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ADMINISTRATION POLICY CHANGE THREATENS HEALTH CARE COVERAGE FOR POOR INFANTS

By Sarah deLone¹

Since 1984, federal Medicaid law has required that states provide one year of automatic Medicaid eligibility to babies whose mothers are sufficiently poor that the baby's birth was covered by Medicaid.² For the past 22 years, these babies have been able to get check-ups and other health care services that can be critical to their health and development, without the delays in coverage that otherwise would result if the babies were made *ineligible* for Medicaid until an application has been filed on their behalf, all necessary paperwork has been completed, and the state Medicaid agency has processed the application.

Now, without any change in the law, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services has instructed states that they may no longer provide automatic coverage to some babies, even though these babies have been born in the United States and are U.S. citizens and Medicaid has covered the cost of their birth. According to CMS, when a baby is born to a mother who does not herself meet the citizenship requirements for Medicaid, the baby may *not* be covered by Medicaid until an application is filed and all necessary documents — including proof of the baby's citizenship and identity — are submitted, despite the fact that the Medicaid program paid for the birth on U.S. soil and knows unquestionably that the infant is a U.S. citizen.³

¹ The author is an attorney and a former technical director at the Centers for Medicare and Medicaid Services for Medicaid eligibility for families and children. She now is a Senior Policy Analyst and FirstFocus Fellow at the Center on Budget and Policy Priorities.

² The requirement that states provide one year of automatic or "deemed" eligibility to babies born to pregnant women who were eligible for and received Medicaid at the time of the baby's birth is found in §1902(e)(4) of the Social Security Act ("Act"), 42 U.S.C. 1396a(e)(4). States must continue to provide Medicaid coverage to such babies as long as they continue to live with their birth mother and the mother either remains eligible for Medicaid or would remain eligible if she were still pregnant. Because pregnant women, once eligible for Medicaid, remain eligible for Medicaid throughout their pregnancy and a two- to three-month postpartum period, regardless of changes in their income (see §1902(e)(6) of the Act), babies eligible for the year of automatic or "deemed" eligibility do not lose coverage if their mother returns to work and experiences a rise in income. The only babies who can lose eligibility during their first year are (1) babies who no longer reside with their birth mother; (2) babies who move out of state; or (3) in states with an asset eligibility limit for pregnant women, babies whose mother experiences a sufficient increase in assets to push her over the asset limit for pregnant women in that state. The automatic coverage lasts for one year. When the baby turns one, states must verify that the infant is a U.S. citizen and continues to meet all Medicaid eligibility requirements in order to continue providing coverage.

³ Undocumented immigrants and most legal immigrants who have been in the United States for less than five years are not eligible for the full scope of benefits covered under a state's Medicaid program. Such immigrants are, however,

Administration Policy Creates Unnecessary Barriers to Coverage for Poor Babies

CMS has created another unnecessary barrier for babies whose births are covered by Medicaid, even for those who receive one year of automatic coverage. In its July 12, 2006 interim final regulations, CMS restricted the type of records that can be used to document citizenship for babies whose births are paid for by Medicaid. As a result, CMS unnecessarily has subjected these children to the risk of losing their Medicaid coverage when their eligibility is redetermined at age 1.

Under the regulations, when a state redetermines an infant's eligibility after 12 months, the state must obtain a birth certificate and an ID document, or cross-match to those documents, to continue Medicaid coverage for the baby. This is true even though a state Medicaid program (or Medicaid managed care organization) has paid for the child's birth in a U.S. hospital and *the state therefore knows that the baby is a U.S. citizen.*

While Congress did not exempt babies who receive automatic coverage from the citizenship documentation requirements once these children reach age 1, Congress did give CMS discretion to determine the types of records that are considered a reliable means of documenting citizenship and personal identity. CMS chose not to use this authority to permit states to consider Medicaid payment for birth as sufficient documentation of citizenship and identity, despite the obvious reliability and low administrative cost of such an approach.

Many of the babies affected by this reversal of policy will likely go without needed health care services for some period of time even though Medicaid coverage should be automatic. For other infants, hospitals and doctors will absorb the cost of care. For all, the new CMS policy is both misguided and contrary to the Medicaid law.

Medicaid and Newborns: A Critical Connection

The importance of children receiving well-child and other primary care services in their early years is well established.⁴ Even for healthy children, obtaining routine preventive care during the first year of life can be critical to healthy development.⁵ For those who experience acute or chronic care

eligible for Medicaid coverage for services necessary to treat an emergency medical condition, provided that they otherwise meet the state's Medicaid eligibility criteria. See section 401(b)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (1996 Welfare Reform Law), 8 U.S.C. 1611(b)(1)(A). For pregnant women, this "emergency Medicaid" includes coverage of labor and delivery. See section 3211.11, paragraph D of CMS's State Medicaid Manual. Further, it should be noted, Medicaid can only pay for the birth of a baby if the baby's mother is eligible for Medicaid – either full or emergency Medicaid – at the time of the baby's birth.

⁴ See, e.g., Helen Pelletier and Melinda Abrams, "ABCD: Lessons from a Four-State Consortium," Commonwealth Fund and National Association of State Health Policy (December 2003) (available at http://www.nashp.org/Files/CW9_ABCD_Lessons_Learned.pdf) and "Children's Health—Why Health Insurance Matters," Kaiser Commission on Medicaid and the Uninsured (May 2002) (available at <http://www.kff.org/uninsured/4055-index.cfm>).

⁵ Both the American Academy of Pediatrics and the federal Maternal and Child Health Bureau recommend six well-child visits in the first year, three in the second, and an average of almost one per year (17 in total) from ages 2 through 21.

conditions or who have special health care needs, obtaining regular medical attention is even more important.⁶

Children are significantly more likely to receive needed health care services if they are insured.⁷ Medicaid – which covers 25 percent of all children living in the United States, 60 percent of all children living below the federal poverty level and nearly 60 percent of all infants under age 1 living in low-income families with income below 200 percent of the poverty level – has a particularly important role to play in ensuring that children receive appropriate care.⁸ For example, Medicaid’s Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit ensures that children receive preventive care, through the provision of comprehensive health assessments (including vision, dental and hearing screenings), and that Medicaid covers medically-necessary treatments for any problems that these health screenings identify.⁹

Linking Medicaid coverage of low-income newborns to coverage of their births has a significant impact on the nation’s ability to ensure that babies from poor families get a healthy start. If new mothers are required to file an application and provide documentation (both of citizenship as well as income and other eligibility requirements) before an infant can receive health care coverage, then coverage of vulnerable babies will be delayed. Moreover, in situations in which an application is never filed, coverage during the critical first year of life may never be obtained.¹⁰

The CMS Policy Reversal

Until recently, CMS correctly recognized that under the law, automatic eligibility for newborns is not dependent upon whether or not the mother herself was eligible for full Medicaid services. Accordingly, CMS had instructed states that they must provide up to a year of automatic eligibility to all infants born to mothers on Medicaid, regardless of the mother’s immigration status or the scope of the services that she is eligible to receive.¹¹

⁶ See, e.g., Broyles, R. Sue et al., “Comprehensive Follow-up Care and Life-Threatening Illnesses Among High-Risk Infants,” *Journal of the American Medical Association*, Vol. 284, No. 16 (October 25, 2000).

⁷ See Paul J. Chung, et al., “Preventive Care for Children in the United States: Qualify and Barriers,” Commonwealth Fund (August 2006) (available at http://www.cmf.org/usr_doc/949_Chung_preventive_care_children.pdf).

⁸ Figures are based on data from 2003. See “Health Coverage for Low-Income Children,” Kaiser Commission on Medicaid and the Uninsured (September 2004), available at <http://www.kff.org/uninsured/2144-04.cfm>.

⁹ Section 1905(r) of the Act. For a good discussion of EPSDT, see “Early and Periodic Screening, Diagnostic, and Treatment Services,” Kaiser Commission on Medicaid and the Uninsured (October 2005) available at <http://www.kff.org/medicaid/7397.cfm>.

¹⁰ Although receipt of Medicaid benefits, let alone receipt of Medicaid benefits by one’s child, does not provide grounds for deportation, many undocumented immigrants understandably may fear that applying for public benefits on behalf of their children could lead to deportation. Therefore, the possibility that no application will be filed for the citizen babies of undocumented parents is of particular concern.

¹¹ Memo, letter and e-mails from CMS Central Office and Region IX on file at the Center on Budget and Policy Priorities.

CMS reversed this policy on July 12, 2006, when it published interim final regulations implementing a provision of the Deficit Reduction Act of 2005 (DRA).¹² That provision requires that all U.S. citizens applying for, or renewing their eligibility for, Medicaid coverage document their citizenship. In the preamble to the regulations, CMS correctly noted that babies born to mothers receiving Medicaid at the time of their birth are automatically eligible for Medicaid for one year without filing an application. Because an application is not required, no documentation of citizenship is necessary during the first year of coverage. Without citing any authority, however, CMS went on to assert that babies born to legal pregnant immigrants who have been in the country for less than 5 years and babies born to undocumented immigrants would *not* receive automatic coverage, even though their births also were covered by Medicaid.¹³

As a result of CMS's policy reversal, the families of these babies will now have to file an application, along with documentation of various eligibility requirements, such as family income, and submit proof of the child's citizenship and identity. The infants will be left without coverage unless and until the application process is completed.

According to recent press reports, CMS maintains that its reversal of policy is based on the new citizenship documentation requirements in the Deficit Reduction Act. CMS Acting Administrator Leslie Norwalk stated that the agency's policy "reflects what the new law says in terms of eligibility." She said that "When emergency Medicaid pays for a birth, the child is not automatically deemed eligible. But the child could apply and could qualify for Medicaid because of the family's poverty status."¹⁴

The claim that the DRA requires the policy reversal is, however, not correct. Nothing in the DRA changes the provision of law enacted in 1984 requiring that one year of automatic coverage — without submission of an application — be provided to newborns whose births are covered by Medicaid, and nothing in the DRA affects which babies are eligible for the automatic coverage.

The DRA simply requires that U.S. citizens who are applying for or receiving Medicaid must provide proof of citizenship. In the July 12 interim final rule, CMS determined that citizens applying for Medicaid after implementation of the DRA must provide proof of citizenship as part of the application process. CMS determined that current Medicaid beneficiaries, whose eligibility must be periodically recertified by the state Medicaid program at regularly-scheduled "eligibility redeterminations," must provide the requisite documentation at their next such redetermination.¹⁵

How do the new requirements contained in the DRA relate to automatic coverage of newborns? In the preamble to the July 12 rule, CMS acknowledges that, under federal law, babies born to mothers who are receiving regular Medicaid coverage (as distinguished from "emergency" Medicaid coverage) at the time of baby's birth receive automatic Medicaid coverage for their first year of life without first having to file an application. CMS then determined that, because of their automatic status, these babies should be treated the same as other current Medicaid beneficiaries, meaning that

¹² Interim Final Rule, Medicaid Program Citizenship Documentation Requirements, 71 *Federal Register* 39214 (July 12, 2006).

¹³ *Id.*, at 39216.

¹⁴ Robert Pear, "Immigrants Face Medicaid Hurdle for Infant Care," *New York Times* (November 3, 2006).

¹⁵ 71 *Federal Register* at 39217.

Presumptive Eligibility: Helpful in Some States but Not the Answer

The Administration has responded to criticism of its policy reversal on automatic eligibility for all babies whose births are covered by Medicaid by suggesting that states can use presumptive eligibility to ensure that newborns who are not automatically made eligible can receive Medicaid coverage while their mothers attempt to obtain the necessary documentation.* Presumptive eligibility can help mitigate the loss of coverage for some babies in some states, but it is by no means a substitute for automatic eligibility.

Presumptive eligibility allows states to provide Medicaid coverage to children when a “qualified entity” certified by the state (e.g., a health care provider) determines that the child appears to be eligible for Medicaid, based on the child’s family income. Coverage is provided for a limited period to give the child’s family an opportunity to file a Medicaid application. However, the extent to which presumptive eligibility can solve the problem created by CMS is limited because:

- Presumptive eligibility provides only temporary coverage — at most two months if no application for regular Medicaid is filed.
- Only nine states currently provide presumptive eligibility to children (a tenth state plans to do so next year).
- If a state wants to offer presumptive eligibility to children, it must do so for *all* children under age 19. A state cannot offer presumptive eligibility just for newborns. States that have not opted to offer presumptive eligibility to children are unlikely to do so simply to mitigate the problem CMS has created for newborns.
- Even in a state that has adopted presumptive eligibility for children, not all providers are certified as qualified entities. Presumptive eligibility provides no help to those babies who are not seen by a qualified entity.

* See, e.g., “CMS Official Defends Medicaid Proof-of-Citizenship for Infant Care,” *Inside CMS*, Vol. 9, No. 23 (November 16, 2006)

they would not have to provide proof of citizenship until their first regularly-scheduled eligibility redetermination at age 1.¹⁶ This ensures continued coverage to these infants for a full year, without risking a delay in coverage or the complete loss of coverage that may result if newborns are first required to submit an application and satisfy various documentation requirements and are denied coverage until the paperwork is complete and their application has been approved.

Until the recent policy reversal, the treatment of babies born to mothers eligible for emergency Medicaid services was no different than the treatment of babies born to mothers eligible for full Medicaid services. In neither case was coverage for a poor baby denied during the child’s first year, and in neither case was the mother required to file an application for her baby or to provide any documentation until the baby’s first birthday. Nothing in the DRA authorizes CMS to abandon the equal treatment afforded to all babies whose birth was covered by Medicaid or to make the distinction CMS now seeks to enforce.¹⁷

¹⁶ *Id.*, at 39216.

¹⁷ Indeed, the United States Court of Appeals for the Second Circuit held that to construe the statute so as to treat the citizen babies of undocumented pregnant women differently than the babies of citizen mothers would violate the babies’ constitutional right to equal protection under the law. *Linda Lewis et al. v. Tommy G. Thompson*, 252 F.3d 567 (2nd Cir. May 22, 2001).

Burden of Erroneous Policy Falls Squarely on States, Providers, and Citizen Babies

While the legal basis for CMS' change in policy is dubious, the impact is clear. Many babies, all of whom are U.S. citizens, may fail to get needed preventive and well-baby care because they have no Medicaid coverage and their parents cannot afford the services. Others may go without critical services for acute or chronic conditions.

Some hospitals are already reporting that they have been unable to discharge some newborns with special needs because lack of coverage has prevented the hospital from arranging home care and other necessary follow-up services.¹⁸ Without payment from Medicaid, these hospitals are left to absorb the high costs of caring for these babies and the babies are kept unnecessarily in the hospital. Many babies who are discharged also may never get care they need, as their mothers may be too fearful or overwhelmed to submit a Medicaid application.¹⁹ Coverage of still other infants may be needlessly delayed, as mothers wait for the baby's birth certificate or other proof of citizenship to become available and for the state to make a decision that the baby is eligible. Furthermore, states, while "relieved" of paying for Medicaid services in the period following a child's birth, may end up

Three-Month Retroactive Coverage: Not a Substitute for Automatic Eligibility

The Administration argues that its new policy denying automatic eligibility to certain babies whose births are paid for by Medicaid will not harm providers because of Medicaid's three-month retroactive coverage.* Under current law, Medicaid pays for covered services that were received by a Medicaid beneficiary during the three month period prior to the month in which the individual applied for Medicaid, provided that the individual would have satisfied the eligibility requirements during the retroactive period, had an application been filed at that time. While this retroactive coverage may result in payment to some providers, it is not an effective substitute for automatic eligibility. Specifically:

- The possibility of retroactive coverage is of no help to low-income mothers who must pay out of pocket for prescription drugs or physician services at the time that care is provided.
- Hospitals, clinics, physicians, and pharmacies have no guarantee at the time they are asked to provide care to a baby that the mother will complete the Medicaid application and satisfy all the documentation requirements.
- Given the uncertainty that a baby ultimately will be determined eligible for Medicaid, some providers will be reluctant to furnish care because of a concern that three-month retroactive coverage will never occur and they will not be paid. The concern about nonpayment will be particularly acute for providers serving sick babies in need of extensive, costly care.

* See, e.g., "CMS Official Defends Medicaid Proof-of-Citizenship for Infant Care," *Inside CMS*, Vol. 9, No. 23 (November 16, 2006)

¹⁸ See letter from American Academy of Family Physicians et al. to Mark B. McClellan, October 12, 2006.

¹⁹ See, e.g., Bauer, Tamar et al., "Challenges Associated with Applying for Health Insurance Among Latina Mothers in California, Florida and New York," *The New York Forum for Child Health*, The New York Academy of Medicine (December 2002), available at <http://www.nyam.org/initiatives/docs/Challenges%201%20-%20longer%20report.pdf>.

paying more later for babies who subsequently face more complicated and expensive medical conditions as a consequence of not receiving needed care early on. The result is likely to be poorer health outcomes for the affected infants, as well as increased financial burdens on hospitals, health care providers, and the states.