, the level of next year's poverty guidelines—the 2011 guidelines—will not be affected by the way in which these 2010 poverty guidelines were calculated.

The poverty guidelines for the remainder of 2010 are provided below. The guideline figures shown represent annual income. These guidelines will remain in effect until HHS publishes the 2011 poverty guidelines, which is expected in late January 2011.

2010 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add \$3,740 for each additional person.

2010 Poverty Guidelines for Alaska

Persons in family	Poverty guideline
1	\$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290

For families with more than 8 persons, add \$4,680 for each additional person.

2010 Poverty Guidelines for Hawaii

Persons in family	Poverty guideline
1	\$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560

For families with more than 8 persons, add \$4,300 for each additional person.

Dated: July 30, 2010.

Kathleen Sebelius,

Secretary of Health and Human Services.

[FR Doc. 2010-19129 Filed 7-30-10; 4:15 pm]

Exhibit 6

“ In 2008, Medicaid is projected to provide health coverage for nearly 63 million low-income Americans over the course of the year.”

Policy Basics is a series of brief background reports on issues related to budgets, taxes, and government assistance programs.

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December 17, 2008

What Is Medicaid?

Created by Congress in 1965, Medicaid is a public insurance program that provides health coverage to low-income families and individuals, including children, parents, seniors, and people with disabilities. Medicaid is funded jointly by the federal government and the states.

Each state operates its own Medicaid program within federal guidelines. Because the federal guidelines are broad, states have a great deal of flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state.

In 2008, Medicaid is projected to provide health coverage for nearly 63 million low-income Americans over the course of the year, including 31 million children, 17 million adults (mostly low-income working parents), 6 million seniors, and 10 million persons with disabilities.

Children account for about half of all Medicaid enrollees but just one-fifth of Medicaid spending. Only one-quarter of Medicaid enrollees are seniors or persons with disabilities, but because these beneficiaries need more (and more costly) health-care services, they account for two-thirds of all Medicaid spending.

Medicaid is sometimes confused with Medicare, the federally administered, federally funded health insurance program for people aged 65 and over as well as some people with disabilities. Unlike Medicaid, Medicare is not limited to those with low incomes and resources. More than 7 million low-income elderly and disabled Americans — so-called “dual eligibles” — are enrolled in both Medicare and Medicaid.

Who Is Eligible for Medicaid?

Medicaid is an “entitlement” program, which means that anyone who meets eligibility rules has a right to receive Medicaid coverage. It also means that states have guaranteed federal financial support for part of the cost of their Medicaid programs.

In order to receive guaranteed federal funding, states must cover certain “mandatory” populations:

- children under age 6 with income below 133 percent of the federal poverty line (in 2008, the poverty line is \$17,600 for a family of three);
- children aged 6-18 with income below the poverty line;
- pregnant women with income below 133 percent of the poverty line;

POLICY BASICS | INTRODUCTION TO MEDICAID

- parents whose income is within the state's eligibility limit for cash assistance that was in place prior to welfare reform; and
- most seniors and persons with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds for the costs of covering additional, "optional" populations, including: pregnant women, children, and parents with income above "mandatory" coverage income limits; elderly persons and persons with disabilities with income below the poverty line; and "medically needy" people — those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses (such as for nursing-home care) that reduce their disposable income to below the eligibility limit.

Every state covers at least one of these "optional" groups. Because states have such broad flexibility to determine which groups they will cover and at what income levels, Medicaid eligibility varies significantly from state to state.

Not all low-income Americans are eligible for Medicaid. In particular, childless adults — that is, those over 21 who are not disabled, not pregnant, and not elderly — are generally not eligible for Medicaid, no matter how poor they are. In addition, legal immigrants are barred from Medicaid for their first five years in this country, even if they meet all of the program's eligibility requirements.

Medicaid is a "counter-cyclical" program. In other words, its enrollment expands to meet rising needs during an economic downturn, when people lose their jobs and their job-based health coverage. That is what happened during the last recession: if Medicaid enrollment had not increased in response to the loss of employer-based coverage, more than 1 million additional adults would have become uninsured.

What Services Does Medicaid Cover?

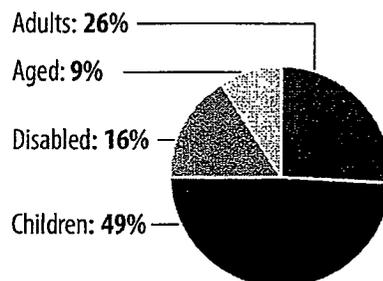
Medicaid does not provide health care directly. Instead, it pays hospitals, physicians, nursing homes, managed care plans, and other health-care providers for covered services that they deliver to eligible patients.

About 60 percent of all Medicaid spending pays for acute-care services such as hospital care, physician services, and prescription drugs; another 30 percent pays for nursing home and other long-term care services and supports. More than half of all nursing-home residents are covered by Medicaid, which pays nearly half of the nation's total costs for long-term health care.

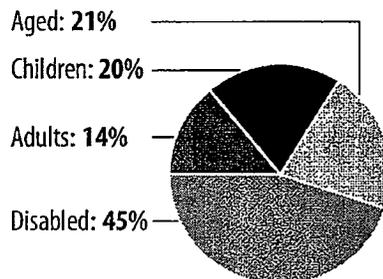
Medicaid also reimburses certain hospitals for the uncompensated costs they incur when they care for uninsured patients. These payments, known as disproportionate share hospital (DSH) payments, account for about 4 percent of Medicaid spending. Finally, about 5 percent of Medicaid spending reflects administrative costs.

Children account for about half of all Medicaid enrollees but just one-fifth of Medicaid spending.

Medicaid Enrollment

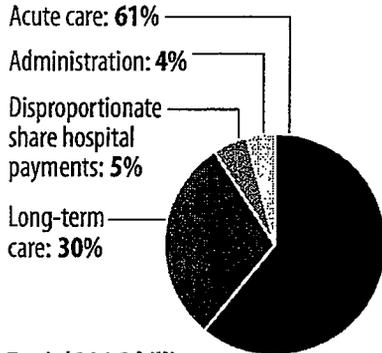


Medicaid Spending



Source: Spending estimates for FY2008 from CBO's March 2008 baseline

Federal Medicaid Expenditures by Service Type



Total: \$204.2 billion

Source: Spending estimates for FY2008 from CBO's March 2008 baseline.

Federal rules require state Medicaid programs to cover certain “mandatory” services, such as: physician, midwife, and certified nurse-practitioner services; inpatient and outpatient hospital services; laboratory and x-ray services; family-planning services and supplies; nursing home and home health care; and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21. EPSDT guarantees that enrollees under age 21 have access to medically necessary services, regardless of whether the state’s Medicaid program otherwise covers these services.

States can — and all states do — cover certain additional services as well. Common examples include prescription drugs, dental care, vision services, hearing aids, and personal-care services for the frail elderly or others with long-term care needs. These services, though listed as “optional” because states are not required to provide them, are critical to meeting the health needs of Medicaid beneficiaries.

States have flexibility to determine the amount, duration, and scope of the services they provide under Medicaid (though the services must be sufficient to achieve the purposes of the Medicaid program). For example, states must cover hospital and physician services, but they can limit the number of hospital days or physician visits they pay for. As a result of this flexibility, Medicaid benefits packages vary substantially from state to state.

The Deficit Reduction Act of 2005 (DRA) gave states even more flexibility, permitting them to replace the existing Medicaid benefit package for some children and adults with scaled-back benefits. However, states still must follow traditional Medicaid coverage rules for certain populations, such as people with disabilities.

Hospitals, physicians, and other health-care providers are not required to participate in Medicaid, and not all do so. State Medicaid programs each have their own way of reimbursing providers for services. Some states pay providers directly for the services they furnish, while others contract with managed plans, which in turn pay the hospitals, physicians, and other providers in their networks. (Some states do both.) Nationally, over half of all Medicaid beneficiaries, mostly children and parents, are enrolled in managed-care plans.

How Is Medicaid Financed? How Much Does It Cost?

Under Medicaid, the federal government contributes at least \$1 in matching funds for every \$1 a state spends on its Medicaid program, whatever those costs may be. The fixed percentage the federal government pays, known as the “FMAP,” varies from state to state, with poorer states receiving larger federal amounts for each dollar they spend than wealthier states. In the poorest states, the federal government pays 76 percent of all Medicaid costs; the national average is about 57 percent.

Together, states and the federal government are projected to spend about \$360 billion on Medicaid in fiscal year 2008. State policies have a large impact on the amount the federal government spends on Medicaid, not only because states are guaranteed federal Medicaid matching funds for the costs of covered services furnished to eligible individuals, but also because states have broad discretion to determine who is eligible, what services they will cover, and what they will pay for covered services.

Medicaid spending is projected to increase 8 percent per year over the next decade. Medicaid costs are growing primarily because overall health care inflation is driving up the cost of the services Medicaid covers, especially hospital care and prescription drugs. Medicaid, however, has been more effective than private health insurance companies at controlling costs. Studies show that in recent years, costs per beneficiary have been rising less rapidly in Medicaid than in private insurance. In addition, the annual costs per beneficiary in Medicaid are less than in private insurance, after adjusting for differences in health status.

How Effective Is Medicaid?

Medicaid pays for over one-third of all births in the United States each year and provides health coverage to one in every four American children. Medicaid also covers more than 21 percent of low-income adults and 60 percent of all nursing-home residents.

Medicaid has greatly reduced the number of Americans without health insurance. If Medicaid did not exist, most of the more than 50 million Americans whose health coverage comes solely through Medicaid would join the ranks of the almost 46 million Americans who are uninsured. This is because private health insurance is generally not an option for Medicaid beneficiaries: many low-income workers do not have access to coverage through their jobs, and people with disabilities or chronic illnesses are often unable to obtain private coverage at any price because of their pre-existing medical conditions. (Moreover, private insurance typically does not cover many of the services that Medicaid provides to meet the needs of vulnerable populations with special health care needs.)

Medicaid coverage provides low-income Americans with access to needed preventive services and medical care. For example, studies have shown that Medicaid helps patients with chronic diseases such as heart disease, diabetes, and asthma receive medical care that can prevent their condition from worsening. People who have lost Medicaid coverage are two to three times more likely than Medicaid beneficiaries to report going without medical care because they cannot afford it.

Numerous studies show that by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases, Medicaid has helped make millions of Americans healthier. For example, expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1-percent reduction in

“ If Medicaid did not exist, most of the more than 50 million Americans whose health coverage comes solely through Medicaid would join the ranks of the almost 46 million Americans who are uninsured.”

“ Numerous studies show that by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases, Medicaid has helped make millions of Americans healthier.”

childhood deaths. Also, expansions of Medicaid coverage for low-income pregnant women led to an 8.5-percent reduction in infant mortality and a 7.8-percent reduction in the incidence of low birth weight.

For more information about Medicaid, including state-by-state information on benefits, eligibility, and spending, see <http://www.kff.org/medicaid/index.cfm>.

Exhibit 7

National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT

Sara Rosenbaum^a
D. Richard Mauery^b
Peter Shin^c
Julia Hidalgo^d

Executive Summary

Medicaid has touched the lives of half of all of the low income young adults of prime military service age. The roots of Medicaid's unique child health eligibility and coverage policies can be traced to a seminal, 1964 government study entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. This study analyzed the underlying causes of the astounding 50 percent rejection rate among the young men drafted into the military in 1962. It documented pervasive evidence of treatable and correctable physical, mental, and developmental conditions, and its findings influenced the course of Medicaid legislation for children, particularly the comprehensive coverage available to children under the EPSDT program. This 1964 report remains relevant in a modern era of national security concern and serves to underscore Medicaid's ongoing importance to children and adolescents.

Introduction

One in every two young adults between the ages of 18 and 24 and of prime military service age comes from a low-income family.¹ Among this group, there is a one-in-two chance that Medicaid will have touched their lives at some point during childhood.²

^a Hirsh Professor and Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services, Washington D.C. We wish to thank David Rousseau of the Kaiser Commission on Medicaid and the Uninsured for his insights and assistance in preparing this report.

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^c Assistant Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services.

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¹ Twice the Federal poverty level (FPL) is \$32,180 for a family of three in 2005. See HHS poverty guidelines at <http://aspe.hhs.gov/poverty/05fedreg.htm>. The percentages of low-income adults aged 18-24 varies by percentage of FPL. According to the March 2004 Annual Social and Economic Supplement of the Current Population Survey, in 2003, 37.3% of adults aged 18-24 (10.4 million) lived at 200% of the FPL; 55.8% (15.5 million) lived at 300% of the FPL; and 69.2% (19.3 million) lived at 400% of the FPL. Source: U.S. Bureau of the Census, Current Population Survey. (2004). "POV01. Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race." Available at: http://pubdb3.census.gov/macro/032004/pov/new01_000.htm. See also the Appendix to this policy brief presenting a special analysis of the March 2004 CPS Supplement by age group of children and young adults at 200% and 400% of the FPL prepared by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute. At 200% FPL, 38% of 18-year-olds and 17% of 19-to-24-year-olds were covered by Medicaid; at 400% FPL 23% of 18-year-olds and 14% of 19-to-24 year-olds were covered by Medicaid.

This Policy Brief is part of a project funded by the Robert Wood Johnson Foundation's program to study Changes in Health Care Financing and Organization (HCFO); its purpose is to examine Medicaid's role in financing health care for members of the U.S. military and their families. This analysis explores Medicaid's child health policy roots in national security.

Although Medicaid's importance for children has been extensively documented,³ these national security roots have been forgotten by most. Indeed, the Medicaid child health eligibility expansions enacted during the Reagan and first Bush Administrations,⁴ which virtually doubled program coverage, are the direct descendents of this history, which in great measure can be traced to a seminal Presidential study that documented the poor health status of young military recruits.

The imperative to focus on Medicaid's role in child health policy is considerable because of Medicaid's sheer reach into the child population. Single-year enrollment numbers show that Medicaid now reaches more than 25 percent of all children, 60 percent of poor children (at or below 100% of the Federal poverty level), and 39 percent of near-poor children (between 100% and 200% of the Federal poverty level).⁵ But even these figures understate Medicaid's reach over time into the population of lower-income children and adolescents from whom the U.S. military forces disproportionately are drawn.⁶

Child health policy has been a pivotal theme in Medicaid since its original enactment. Attention originally was focused on eligibility; within two years, however, this focus would be extended to the actual range and depth of Medicaid coverage for children and adolescents. Evidence of the poor health status of young military recruits played a powerful role in this set of policy reforms,

² See Appendix for methodology used to calculate this estimate.

³ See, e.g., Children's Defense Fund, *EPSDT: Does it Spell Health Care for Poor Children?* (Children's Defense Fund, Washington D.C., 1977); Children's Defense Fund, *Doctors and Dollars are Not Enough* (Washington D.C., 1977); Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid* (MIT Press, Cambridge, MA, 1981); Herz EJ, Chawla AJ, Gavin NI. (1998). Preventive Services for Children Under Medicaid, 1989 and 1992. *Health Care Financing Review* 19(4):25-44; Sardell A, and Johnson K. (1998). The Politics of EPSDT in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits. *The Milbank Quarterly* 76(2): 175-205; Rosenbaum S and Sonosky CA. (2001). Medicaid Reforms and SCHIP: Health Care Coverage and the Changing Policy Environment. In C. J. DeVita & R. Mosher-Williams (Eds), *Who Speaks for America's Children? The Role of Child Advocates in Public Policy* (pp. 81-104). Washington, DC: Urban Institute Press; Klerman, LV. (1991). "Alive and Well? A Research and Policy Review of Health Programs for Poor Young Children." New York, NY: National Center for Children in Poverty; O'Connell M., Watson, S. (2001). "Medicaid and EPSDT." Neighborhood Legal Services, Buffalo, NY Available at: <http://www.nls.org/conf/epsdt.htm>; Olson K, Perkins J, Pate T. (1998). "Children's Health Under Medicaid: A National Review of Early Periodic Screening, Diagnosis, and Treatment." National Health Law Program. Available at: <http://www.healthlaw.org/pubs/child1998healthxsum.html>.

⁴ Rowland, D., Salganicoff, A., Keenan, P.K. (1999). The key to the door: Medicaid's role in improving health care for women and children. *Ann. Rev. Public Health* 20:403-26.

⁵ Kaiser Commission on Medicaid and the Uninsured. (2004). "Key Facts: Health Coverage for Low-Income Children -- September 2004 Update." Available at: <http://www.kff.org/uninsured/2144-04.cfm>. Accessed April 25, 2005.

⁶ See footnote 1 supra and the Appendix for estimates of poverty rates by age group as well as a discussion of the income estimates derived from the 1998 Department of Defense Population Report (available at: http://www.dod.mil/prhome/popprep98/html/7-index_scores.html). Accessed April 25, 2005.

and at a time when national security and preparedness concerns have once again become prominent features of U. S. policy landscape, this historical context is worth exploring.

This Policy Brief begins with a brief overview of Medicaid and child health, examining both its early eligibility structure as well as the advent of Medicaid's special benefit for children, which is known as "early and periodic screening, diagnosis and treatment (EPSDT)." The Brief then describes the findings from this pivotal 1964 study that so strikingly influenced Medicaid's child health policy: *One Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. The Brief concludes with a discussion of the continued relevance of this history to Medicaid reform.

Background and Overview: Medicaid Child Health Policy

Beginning in 1965, Medicaid was designed to cover low-income children from birth through young adulthood. Consistent with welfare program eligibility rules of the time,⁷ the original Medicaid legislation made coverage of children under age 21 living in families who received Aid to Families with Dependent Children (AFDC). At the same time, the statute also gave states the option to extend coverage to all children under age 21 living in low-income families who did not qualify for cash welfare. This state option to extend coverage to all low-income children was unanimously adopted by the Senate in response to a Floor amendment offered by Senator Abraham Ribicoff of Connecticut.⁸ By the early 1980s, when the modern period of Medicaid child health expansion commenced, approximately half of all states had pursued this option.⁹

Although the original Medicaid legislation provided states with an option to expand eligibility, the original Act did not provide for special standards related to the coverage of children; no minimum preventive and developmental benefit package was specified, nor were there requirements related to outreach to families and support in securing services.

The Medicaid EPSDT amendments were part of a larger package of reforms sent to Congress by President Johnson in 1967, which were aimed at improving the availability and quality of pediatric health care throughout the U.S.¹⁰ In his Letter to Congress transmitting his child health recommendations, the President stated:

Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder—

⁷ In 1981 the maximum age limit for AFDC benefits was reduced from 21 to 18. (1981 Omnibus Budget Reconciliation Act, Public Law 97-35). In 1996 AFDC was repealed and replaced with the Temporary Aid to Needy Families (TANF) program. The maximum age limit for children under TANF is set at 18 (or 19 if child is a full-time student in a secondary school (or in the equivalent level of vocational or technical training)). (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193).

⁸ Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid*. supra note 3, pp. 18-19.

⁹ Sara Rosenbaum and David Rousseau, "Medicaid at Thirty Five" *St. Louis University Law Journal* 45:1 pp. 1-71 (Winter, 2001). See also, *The Deficit Reduction Act of 1984*, House of Representatives Conference Report no. 98-861, GPO 35-426 0 (Washington, D.C.: US. GPO, 23 June 1984) for a discussion of how many states opted to extend coverage to poor children regardless of their family's work status or family composition.

¹⁰ United States House of Representatives, Committee on Ways and Means, Hearings on the President's Proposals for Revisions in the Social Security System. (GPO, Washington D.C., 1967).

these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear—to give every child the chance to fulfill his promise. Even during these years of unparalleled prosperity: [...] more than four million children will suffer physical handicaps and another two million will fall victim to preventable accidents or disease....

Under the Medicaid program enacted in 1965, the 25 states now in partnership with the Federal Government will help pay hospital costs and doctors' bills for more than 3.5 million poor children this year. By next year, we expect 23 more states to join Medicaid. I am requesting increased funds for ...Medicaid program, including....legislation to expand the timely examination and treatment of ... poor children....¹¹

These sweeping recommendations, which became the EPSDT amendments, were enacted as part of the Social Security Act Amendments of 1967.¹² Termed “altogether different in kind and style”¹³ from anything that preceded them, the Medicaid EPSDT amendment provided for such early and periodic screening and diagnosis of individuals who are eligible [for Medicaid] and under the age of 21, to ascertain their physical and mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby.¹⁴

In sum, within two years of enactment, the President and Congress had come to understand Medicaid’s singular potential to promote child health and development, not merely to finance treatment for diagnosed illnesses. Medicaid’s special relationship to childhood growth and development among low income children was crystallized in the EPSDT amendments.

The continuing evolution of EPSDT has spanned nearly four decades, with important modifications in 1972, and again in 1981 under the Reagan Administration, to add specific outreach and family support requirements to promote health care access.¹⁵ Amendments under the first Bush Administration in 1989 further broadened medical assistance coverage to ensure full coverage for all physical, mental, and developmental conditions. Today EPSDT ensures coverage for all medically necessary diagnostic and treatment services that fall within the federal definition of “medical assistance” for virtually all Medicaid enrolled children. With very limited exceptions for “medically needy children,” EPSDT is a service requirement for children who qualify for Medicaid on either a mandatory or optional basis.¹⁶

Several aspects of the EPSDT benefit make it unique. First, the range and depth of the periodic and interperiodic health examinations provided under the program are striking, with explicit requirements to assess growth and development as an essential part of the screening (i.e., assessment) process.

¹¹ Lyndon B. Johnson. Special Message to the Congress Recommending a 12-Point Program for America’s Children and Youth, February 8, 1967. Transcript available at: <http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&st1=Johnson>.

¹² Pub. L. 90-248.

¹³ *Welfare Medicine in America*, supra, note 4, p. 248.

¹⁴ *An Ounce of Prevention*, supra note 3, pp. 22-25.

¹⁵ Social Security Amendments of 1972. October 30, 1972. Pub. L. 92-603.

¹⁶ EPSDT is an optional benefit only in the case of children whose eligibility is based on their “medically needy” status. 42 U.S.C. §1396a(a)(10)(C). This change was made in 1981.

Second, EPSDT covers an unparalleled range of diagnostic and treatment services for children whose examinations reveal potential physical, mental, or developmental conditions. Unlike conventional commercial insurance, these special coverage standards do not distinguish between acute conditions that can be cured and lifelong and chronic conditions whose effects and severity can be “ameliorated” through health care. Third, from its inception in 1967, EPSDT has been governed by a special medical necessity standard whose scope derives directly from the statutory terms “early” and “ameliorate.”¹⁷ Federal agencies and courts alike have interpreted these term to require health care interventions at the earliest possible time, when needed to ameliorate (i.e., lessen) the effects of conditions, both physical and mental, that potentially could impair childhood growth and development.¹⁸

Figure 1 summarizes all required screening diagnosis and treatment services covered under EPSDT.

Figure 1. Required Screening, Diagnosis, and Treatment Services in EPSDT

Periodic and Interperiodic (as needed) Screening and Preventive Services

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory Tests
- Lead Toxicity Screening
- Health Education

Diagnosis and Treatment Services

- Diagnosis and Treatment Services
- Vision Services
- Dental Services
- Hearing Services
- Medically necessary health care that falls within the federal definition of “medical assistance” and that is necessary to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

Source: “Medicaid and EPSDT.” DHHS, Centers for Medicare and Medicaid Services.
<http://www.cms.hhs.gov/medicaid/epsdt/default.asp>.

¹⁷ §1905(r)(5) of the Social Security Act, 42 USC §1396d(r)(5).

¹⁸ “Medicaid at Thirty-Five.” *op. cit.*

The Historical Context for Medicaid Child Health Policy

*The findings of this Task Force are dramatic evidence that poverty is still with us, still exacting its price in spoiled lives and failed expectations. For entirely too many Americans the promise of American life is not being kept. * * * I wish to see an America in which no young person, whatever the circumstances, shall reach the age of 21 without the health, education, and skills that will give him an opportunity to be an effective citizen and a self-supporting individual. * * ** [Lyndon B. Johnson, January 5, 1964]¹⁹

One historical study in particular sheds light on how federal policy makers might have come to structure within Medicaid such a broad and unprecedented health policy for low income children. Entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*,²⁰ the study shed overpowering light on the health status of young military draftees. Among its most significant findings: the majority of young men rejected for compulsory military service in the early 1960s failed as a result of physical and mental health conditions, many of which could have been diagnosed and successfully treated in childhood and adolescence. These young adults typically came from impoverished families and had experienced unrelenting deprivation in health care, education, and employment. The report's findings provided compelling evidence for an underlying tenet of President Johnson's conclusion that improving the health and well being of the nation's poor required strategies aimed at ameliorating the effects of social, economic, and health disparities.

The Task Force on Manpower Conservation: Establishment, Charge and Findings

On September 30, 1963, President John F. Kennedy established the Task Force on Manpower Conservation to investigate why, in 1962, an astonishing 49.8 percent of 306,073 Selective Service draftees failed their pre-induction peacetime medical and/or mental aptitude examinations, thus disqualifying them for military service. Beyond its obvious implications for national military preparedness, in the President's view²¹ these figures presented arresting evidence of both the diminished, yet preventable, health status of low-income children and the long-term strength and productivity of the nation.

The President directed that the Secretaries of Defense, Labor, and Health, Education, and Welfare (HEW, predecessor of DHHS) lead a Task Force that would "prepare a program for the guidance, testing, counseling, training and rehabilitation of youths found disqualified because of failure to meet the physical or mental standards of the Armed Forces, and to make such recommendation as their survey of this situation suggests." The Task Force was ordered to submit a final report no later than January 1, 1964.²²

¹⁹ Statement on the report, *One-Third of a Nation*. Cited in: The health status of American youth: A report on young men found unqualified for military service." *Clinical Pediatrics*. 3(11):625-628. November 1964.

²⁰ The President's Task Force on Manpower Conservation. *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. The White House. Washington, DC. January 1, 1964.

²¹ Statement by the President [Kennedy]: Establishing the Task Force on Manpower Conservation. September 30, 1963. Cited in *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. pages A-1 -A-2.

Two months after Kennedy's directive, the Task Force issued its final report, which concluded that the military draft failure rate provided powerful evidence of "the unfinished business of the Nation."²³ The information presented in the report offered a sobering look into the health conditions and socio-economic characteristics of the young men rejected for military service. Reasons for rejection included "medical," "mental," and "administrative or moral." Medical examinations included both physical and psychological criteria designed to identify men whose conditions "may endanger the health of other individuals, cause excessive loss of time from duty, excessive restrictions on location of assignment, or become aggravated through performance of military duty." Mental examinations were conducted through administration of the Armed Forces Qualification Test (AFQT), a written exam designed to test mental aptitude for military service, including questions on vocabulary, reading, writing, arithmetic, and mechanical understanding. Men rejected for administrative or moral reasons included those who had "significant criminal records, anti-social tendencies, such as alcoholism or drug addiction, or for other traits of character which would make them unfit in a military environment."²⁴

In reviewing the records of all categories of examinations for military service between August 1958 and June 1960, the Department of Defense calculated the overall rate of reasons for rejection at 31.7 percent. The Task Force report, using updated information, estimated that the overall rejection rate had since increased to 35–36 percent. This overall rejection rate included both voluntary enlistees and draftees; the 49.8 percent rejection rate noted above was for 1962 draftees only.²⁵

Table 1 shows that among the reasons for rejection, "administrative" reasons accounted for less than four percent of the failure rate among enlistees and draftees and less than three percent of the failure rate among draftees only. Far more important in terms of the high rejection rates were failure rates for medical examinations and mental tests, which (not surprisingly) were particularly elevated among the draftee-only group, since enlistees could be expected to self-select from a healthier socioeconomic pool.

²² *Ibid.*

²³ Letter of Transmittal. President's Task Force on Manpower Conservation. Reprinted in *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. January 1, 1964.

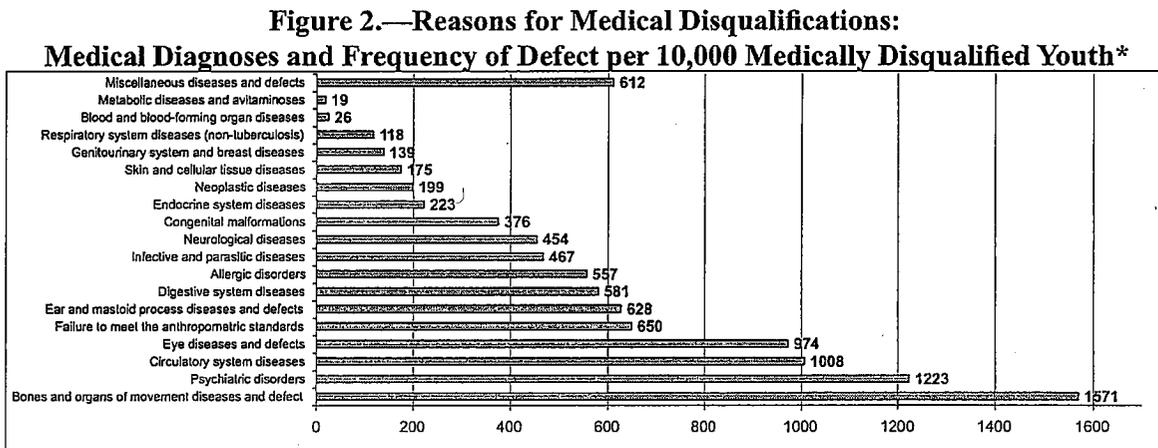
²⁴ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* pp. 9-10.

²⁵ The report attributed the differential to large numbers of young men who were examined and accepted for voluntary enlistment or officer training programs at younger ages, before reaching the age of referral for draftee examinations.

Table 1.—Percentages of Military Rejections by Reason, 1958-1962

Reason for Rejection	Enlistees and Draftees, 1958-60	Draftees Only, 1962
	Percent	
Failed medical examination only	14.8	24.5
Failed mental tests only	1.5	22.7
Failed both medical and mental tests	1.5	1.5
Administrative reasons	3.9	2.6
Total rejected	31.7	49.8

Figure 2 presents the reasons for medical rejection noted in the report. Most frequently noted were diseases and disorders of bones and organs of movement, psychiatric disorders, circulatory diseases, eye diseases, and failure to meet anthropometric standards (height and weight).



* Based on examinations conducted between August 1953 through July 1958. Source: Bernard D. Karpinos, "Qualifications of American Volunteers for Military Service." Medical Statistics Division. Office of the Surgeon General, Department of the Army, 1962. Reprinted in *One-Third of a Nation*, p. 26.

Within these diagnostic categories, the report detailed the most frequent specific causes for medical disqualification, as shown in Table 2

Table 2.—Frequently Mentioned Causes for Medical Disqualification

Diagnostic Category	Main Causes of Disqualification
Psychiatric disorders	Character and behavior disorders
Neurological diseases	Epilepsy
Infective and parasitic diseases	Acute poliomyelitis and tuberculosis

Table 2.—Frequently Mentioned Causes for Medical Disqualification

<i>Diagnostic Category</i>	<i>Main Causes of Disqualification</i>
Neoplastic diseases	Pilonidal cyst ²⁶
Allergic disorders	Asthma
Circulatory system diseases	Chronic rheumatic heart disease and
Digestive system diseases	Hernia of the abdominal cavity
Anthropometric standards	Overweight
Defects of bones and organs of movement	Deformities or impairments and amputation of extremities

The Task Force noted that these conditions represented a spectrum of severity and potential for treatment. The report concluded that one out of ten medical rejectees had conditions entirely correctable with medical intervention, ranging from serious infectious diseases like syphilis and tuberculosis to hernias and cleft palates. One out of five rejectees had more chronic conditions requiring longer term treatment such as epilepsy, asthma, and heart disease. Another one out of four rejectees had need of intensive treatment services for conditions such as deafness, loss of limbs, spinal curvature, and serious congenital malformations. Finally, the Task Force noted that one in four medical rejectees had conditions for which medical treatment was not the answer. This included men who were totally blind, or too tall or too short to meet military standards.

In addition to the 24.5 percent of draftees who were rejected for medical reasons, the report noted that another 22.7 percent were rejected for failing the AFQT for mental aptitude for military service. These were men who scored in “mental groups” IV and V (30th percentile or less) in the AFQT scoring system:

Table 3.—Armed Forces Qualification Test Scoring System

<i>Mental Group</i>	<i>Required Correct Answers</i>	<i>Corresponding Percentile Score</i>
I.	89 – 100	93 – 100
II.	74 – 88	65 – 92
III.	59 – 73	31 – 64
IV.	25 – 52	10 – 30
V.	24 or less	9 or below

²⁶ “A pilonidal cyst is a cyst at the bottom of the tailbone (coccyx) that can become infected and filled with pus. Once infected, the technical term is pilonidal abscess. [One] theory is that pilonidal cysts appear after trauma to the sacrococcygeal region (the region relating to both the sacrum [the lower vertebrae] and coccyx). During World War II, more than 80,000 soldiers developed pilonidal cysts that required a hospital stay. People thought the cysts were due to irritation from riding in bumpy Jeeps. For a while, the condition was actually called ‘Jeep disease’.” <http://www.emedicinehealth.com/articles/20243-1.asp>. Accessed Feb. 5, 2005.

To investigate the reasons for this high failure rate of the AFQT among draftees, the Task Force commissioned the Department of Labor and the Selective Service System to interview a national sample of 2,500 recent AFQT rejectees to develop a deeper understanding of the socio-economic conditions that may have affected their lack of educational performance. Much of the Task Force report provides detailed information about these AFQT rejectees' lives, including their incomes, family history, marital status, education, and employment. The common themes that emerged were extreme poverty, limited education, and families living under conditions of significant stress and poverty. Significant disparities by race and national origin were evident in the data as well, with far deeper poverty, higher rates of unemployment, and lower educational attainment among minority rejectees.

The Task Force also found wide variations in rejection rates among the states, particularly for mental rejectees, ranging from as low as 3 percent in some states to as high as 50 percent in others. Southeastern states generally had higher rates of mental rejectees compared to states in the Mountain, Great Plains, and Far West regions, where medical reasons were more common. The Task Force attributed this variation to variations in demographic and socioeconomic status and overall living conditions for the poor.²⁷

Despite the evidence of pervasive harm to children documented in the report, the Task Force concluded that:

*...in every generation, talent appears at every social stratum, in every geographic area. Given equal opportunity, * * * the poor will prove their worth at an early age and go on to live lives of substantial achievement. However, this process can easily be thwarted, and * * * [T]here is little question that the process has not worked for a great many of them young men who fail to meet the mental requirements for military service in the United States today*²⁸

Most of the Task Force's recommendations focused on the development of compensatory programs for young low-income adults rejected from the military draft. However, the Task Force also made recommendations regarding improvements in screening, diagnosis, and treatment of diseases and conditions in early childhood and adolescence, with a strong emphasis on the placement of programs in schools.^{29,30}

The work of the Task Force in combination with subsequent studies on the health status of infants, children, and children with disabilities,³¹ formed the contextual basis for the President's 1967 child health recommendations to Congress.³² Immediately following their submission, the President's

²⁷ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 12.

²⁸ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 15.

²⁹ *Ibid.* p. 29.

³⁰ *Ibid.* p. 35.

³¹ *An Ounce of Prevention; EPSDT: Does it Spell Health Care for Poor Children? Supra*, note 3.

³² Lyndon B. Johnson. Special Message to the Congress Recommending a 12-Point Program for America's Children and Youth, February 8, 1967. *op. cit.*

recommendations were translated into legislative language providing for the amendments to the Social Security Act that incorporated the EPSDT program and its standards into Medicaid.³³

Conclusion

For 40 years, Medicaid has provided essential health coverage to tens of millions of low-income children and youth. Medicaid is a dominant force in the U.S. health care system and its early policy roots are often difficult to discern. This Policy Brief has explored the national security study that lies at the foundations of Medicaid child health policy. The findings of *One Third of a Nation*, as well as the language of the Medicaid statute itself, serve to underscore the fact that Medicaid child health policy hardly has been happenstance. From its virtual enactment, Medicaid aimed to cover all low income children with the broadest possible developmental health benefits. By 1967, the very concept of coverage itself had been transformed, and this transformation has continued throughout Medicaid's history.

The need for a continued Medicaid child health policy that aims at growth and development, not merely treatment of episodic illness, continues to reverberate, not only in a broader health policy context, but as a matter of national security. During a March 12, 1998 hearing before the House Armed Services Committee, Mark E. Gebicke, Director of Military Operations & Capabilities Issues for GAO's National Security & International Affairs Division, stated, "Of the 25,430 enlistees who entered the services in fiscal year 1994 and were discharged in their first 6 months, 29 percent failed to meet minimum performance standards, 27 percent were found medically unqualified for military service and 14 percent had character or behavior disorders."³⁴ The importance of a continuing commitment to broad child health policy endures, even as the health system itself is transformed. National security depends on the growth and development of children; in view of the demographics of those who serve, this dependence is particularly striking in the case of the low-income children who are at greatest risk for poor health outcomes. In this respect, Medicaid's role in reducing health disparities among low-income and minority children remains a paramount national concern.

³³ Social Security Amendments Act of 1967. Pub. L. 90-248.

³⁴ Testimony of Mr. Mark E. Gebicke, Director, Military Operations & Capabilities Issues National Security & International Affairs Division, U.S. General Accounting Office. Available at: <http://www.house.gov/hasc/testimony/105thcongress/3-12-98gebicke.htm>. Accessed April 6, 2005.

APPENDIX

Statistical Methodology for Calculating the Proportion of Military Recruits Who May Have Been Covered by Medicaid at Some Point in Their Lives Prior to Recruitment

The purpose of this analysis was to estimate the proportion of military recruits who may have been covered by Medicaid at some point in their lives prior to recruitment. Ideally, longitudinal data would be used to track health insurance coverage of a cohort of individuals from time of birth to recruitment and identify at least one point in time in which they were covered by Medicaid.³⁵ From such data, a simple calculation can be made by counting the number of recruits covered by Medicaid at any time in their youth and dividing it by the total number of recruits. Although the Department of Defense (DOD) and services collect demographic data on recruits, limited information was publicly available. Unfortunately, none focused on or detailed medical history or health insurance information of recruits.³⁶

Alternatively, data from the 2003 Current Population Survey (CPS) and the 2002 socioeconomic information from the 1998 DOD *Population Representation in the Military* reports were used to estimate the population pool from which individuals are likely to have been recruited. Specifically, the 2002 DOD report shows the average age of recruits is 20 years, and over half of the activity duty force is between 17-24 years.³⁷ This information was used to focus the analysis of the CPS data on persons aged 24 years and younger.³⁸ Table 1 shows the proportion of individuals with incomes less than 200 percent of the Federal poverty level (FPL) covered by Medicaid.

Table 1. Percent Covered by Medicaid, 200% FPL

Age	Percent
Under 1	61%
1-5	59%
6-17	48%
18 only	32%
19-24	17%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

These estimates may be considered too high because of the lower income threshold; and the 1998 DOD *Population Representation* report suggests recruits may not come primarily from the low

³⁵ Creswell JW, *Research Design: Qualitative and Quantitative Approaches* (Thousand Oaks, CA: Sage Publications) 1994.

³⁶ The DOD may collect information on insurer prior to recruitment. *Military personnel: first-term recruiting and attribution continue to require focused attention.* Testimony of Rabkin NJ before the Subcommittee on Personnel, Committee on Armed Services, United States Senate, February 24, 2000 (<http://www.gao.gov/cgi-bin/getrpt?GAO/T-NSIAD-00-102>).

³⁷ <http://www.dod.mil/prhome/poprep2002/> (Accessed April 5, 2004).

³⁸ The 2004 Federal poverty guideline for a family of three was \$15,670.

end of the socioeconomic spectrum.³⁹ Therefore, the income limit was expanded to 400 percent of FPL, or \$60,000 per year for a family of three.⁴⁰ Table 2 shows the proportion of the population covered by Medicaid and likely to be targeted by the military for service.

Table 2. Percent Covered by Medicaid, 400% FPL

Age	Percent
Under 1	46%
1-5	42%
6-17	33%
18 only	23%
19-24	14%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

Based on the population pool eligible for military service, Medicaid covers approximately one in two persons at some point prior to recruitment. That is, at least 46 percent of recruits may have received Medicaid during infancy, and this estimate may be higher as some individuals become eligible in later years. Given that the data provides only a single point-in-time estimate and does not include the actual cohort of individuals recruited, the one-in-two proportion is given as a conservative estimate for the purpose of this analysis.

³⁹ http://www.dod.mil/prhome/poprep98/html/7-index_scores.html (Accessed April 5, 2004).

⁴⁰ The 1998 DOD report indicated "both active and reserve recruits are primarily from families in the middle and lower middle socioeconomic strata," which is adjusted by a higher level of education and reading skills compared to their civilian counterparts in addition to employment status, occupation, and home ownership. For purposes of a more conservative estimate, the population pool of potential recruits is adjusted to 400 percent of FPL.

Exhibit 8

***2834 P.L. 90-248, SOCIAL SECURITY AMENDMENTS OF 1967**

House Report (Ways and Means Committee) No. 90-544,

Aug. 7, 1967 (To accompany H.R. 12080)

Senate Report (Finance Committee) No. 90-744,

Nov. 14, 1967 (To accompany H.R. 12080)

Conference Report No. 90-1030,

Dec. 11, 1967 (To accompany H.R. 12080)

Cong. Record Vol. 113 (1967)

DATES OF CONSIDERATION AND PASSAGE

House Aug. 17, Dec. 13, 1967

Senate Nov. 22, Dec. 14, 15, 1967

The Senate Report and the Conference Report are set out.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

SENATE REPORT NO. 90-744

Nov. 14, 1967

THE Committee on Finance, to which was referred the bill (H.R. 12080) to provide an increase in benefits under the old-age, survivors, and disability *2835 insurance system, to provide benefits for additional categories of individuals, to improve the public assistance program and programs relating to the welfare and health of children, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill do pass.

I. BRIEF SUMMARY OF THE BILL

The proposals embodied in H.R. 12080 as reported by the committee would make major improvements in the provisions of the Social Security Act relating to the old-age, survivors, and disability insurance program, the hospital and medical insurance programs, the medical assistance program, the aid to families with dependent children, and other public assistance programs and the child welfare and child health programs.

Old-Age, Survivors, and Disability Insurance

The bill would increase social security benefits of the 23.8 million elderly and disabled people, widows and orphans receiving benefits and would improve the protection of the old-age, survivors, and disability insurance provisions of the social security program, by providing--

- (1) An across-the-board benefit increase of 15 percent for people on the rolls, with a minimum monthly primary insurance amount of \$70;
- (2) An increase in the earnings base from \$6,600 to \$8,000 in 1968, \$8,800 in 1969, and \$10,800 in 1972.
- (3) An increase from \$35 to \$50 in the special payments now provided for certain people age 72 and older who have not worked long enough to qualify for regular cash benefits;
- (4) An increase from \$1,500 a year to \$1,680 in 1968, and to \$2,000 in 1969 and thereafter, in the amount that an individual may earn in a year and still get full benefits;
- (5) Actuarially reduced benefits at age 60 for both men and women;
- (6) Liberalized insured-status requirements and a liberalized definition of disability for disability insurance benefits for the blind;
- (7) New guidelines for determining when a disabled worker cannot engage in substantial gainful activity;
- (8) An alternative insured-status requirement for workers disabled before age 31;

C. IMPROVEMENT OF CHILD HEALTH

Title V of the original Social Security Act provided formula grants to States for two separate health programs: maternal and child health and crippled children's services. Authorizations for these programs have been increased by the Congress from time to time, most recently in 1965.

Beginning in 1963, new earmarked authorizations were enacted for separate additional programs. Amendments in 1963 established new programs of project grants for maternity and infant care in low-income areas and grants for research relating to health services for mothers and children. Additional amendments in 1965 set up a project grant program of comprehensive health services to children and youth in low-income areas and another program to train professional personnel for the care of crippled children. A proposal in the committee bill would initiate yet another project grant program, this one for the dental health of children.

In view of these developments as well as the initiation of other health programs for the children of low-income families, both within and beyond the jurisdiction of the committee, it was believed that the time had come to consolidate and more rationally arrange the various title V programs. (The child welfare services program, as indicated earlier, is moved to title IV.) The committee believes that these changes will facilitate the review of these programs by Congress and other interested organizations and individuals. Representatives of the Department of Health, Education, *3030 and Welfare assured the committee that there is a high degree of coordination between the various executive agencies providing health services to low-income children. It is hoped that this legislation will further this coordination as well as lead to more orderly program development.

The bill consolidates the existing authorities into a single authorization with broad flexible categories. The House bill accordingly eliminates all present earmarked programs beginning July 1, 1968, and replaces them with one total dollar authorization. Under the House bill for the 4 fiscal years 1969 to 1972, 50 percent of the authorization will be for formula grants to States; 40 percent will be for project grants; and 10 percent will be for research and training. The Secretary would have limited authority to adjust these percentages. The Secretary would also determine the allocations within these percentages for different types of formula grants, projects, etc.

Under existing law, project grant authority rests with the Secretary of Health Education, and Welfare. The committee is concerned with the tendency of such authorizations to be continued, through legislative extensions, indefinitely into the future and believes that the basic responsibility for health services for mothers and children rests with the States. The bill, therefore, requires the States to assume responsibility for the project grants beginning July 1972; as of that date, the Secretary's project grant authority will lapse and the funds will be given directly to the States.

The authorizations in the House bill are shown in the following table:

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

*3031 1. Formula Grants to States

Present law provides separate State grant programs for maternal and child health and crippled children's services.

(a) Maternal and child health services

Federal funds expended by States in fiscal year 1966 for maternal child health services amounted to approximately \$42.9 million; expenditures from State and local funds were approximately \$87.3 million-- more than twice as much. States use Federal funds, together with State and local funds, to pay the costs of conducting prenatal and postpartum clinics where mothers may receive family planning services if they wish them; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses and where their many questions about the care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality, especially in rural areas. Funds are used to make doctors, dentists, and nurses available to schools for health examinations, and they are also used for immuni-

zations. These funds support 134 mental retardation clinics in 50 States where over 30,000 children received diagnostic treatment and counseling services last year.

During fiscal year 1966 State maternal and child health programs provided the following clinic, hospital, and public health nursing services:

Prenatal and postpartum care in medical clinics for 282,000 maternity cases.

Hospital inpatient care (prenatal or delivery) for 61,000 maternity cases.

Public health nursing visits for 521,000 maternity cases.

Child health supervision (through well-child conferences) of 1,722,000 children, including 680,000 infants.

These programs also provided examinations, tests, and immunizations during that year as follows:

1,926,000 school health medical examinations.

8,847,000 school health vision screening tests.

5,425,000 school health hearing screening tests.

2,386,000 school health dental screening tests.

2,840,389 smallpox immunizations.

4,074,868 diphtheria immunizations.

2,430,417 pertussis immunizations.

4,425,412 tetanus immunizations.

(b) Crippled children's services

About \$116 million, of which about \$44 million or 38 percent was from Federal funds, was expended by States for crippled children's services during fiscal year 1966. State crippled children's agencies use their funds to locate children to provide diagnostic services, and then to see that each child *3032 gets the medical care, hospitalization, and continuing care by a variety of professional people that he needs. Less than half of the children served have orthopedic handicaps; the rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, heart disease, and many congenital defects. A State crippled children's agency holds clinics periodically, some traveling from place to place; others are held in permanent locations. Any parent may take his child to a crippled children's clinic for diagnosis.

The number of children served under the crippled children's program has more than doubled since 1950. In fiscal year 1966, about 438,000 children received care under this program. About 325,000 children attended diagnostic clinics and nearly 80,000 children received hospitalization.

(c) Consolidated programs

The committee bill combines the maternal and child health programs and crippled children's services into one program with the same State plan requirements of existing law except for the new requirements noted under the next three headings and for the State assumption of responsibility for project grants in 1972. Existing requirements on States such as extending the provision of maternal and child health and crippled children's services to make them available by 1975 to children in all parts of the State and requiring the States to pay the reasonable cost of inpatient hospital care are continued. The bill also defines a crippled child in order to assure that there will be no duplication of services provided under this program with those provided through community mental health programs.

(d) Early identification of health defects of children

States will be required to make more vigorous efforts to screen and treat children with disabling conditions. Though all States have crippled children's services programs there are substantial differences in the rate of children served among the States, the highest being 17.7 per 1,000 population under 21 years of age and the lowest being 1.6 per 1,000. Many handicapped children or children with potentially crippling conditions fail to receive needed care because their conditions may not be included under the State's program. Other States have not carried on aggressive programs of early identification of children in need of treatment because of lack of funds to provide the necessary care and treatment.

The committee believes that the new plan requirement coupled with increases in funds authorized will help States with

Exhibit 9

UNITED STATES PUBLIC LAWS
101st Congress - First Session
Convening January 3, 1989

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Additions and Deletions are not indicated in this database.
For Legislative History of Act, see LH database or Report for
this Public Law in U.S.C.C. & A.N. Legislative History section.

PL 101-239 (HR3299)
December 19, 1989
OMNIBUS BUDGET RECONCILIATION ACT OF 1989

An Act to provide for reconciliation pursuant to section 5 of the concurrent resolution on the budget for the fiscal year 1990.

Be it enacted by the Senate and House of Representatives of the United States
of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1989".

SEC. 2. TABLE OF CONTENTS.

Title I--Agriculture and related programs.

Title II--Student loan and pension fiduciary amendments.

Title III--Regulatory agency fees.

Title IV--Civil service and postal service programs.

Title V--Veterans programs.

Title VI--Medicare, medicaid, maternal and child health, and other health provisions.

Title VII--Revenue provisions.

Title VIII--Human resource and income security provisions.

Title IX--Offshore oil pollution compensation fund.

Title X--Miscellaneous and technical Social Security Act amendments.

Title XI--Miscellaneous.

years of age".

<< 42 USCA § 1396a >>

(2) PAYMENT AMOUNTS.--Section 1902(a)(13)(E) of such Act (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting ", and for payment for services described in section 1905(a)(2)(C) under the plan," after "provided by a rural health clinic under the plan".

<< 42 USCA § 1396a NOTE >>

(d) EFFECTIVE DATE.--(1) The amendments made by subsections (a) and (b) (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.

(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first *2262 regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

<< 42 USCA § 1396d >>

(a) IN GENERAL.--Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(r) The term 'early and periodic screening, diagnostic, and treatment services' means the following items and services:

"(1) Screening services--

(A) which are provided--

"(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

"(B) which shall at a minimum include--

"(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

"(ii) a comprehensive unclothed physical exam,

"(iii) appropriate immunizations according to age and health history,

"(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

"(v) health education (including anticipatory guidance).

"(2) Vision services--

"(A) which are provided--

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

"(3) Dental services--

"(A) which are provided--

"(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

"(4) Hearing services--

*2263 "(A) which are provided--

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

"(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services."

<< 42 USCA § 1396a >>

(b) REPORT ON PROVISION OF EPSDT.--Section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) is amended--

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the semicolon at the end of subparagraph (C) and inserting ", and", and

(3) by adding at the end the following new subparagraph:

"(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

"(i) the number of children provided child health screening services,

"(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

"(iii) the number of children receiving dental services, and

"(iv) the State's results in attaining the participation goals set for the State under section 1905(r);".

<< 42 USCA § 1396d >>

(c) ANNUAL PARTICIPATION GOALS.--Section 1905(r) of such Act, as added by subsection (a), is amended by adding at the end the following: "The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services."

<< 42 USCA § 1396a >>

(d) CONFORMING AMENDMENTS.--(1) Section 1902(a)(43)(A) of such Act (42 U.S.C. 1396a(a)(43)(A)) is amended by striking "and treatment services as described in section 1905(a)(4)(B)" and inserting "and treatment services as described in section 1905(r)".

*2264 (2) Section 1905(a)(4) of such Act (42 U.S.C. 1396d(a)(4)) is amended by amending clause (B) to read as follows: "(B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and".

<< 42 USCA §§ 1396a NOTE, 1396d nt >>

Exhibit 10

other outreach locations. These simplified forms would contain only those information requirements necessary to determine eligibility for Medicaid. This information would include verification of the woman's pregnancy; age of the child (which could be provided through methods other than a formal birth certificate, such as verification from a hospital or from a child's health care provider regarding the child's date of birth); size and income of the family; verification of lawful residence in the U.S.; information concerning third party liability; and, in the case of children only, disclosure of paternity information in circumstances where such information is applicable. States using initial intake applications that included this information would not be required to use separate applications for making final eligibility determinations.

The entire application process could be conducted at the hospitals, clinics, and other outreach locations. If the eligibility worker at the outreach location is a welfare agency employee or contractor, the final eligibility determination could be made at that location. However, even if the eligibility worker is an employee of the hospital or clinic, the pregnant woman or child would not be required to go to the welfare office for a face-to-face interview in order to complete the eligibility determination process. Instead, the simplified application form, along with necessary documentation, would then be forwarded to the welfare office for a final determination.

Section 4212—Extension of Medicaid transition coverage

Under current law, States are required, effective April 1, 1990, to extend Medicaid coverage for 12 months to families who lose AFDC benefits due to earnings, and who continue to report earnings during this period. During the first 6 months of the transition period, States may not impose any premium requirement for this coverage; during the second 6 months, States may, at their option, impose an income-related premium. This requirement is repealed on September 30, 1998.

This Medicaid transitional coverage requirement was one of the provisions of the Family Support Act of 1988 (P.L. 100-460) designed to encourage families to leave welfare and become self-sufficient. Many of these former welfare recipients are employed in low-wage jobs that do not offer health insurance coverage. According to a General Accounting Office study, more than half of former welfare recipients who work are uninsured ('Evaluation of 1981 AFDC Changes: Final Report' (GAO/PEMD-85-4, July, 1985)). The Committee is concerned that, in many cases, 12 months is not sufficient time for a mother to make the transition from welfare to a job that offers health insurance coverage for her and her children.

To further encourage welfare families to work, the Committee bill would allow the States, at their option, to extend the current 12-month transitional coverage period for an additional 12 months (or 3, 6, or 9 months, as the State elects). Thus, a State could offer a working welfare family a total of 24 months of transitional Medicaid coverage (12 mandatory, 12 optional). Under the bill, the structure of the current mandatory benefit would remain unchanged. Thus, States could, at their option, impose the same income-related premium during this optional 12-month period that they are allowed to impose during the 2nd mandatory 6-month period. The Committee bill would also repeal the sunset.

The Committee bill would also make some technical corrections to current law. It clarifies that Medicaid transition coverage terminates at the close of the first month in which the family ceases to include a child, whether or not the child is a dependent child under part A of Title IV, or would be if needy. The Committee bill also clarifies that families who, prior to April 1, 1990, are receiving Medicaid extension coverage under the current law 9-month provision are entitled to continue receiving this extension coverage after that date until their 9-month coverage period expires.

Section 4213—Early and periodic screening, diagnostic, and treatment services

(a) *In general.*—Under current law, States are required to offer early and periodic screening, diagnostic, and treatment (EPSDT) services to children under age 21. States are required to inform all Medicaid-eligible children of the availability of EPSDT services, to provide (or arrange for the provision of) screening services in all cases when they are requested, and, to arrange for (directly or through referral to appropriate agencies or providers) corrective treatment for which the child health screening, indicates a need.

The EPSDT benefit is, in effect, the nation's largest preventive health program for children. Each State must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. These services are available to children under EPSDT even if they are not available to other Medicaid beneficiaries under the State's plan.

The EPSDT benefit is not currently defined in statute. In the view of the Committee, as Medicaid coverage of poor children expands, both under current law and under the Committee bill, the EPSDT benefit will become even more important to the health status of children in this country. The Committee bill would therefore define the EPSDT benefit in statute to include four distinct elements: (1) screening services, (2) vision services, (3) dental services, and (4) hearing services. Each of these service elements would have its own periodicity schedule that meets reasonable practice standards. These items and services must be covered for children even if, under the State Medicaid plan, they are not offered to other groups of program beneficiaries.

Under the Committee bill, screening services must, at a minimum, include (1) a comprehensive health and developmental history (including assessment of both physical and mental health development), (2) a comprehensive unclothed physical exam, (3) appropriate immunizations according to age and health history, (4) laboratory tests (including blood lead level assessment appropriate for age and risk factors), and (5) health education (including anticipatory guidance). The Committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counselling to both parents and children.

Under the Committee bill, vision services must, at a minimum, include diagnosis and treatment for defects in vision, including eye-glasses. Dental services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Hearing services must, at a minimum, include diagnosis and treatment for defects in hearing, including the provision of hearing aids. While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit. For example, States may not limit dental care to emergency services only, *Mitchell v. Johnston*, 701 F.2d 337 (5th Cir. 1983).

The Committee bill also clarifies the periodic nature of EPSDT services. With respect to screening services, the bill requires that they be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. The Committee intends that these health examinations be provided at intervals that are no greater than those described for well-child care in the 'Guidelines for Health Supervision' (1981) of the American Academy of Pediatrics. The Committee is informed that some States use periodicity schedules for medical examinations to govern the frequency with which children may receive dental examinations. The Committee intends that, among older children, dental examinations occur with greater frequency than is the case with physical examinations.

The Committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. The Committee emphasizes that the determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with a child outside of the health care system (e.g., State early intervention or special education programs, Head Start and day care programs, WIC and other nutritional assistance programs). As long as the child is referred to an EPSDT provider, the child would be entitled to an interperiodic health assessment (or dental, vision, or hearing assessment) or treatment services covered under the State plan.

These same considerations apply with respect to vision, dental, and hearing services, all of which must be provided when indicated as medically necessary to determine the existence of suspected illnesses or conditions. For example, assume that a child is screened at age 5 according to a State's periodicity schedule and is found to have no abnormalities. At age six, the child is referred to the school nurse by a teacher who suspects the child of having a vision problem. Under the Committee bill, the child can—and should—be referred at that point to a qualified provider of vision care for full diagnostic and treatment services, and the State must make payment for those services, even though the next regular vision exam under the State's periodicity mschedule does not occur until age 7.

While States may, at their option, impose prior authorization requirements on treatment services, the Committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.

The Committee notes that Medicaid-eligible children are entitled to EPSDT benefits even if they are enrolled in a health maintenance organization, prepaid health plan, or other managed care provider. The Committee expects that States will not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit. The Committee further expects that, in setting payment rates for managed care providers, the States will make available the resources necessary to conduct the required periodic and interperiodic screenings and to provide the required diagnostic and screening services.

The Committee bill clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit.

(b) *Report on the provision of EPSDT.*—In order to assess the effectiveness of State EPSDT programs in reaching eligible children, the Committee bill would require the States to report annually to the Secretary, in a uniform form and manner established by the Secretary, the following information, broken down by age group and by basis of eligibility for Medicaid: (1) the number of children receiving child health screening services; (2) the number of children referred for corrective treatment (the need for which is disclosed by the screening); and (3) the number of children receiving dental services. These reports would be due April 1 of each year (beginning with April 1, 1991) and would apply to services provided during the Federal fiscal year ending the previous September 30 (beginning with FY 1990).

Section 4214—Extension of payment provisions for medically necessary services in disproportionate share hospitals

(a) *Coverage of medically necessary services for children.*—Under current law, States may impose reasonable limits on the amount, duration, and scope of covered services. However, effective July 1, 1989, States are prohibited from imposing any fixed durational limit on Medicaid coverage of medically necessary inpatient hospital services provided to infants under age 1 by disproportionate share hospitals. As of January, 1989, according to the National Association of Children's Hospitals and Related Institutions, 12 States imposed durational limits on inpatient hospital services for children (Alabama, Alaska, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Missouri, Oregon, Tennessee, Texas, and West Virginia).

The purpose of the current law exception to fixed durational limits is to prohibit States from using arbitrary length of stay limitations (e.g., 20 days per year) to reduce payments for medically necessary services provided by hospitals, including many public and children's hospitals, that serve a disproportionate number of low-income patients. The Committee bill would extend this current law prohibition to any fixed durational limits on payment for inpatient services provided to children under age 18 by disproportionate share hospitals. The requirement is effective for inpatient hospital services furnished on or after July 1, 1990.

(b) *Assuring adequate payment for inpatient hospital services for children in disproportionate share hospitals.*—Under current law, States may reimburse hospitals for inpatient services on a prospective basis. If they choose to do so, States must, effective July 1, 1989, provide for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals involving exceptionally high costs or exceptionally long lengths of stay for infants under 1 year of age. According to the National Association of Children's Hospitals and Related Institutions, as of January, 1989, a total of 44 States pay for inpatient hospital services on a prospective basis; only 17 of these do not make outlier adjustments for high cost or long-stay cases (Alabama, Alaska, California, Colorado, Connecticut, D.C., Florida, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, and Washington).

The Committee bill would extend this current law requirement to cases involving children from age 1 up to age 18. States that pay for inpatient hospital services on a prospective basis would be required to submit to the Secretary, no later than April 1, 1990, a State plan amendment that provides for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for children age 1 up to age 18.

Section 4215—Requiring 'Section 209(b)' States to provide medical assistance to disabled children receiving SSI benefits

Under current law, States have the option of requiring aged, blind, and disabled individuals receiving Supplemental Security Income benefits to meet eligibility criteria more restrictive than those under SSI in order to qualify for Medicaid. States that elect this '209(b)' option must use eligibility criteria that were in lawful and in effect in that State on January 1, 1972.

While many of these '209(b)' States use more restrictive financial eligibility criteria, the Committee understands that 4 of these States (Connecticut, Minnesota, Missouri, and New Hampshire) exclude from Medicaid coverage disabled children under 18 who receive SSI benefits, because the January, 1972, Aid to the Blind and Disabled Programs did not cover disabled children. Under existing precedent, disabled children may not be excluded from Medicaid coverage if they are also eligible for AFDC, *West v. Cole*, 390 F. Supp. 91 (N.D. Miss. 1975). However, in the case of a disabled child not categorically related to AFDC, a '209(b)' State may exclude such a child from Medicaid coverage because eligibility criteria that were in effect in January, 1972, did not recognize disabled children.

Exhibit 11

C**Effective:[See Text Amendments]**Code of Federal Regulations Currentness

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)

Subchapter C. Medical Assistance Programs

§ Part 441. Services: Requirements and Limits Applicable to Specific Services (Refs & Annos)§ Subpart B. Early and Periodic Screening, Diagnosis, and Treatment (Epsdt) of Individuals Under Age 21 (Refs & Annos)

→ § 441.56 Required activities.

(a) Informing. The agency must--

(1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.

(2) Using clear and nontechnical language, provide information about the following--

(i) The benefits of preventive health care;

(ii) The services available under the EPSDT program and where and how to obtain those services;

(iii) That the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and

(iv) That necessary transportation and scheduling assistance described in § 441.62 of this subpart is available to the EPSDT eligible individual upon request.

(3) Effectively inform those individuals who are

blind or deaf, or who cannot read or understand the English language.

(4) Provide assurance to CMS that processes are in place to effectively inform individuals as required under this paragraph, generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

(b) Screening.

(1) The agency must provide to eligible EPSDT recipients who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. (See paragraph (c)(3) of this section for requirements relating to provision of immunization at the time of screening.) As a minimum, these screenings must include, but are not limited to:

(i) Comprehensive health and developmental history.

(ii) Comprehensive unclothed physical examination.

(iii) Appropriate vision testing.

(iv) Appropriate hearing testing.

(v) Appropriate laboratory tests.

(vi) Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. An agency may request from CMS an exception from this age requirement (within an outer limit of age 5) for a two year period and may request additional two year exceptions. If an agency requests an exception, it must demonstrate to CMS's satisfaction that there is a shortage of dentists that prevents the agency from meeting the age 3 requirement.

(2) Screening services in paragraph (b)(1) of this section must be provided in accordance with

reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child health care.

(c) Diagnosis and treatment. In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT recipients, the following services, the need for which is indicated by screening, even if the services are not included in the plan--

(1) Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;

(2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and

(3) Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.)

(d) Accountability. The agency must maintain as required by §§ 431.17 and 431.18--

(1) Records and program manuals;

(2) A description of its screening package under paragraph (b) of this section; and

(3) Copies of rules and policies describing the methods used to assure that the informing requirement of paragraph (a)(1) of this section is met.

(e) Timeliness. With the exception of the informing requirements specified in paragraph (a) of this section, the agency must set standards for the timely provision of EPSDT services which meet reasonable standards of medical and dental practice, as determined by the agency after consultation with recognized medical and dental organizations involved in child health care, and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services.

[49 FR 43666, Oct. 31, 1984; 49 FR 45431, Nov. 16, 1984]

SOURCE: 43 FR 45229, Sept. 29, 1978; 44 FR 29424, May 18, 1979; 49 FR 43666, Oct. 31, 1984; 51 FR 41338, Nov. 14, 1986, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

42 C. F. R. § 441.56, 42 CFR § 441.56

Current through September 30, 2010; 75 FR 60371

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Exhibit 12

C**Effective:[See Text Amendments]**Code of Federal Regulations Currentness

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)

Subchapter C. Medical Assistance Programs

▣ Part 441. Services: Requirements and Limits Applicable to Specific Services (Refs & Annos)▣ Subpart B. Early and Periodic Screening, Diagnosis, and Treatment (Epsdt) of Individuals Under Age 21 (Refs & Annos)**→ § 441.59 Treatment of requests for EPSDT screening services.**

(a) The agency must provide the screening services described in § 441.56(b) upon the request of an eligible recipient.

(b) To avoid duplicate screening services, the agency need not provide requested screening services to an EPSDT eligible if written verification exists that the most recent age-appropriate screening services, due under the agency's periodicity schedule, have already been provided to the eligible.

SOURCE: 43 FR 45229, Sept. 29, 1978; 44 FR 29424, May 18, 1979; 49 FR 43666, Oct. 31, 1984; 51 FR 41338, Nov. 14, 1986, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

42 C. F. R. § 441.59, 42 CFR § 441.59

Current through September 30, 2010; 75 FR 60371

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Exhibit 13



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at <http://www.hcfa.gov/medicaid/olmstead/olmshome.htm>.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

Attachment 4-B

Subject: EPSDT and HCBS Waivers

Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.
- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Exhibit 14

C

Effective:[See Text Amendments]

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Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid
Services, Department of Health and Human Ser-
vices (Refs & Annos)

Subchapter C. Medical Assistance Programs

▣ Part 440. Services: General Provisions
(Refs & Annos)▣ Subpart B. Requirements and Limits
Applicable to All Services**→ § 440.230 Sufficiency of amount,
duration, and scope.**(a) The plan must specify the amount, duration, and
scope of each service that it provides for--

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, dura-
tion, and scope to reasonably achieve its purpose.(c) The Medicaid agency may not arbitrarily deny or
reduce the amount, duration, or scope of a required
service under §§ 440.210 and 440.220 to an otherwise
eligible recipient solely because of the diagnosis, type
of illness, or condition.(d) The agency may place appropriate limits on a
service based on such criteria as medical necessity or
on utilization control procedures.[46 FR 47993, Sept. 30, 1981]SOURCE: 43 FR 45224, Sept. 29, 1978; 51 FR 41338,
Nov. 14, 1986, unless otherwise noted.AUTHORITY: Sec. 1102 of the Social Security Act
(42 U.S.C. 1302).

42 C. F. R. § 440.230, 42 CFR § 440.230

Current through September 30, 2010; 75 FR 60371

Exhibit 15

S. REP. 89-404, S. Rep. No. 404, 89TH Cong., 1ST Sess. 1965, 1965 U.S.C.C.A.N. 1943, 1965 WL 4458 (Leg.Hist.)

*1 *1943 P.L. 89-97, SOCIAL SECURITY AMENDMENTS OF 1965

House Report (Ways and Means Committee) No. 89-213,

Mar. 29, 1965 (To accompany H.R. 6675)

Senate Report (Finance Committee) No. 89-404,

June 30, 1965 (To accompany H.R. 6675)

Conference Report No. 89-682,

July 26, 1965 (To accompany H.R. 6675)

Cong. Record Vol. 111 (1965)

DATES OF CONSIDERATION AND PASSAGE

House Apr. 8, July 27, 1965

Senate July 9, July 28, 1965

The Senate Report and the Conference Report are set out.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

SENATE REPORT NO. 89-404

June 30, 1965

THE Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

PART I

I. BRIEF SUMMARY

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

Second, to expand the services for maternal and child health, crippled children, child welfare, and the mentally retarded, and to establish a 5-year program of 'special project grants' to provide comprehensive health care and services for needy children (including those who are emotionally disturbed) of school age or preschool age.

*1944 Third, to revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors, and disability insurance system by--

(1) increasing benefits by 7 percent across the board with a \$4 minimum increase for a worker who retired at age 65 or older;

(2) continuing benefits to age 22 for children attending school;

(3) providing actuarially reduced benefits for widows at age 60;

(4) liberalizing the definition of disability, providing disabled child's benefits with respect to disability before age 22, providing rehabilitation services for disabled workers, and facilitating determinations of disability;

(5) limiting the duplication of disability benefits and those under workmen's compensation;

retired workers 65 and over would be \$4 a month (\$6 a month for man and wife who are both 65 and are receiving benefits based on the same earnings record), the minimum benefit increase would fully cover the amount of monthly premiums for the supplementary plan. Under the House bill, persons enrolling who are entitled to monthly social security or railroad retirement benefits would have the premiums deducted from their monthly benefits. The committee-approved bill adds a similar provision for withholding the premiums of an enrolled individual from the annuity he receives under the civil service retirement system or another retirement system administered by the Civil Service Commission. If the wife of such an individual is also enrolled, and he agrees, her premium may also be withheld from his monthly annuity. (Of course, in any case enrollment in the plan is voluntary.) Deducting the premium from monthly benefits would help keep collection costs to a minimum. The method of collecting premiums for those who are not entitled to monthly benefits would be prescribed by the Secretary. People who are entitled to monthly benefits but *1986 who, because they have not retired, may not actually receive them or those who may receive only a part of them could estimate the amount by which premiums will exceed the amount of their benefits and could pay in advance the required additional amount to the Secretary. If advance payment is not made in these cases, the Secretary would specify the payment procedure. It is expected that the annual calculation of adjustment in benefits needed where a beneficiary has worked in the prior year would take into account the premiums owed and paid in connection with the supplementary plan.

*41 Provision is made for the Secretary to adjust the premium amounts supporting the program if medical or other costs rise, but there would be no increase in premiums before 1968, and increases would be made not more often than every 2 years after 1968. To take into account the higher cost of insuring an older individual, premiums payable by a person who enrolled later than the first period when enrollment was open to him or who reenrolled after his enrollment was terminated would be increased by 10 percent for each full year he could have been but was not enrolled.

There would be a contribution from Federal general revenues equal to the aggregate premiums payable by enrollees. In addition, under the House-passed bill, funds could be appropriated in fiscal year 1966 and remain available through the next fiscal year as repayable advances (without interest) to the trust fund in order to provide an operating fund at the beginning of the program and to provide a contingency reserve. The committee-approved bill modifies this provision, to take account of the later effective date of the supplementary plan and to provide greater flexibility as to the time of the appropriation. The appropriation would be available through the calendar year 1968. The amount that would be appropriated for this purpose would be \$18 per person eligible to enroll at the beginning of the supplementary program, January 1, 1967.

A new separate trust fund would be established-- the Federal supplementary medical insurance trust fund. All premiums and Government contributions for the supplementary program would be paid into the fund and all benefits and administrative expenses would be paid from the fund.

3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

(a) Conditions and limitations on payment for services

(1) Physicians' role

The committee's bill provides that the physician is to be the key figure in determining utilization of health services-- and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

*1987 In the case of in-patient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that in-patient diagnostic study was medically required and that the services were necessary for such purpose. The first physician recertification in each case of in-patient hospital services furnished over a period of time would be required no later than the 20th day

Exhibit 16

C**Effective: January 1, 2009**United States Code Annotated Currentness

Title 42. The Public Health and Welfare

Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)

→ § 12101. Findings and purpose

(a) Findings

The Congress finds that—

(1) physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination; others who have a record of a disability or are regarded as having a disability also have been subjected to discrimination;

(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;

(4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;

(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

(6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;

(7) the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

(8) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

(9) Redesignated (8)

(b) Purpose

It is the purpose of this chapter--

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

CREDIT(S)

(Pub.L. 101-336, § 2, July 26, 1990, 104 Stat. 328; Pub.L. 110-325, § 3, Sept. 25, 2008, 122 Stat. 3554.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-485(Parts I to IV), House Conference Report No. 101-596, and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 267.

References in Text

This "chapter", referred to in subsec. (b), was in the original this "Act", meaning Pub.L. 101-336, July 26, 1990, 104 Stat. 327, which enacted this chapter and section 225 of Title 47, and amended section 706 of Title 29, and sections 152, 221, and 611 of Title 47. For complete classification of this Act to the Code, see Short Title of 1990 Acts note set out under this section and Tables.

Amendments

2008 Amendments. Subsec. (a)(1). Pub.L. 110-325, § 3(1), rewrote subsec. (a)(1), which formerly read: "some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;"

Subsec. (a)(7) to (a)(9). Pub.L. 110-325, § 3(2), (3), struck out par. (7) and redesignated former pars. (8) and (9) as pars. (7) and (8), respectively. Prior to deletion, par. (7) read: "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;"

Effective and Applicability Provisions

▷

Effective:[See Text Amendments]

United States Code Annotated Currentness

Title 42. The Public Health and Welfare

Chapter 126. Equal Opportunity for Individuals with Disabilities (Refs & Annos)

▣ Subchapter II. Public Services (Refs & Annos)

▣ Part A. Prohibition Against Discrimination and Other Generally Applicable Provisions

→ **§ 12132. Discrimination**

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

CREDIT(S)

(Pub.L. 101-336, Title II, § 202, July 26, 1990, 104 Stat. 337.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1990 Acts. House Report No. 101-485(Parts I-IV), House Conference Report No. 101-596, and Statement by President, see 1990 U.S. Code Cong. and Adm. News, p. 267.

Effective and Applicability Provisions

1990 Acts. Section effective 18 months after July 26, 1990, see section 205(a) of Pub.L. 101-336, set out as a note under section 12131 of this title.

CODE OF FEDERAL REGULATIONS

State and local governments, nondiscrimination in services on basis of disability, see 28 CFR § 35.101 et seq.

LAW REVIEW COMMENTARIES

AIDS, prisoners, and the Americans with Disabilities Act. 1995 Utah L.Rev. 839.

Attorneys: The Americans with Disabilities Act should not impair the regulation of the legal profession where mental health is an issue. 49 Okla.L.Rev. 353 (1996).

Cast adrift: Homeless mentally ill, alcoholic and drug addicted. 44 Cath.U.L.Rev. 551 (1995).

Cautions defense: Should I be afraid to guard you? 5 Marq.Sports L.J. 279 (1995).

Disability discrimination by state and local government: Relationship between Section 504 of the Rehabilitation Act and Title II of the Americans With Disabilities Act. Mark C. Weber, 36 Wm. & Mary L.Rev. 1089 (1995).

Exhibit 17



Effective:[See Text Amendments]

Code of Federal Regulations Currentness
 Title 28. Judicial Administration
 Chapter I. Department of Justice
Part 35. Nondiscrimination on the Basis of Disability in State and Local Government Services (Refs & Annos)
Subpart B. General Requirements

→ § 35.130 General prohibitions against discrimination.

<For statute(s) affecting validity, see: 42 U.S.C.A. § 12101 et seq.>

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability--

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to

provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

(vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

(iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(4) A public entity may not, in determining the site or location of a facility, make selections--

(i) That have the effect of excluding individuals with disabilities from, denying them the benefits

of, or otherwise subjecting them to discrimination; or

(ii) That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

(5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(c) Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(d) A public entity shall administer services, programs, and activities in the most integrated setting

appropriate to the needs of qualified individuals with disabilities.

(e)(1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

<Text of subsection (h) added by 75 FR 56178, effective March 15, 2011.>

(h) A public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.

[Order No. 3180-2010, 75 FR 56178, Sept. 15, 2010]

SOURCE: 56 FR 35716, July 26, 1991; 75 FR 56177, Sept. 15, 2010, unless otherwise noted.

AUTHORITY: 5 U.S.C. 301; 28 U.S.C. 509, 510; 42 U.S.C. 12134.

28 C. F. R. § 35.130, 28 CFR § 35.130

Current through September 30, 2010; 75 FR 60371

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END OF DOCUMENT

Exhibit 18

medicaid

and the **uninsured**

November 2009

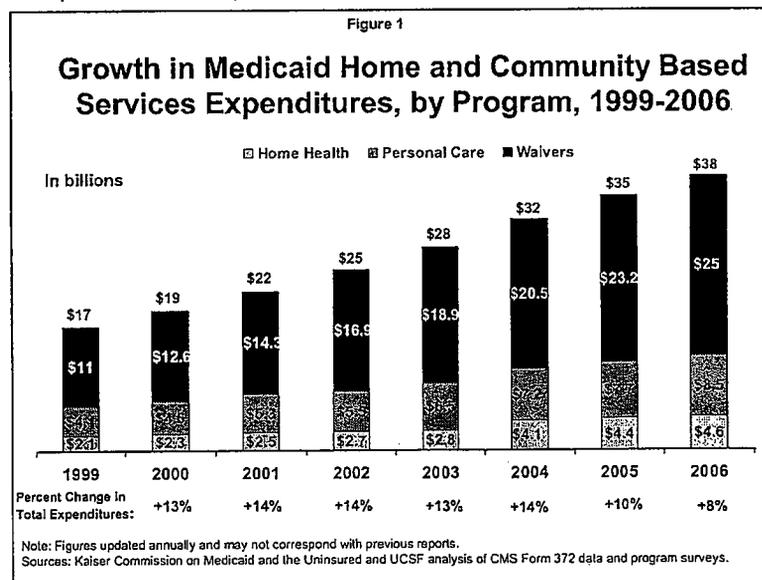
Medicaid Home and Community-Based Service Programs: Data Update

EXECUTIVE SUMMARY

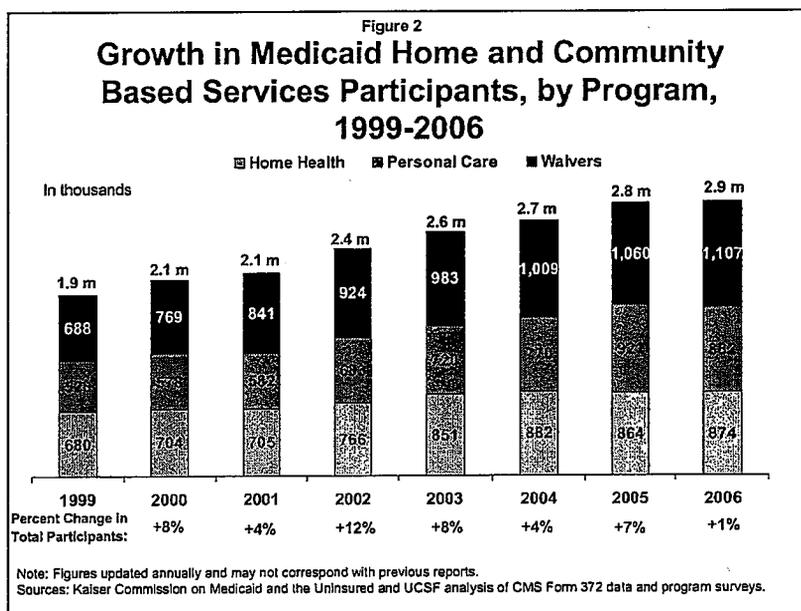
Developing home and community-based service (HCBS) alternatives to institutional care has been a priority for many state Medicaid programs over the last three decades. While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007. The recent financial crisis could impact the ability of many states to provide Medicaid services to the growing number of people who rely on the program for health and long-term care services. The ongoing debate about health care reform could also affect Medicaid eligibility and services provided in home and community-based settings. This report presents a summary of the main trends to emerge from the latest (2006) expenditures and participant data for the three main Medicaid HCBS programs: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit. It also presents findings on eligibility criteria, provider, service and waiting lists for all three programs, as well as provider reimbursement rates for the home health benefit and the personal care services benefit in 2008.

Key Findings:

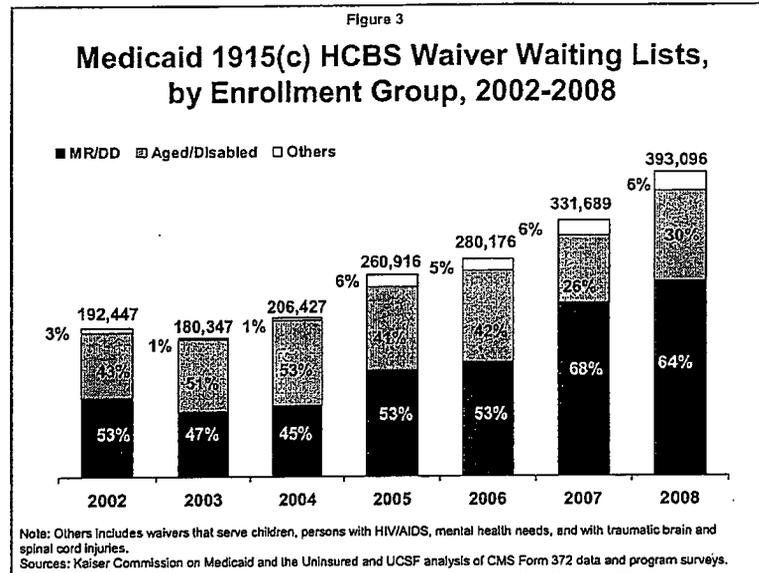
- **In 2006, overall spending on Medicaid HCBS increased 8 percent (Figure 1).** The overall growth in spending (including 1915(c) waivers, home health, and personal care services) was 2 percentage points lower than the 10 percent growth rate in 2005 and down from the 14 percent growth rate in 2004. Spending growth on total HCBS programs in 2006 was led by the personal care program with 10 percent annual growth, followed by the waiver program and the home health benefit at 8 percent and 5 percent increases respectively.



- There was a slight increase in total participants in Medicaid HCBS programs with nearly 2.9 million individuals being served through these programs in 2006 (Figure 2). There was only a 1 percent increase in participants in 2006, down sharply from the almost 7 percent increase in 2005 and 4 percent increase in 2004. More than 1.1 million individuals were served through HCBS waivers, 873,607 individuals received care through the home health benefit and 881,762 individuals received the personal care services benefit. Participation in the waiver and home health program grew by 4 percent and 1 percent respectively even as the number of waivers fell from 277 to 269. There was a 4 percent decline in the number of individuals receiving personal care in 2006 compared to 2005, mainly due to a large decline in the Texas program.



- In 2008, all states reported using cost controls on HCBS waivers such as restrictive financial and function eligibility standards, enrollment limits, and waiting lists. About 32 percent of reporting waiver programs used more restrictive financial eligibility standards for HCBS waiver programs than for nursing facilities. However, only 14 waivers used more restrictive functional eligibility criteria for waivers than for institutional care. This year's survey also found a 19 percent increase in the number of persons on waiting lists for waiver services (Figure 3). In 2008, 393,096 individuals were on waiting lists, up from 331,689 in 2007 and 280,176 in 2006. The average length of time an individual spent on a waiting list ranged from 9 months for aged waivers to 32 months for MR/DD waivers. More than half (56%) of states offering the personal care benefit had some form of cost controls in place, with the majority utilizing service limitations. Among home health programs, 27 percent of states had some form of cost control related to expenditure or service restriction.



- The use of consumer direction was present in each of the three Medicaid HCBS programs.** Consumer direction can include initiatives such as consumer choice in the allocation of their service budgets or the hiring and firing of service providers. Consumer direction was allowed in most waiver states, with 71 percent of waiver states allowing consumer direction in at least some of their waivers in 2008. In states with the optional state plan personal care program, 41 percent allowed consumer direction. In contrast, the percentage of home health programs allowing consumer direction within their program was 21 percent in 2008.

Over the past three decades, policy makers have responded to consumer preferences for alternatives to institutional care, by expanding Medicaid HCBS programs. In 2006, the number of Medicaid enrollees receiving HCBS services grew to almost 2.9 million, a 1 percent increase over the previous year. Although the number of Medicaid enrollees in HCBS waivers also increased in 2008, the 31 percent increase in the number of individuals on waiting lists highlights the demand for services, especially those serving the MR/DD and aged/disabled populations. In addition, inter-state variations in Medicaid HCBS programs and spending are still a concern. The growing number of states using more restrictive financial or functional eligibility standards in their HCBS programs compared to institutional care is at odds with the desire to serve more Medicaid beneficiaries in community-based setting.

As the recession and accompanying state budget deficits continue, states will be faced with new uncertainties for the provision of Medicaid HCBS services in the coming years. The possibility of new 1915(i) and 1915(j) waivers under the Deficit Reduction Act, which would allow states to provide HCBS as a state plan and to allow self direction of personal care services in a state plan as well as the increased Federal Medical Assistance Percentage (FMAP) provided for under the 2009 American Recovery and Reinvestment Act may increase access to home and community based services but at the same time place limits on services and costs. Therefore, targeted research is needed to investigate the impact of cost controls on access, quality and overall Medicaid costs as well as the differences in services and spending across states.

INTRODUCTION

Developing home and community-based service (HCBS) alternatives to institutional care has been a priority for many state Medicaid programs over the past three decades. While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007.¹ States have responded to consumer preferences and the Supreme Court ruling in the *Olmstead* case, which confirms the discriminatory nature of policies that lead to the unnecessary institutionalization of participants on public programs such as Medicaid, in their efforts to direct state long-term care delivery systems toward more community-based care.² In 2009, Medicaid enrollment grew by 5.4 percent and expenditures grew by 7.9 percent, but the financial crisis and resulting recession is expected to greatly impact the ability of many states to provide Medicaid services to the growing number of individuals eligible for Medicaid. In fiscal year 2010, 48 states are reporting a budget deficit and many states are expected to report such deficits well into fiscal year 2011.³ These fiscal problems will bring new uncertainties for the provision of Medicaid HCBS in the coming years.

Over the last eight years, we have tracked the development of the three main Medicaid HCBS programs: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit. Beginning in 2002, we also surveyed the policies, such as eligibility criteria and waiting lists that states use to control spending growth in waiver programs. Starting from 2007, we expanded the policy survey to include the home health benefit and the state plan personal care services benefit. On these surveys, we collected data on eligibility criteria, provider and services data as well as provider reimbursement rate data. This report presents a summary of the main trends to emerge from the latest (2006) expenditures and participant data for the three Medicaid HCBS programs, and findings from the survey of policies used on 1915(c) waivers, the home health benefit and the optional state plan personal care services benefit in 2008.

MEDICAID HCBS PARTICIPANTS AND EXPENDITURES

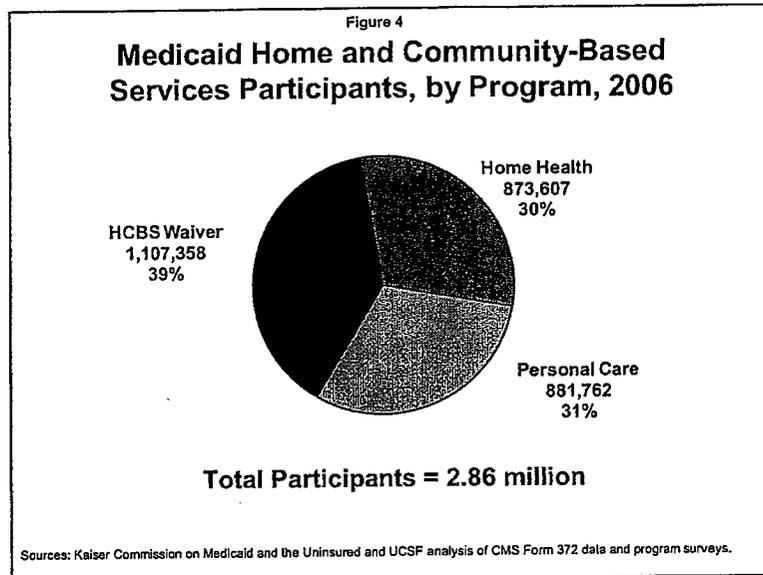
Medicaid Home Health, Personal Care Services, and 1915(c) Waiver Participants.

As noted above, there are three main ways a state can provide Medicaid HCBS: (1) optional 1915(c) HCBS waivers, (2) the mandatory home health benefit, and (3) the optional state plan personal care services benefit.

In 2006, all states and DC operated the Medicaid home health benefit while 48 states and DC operated multiple HCBS waivers (Arizona and Vermont operate their Medicaid long-term care program under a Section 1115 demonstration waiver). The number of states actively offering the optional state plan personal care benefit in 2006 was 31, with Louisiana the latest state to start a program in 2004. (Two states had approval for the personal care benefit but did not have clients in their programs: Delaware and Rhode Island).

In 2006, nearly 2.9 million individuals received Medicaid home and community-based services (Figure 4, Table 1A). Participation in HCBS programs increased only 1 percent between 2005 and 2006. This compares with the almost 7 percent increase in total

Medicaid HCBS participants in the 2004 to 2005 period. Of those participants, 1,107,358 individuals were served through HCBS 1915(c) waivers, 873,607 individuals received care through the home health benefit, and 881,762 individuals received personal care services through the optional state plan benefit (Table 1B, 1C, and 1D).



Between 1999 and 2006, the number of individuals receiving Medicaid home and community-based services grew steadily each year by an average of 6 percent (Table 1A and Figure 5), which was more than the 4.3 percent average annual increase in total Medicaid enrollment in the same period.³ The higher growth in HCBS participants compared to total Medicaid participants indicates a growing demand for Medicaid HCBS services.

Over the 1999 to 2006 period there was, however, great inter-state variation in average Medicaid HCBS participant annual growth rates ranging from large increases in Nevada (22 percent), Hawaii and North Carolina (20 percent), to reductions in New Hampshire (-5 percent), Arkansas, Connecticut and South Carolina (-1 percent). Declines in these states may be due to fiscal deficits, policy changes or a reduction in services over the study period that curtailed Medicaid HCBS participation through discretionary cost control methods or legislative orders.

Exhibit 19

UNITED STATES PUBLIC LAWS
101st Congress - Second Session
Convening January 23, 1990

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Additions and Deletions are not identified in this document.
For Legislative History of Act, see LH database or Report for
this Public Law in U.S.C.C. & A.N. Legislative History section.

<< STATUTES-AT-LARGE PAGE BREAKS ARE NOT YET AVAILABLE FOR THIS DOCUMENT >>

PL 101-508 (HR 5835)
November 5, 1990
OMNIBUS BUDGET RECONCILIATION ACT OF 1990

An Act to provide for reconciliation pursuant to section 4 of the concurrent resolution on the budget for fiscal year 1991.

Be it enacted by the Senate and House of Representatives of the United States
of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1990".

SEC. 2. TABLE OF TITLES.

- Title I. Agriculture and related programs.
- Title II. Banking, housing, and related programs.
- Title III. Student loans and labor provisions.
- Title IV. Medicare, medicaid, and other health-related programs.
- Title V. Income security, human resources, and related programs.
- Title VI. Energy and environmental programs.
- Title VII. Civil service and postal service programs.
- Title VIII. Veterans' programs.
- Title IX. Transportation.
- Title X. Miscellaneous user fees and other provisions.

(c) Effective Date.--This section shall take effect on the date of the enactment of this Act and shall apply with respect to--

- (1) personal care services furnished before such date pursuant to regulations in effect as of July 1, 1989; and
- (2) such services furnished before October 1, 1994.

SEC. 4721. MEDICAID COVERAGE OF PERSONAL CARE SERVICES OUTSIDE THE HOME.

<< 42 USCA § 1396d >>

(a) In General.--Section 1905(a)(7) (42 U.S.C. 1396d(a)(7)) is amended by striking "services" and inserting "services including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility".

<< 42 USCA § 1396d NOTE >>

(b) Effective Date.--The amendment made by this section shall become effective with respect to personal care services provided on or after October 1, 1994.

<< 42 USCA § 1396d >>

SEC. 4722. MEDICAID COVERAGE OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT SERVICES.

Section 1905(a) of the Social Security Act is amended by adding at the end the following new sentence: "No service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency."

SEC. 4723. MEDICAID SPENDDOWN OPTION.

<< 42 USCA § 1396b >>

(a) In General.--Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)) is amended by--

(1) inserting "(A)" after "(2)"; and

(2) by adding before the period at the end the following: "or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph."

<< 42 USCA § 1396a >>