

# PEDIATRICS®

## Medicaid Policy Statement

Committee on Child Health Financing

*Pediatrics* 2005;116;274-280; originally published online May 16, 2005;

DOI: 10.1542/peds.2005-0891

**This information is current as of July 29, 2005**

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://www.pediatrics.org/cgi/content/full/116/1/274>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2005 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



# AMERICAN ACADEMY OF PEDIATRICS

## POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Child Health Financing

### Medicaid Policy Statement

**ABSTRACT.** Medicaid is a vital safety net for children that must be maintained. It is the largest single insurer of children, yet millions of children who are eligible remain unenrolled. Every effort should be made to implement expanded eligibility and streamlined enrollment procedures. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits should be maintained for all eligible children. On average, Medicaid covers 30% of a pediatrician's patients, yet inadequate reimbursement affects children's access to care. States should increase reimbursement to at least parity with Medicare. *Pediatrics* 2005;116:274–280; *Medicaid, EPSDT, Medicaid managed care, eligibility, equal access.*

ABBREVIATIONS. AAP, American Academy of Pediatrics; SCHIP, State Children's Health Insurance Program; EPSDT, Early and Periodic Screening, Diagnosis, and Treatment; CMS, Centers for Medicare and Medicaid Services.

#### INTRODUCTION

Every child, regardless of health status, requires health insurance. Research has consistently shown the important role that health coverage plays in children's access to and use of health care services and attainment of positive health outcomes.<sup>1</sup> Medicaid is a vital component of the American health and social safety net, particularly for low-income children and children with special health care needs.<sup>2</sup> The entitlement to Medicaid should be protected to ensure the health and well-being of millions of children.

The American Academy of Pediatrics (AAP) recognizes the achievements of the Medicaid program in improving access to health care services for infants, children, adolescents, and young adults, hereafter referred to as children. The Medicaid program provides documented improvement in health care access, preventive visits, and having a usual source of care, resulting in improved health care outcomes and overall health status of children.<sup>3–5</sup> The AAP and its members have made a strong commitment to the Medicaid program. In general, pediatricians serve more Medicaid patients than do other primary care physicians.<sup>6,7</sup> On average, 30% of a pediatrician's patients are covered by Medicaid,<sup>8</sup> illustrating the commitment of pediatricians to ensure that Medicaid-insured children have access to a medical home.<sup>9</sup>

The 1990s brought significant progress in expanding health care coverage for children younger than 21 years through Medicaid expansions and the creation of the State Children's Health Insurance Program (SCHIP). In 2000, annual Medicaid enrollment reached 24.2 million or 30.7% of infants, children, and adolescents younger than 21 years.<sup>10</sup> This enrollment represents an 8% increase in the proportion of children covered by Medicaid since 1993.<sup>11</sup> Between 2000 and 2002, Medicaid and SCHIP covered an additional 3.4 million children and kept the proportion of uninsured children constant (below 12%) even as employment-based coverage continued to drop.<sup>12</sup> Still, an estimated 9.2 million children 0 through 18 years of age were uninsured in 2002, of whom 4.1 million were eligible for Medicaid, 2.4 million were eligible for SCHIP programs, and 2.8 million were not eligible for either program.<sup>10</sup>

With the recent economic downturn, however, state and federal budget deficits threaten to undo gains just when demand for these programs is increasing. Not since World War II have states faced worse financial crises. States are confronting difficult decisions: whether to bypass entitled eligibility, limit outreach, restrict or eliminate benefits, cut provider payments, or alter policy through waivers. In 2003, all 50 states implemented cost-containment strategies, most of which were directed at adults.<sup>13</sup> Because parental insurance is a predictor of children's insurance status, decreasing the eligibility of adults will have a predictable negative effect on children's coverage. In the future, children are likely to be more affected by state Medicaid budget shortfalls.

At the federal level, major program reforms are also under consideration, including allowing states more flexibility in changing Medicaid rules and regulations without waivers, altering eligibility requirements, cutting benefits to optional Medicaid eligibility groups, implementing cost sharing, and offering capped funding allotments or block grants for acute and long-term care. Although children through 20 years of age represent 54% of all Medicaid enrollees, they account for only 23.5% of all Medicaid expenditures.<sup>10</sup> The demographic trend toward more elderly individuals requiring Medicaid long-term care support creates significant pressure on federal and state governments to contain costs. Consequently, state and federal cost-containment strategies targeting children are not likely to yield significant savings and, in fact, may result in far greater state

doi:10.1542/peds.2005-0891

PEDIATRICS (ISSN 0031 4005). Copyright © 2005 by the American Academy of Pediatrics.

expenditures. Costs do not disappear when children are cut from or drop out of the Medicaid program as a result of cost-containment strategies. States may experience higher expenditures in areas such as primary clinics in public health departments, increased utilization of emergency departments, and an increase in the number of preventable hospitalizations. Other costs, which are more difficult to quantify, such as school absences for children and missed work for parents when children are sick as well as the adverse consequences of delayed treatment, are also likely.<sup>14</sup> The AAP, therefore, continues to maintain its strong support for the Medicaid program and offers a series of recommendations to support continued improvements. The following recommendations apply to all Medicaid programs, including fee-for-service, managed care, and prepaid programs unless otherwise specified.

### ELIGIBILITY

The AAP recommends that states implement the following eligibility provisions to ensure coverage of all children eligible for Medicaid under federal legislation.

1. Maintain, or preferably extend, coverage under regular Medicaid and Medicaid-SCHIP programs to cover children up to a higher family income level.
2. Expand coverage of all low-income adolescents through 21 years of age.
3. Continue to take advantage of the flexibility provided by federal law to disregard certain income, assets, and resources so that eligibility levels for children are higher.
4. Maintain Medicaid eligibility, coverage, and access for children with special health care needs through home- and community-based services waivers\* and Katie Beckett programs.‡
5. Adopt and maintain presumptive Medicaid eligibility policies for children who are presumed eligible for Medicaid on the basis of income to enroll temporarily and receive services, similar to the option available for pregnant women.
6. Streamline the eligibility determination process to simplify child enrollment and retention and to decrease administrative costs.<sup>15</sup>
7. Ensure that a redetermination of eligibility be made before disenrolling any children from Medicaid because of changes in their eligibility for cash assistance under the Temporary Assistance for Needy Families (TANF) program or the Supplemental Security Income (SSI) program.
8. Ensure that children who are removed from their homes by the state and placed in the foster care system are immediately enrolled in Medicaid.

\* Section 1915(c) of the Social Security Act allows federal Medicaid matching payments to be used for certain long-term care services that would otherwise not qualify. These home- and community-based services may be provided to Medicaid beneficiaries who, but for the provision of these services, would require the level of care provided in a hospital or nursing facility of an intermediate care facility.

‡ Section 1902(e)(3) of the Social Security Act, 42 USC 1396a(e)(3), allows states to provide Medicaid coverage to disabled children receiving medical care at home who would qualify for Medicaid if they were institutionalized.

9. Congress should pass the Family Opportunity Act, which would permit a Medicaid buy-in option for families with children who have chronic disabling conditions and who are not Medicaid eligible.
10. Implement the Medicaid option to cover youth exiting foster care on or after their 18th birthday.
11. Implement continuous Medicaid eligibility for children through 21 years of age with screening or evaluation only once during a 12-month period.

### OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states continue their important work to strengthen outreach, enrollment, and retention to ensure that all potentially eligible Medicaid recipients are enrolled in the program.

1. Eliminate means testing, enrollment caps, waiting lists, and requirements that applicants be uninsured for a period of time before enrollment in Medicaid programs.
2. Maintain or increase outreach efforts to reach families whose children are potentially eligible for Medicaid but not enrolled, including but not limited to legal immigrants, SCHIP-eligible children whose family income has changed, and privately insured children in low-income families.
3. Accept applications by mail, by phone, and online, replicating effective strategies of automatic enrollment piloted in Covering Kids initiatives.<sup>16</sup>
4. Continue to expand the use of multiple enrollment sites and "express-lane" eligibility determination, including hospitals, birth certificate clerks' offices, primary care offices, health care centers, emergency departments, urgent care centers, child care centers, Head Start programs, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs, schools, child care resources and referral agencies, and places of worship.
5. Extend automatic enrollment in Medicaid for children in families deemed eligible for Temporary Assistance for Needy Families, Supplemental Nutrition Program for Women, Infants, and Children, and food stamps.<sup>17</sup>
6. Coordinate Medicaid and SCHIP outreach and universal enrollment processes, including the use of common application forms that are short and written in easily understood language and translated into multiple languages.
7. Encourage and provide incentives for collaboration among enrollment entities, health care professionals, and health plans to improve effective communication and coordination to enroll eligible families and retain participating children.
8. Establish federal policy to prevent denial of citizenship because of previous receipt of Medicaid and any other health services.

### BENEFITS AND COST SHARING

Medicaid benefits vary by state.<sup>18</sup> The AAP recommends that Medicaid continue to offer all eligible children the Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT) benefit and all other mandatory and optional benefits. In addition:

1. Clearly specify the full scope of pediatric Medicaid benefits, including EPSDT, in consumer brochures, state plan documents, and managed care contracts. States should also inform families about Medicaid benefits excluded from managed care contracts and educate them on how to access these carved-out but covered services.
2. Encourage states to ensure that EPSDT, in combination with other mandatory and optional benefits, covers the benefits outlined in the AAP policy statement "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years."<sup>19</sup>
3. Ensure that states' EPSDT periodicity schedules are consistent with the AAP periodicity schedule in "Recommendations for Preventive Pediatric Health Care"<sup>20</sup> and *Bright Futures*<sup>21</sup> and that immunization schedules are consistent with the recommended childhood and adolescent immunization schedule published annually by the AAP, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.<sup>22</sup>
4. Ensure that states' medical necessity definitions, consistent with EPSDT policy, are included in all consumer brochures, state plan documents, and managed care contracts. When making medical necessity determinations, state Medicaid agencies should consider whether health interventions for children assist in achieving, maintaining, or restoring health and functional capacity; are appropriate for age and developmental status; and will take into account the specific needs of the child.<sup>23</sup>
5. Encourage states to offer the full scope of pediatric Medicaid benefits, including EPSDT, for children under Section 1115 demonstration waivers and Health Insurance Flexibility and Accountability waivers.<sup>§</sup>
6. Promote parity of behavioral health benefits with medical benefits in insurance plans.<sup>19</sup>
7. Maintain the policy prohibiting cost sharing on all Medicaid benefits for children, particularly preventive services.

#### MANAGED CARE

In recent decades, fiscal and policy considerations have encouraged the use of managed health care delivery models for Medicaid programs. At present, nearly 52.2% of Medicaid beneficiaries receive their health care services through managed care plans.<sup>24</sup> The AAP recommends implementing the following safeguards to ensure that the federal government (through its policies) and states (through contracting with health plans, managed care organizations, pri-

mary care case management programs, and behavioral health plans) meet the health care needs of children.

1. Ensure that every effort is made by states for Medicaid beneficiaries to make timely and informed selections of managed care organizations and primary care clinicians. This effort includes providing sufficient education and support to consumers, such as face-to-face counselors to provide information on how to choose a health plan, how to access primary care and referral services and out-of-pocket plan benefits, and how to use appeal and grievance procedures.
2. Provide educational materials for families that are culturally sensitive and written at literacy levels and in languages used by Medicaid recipients. Quality-performance data should also be available from states and meaningful to Medicaid consumers. Consumer-education efforts must address the lack of resources, information, and training that prevents many consumers from being involved in advisory and oversight bodies.<sup>25</sup>
3. For Medicaid participants who do not choose and must be assigned to a managed care organization, use practical criteria to assign them, including current and previous relationships with primary care and specialty clinicians, location of clinicians, assignment of other family or household members, cultural and linguistic preferences, choices by other members in the service area, and capacity of managed care organizations to provide special care or services appropriate for children. Pediatricians should be considered primary care clinicians (not subspecialists), eligible to have children assigned to them in all default enrollment systems and state-based enrollment broker options. Every effort should be made to allow Medicaid patients to remain with their medical home.
4. Include in the provider network of all managed care organizations and fee-for-service programs<sup>26</sup> sufficient numbers of appropriately trained and board-eligible or board-certified providers of pediatric care, including primary, medical subspecialty, surgical specialty, and psychiatric pediatric care, or provide a network outside the plan. Physicians and other licensed providers of developmental, behavioral, and substance-abuse services should be accessible or available by referral from the primary care clinician to provide medically necessary services without restrictions from the managed care organization. In addition, Medicaid-eligible children should have access to children's mental health and substance-abuse services, oral health care, social work services, developmental evaluation services, occupational therapy services, physical therapy services, speech therapy and language services, school-linked clinic services, and other necessary public health services. The network should also include hospitals that specialize in the care of children in both inpatient and outpatient settings. In determining network adequacy, states should base de-

§ Section 1115 of the Social Security Act (42 USC 1315) allows states to waive compliance with any provision of Medicaid, in addition to other federal programs authorized by the Act, for any experimental, pilot, or demonstration project that would promote the objectives of the Medicaid program. A Health Insurance Flexibility and Accountability waiver allows states to cut benefit packages and increase cost sharing.

- terminations on the number of Medicaid providers accepting all new Medicaid patients.
5. With federal support, states should offer incentives for managed care organizations, fee-for-service programs, and primary care case management programs to identify children with special health care needs and offer plan providers enhanced payments for providing a medical home, including family education, practice-based care coordination, and transition to adult care, for these children.
  6. Require state coordination of care between Title V agencies and mental health agencies that serve Medicaid managed care beneficiaries.
  7. Encourage states to implement special planning and oversight of the use of managed care for children with special health care needs, including children in foster care and children with mental health conditions. This should cover benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, care coordination, quality-performance measures for preventive care delivery for children with various types of chronic conditions, family participation, pediatric risk-adjustment mechanisms, and other financial incentives for high-quality care.
  8. Encourage states to select managed care organizations on the basis of their ability or demonstrated readiness to provide Medicaid-eligible children with quality care based on the use of quality-performance measures. Also, managed care organizations should be selected on the basis of their abilities to complement and coordinate services with existing maternal and child health programs to ensure maximum health benefits to families.
  9. Streamline Medicaid administrative processes to create a minimal paperwork burden for physicians.

#### ACCESS TO PEDIATRIC SERVICES

The AAP recommends that the Centers for Medicare and Medicaid Services (CMS) and states focus new attention on the availability of and access to a wide range of pediatric services.

1. For all families with children, encourage the availability of medical homes that include access to primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, developmental and behavioral service providers, care coordinators, and hospitals with appropriate pediatric expertise. Efforts should be made by state Medicaid agencies and managed care organizations to maintain established relationships of children with their primary care and specialty pediatricians to avoid disruptions in the continuity of care.
2. Ensure that behavioral health panels include mental health professionals with adequate training and experience in caring for children and adolescents.

3. Support the “prudent-layperson” standard<sup>||</sup> and oppose copayments for emergency care to allow timely access to emergency services.
4. Provide pediatric-appropriate medication formularies to provide quality care.
5. Support ongoing research to monitor the Medicaid participation rates of primary care and specialty pediatricians and to evaluate other aspects of access to and quality of care for children under Medicaid.

#### FINANCING AND REIMBURSEMENT

The AAP recommends that the CMS and state Medicaid agencies reexamine their reimbursement policies that are woefully inadequate for physicians who care for children. Adequate Medicaid reimbursement is necessary to achieve access. Low payment, capitation, and paperwork concerns all relate to low Medicaid participation by primary care office-based pediatricians, pediatric medical subspecialists and pediatric surgical specialists, mental health providers, and dentists.<sup>27</sup> State policy makers should address these 3 factors to ensure sufficient primary care physician capacity to appropriately serve children enrolled in Medicaid. States must pay primary care pediatricians and pediatric medical subspecialists and pediatric surgical specialists adequately so they can continue to provide and improve quality care for low-income children.

Federal and state policy makers and private managed care administrators should ensure appropriate levels of reimbursement and payment rates. All states should regularly review Medicaid reimbursement rates and raise them to at least parity with Medicare. Health care for children is relatively inexpensive when compared with that for adults. Moreover, cutting state funding for Medicaid means losing significant federal matching funds. Failure to invest adequately in the health of children today could have serious consequences for the populations of tomorrow.<sup>28</sup>

The AAP recommends that policy makers:

1. Increase the Federal Medical Assistance Percentage as necessary to provide critical fiscal relief to states and to maintain disproportionate share hospital payments.
2. Oppose the conversion of Medicaid financing to an annual allotment or block grant program with a fixed budget and oppose caps on federal Medicaid spending.
3. Enforce the federal equal-access provision requiring that state plans for medical assistance ensure that payments are “sufficient to enlist enough providers so that care and services are

<sup>||</sup> Section 4704 (b)(2)(C) of the Balanced Budget Act of 1997 (Public Law 105-33) defines the prudent-layperson standard as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”

available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”<sup>29</sup> Strong evidence demonstrates that adequate reimbursement is a prerequisite for states to comply with federal law.

4. Require all states to increase Medicaid reimbursement rates to at least parity with Medicare.
5. Require all states to establish a process to review and update Medicaid provider payment rates on an annual basis.
6. Adjust payments for case-mix differences based on chronic conditions, a pediatric diagnostic classification system, or other risk-adjustment mechanism. Because pediatric risk-adjustment techniques are not well developed, contract provisions should be included to address carved-out services, outlier payment, reinsurance or shared-risk arrangements for individual children, and aggregate plan loss or profits.
7. All financing mechanisms should be sufficient to adequately fund the overall costs of caring for children eligible for Medicaid and should provide adequate reimbursement to physicians caring for these patients. New financing approaches should be piloted and evaluated with an analysis of the effect on children, their families, and their pediatricians before broad implementation. When states raise capitation rates, they should ensure funds are used by health plans to improve access, quality, and reimbursement of health services.
8. Eliminate barriers to pediatricians’ reimbursement for the behavioral health services that they legitimately provide within their scope of skills as general pediatricians.
9. Provide Medicaid reimbursement for pediatrician-directed care coordination of children with special health care needs.
10. Provide Medicaid reimbursement for observation, rapid-treatment, and 23-hour units, day medicine services, and necessary interhospital transport services.
11. Adjust Medicaid reimbursement, including capitation payments, or create contingency funds to account for advances in pediatric care, including but not limited to new vaccines and new technologies. Timely adjustments to coverage and capitation rates reflecting these medical advances should be included in all state managed care contracts.
12. Adopt health plan reimbursement levels that value services to children. Encourage the CMS to obligate states contracting with managed care organizations to disclose their physician-payment methodologies and rates (whether fee-for-service or capitated) for each child eligibility group on an annual basis. The CMS should require states to make nonproprietary information easily available on request. The adequacy of Medicaid payments should be based on the true costs of delivering care and not on the commercial market rate, which may be inadequate.

13. Initiate a process to modify the resource-based relative-value scale for children to correct inequities pertaining to pediatrics. In particular, a system for the ongoing evaluation of expenses for practice overhead, including expenses specific to pediatrics, should be implemented.
14. Establish a National Medicaid Payment Advisory Commission and a national Medicaid utilization database with AAP representation to address the many child health services payment issues within the Medicaid program.
15. Encourage states to offer a provider-relations committee to address reimbursement issues.
16. Explore innovative methods to establish trust funds to support graduate medical education relevant to the provision of care for Medicaid participants and to ensure a qualified pediatric workforce.
17. Require the federal government to provide reimbursement for trained interpreter services for patients with limited English proficiency to decrease errors in medical interpretation and potential adverse clinical consequences.<sup>30</sup>

#### QUALITY-IMPROVEMENT ACTIVITIES

The AAP recommends enhancing state Medicaid quality-improvement activities for children, including those with special health care needs, in collaboration with state AAP chapters.

1. Implement quality-performance measures by states that address access to care, utilization, effectiveness, and satisfaction related to preventive, primary, acute, and chronic care for children. Such performance measures should be consistent with current pediatric practice parameters of the AAP.
2. Establish appropriate incentives from federal and state programs so that Medicaid plans and providers deliver high-quality services.
3. Ensure uniform and consistent EPSDT reporting with minimal paperwork burden on providers and a review process and compliance plan that is conducted by persons specifically trained in and practicing pediatrics. Educational and nonpunitive programs should be implemented to ensure effective and uniform EPSDT.
4. Conduct the Consumer Assessment of Health Plan Survey for a representative sample of children enrolled in state Medicaid programs, especially children with special health care needs, and the screener for parents of children with special health care needs. The Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance should include pediatricians in updating the survey and the Health Employer Data and Information System (HEDIS). The AHRQ and other agencies should include pediatricians in establishing new quality-performance measures affecting children.
5. Federal and state agencies should work with the AAP to develop programs to improve the quality

of pediatric care as well as tools and measures to monitor changes, especially in the provision of medical homes for children with special health care needs.

6. States should update meaningful provider-assessment and -certification activities, including peer review, provider credentialing, medical record reviews, and timely analysis and reporting of findings to providers, plans, and beneficiaries.
7. Encourage Medicaid programs to partner with other state agencies such as Title V offices to support practice-level improvements in pediatric care, especially in providing a medical home for children with special health care needs.
8. States should monitor enrollment patterns and reasons for enrollment changes to ensure that managed care organizations do not encourage "high-cost" persons to switch to other plans and do not underserve Medicaid beneficiaries.
9. States should implement general administrative-review processes to ensure that managed care organizations and behavioral health organizations are qualified and available.
10. States should provide timely, linguistically appropriate, and meaningful results of quality-related activities to beneficiaries to facilitate their participation in health care decision-making.

#### COMMITTEE ON CHILD HEALTH FINANCING, 2003–2004

Thomas K. McInerney, MD, Chairperson

Charles J. Barone, II, MD

Jeffrey M. Brown, MD, MPH

Richard Lander, MD

\*John R. Meurer, MD, MBA

Richard Y. Mitsunaga, MD

Mark S. Reuben, MD

Steven E. Wegner, MD, JD

Mark J. Werner, MD, CPE

#### CONSULTANT

Margaret McManus, MHS

#### STAFF

Jean Davis, MPP

\* *Lead author*

#### REFERENCES

1. Lewit EM, Bennett C, Behrman RE. Health insurance for children: analysis and recommendations. *Future Child*. 2003;13:5–29
2. Ku L, Nimalendran S. *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP*. Washington, DC: Center on Budget and Policy Priorities; 2004. Available at: [www.cbpp.org/1-15-04health.htm](http://www.cbpp.org/1-15-04health.htm). Accessed June 8, 2004
3. Inkelas M, Halfon N, Uyeda K, et al. *The Health of Young Children in California: Findings From the 2001 California Health Interview Survey*. Los Angeles and Sacramento, CA: UCLA Center for Health Policy Research and First 5 California; 2003. Available at: [www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=71](http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=71). Accessed June 8, 2004
4. Children Now. *California Report Card 2002*. Oakland, CA: Children Now; 2002
5. Centers for Medicare and Medicaid Services. *Program Information on Medicaid and State Children's Health Insurance Program (SCHIP)*. Washington, DC: US Department of Health and Human Services; 2004. Available at: [www.cms.hhs.gov/charts/Medicaid/infomedicaid\\_schip.pdf](http://www.cms.hhs.gov/charts/Medicaid/infomedicaid_schip.pdf). Accessed June 28, 2004
6. Grumbach K, Hart LG, Mertz E, Coffman J, Palazzo L. Who is caring for the underserved? A comparison of primary care physicians and non-physician clinicians in California and Washington. *Ann Fam Med*. 2003; 1:97–104
7. Perloff JD, Kletke PR, Fossett JW, Banks S. Medicaid participation among urban primary care physicians. *Med Care*. 1997;35:142–157
8. Yudkowsky BK, Tang SF, Siston AM. *Pediatrician Participation in Medicaid/SCHIP. Survey of Fellows of the American Academy of Pediatrics, 2000*. Elk Grove Village, IL: American Academy of Pediatrics; 2000. Available at: [www.aap.org/statelegislation/med-schip/USdpc.pdf](http://www.aap.org/statelegislation/med-schip/USdpc.pdf). Accessed June 8, 2004
9. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110:184–186
10. American Academy of Pediatrics, Division of Health Policy Research. *Children's Health Insurance*. Elk Grove Village, IL: American Academy of Pediatrics; 2003. Available at: [www.aap.org/research/factsheet.pdf](http://www.aap.org/research/factsheet.pdf). Accessed May 3, 2005
11. American Academy of Pediatrics, Division of Health Policy Research. *FY 1993 Medicaid State Reports*. Elk Grove Village, IL: American Academy of Pediatrics; 1994
12. Cunningham PJ, Reschovsky JD, Hadley J. *SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage*. Washington, DC: Center for Studying Health System Change; 2002. Available at: [www.hschange.com/CONTENT/508](http://www.hschange.com/CONTENT/508). Accessed June 8, 2004
13. Smith V, Ramesh RK, Gifford K, Ellis E, Wachino V. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004. Results From a 50-State Survey*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2003. Available at: [www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126](http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126). Accessed June 8, 2004
14. Shirk C. *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP*. Portland, ME: National Academy for State Health Policy; 2004. Available at: [www.nashp.org/Files/final\\_version\\_chip\\_23.pdf](http://www.nashp.org/Files/final_version_chip_23.pdf). Accessed June 8, 2004
15. Fairbrother G, Dutton MJ, Bachrach D, Newell KA, Boozang P, Cooper R. Costs of enrolling children in Medicaid and SCHIP. *Health Aff (Millwood)*. 2004;23:237–243
16. O'Brien E, Mann C. *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*. Columbia, SC: Covering Kids and Families National Program Office; 2003. Available at: <http://coveringkidsandfamilies.org/resources/index.php?InfoCenterID=178>. Accessed June 8, 2004
17. Children's Partnership, Kaiser Commission on Medicaid and the Uninsured. *Putting Express Lane Eligibility Into Practice*. Santa Monica, CA: Children's Partnership; 2000. Available at: [www.childrenspartnership.org/bbar/chealth.html](http://www.childrenspartnership.org/bbar/chealth.html). Accessed June 8, 2004
18. Kaiser Commission on Medicaid and the Uninsured. Medicaid benefits. Available at: [www.kff.org/medicaidbenefits/index.cfm](http://www.kff.org/medicaidbenefits/index.cfm). Accessed June 28, 2004
19. American Academy of Pediatrics, Committee on Child Health Financing. Scope of health care benefits for newborns, infants, children, adolescents, and young adults through age 21 years. *Pediatrics*. 1997;100: 1040–1041
20. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for preventive pediatric health care. *Pediatrics*. 2000;105:645–646
21. Green M, Palfrey JS, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2000
22. American Academy of Pediatrics, Committee on Infectious Diseases, Advisory Committee on Immunization Practices, American Academy of Family Physicians. Recommended childhood and adolescent immunization schedule—United States, July–December 2004. *Pediatrics*. 2004; 113:1448–1450
23. Berman S. A pediatric perspective on medical necessity. *Arch Pediatr Adolesc Med*. 1997;151:858–859
24. American Academy of Pediatrics, Division of Health Policy Research. *FY 2000 Medicaid State Reports*. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Available at: [www.aap.org/research/medic00.htm](http://www.aap.org/research/medic00.htm). Accessed June 28, 2004
25. Molnar C. Addressing challenges, creating opportunities: fostering consumer participation in Medicaid and Children's Health Insurance managed care programs. *J Ambul Care Manage*. 2001;24:61–67
26. Skaggs D, Clemens SM, Vitale MG, Femino JD, Kay RM. Access to

- orthopedic care for children with Medicaid versus private insurance in California. *Pediatrics*. 2001;107:1405–1408
27. Berman S, Dolins J, Tang SF, Yudkowsky B. Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients. *Pediatrics*. 2002;110:239–248
28. Freed GL, Fant K. The impact of the “aging of America” on children. *Health Aff (Millwood)*. 2004;23:168–174
29. Omnibus Budget Reconciliation Act of 1989 (Pub L No. 101-239), §1396a(a)(30)(A)
30. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111:6–14

---

*All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.*

## WHAT IS A BLOG?

“Blog is short for weblog. Log means ‘diary,’ as in a captain’s log on a ship. Weblog means a diary of sorts maintained on the Internet by one or more regular contributors. Usually just one, sometimes two or three, rarely more than three.

The first blog appeared in 1999. Give or take a year.

There are now more than 4,000,000 blogs. Think about that. From 1 to 4,000,000 in five years.

Blogs first got noticed when they invaded the realm of politics and journalism in a big way. An entire universe of *poliblogs* sprang up to do commentary on politics and, necessarily, about media. These blogs raised huge sums of money for candidates [and] changed the contours of citizen political participation.”

Hewitt H. *Blog: Understanding the Information Reformation That’s Changing Your World*. Nashville, TN: Thomas Nelson, Inc.; 2005:ix

Noted by JFL, MD

**Medicaid Policy Statement**  
Committee on Child Health Financing  
*Pediatrics* 2005;116;274-280; originally published online May 16, 2005;  
DOI: 10.1542/peds.2005-0891

**This information is current as of July 29, 2005**

**Updated Information  
& Services**

including high-resolution figures, can be found at:  
<http://www.pediatrics.org/cgi/content/full/116/1/274>

**References**

This article cites 14 articles, 10 of which you can access for free at:  
<http://www.pediatrics.org/cgi/content/full/116/1/274#BIBL>

**Subspecialty Collections**

This article, along with others on similar topics, appears in the following collection(s):  
**Office Practice**  
[http://www.pediatrics.org/cgi/collection/office\\_practice](http://www.pediatrics.org/cgi/collection/office_practice)

**Permissions & Licensing**

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:  
<http://www.pediatrics.org/misc/Permissions.shtml>

**Reprints**

Information about ordering reprints can be found online:  
<http://www.pediatrics.org/misc/reprints.shtml>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

