

Medicaid's Role in Treating Children in Military Families

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Executive Summary

This analysis examines Medicaid's role in meeting the health care needs of children in military families who receive their health insurance coverage through TRICARE. TRICARE is the Department of Defense's worldwide health insurance program for active duty and retired military service members and their families. The 2000-2002 National Survey of Children with Special Health Care Needs, as well as a series of semi-structured telephone interviews, were used to assess Medicaid's role as a supplemental insurer for military children with special health care needs (CSHCN).

Data show that Medicaid covers one in 12 military children and one in 9 military children with special health care needs. When compared to military children without Medicaid coverage, military children with Medicaid are more likely to be nonwhite and twice as likely to have low family incomes, a finding consistent with Medicaid's financial eligibility rules. For military children with no serious health problems, TRICARE would meet most preventive and routine needs. But for children with special needs, TRICARE's limitations, similar to those found in a commercial employee health benefit plan, could lead to significant under-insured status requiring supplemental coverage and/or significant out-of-pocket costs for military service members.

Among the 14 percent of all military children who have a special health care need, 11 percent with TRICARE coverage are also covered by Medicaid. In addition, military CSHCN are more likely than privately insured civilian CSHCN to have Medicaid (one in 9 versus one in 11). Among military CSHCN who are enrolled in Medicaid, 49 percent have low family incomes and 31 percent are nonwhite.

Military CSHCN on Medicaid are almost five times more likely than those not also enrolled Medicaid to have fluctuating and changing needs (a measure of special need) and ten times more likely to receive Supplemental Security Income. The average severity rank of CSHCN on Medicaid also exceeds the level of severity reported for military CSHCN without Medicaid (6 vs. 4 on a ten-point scale). Military CHSCN are also more likely to receive services through Title V maternal and child health agencies than their non-military counterparts.

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Medicaid coverage is critical to military CSHCN. However, compared to their counterparts who do not receive Medicaid, military CSHCN who are enrolled in Medicaid are less likely to receive the care they need, particularly mental health services.

The semi-structured interviews with military health system personnel suggest that the military health system views Medicaid as an important supplement to TRICARE. Personnel actively assists families with CSHCN to apply for help. The interviews also underscore that despite the value of Medicaid, military CSHCN are likely to face the same barriers that commonly confront other Medicaid-enrolled children, particularly in the case of children with mental and behavioral health problems, for whom specialty care can be in critically short supply.

TRICARE's new Extended Care Health Option (ECHO) program, initiated in September 2005, may reduce reliance on Medicaid among lower income military CSHCN. However, despite the implementation of ECHO, which supplements TRICARE basic benefits for qualifying special needs children of active duty service members, ECHO contains limitations that would not apply to children covered by Medicaid. Specifically, ECHO applies only to certain conditions, contains significant coverage limits, caps annual spending at \$30,000 per recipient, and contains substantial cost sharing requirements.

As with CSHCN generally, military CSHCN have substantial need for supplemental and enriched health coverage. To a significant degree not well understood, Medicaid plays such a role, although its capacity to mitigate need in the case of military children may be lessened by the state-to-state mobility, interstate variations in coverage and health care resources, and residential isolation on military bases located outside of metropolitan regions.

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Introduction

This analysis, supported by a grant from the Robert Wood Johnson Foundation's "Changes in Health Care Financing and Organization (HCFO)" program, examines Medicaid's role in financing health care for children whose parents are members of the military, and who derive health insurance coverage through the military health system.

Although more than 25 million children are covered by Medicaid and the State Children's Health Insurance Program (SCHIP),¹ relatively little research has focused on Medicaid's role as a supplemental insurer for children enrolled in a primary health benefits plan (such as one offered to civilian or military employees), whose coverage is insufficient in relation to their need for health care. One of Medicaid's most notable strengths is its capacity to supplement – or wrap around -- primary health insurance through a coordination of benefits mechanism. This ability to wrap around primary coverage is not a feature of SCHIP programs in states that have elected to establish separately administered SCHIP plans. Thus, this inquiry is limited to Medicaid. Children with both primary insurance and Medicaid coverage can be considered "dual enrollees," much the same way that low-income Medicare beneficiaries can receive supplemental coverage through Medicaid. As with Medicare, Medicaid operates as a secondary payer in these situations, covering services and benefits not available through the primary insurer but falling within Medicaid's scope.²

An earlier paper in this series examined the roots in "military preparedness" of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, Medicaid's comprehensive child health benefit.³ This paper illustrates another dimension of EPSDT, as a program that aids military families whose children have significant health care needs. This analysis considers Medicaid's role in the lives of military children generally, and in particular, military children with special health care needs.

Following a background and overview, we present findings from our analysis of federal data on Medicaid's role as a supplemental insurer for military children with special needs, as well as the results of our research into the actual experiences of military CSHCN in four communities with military bases. We conclude with a discussion of the implications of our findings for better understanding Medicaid's role as a supplemental insurer for military children with special health care needs.

¹ Congressional Budget Office (2004). "Fact Sheet for CBO's March 2004 Baseline: Medicaid and the State Children's Health Insurance Program." Available at: <http://www.cbo.gov/factsheets/2004b/Medicaid.pdf>.

² With TRICARE, the military health insurance system, TRICARE is normally the secondary payer for enrollees that have other health insurance such as Medicare or civilian private sector insurance. In the case of Medicaid, however, TRICARE is the primary payer for TRICARE covered benefits that are also covered by Medicaid. If not a TRICARE covered benefit, Medicaid is responsible for reimbursement at prevailing Medicaid rates.

³ Rosenbaum, S., Mauery, D.R., Shin, P., and Hidalgo, J. National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT (The George Washington University School of Public Health and Health Services, Department of Health Policy, Washington D.C. April 2005.) http://www.gwumc.edu/sphhs/healthpolicy/new_publications.html (Accessed September 11, 2005)

Background and Overview

Unlike the State Children's Health Insurance Program, whose anti-crowd-out provisions prevent separately administered SCHIP plans from operating as supplemental insurers for children with special needs,⁴ federal Medicaid policies permit Medicaid to operate in a supplementary role, with coordination of benefits between the primary insurer and Medicaid. TRICARE, the insurance system for military families, offers commercial coverage similar in structure and scope to the products and services offered to the civilian employed population. Through its third party liability recovery provisions, Medicaid thus can be coordinated with TRICARE in cases in which the needs of a Medicaid-eligible family member exceed the limits of TRICARE coverage.

Medicaid's role as a supplemental insurer is especially important for children with special health care needs (CSHCN). Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program covers all covered children for care and services that may extend well beyond the reach of private health insurance. Figure 1 shows EPSDT's reach across Medicaid-enrolled children. Figure 2 shows the range of EPSDT services. Figure 3 shows how, as a result of EPSDT, children's Medicaid coverage differs fundamentally from that of children who rely on commercial insurance (including separately administered SCHIP plans in most states).⁵

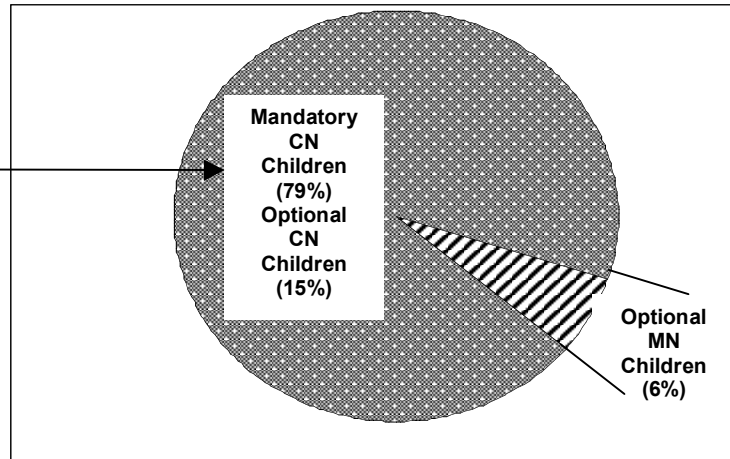
⁴ Rosenbaum, S., Markus A.R., and Sonosky, C. .Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP. *The Journal of Health and Biomedical Law*. March 2005. A link can be found at http://www.gwumc.edu/sphhs/healthpolicy/new_publications.html

⁵ Id.

Children's Enrollment in Medicaid as "Mandatory" and "Optional" Groups, 2001

Total = 24.7 million children

- EPSDT is required for all categorically needy (CN) children – 94% of all Medicaid children
- EPSDT is optional for medically needy (MN) children – 6% of all Medicaid children



Source: Sommers A., Ghosh A., & Rousseau D. *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*. Kaiser Family Foundation. June 2005.

Figure 1. EPSDT Requirements Across Medicaid Eligibility Groups, 2001⁶

⁶ Source: Rosenbaum, S. *Medicaid EPSDT Benefits: Their Role in Child Health and Development*. Alliance for Health Reform, September 9, 2005.

Figure 2. EPSDT Benefits

MEDICAL	
Periodic and “as needed” screening services that include: <ul style="list-style-type: none"> • Unclothed physical examination • Comprehensive health and Developmental history (including assessment of both physical and mental health development) • Immunizations recommended by the CDC advisory committee on immunization practices (ACIP) • Health education and anticipatory guidance 	
Vision Services (assessment, diagnosis and treatment, including eyeglasses)	
Hearing Services (assessment, diagnosis and treatment, including hearing aids and speech therapy)	
Dental Services (preventative, restorative, and emergency care beginning not later than age 3 or earlier if medically indicated)	
Necessary healthcare diagnosis services, treatment and other measures classified as medical assistance to correct or ameliorate defects and physical and mental health conditions discovered by screening services, <i>whether or not such services are covered under the state medical assistance plan.</i> These services include: <ul style="list-style-type: none"> • Physician services • Hospital Services (outpatient and inpatient) • Federal qualified health center services • Rural health clinic services • Family planning services and supplies • Medical care or any other type of remedial care recognized under state law or furnished by licensed practitioners within the scope of their practice; as defined by state law • Home based care • Private duty nursing services • Dental services • Clinic services • Physical therapy and related services • Prescribed drugs • Dentures • Prosthetic devices • Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21 • Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law • Case management • Respiratory care • Personal care services • Any other medical or remedial care recognized by the Secretary of Health and Human Services 	
“Preventive” standard of medical necessity: recognized in agency implementing guidelines and a long line of judicial decisions, which recognizes the prevention of disabilities as the standard of coverage and emphasizes attainment of growth and development.	
ADMINISTRATIVE	
<ul style="list-style-type: none"> • Effective informing of eligible children • Transportation, scheduling and other assistance in securing covered services and assistance in securing uncovered services, particularly services offered by state WIC programs and Title V agencies for families who want them • Reporting 	

Source: Centers for Medicare and Medicaid Services. (2005). “Medicaid and EPSDT.” Available at: <http://www.cms.hhs.gov/medicaid/epsdt/default.asp>. Accessed September 26, 2005.

Figure 3. How EPSDT Differs from Private Health Insurance and SCHIP⁷

EPSDT	Private Health Insurance/SCHIP
<ul style="list-style-type: none"> ▪ Detailed screens to assess growth and development ▪ Vision, dental and hearing required ▪ Detailed diagnosis and treatment services ▪ “Preventive” standard of medical necessity ▪ Cost-sharing prohibited (< age 18) 	<ul style="list-style-type: none"> ▪ “Well-child” care ▪ Vision, dental and hearing optional ▪ “Actuarial” benefit design, with limitations and exclusions permitted ▪ Insurer-designed medical necessity definitions ▪ Cost-sharing permitted within limits

According to the 2000-2002 National Survey of Children with Special Health Care Needs conducted by the National Center for Health Statistics of the U.S. Centers for Disease Control and Prevention, approximately 14 percent of all children can be considered as having special health care needs.⁸ For purposes of this analysis we use the Survey definition: “Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”⁹ Children with special health care needs use (or may be in a position to need) higher levels of services such as expensive therapies, extended medical and prescription drug treatment for serious physical and mental health conditions, specialized medical equipment, special nursing services, medical case management, and family support services (such as transportation and respite care).

An August 2004 article published in the journal *Pediatrics* presented for the first time national estimates of the prevalence of special health care needs among children of military families. Williams, Schone, et al (2004) conducted analyses of existing military health survey databases, a

⁷ Source: Rosenbaum, S. *Medicaid EPSDT Benefits: Their Role in Child Health and Development*. Alliance for Health Reform, September 9, 2005.

⁸ Blumberg SJ, Olson L, Frankel M, et al. “Design and operation of the National Survey of Children with Special Health Care Needs, 2001.” National Center for Health Statistics. *Vital Health Stat* 1(41). 2003. Available at: http://www.cdc.gov/nchs/data/series/sr_01/sr01_041.pdf.

⁹ *Ibid*, page 2. In addition to questions on ability to do things other children can do, the Survey also asks parents whether the child needs or uses the following: more medical care, mental health, or educational services than is usual for most children; medicine prescribed by a doctor; special therapy; or treatment for an emotional, developmental, or behavioral problem.

special survey of child health care needs, and administrative claims data.¹⁰ There are approximately two million children covered by the military health system. Approximately 60 percent of these children (1.2 million) are enrolled in TRICARE Prime, an HMO-type option (described in further detail in the next section). The authors found that approximately 23 percent of the 1.2 million children enrolled in TRICARE Prime have conditions commonly identified as special health care needs.

For children with no serious health problems, TRICARE coverage would meet most preventive and routine needs. But for children with special health care needs, TRICARE's limitations, which are similar to those found in a commercial employee health benefit plan, could lead to significant under-insurance and a need for supplemental coverage in order to avert significant out-of-pocket financial exposure and risk of underservice. In recent years, the limited ability of the military health care system to meet the needs of persons with disabilities and CSHCN has been the subject of growing attention. For example, in 2001, the GAO reviewed existing military disability programs and found that these programs needed substantial improvements to better track program expenditures, to assess the effects of various service and cost limits on enrollee access, and to measure the cost-effectiveness of services as related to improved health outcomes.¹¹ Results from the most recent Department of Defense "Health Care Survey of DoD Beneficiaries" revealed that, compared to children without special health care needs, military families with CSHCN encountered more problems obtaining services (e.g., prescription medicines, special medical equipment, special therapy, counseling services), as well as delays obtaining authorizations for services, locating health plan information, and adequate customer service.¹²

Anecdotal reports of military families encountering obstacles in obtaining adequate care for their disabled/special needs children have surfaced over the past number of years. Of particular concern for families who supplemented TRICARE coverage with Medicaid has been fragmentation of, and sometimes loss of, needed health care services as a result of transfers from one state to another, because of interstate variations in coverage and health care resources.¹³ Medicaid enrollment and coverage barriers arising from interstate movement have long been a problem for low-income populations such as migrant laborers, and the catastrophic consequences of Hurricane Katrina have served to underscore the problems for low-income, Medicaid-eligible populations whose need for health care crosses state lines. In addition, in recent years military families have reported that changes in TRICARE regional contractors also can lead to additional disruptions in care that further complicate the access problems that arise from interstate movement.¹⁴

¹⁰ Williams TV, Schone EM, Archibald ND, Thompson JW (2004). A national assessment of children with special health care needs: Prevalence of special needs and use of health care services among children in the military health system. *Pediatrics*. 114(2):384-393.

¹¹ General Accounting Office (2001). "Defense Health Care: Disability Programs Need Improvement and Face Challenges." Report Number GAO-02-73.

¹² U.S. Department of Defense, TRICARE, Health Program Analysis & Evaluation Directorate (2005). "HCSDB Issue Brief: Experiences of Children with Special Health Care Needs in TRICARE." Available at: http://www.tricare.osd.mil/survey/hcsurvey/childIssueBriefJan27_rev.pdf. Accessed September 2, 2005.

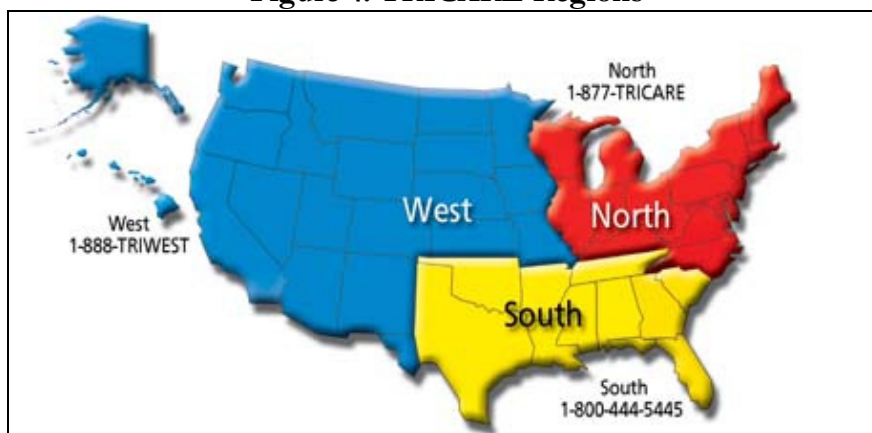
¹³ Freedberg, S.J. (2001). "Military Health Care Plan Fails Families with Disabled Children." *National Journal*. Available at: <http://www.govexec.com>. Accessed June 1, 2005.

¹⁴ Klamper, A. (2005). "Panel Investigates Military Family TRICARE Complaints." *CongressDaily*. Available at: <http://www.govexec.com>. Accessed June 1, 2005.

Brief Overview of TRICARE

TRICARE is the Department of Defense's worldwide health care program for active duty and retired military service members and their families. TRICARE operations are overseen by the TRICARE Management Activity unit headquartered in Falls Church, Virginia, and Aurora, Colorado. As shown in Figure 4, the United States is divided into three regions, each of which has a single contracted managed care plan for benefits administration: HealthNet Federal Services in the North, Humana Military Healthcare Services in the South, and TriWest Healthcare Alliance in the West. Benefits and coverage standards are the same across the country.

Figure 4. TRICARE Regions



Source: <http://www.osd.mil>.

TRICARE eligibility and enrollment functions are handled through the centralized Defense Enrollment Eligibility Reporting System (DEERS). This database contains the names, addresses, and plan enrollment information for each TRICARE member. Active duty service members are automatically entered into DEERS when they join the military; however each service member must take action to register his or her family members and ensure they are correctly entered into the database. In addition, each service member is responsible for submitting updated information to the DEERS system in the event of changes that may affect TRICARE eligibility, (e.g., changes in military career status, addresses, and family status such as marriage, divorce, birth, and adoption).¹⁵

For active duty service members and retired service members under age 65, there are three health insurance options available: TRICARE Prime, TRICARE Extra, and TRICARE Standard. TRICARE for Life is the program designed for retired service members ages 65 and older. For the purposes of this report, we focus on the options available to those active military service members under age 65, since they are more likely to have families with dependent children.

TRICARE Prime is a voluntary health maintenance organization (HMO)-type option that also includes a point-of-service (POS) option. All active duty service members must enroll in Prime. Enrollment of their family members is optional and current enrollment statistics show that 80 percent of family members are enrolled in Prime. Under the terms of the HMO benefit, Prime

¹⁵ U.S. Department of Defense. "TRICARE Defense Enrollment Eligibility Reporting System Information." Available at: <http://www.tricare.osd.mil/deers/default.cfm>. Accessed August 29, 2005.

enrollees pay no premiums and have no deductibles or copayments. Enrollees are assigned a primary care physician who authorizes referrals to specialists within the TRICARE Prime provider network. Prime enrollees also receive priority treatment at military treatment facilities. Prime also includes a point-of-service (POS) option that allows enrollees to receive care from out-of-network providers, however the cost to enrollees can be substantial. The Prime POS annual deductible is \$300 for individuals and \$600 for a family. After the deductible is satisfied, enrollees are then responsible for 50 percent of TRICARE allowable charges for both outpatient and inpatient services. Any additional charges by non-network providers are also the responsibility of the enrollee, up to 15 percent of the allowable charge, as permitted by law. POS charges may also apply to Prime enrollees who receive care from a Prime network provider if prior authorization from the primary care provider was not obtained. Although health care services are provided at no cost to Prime enrollees who stay within the provider network, some may incur out-of-network charges. The annual catastrophic cap for out-of-pocket expenses is \$3,000.

TRICARE Extra is a preferred-provider (PPO) type of organization and is available to family members of active duty service members. Enrollees are not assigned a primary care provider and may obtain care from any TRICARE Extra network provider. The annual deductible is \$150 for individuals and \$300 for a family for military rank E-5 and above, and \$50 for individuals and \$100 for a family for military rank E-4 and below. Enrollee cost-sharing is 15 percent of the negotiated network fee for outpatient care and the greater of \$25 or \$13.32 per day for inpatient care. The co-payment for inpatient mental health admission is \$20 per day. The annual catastrophic cap for out-of-pocket costs is \$1,000.

TRICARE Standard is the program formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and is available to family members of active duty service members. The annual deductibles and daily inpatient cost-share amounts are the same as for TRICARE Extra; however, the cost-share for outpatient care is 20 percent of the negotiated fee. Enrollees may seek care at military treatment facilities on a space-available basis and from providers who have been authorized as TRICARE providers. Providers that are not TRICARE certified participating providers are allowed to charge up to 15 percent more than the TRICARE allowable charge and enrollees are responsible for paying the difference to the provider. All services must meet medical necessity criteria and be provided at an “appropriate level of care.” The annual catastrophic cap for out-of-pocket costs is \$1,000.¹⁶

TRICARE Benefits for Children and Persons with Disabilities and Special Health Care Needs

The TRICARE basic benefit package includes a well-baby and well-child care benefit modeled after the basic SCHIP requirements for children, which themselves reflect commercial plan customs. The benefit includes routine newborn care, health supervision examinations, routine immunizations, periodic health screenings, and developmental assessments delivered in accordance with the American Academy of Pediatrics guidelines. In addition, testing for tuberculosis and elevated blood lead levels is included. However, with the exception of immunizations, which are covered for children over age 6, the TRICARE well-child benefit is limited to children from birth to

¹⁶ U.S. Department of Defense. “TRICARE Handbook.” Available at: http://www.tricare.osd.mil/TricareHandbook/Show_all.cfm. Accessed August 1, 2005.

age 6.¹⁷ This age limit in the TRICARE well-child benefit is markedly different from EPSDT, which covers children, adolescents, and young adults up to age 21. Notably, the TRICARE well-child benefit includes “additional services or visits that may be required because of specific findings,” thus allowing a clinician to order a medically necessary service not otherwise covered. Cost-sharing is required for persons enrolled in TRICARE Extra or TRICARE Standard.¹⁸

Services for children and adults with disabilities and special health care needs are limited under the TRICARE basic benefit package and subject to pre-authorization requirements. Durable medical equipment such as wheel chairs, hospital beds, respirators, and hearing aids¹⁹ are covered. Long-term care and custodial care (assistance with daily living) are not covered, but coverage is available for skilled nursing visits in the home. Residential treatment centers for children with serious mental disorders are available for up to 150 days per year. Individual case management services are provided for catastrophically ill or injured persons with extraordinary medical or psychological disorders and waivers can be sought to exceed benefit limits for services or supplies such as home health care, medical supplies, back-up durable medical equipment, extended skilled nursing care, and home health aides.²⁰

Special services have been available for military family members with special needs for many decades, but these services have proven inadequate. As of September 1, 2005, the 40-year-old “Program for Persons with Disabilities” (PFPWD) was replaced by an enhanced program known as the “Extended Care Health Option” (ECHO). This program supplements TRICARE basic benefits for qualifying disabled or special needs family members of active duty service members.²¹

To qualify for the TRICARE ECHO program, a family member must have: 1) “moderate or severe mental retardation; or 2) a serious physical disability; or 3) an extraordinary physical or psychological condition of such complexity that the beneficiary is homebound.”²² This third qualifying condition is an expansion over what the former PFPWD considered as qualifying for the program. Active duty service members who have a disabled or special needs family member must register with their local Exceptional Family Member Program (EFMP), which provides enrollee assistance in ensuring that military families are located in geographic areas where their needs can be

¹⁷ TRICARE Standard also covers other types of medical care for the child, as it would for any eligible person. For children age 6 and over (indeed, for all dependents), immunizations are also covered, and can be provided independently of other preventive services. *Source:* U.S. Department of Defense. “TRICARE Handbook.” Available at: http://www.tricare.osd.mil/TricareHandbook/Show_all.cfm. Accessed August 1, 2005.

¹⁸ *Ibid.*

¹⁹ Prior to September 1, 2005, coverage for hearing aids and related services was only available to persons enrolled in TRICARE’s Program for Persons with Disabilities. It is now offered as a benefit for all TRICARE enrollees. The criterion for a child qualifying for this coverage is 26dB HL or greater hearing threshold level in one or both ears when tested in the in one of the following frequency ranges: 500, 1,000, 2,000, 3,000 or 4,000 Hz. *Source:* U.S. Department of Defense Press Release. August 18, 2005. “Hearing Aids Now Available for Active Duty Family Members through TRICARE.” Available at: <http://www.tricare.osd.il/news/2005/news0523.cfm>. Accessed August 31, 2005.

²⁰ *Ibid.*

²¹ Federal regulations governing ECHO are Title 32, Part 199.5, “National Defense Civilian Health And Medical Program of the Uniformed Services (CHAMPUS), TRICARE Extended Care Health Option (ECHO).” Available at: <http://www.tricare.osd.mil/CFR/C5.PDF>. Accessed August 12, 2005. See also, U.S. Department of Defense. “TRICARE Unveils New Extended Care Health Option (ECHO) Program.” Available at: <http://www.tricare.osd.mil/echo/default.cfm>. Accessed August 12, 2005.

²² U.S. Department of Defense. “TRICARE Extended Care Health Option (ECHO) for Certain Active Duty Family Members.” Available at: <http://www.tricare.osd.mil>. Accessed August 29, 2005.

met. Once enrolled in the EFMP, the previously described DEERS database that tracks TRICARE eligibility and enrollment is updated to indicate eligibility for ECHO benefits.

ECHO provides coverage for the following extended services not covered by the TRICARE basic benefit for qualifying beneficiaries:

- Medical and rehabilitative services
- Training to use assistive technology devices
- Special education
- Institutional care when a residential environment is required
- Transportation under certain circumstances
- Assistive services, such as those from a qualified interpreter or translator
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through home health
- In-home respite care services
- ECHO respite care (16 hours per month)
- ECHO home health care respite care – up to 40 hours per week for homebound persons.²³

TRICARE enrollees, including those in TRICARE Prime, must pay a sliding scale monthly cost-share based on military rank. This cost-share ranges from \$25 for ranks E-1 to E-5 to \$250 for rank O-10. ECHO reimburses up to \$2,500 per month per qualifying beneficiary (an increase from \$1,000 per month limit in the former PFPWD program). Monthly expenses above \$2,500 must be paid by the enrollee.²⁴ An annual cap of \$30,000 is thus imposed.

Of special note in the case of ECHO is that for five ECHO services, public facilities and services for persons with disabilities or special health care needs must be sought first to the extent that they are available and adequate before ECHO benefits are provided. Under the former PFPWD, eligible families were required to seek public sources for all PFPWD services. The specific services that ECHO enrollees must attempt to access first from public sources are:

- Training
- Rehabilitation
- Special education
- Assistive technology devices
- Institutional care in private nonprofit, public, and state institutions/facilities, and if appropriate, transportation to and from such institutions and facilities

If public sources for these services are not available or adequate, the enrollee must provide TRICARE with a letter from a “proper public official explaining why public assistance is unavailable

²³ Beneficiaries can use only one of these two respite care benefits in a given month.

²⁴ An E-1 with 2 years or less of service earns approximately \$1,235 per month. An O-10 earns \$12,433 per month. Source: U.S. Department of Defense. “Proposed Basic Pay – Effective January 1, 2005.” Available at www.dod.mil/dfas/money/milpay/pay/paytable2005-rev1.pdf. Accessed August 15, 2005.

or insufficient.”²⁵ Once a letter of unavailability or insufficiency is approved by TRICARE, ECHO benefits are provided, governed by medical appropriateness and prior authorization procedures.

ECHO appears to be an extension of previous services, but it also appears to have limitations that would not apply under Medicaid EPSDT. First, unlike Medicaid, ECHO appears designed to be condition-specific; that is, a child’s diagnosis would need to conform to one of the enumerated diagnoses in order to trigger the added benefits. In contrast, EPSDT is available to any child who meets Medicaid financial eligibility rules, for any physical or mental health condition requiring diagnosis and treatment. Furthermore, ECHO appears to require a diagnosis of considerable severity; it does not appear to be designed to trigger in the case of families whose children have mild or moderate conditions that require ameliorative interventions but nonetheless need enriched health and developmental services to avert long-term limitations.

Given the recent nature of the TRICARE expansions, it will take some time to understand its impact if any on the use of Medicaid benefits among children with special needs. In light of the limitations on coverage available through ECHO, it would appear that the military health system may continue to depend on Medicaid to reach a significant proportion of special needs children, either as a supplementary payer for basic TRICARE services, or as a further supplement to ECHO. This will be especially true for access to services for military CSHCN who do not meet ECHO’s eligibility criteria and who depend on more limited services available in the TRICARE basic benefit, as well as for access to needed intensive and wrap-around services available only from Medicaid.

Methods

We utilized two research methods to measure and evaluate Medicaid’s role for TRICARE-enrolled children with special health care needs. First, we conducted a quantitative analysis of survey data to identify the size of this population and its characteristics and needs. The data used to analyze Medicaid’s role in caring for children with special health care needs who have coverage through the military health system are derived from the 2000-2002 State and Local Area Integrated Telephone Survey (SLAITS) National Survey of Children with Special Health Care Needs (CSHCN). This special survey includes information on health care coverage status on children with and without special needs and more detailed access data on children with special needs. The survey is sponsored by the Centers for Disease Control and Prevention’s National Center for Health Statistics and uses the same sampling frame as the National Immunization Survey.²⁶ The National Survey of CSHCN involved random telephone survey of 3,000 representative households in all 50 states and the District of Columbia and a sample of at least 750 children with special health care needs in each state. Statistical tests show all differences between groups (e.g., civilian and military) are significant.

To supplement the quantitative analyses, we selected a purposive sample of four large military bases representing the Army, the Navy, and the Air Force in geographically different areas of the U.S for telephone interviews.²⁷ We believed that the large active duty service member and

²⁵ U.S. Department of Defense. “TRICARE Extended Care Health Option (ECHO) for Certain Active Duty Family Members.” *op. cit.*

²⁶ Blumberg SJ, Olson L, Frankel M, et al. “Design and operation of the National Survey of Children with Special Health Care Needs, 2001.” National Center for Health Statistics. *Vital Health Stat* 1(41). 2003. *op cit.*

²⁷ Five bases, which included a Marine Corps base, were initially selected, however the Marine base did not respond to our requests for interviews during the period of our study.

dependent populations of these bases would increase the chances that CSHCN would be among the family members served by TRICARE, ECHO, and possibly Medicaid. Two of the bases were located in the Southwest area of the U.S., one in the Southeast, and one in the Northeast. The populations of active duty service members and dependents across these bases ranged from 8,000 to over 60,000.

We conducted a series of semi-structured telephone interviews TRICARE Beneficiary Counseling and Assistance Coordinators (BCACs) at these bases. The BCAC program, mandated by Congress, is used to assist families with understanding how TRICARE works, how to navigate provider and service systems, and to help families access the full range of care they may need, including care available from public programs such as Medicaid and Title V.²⁸

The interviews consisted of nine questions designed to ascertain the extent to which bases track military CSHCN who are or who may be eligible for Medicaid; the types of conditions that may trigger a need for Medicaid; obstacles and facilitators to Medicaid access; and individual base experiences with CSHCN to inform our understanding of how the TRICARE/Medicaid interface works on a day-to-day basis for military families with special needs children. We also inquired about interviewees' thoughts on the potential effects of the new ECHO program as it may affect the need for Medicaid among military CSHCN. Qualitative analysis of the interview findings was completed by cross-referencing responses to each question to identify similarities and differences across bases.

Findings

Findings from the SLAITS Data on CSHCN with TRICARE and/or Medicaid Coverage

Military Children

The SLAITS data indicate that, during the 2000-2002 time period, an estimated two million children had some form of military health coverage (military children). Twenty-eight percent of military children came from low-income families, and 35 percent were non-white. An estimated eight percent of military children (150,476) also had supplemental Medicaid coverage during this time period. Medicaid thus covered more than one in 12 military children.

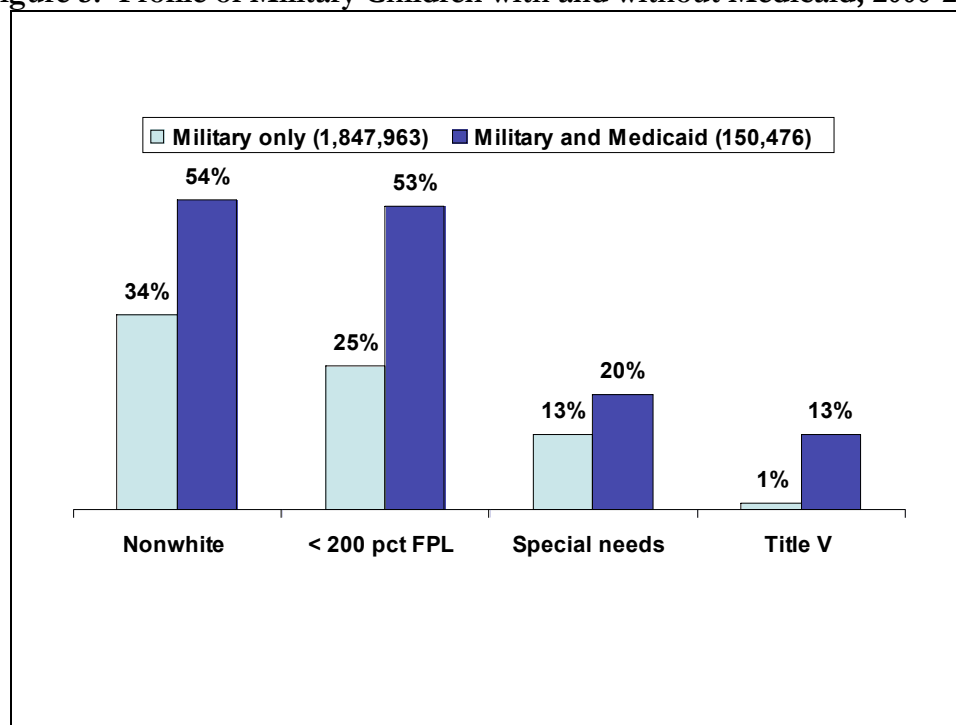
Military Children With and Without Medicaid

Children with both military coverage and Medicaid enrollment have characteristics that set them apart from military children without Medicaid coverage. Children with dual military/Medicaid coverage are more likely to be nonwhite and are twice as likely to be low-income. Figure 5 shows that 53 percent of military children with Medicaid had incomes less than 200 percent of the Federal Poverty Level (FPL) and 54 percent were nonwhite. In contrast, 25 percent of military children without Medicaid coverage had incomes less than 200 percent of FPL, and 34 percent were nonwhite.

²⁸ U.S. Department of Defense. "Beneficiary Counseling and Assistance Coordinator (BCAC) Directory." Available at: <http://www.tricare.osd.mil/bcac>. Accessed July 11, 2005.

Children with dual coverage are also more likely to have special health care needs. They also are more likely to receive additional services and supports through State Title V maternal and child health programs for children with special health care needs.²⁹ Twenty percent of military children with Medicaid coverage reported a special health care needs compared to 13 percent of those without Medicaid. Whereas 13 percent of special needs children with Medicaid received help through state Title V agencies, less than one percent of children without Medicaid received Title V services.³⁰

Figure 5. Profile of Military Children with and without Medicaid, 2000-2002



Source: National Survey of Children with Special Health Care Needs, 2000-2002

²⁹ The Title V Maternal and Child Health Services Block Grant provides federal grants to support state programs to improve the health of mothers and children and children with special health care needs. For an overview of Title V of the Social Security Act, see Association of State Maternal and Child Health Programs, "Children with Special Health Care Needs". Available at <http://www.amchp.org/policy/children-cshcn.htm>

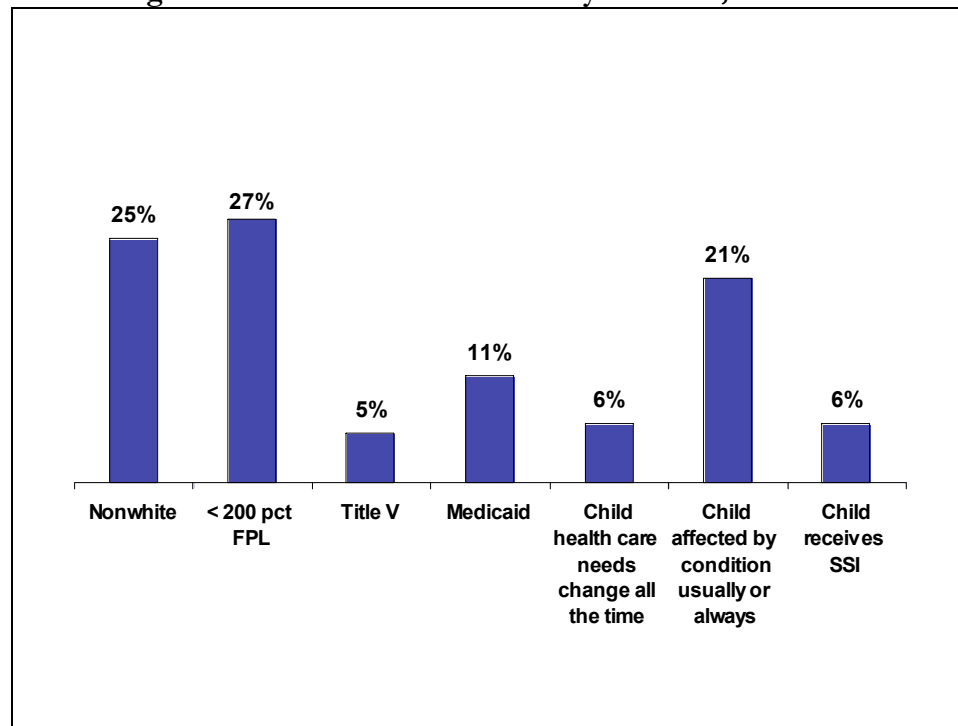
³⁰ Administered by the DHHS Health Resources and Services Administration, "Title V grants to state health agencies are used to meet locally determined needs, consistent with national health objectives. These aims include preventing death, disease and disability; assuring access to quality health care; and providing family-centered, community-based services for children with special health care needs. Additionally, funds set aside at the federal level are used to improve and support community and state service systems through training, research, special projects of regional and national significance (SPRANS) and community-integrated service systems (CISS) projects. The Title V MCH Block Grant funds programs serve over 27 million women, children, youth and families in all 50 states, the District of Columbia and eight U.S. territories. Title V programs fund public and private providers of basic preventive and primary health care, especially for uninsured, underinsured and publicly insured families." Source: Association of Maternal and Child Health Programs. Available at: <http://www.amchp.org/aboutamchp/titlev.htm>.

Military Children with Special Health Care Needs (CSHCN)

Special health care needs are prevalent among children with military health benefits. The SLAITS data show that 14 percent of all military children had a type of health condition that would result in a child's classification under program terminology as a "special needs" child. This 14 percent estimate differs from the 23 percent estimate calculated by Williams, Schone et al (2004) to the extent that it includes all military children regardless of type of military coverage rather than enrollment in TRICARE Prime alone.³¹

Figure 6 shows 27 percent of military CSHCN were low-income³² and 25 percent were nonwhite. Six percent of military CSHCN experienced constantly changing health care needs and 21 percent were frequently affected by a disabling condition. Medicaid was present among 11 percent of military CSHCN, while 5 percent also received services and supports through state Title V agencies and six percent received Supplemental Security Income (SSI) disability payments (an indicator of the severity of their conditions).

Figure 6. Characteristics of Military CSHCN, 2000-2002



Source: National Survey of Children with Special Health Care Needs, 2000-2002

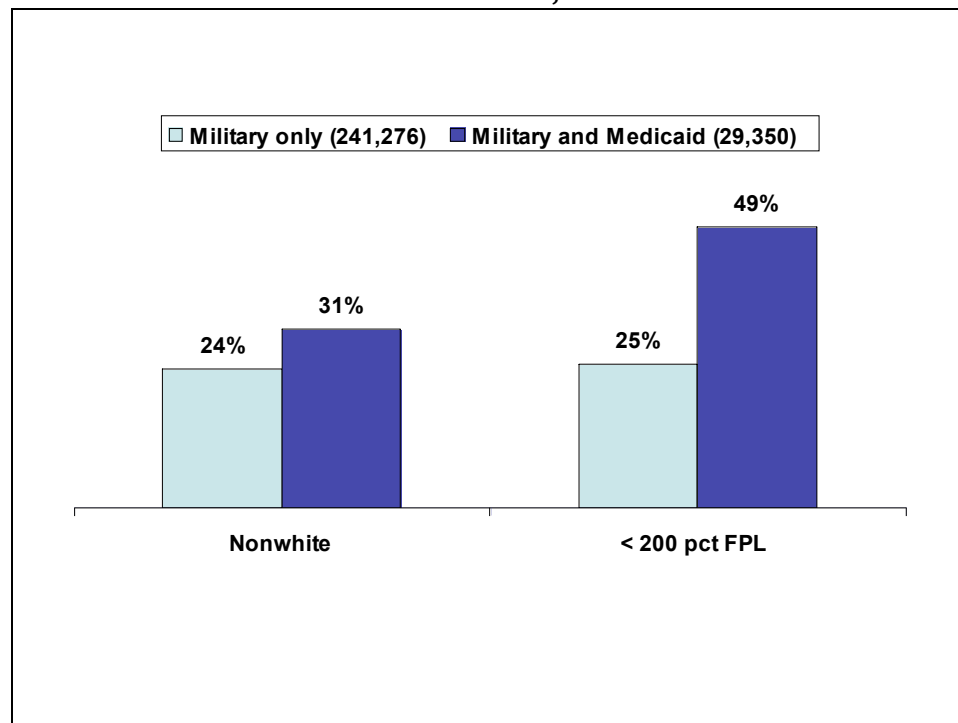
³¹ See footnote 10 for full citation..

³² Family incomes at or below 200 percent of the Federal poverty level.

Military CSHCN With and Without Medicaid

A total of 271,000 military children are considered to have a special need. Among this group, 11 percent is enrolled in Medicaid. The data indicate significant differences in the profile of military CSHCN with and without Medicaid. Figure 7 shows that 25 percent of the military CSHCN without Medicaid coverage had incomes less than 200 percent of FPL and 24 percent were nonwhite. In contrast, 49 percent of military CSHCN with Medicaid had incomes less than 200 percent of FPL and 31 percent were nonwhite.

**Figure 7. Profile of Military CSHCN
With and Without Medicaid, 2000-2002³³**

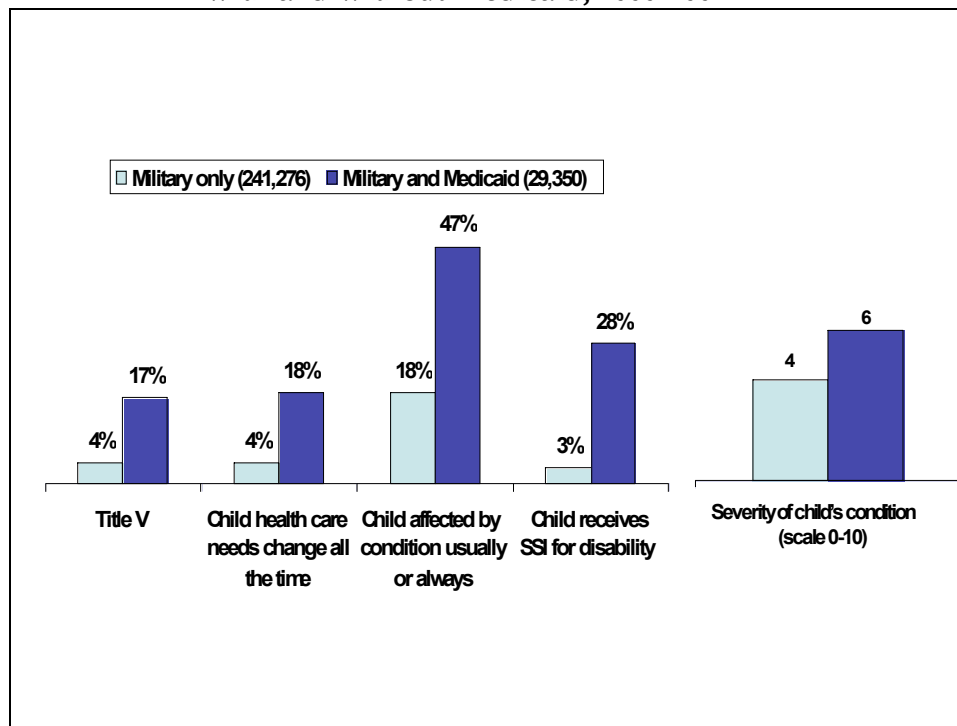


Source: National Survey of Children with Special Health Care Needs, 2000-2002

³³ The data are from the health insurance data file which includes all children with and without special needs.

Figure 8 shows Medicaid coverage is significantly associated with military CSHCN with serious and complex needs. Military CSHCN on Medicaid were almost five times more likely those without Medicaid to have needs that change all the time and ten times more likely to receive Supplemental Security Income. The average severity rank of CSHCN on Medicaid also exceeded the level of severity reported for military CSHCN without Medicaid (6 vs. 4 on a ten-point scale).

Figure 8. Health Care Needs of Military CSHCN Children With and Without Medicaid, 2000-2002



Source: National Survey of Children with Special Health Care Needs, 2000-2002

In terms of health care access and use, the literature consistently show Medicaid coverage makes a major difference for low-income children, enhancing the likelihood of having a usual source of care and addressing unmet needs.³⁴ However, the data suggest dually enrolled military CSHCN face significant barriers to care. Table 1 shows that dually enrolled CSHCN are nearly as likely as CSHCN without Medicaid to report a usual source of care and are more likely to receive care in physician offices. At the same time, dually enrolled CSHCN are far more likely to report a shortage of needed specialty services in their communities that cause them to forgo needed care, a finding that is not surprising given their greater poverty, and the greater severity of need they experience relative to military CSHCN without Medicaid. They also are more likely to report forgoing care because of a lack of transportation, financial resources to pay provider, and availability of culturally appropriate services. These barriers to care are consistent with the barriers faced by lower income children generally.

**Table 1. Measures of Access to Care
Military CSHCN With and Without Medicaid, 2000-2002**

	Military and No Medicaid (241,276)	Military and Medicaid (29,350)
Child has usual health care source	93 %	90 %
Kind of place child goes to for health care:		
Doctor's office	48 %	65 %
Clinic or health center	25 %	24 %
Emergency room	2 %	2 %
Past 12 months, child's health care delayed or foregone	7 %	15 %
Due to:		
Lack of transportation	24 %	49 %
Lack of money to pay provider	63 %	73 %
Type of care not available in the area	25 %	60 %
Language, communication, cultural problems with provider	5 %	22 %

Source: National Survey of Children with Special Health Care Needs, 2000-2002

Other access measures suggest that although Medicaid is associated with significant health care use among military CSHCN, Medicaid enrolled military children continue to experience some of the same access barriers generally found among Medicaid-enrolled children with special health care needs.³⁵ Even with the support of Title V agencies, military CSHCN with dual enrollment face health care barriers, perhaps as a result of the same factors that inhibit access among Medicaid-enrolled CSHCN generally (e.g., a shortage of health care specialty providers willing to treat

³⁴ See, for example, Institute of Medicine 2001. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academy Press.

³⁵ Newacheck, P., et al, "Access to Health Care for Children with Special Health Care Needs," *Pediatrics*, Vol. 105, No. 4, April 2000, p. 760-766 <http://pediatrics.aappublications.org/cgi/reprint/105/4/760.pdf>
Szilagyi, P. "Care of Children with Special Health Care Needs," *Future of Children*, Spring 2003, p. 137-152
http://www.futureofchildren.org/usr_doc/tfoc13-1i.pdf. Newacheck PW, Pearl M, Hughes DC, and Halfon N, "The role of Medicaid in ensuring children's access to care." *JAMA*. 1998 Nov 25;280(20):1789-93

Medicaid-enrolled children). These problems may be exacerbated by the mobility and residential isolation experienced by these children and identified by the GAO and others. For example, despite their more severe conditions, Medicaid-enrolled military CSHCN have more limited access to certain specialty services, including dental care, mental health care and home care. Table 2 shows military CSHCN with dual coverage are less likely to receive all the health care services when needed. For example, although approximately half of each group of children with and without Medicaid needed a specialist over a 12 month period, CSHCN with Medicaid were less likely to receive all needed care: 81 percent in the case of CSHCN with Medicaid versus 94 percent of CSHCN without Medicaid.

In the cases of mental health and home care, the disparity is also significant. Approximately 60 percent of CSHCN with Medicaid coverage needed mental health care but only 72 percent of those who needed care received services. In contrast, 22 percent of military CSHCN without Medicaid needed mental health care and 88 percent of those who needed the care reported receiving needed services.

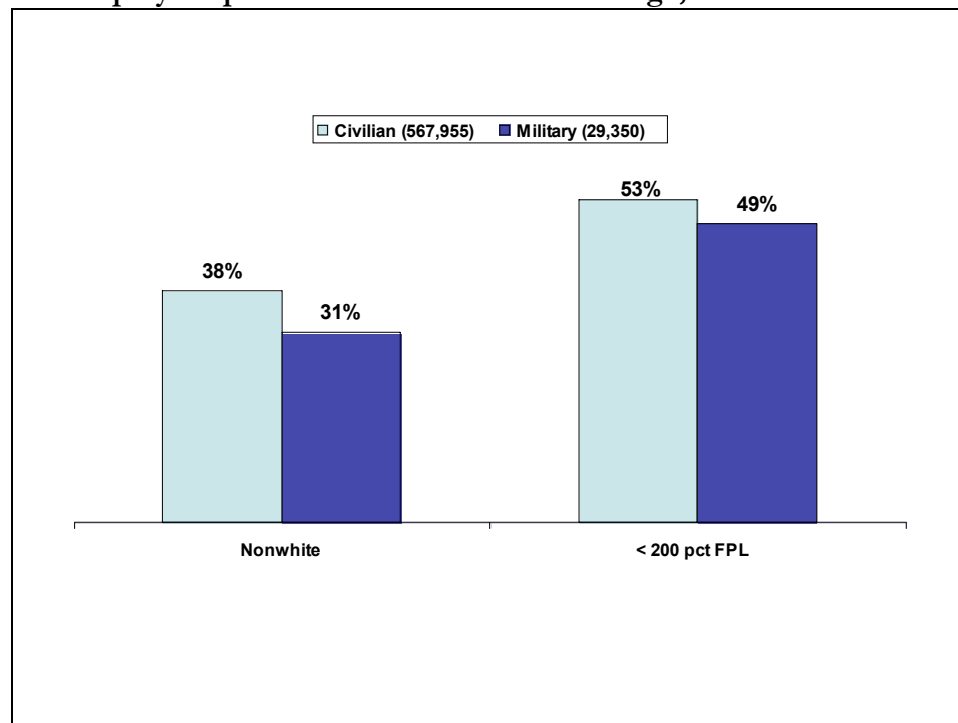
Table 2. Military CSHCN' Access to Specialty Services, 2000-2002

During past 12 months:	No Medicaid (241,276)	Medicaid (29,350)
Needed care from a specialist	50 %	48 %
Received all needed care from a specialist	94 %	81 %
Needed dental care including check-ups	82 %	85 %
Received all needed dental care including check-ups	92 %	75 %
Needed mental health care	22 %	60 %
Received all needed mental health care	88 %	72 %
Needed mental health care/counseling	9 %	35 %
Received all needed mental health care/counseling	88 %	70 %
Needed home care	3 %	15 %
Received all home care needed	96 %	86 %

Source: National Survey of Children with Special Health Care Needs, 2000-2002

As noted, 11 percent of military CSHCN had Medicaid coverage. This figure compares to a 9 percent Medicaid enrollment rate among civilian CSHCN with private health insurance coverage. Figure 9 shows significant differences in population characteristics of dually enrolled CSHCN (i.e., children who have both employment-sponsored coverage and Medicaid). Civilian CSHCN who also have Medicaid coverage are more likely to be low-income and nonwhite than military CSHCN also covered under Medicaid.

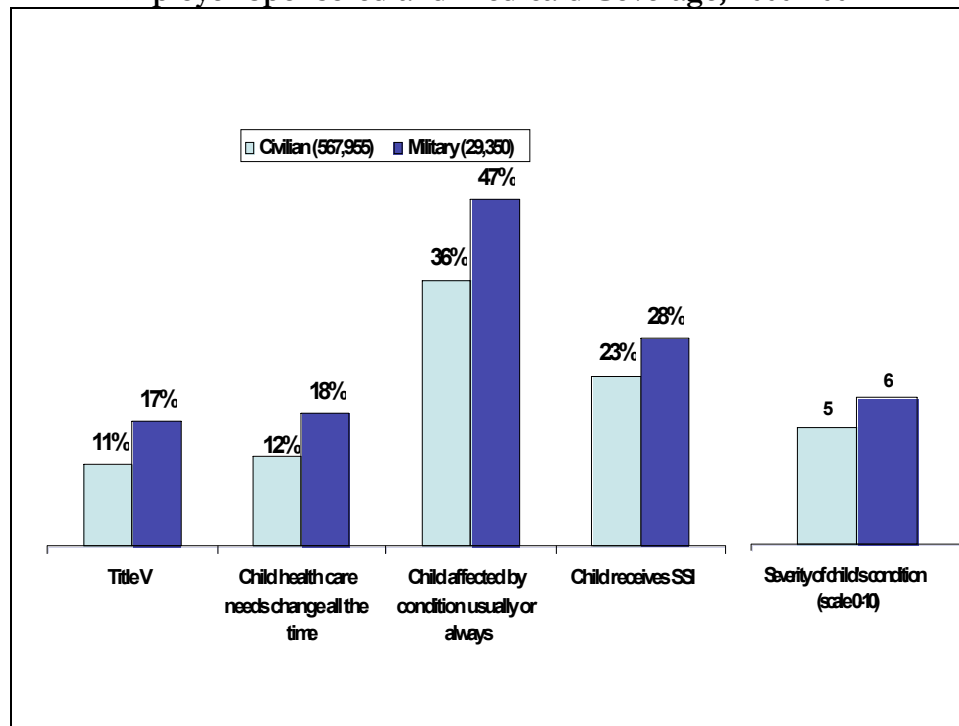
Figure 9. Military and Civilian CSHCN with Employer-Sponsored and Medicaid Coverage, 2000-2002



Source: National Survey of Children with Special Health Care Needs, 2000-2002

Civilian and military CSHCN who also are enrolled in Medicaid differ significantly as well in terms of health care needs. Figure 10 indicates military CSHCN with Medicaid coverage are more likely to experience complex and severe health problems than civilian CSHCN with Medicaid. In addition, a significantly greater proportion of military CSHCN continue to report receipt of Title V services and SSI. The average severity rank for military CSHCN on Medicaid is also significantly greater than is the case for civilian CSHCN with dual coverage.

Figure 10. Health Care Needs of Military and Civilian CSHCN with Employer-Sponsored and Medicaid Coverage, 2000-2002



Source: National Survey of Children with Special Health Care Needs, 2000-2002

TRICARE and Medicaid: The Experiences of Four U.S. Military Bases

Following selection of four military bases (described above in “Methods”), we interviewed TRICARE Beneficiary Counseling and Assistance Coordinators (BCACs) at each of the bases in our sample since these staff members interact daily on a one-on-one basis with TRICARE enrollees to assist in their understanding of, and access to, military and other health care services. At one base, we were referred to the local Medicaid office for additional clarification. Interviewees at all four bases reported that coordination of benefits and reconciliation of billing claims for enrollees dually eligible for TRICARE and Medicaid are handled by the regional TRICARE managed care contractor, e.g., HealthNet Federal Services in the North, Humana Military Healthcare Services in the South. This provides for a centralized point to ensure that benefits are coordinated and cost allocations for claims payments are appropriate between TRICARE and Medicaid, simplifying paperwork for both providers and enrollees.

Two of the four interviewees noted the important role that the military’s Exceptional Family Member Program (EFMP) plays in assisting families with CSHCN in identifying availability of, and eligibility for, services at the local level. For example, EFMP staff members work with BCACs to assist families in accessing the local social services agency to determine program eligibility and procedures for application and access to providers. The EFMP staff also reviews whether services are available in an area to which a service member is slated to be transferred; if not, the EFMP staff can recommend against the proposed transfer. Table 3 displays a summary of the responses received from interviewees at the four military bases that agreed to interviews:

Table 3. Summary of Military Bases' Answers to Interview Questions

Questions	Base #1 (Southwest U.S.)	Base #2 (Southwest U.S.)	Base #3 (Southeast U.S.)	Base #4 (Northeast U.S.)
1. Approximately how many or what percent of TRICARE families are also using Medicaid?	Anecdotal estimate: 200-300 children.	Believed? more than 90% of base families are ineligible for Medicaid	Aware of some Medicaid use at base	Stated it is ? "fairly rare"
2. What are the typical special health conditions of these children that trigger need for Medicaid?	Generally triggered by need for long-term care	None specifically identified	None specifically identified	Most often children with autism, cerebral palsy, premature infants with birth defects
3. What services does Medicaid cover/provide that aren't provided by TRICARE?	Certain long-term therapies, home health services for home-bound children with disabilities	Not identified	Some durable medical equipment	Supplemental services for speech therapy
4. Is there Medicaid outstationing on the bases? If not where can families apply?	Family must apply at Medicaid office	Family must apply at Medicaid office	Family must apply at Medicaid office	Family must apply at Medicaid office
5. What Medicaid outreach and enrollment activities does TRICARE perform for its enrollees?	None identified	Local Medicaid official visits regularly brief EFMP staff on availability of Medicaid services	Local EFMP staff assist in Medicaid enrollment	Local EFMP staff assist in Medicaid enrollment
6. How are case management activities carried out?	Primary care provider in TRICARE Prime is responsible	Primary care provider in TRICARE Prime is responsible	Primary care provider in TRICARE Prime is responsible	EFMP uses "special needs care coordinators"
7. How does coordination of benefits occur?	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor
8. How are billing mechanisms accomplished for dual eligibles?	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor	Handled by regional TRICARE contractor
9. To what extent will ECHO affect use of Medicaid by military CSHCN?	May have somewhat lower use of Medicaid since some services are covered by TRICARE/ECHO	Not sure	Not sure	ECHO covers some services and supplies not covered by Medicaid

In general, the interviewees did not identify the types of special health conditions that trigger the need for Medicaid services with the exception of one BCAC interviewee who cited three in particular: children with autism, children with cerebral palsy, and premature babies with birth defects born to mothers with high-risk pregnancies. For children with learning disabilities, TRICARE works with local early intervention programs and coordinates services with resources provided by the state or county Individuals with Disabilities Education Act (IDEA) program.

Interviewees stated that they do not track the number of families using both TRICARE and Medicaid coverage at each base. Some believed use of Medicaid services by TRICARE enrollees was rare while another recalled that approximately 200-300 children were dually eligible. Additionally, all interviewees indicated that they anticipate that the implementation of ECHO and the shift of services previously only available in the PFPWD to the TRICARE basic benefit may reduce the need for access to Medicaid, since the new program provides enhanced services (including some long-term custodial services and therapies and respite care). Further, ECHO's higher reimbursement level (\$2,500 per month) will reduce the financial impact in the form of out-of-pocket payments for families with CSHCN. One interviewee acknowledged, however, that for some services not covered by TRICARE/ECHO, access to these services via Medicaid remains highly important.

The interviews suggested that the military health system views Medicaid as an important supplement to TRICARE and actively assists families with CSHCN apply for help. The interviews also underscore that despite the value of Medicaid, military CSHCN are likely to face the types of barriers common to other Medicaid-enrolled children, particularly in the case of children with mental and behavioral health problems, for whom specialty care can be in critically short supply.

- *Assistance is available for service members to understand Medicaid and how to apply for it.* At none of the bases we interviewed does the Medicaid agency itself conduct out-stationed, on-site enrollment assistance for military CSHCN. However, a Medicaid official reported that she visits the nearby base on an annual basis to brief BCACs and other military health care staff on the availability of Medicaid and other public programs to enhance their understanding of the role Medicaid can play for those families that meet the state's Medicaid income threshold. One BCAC interviewee noted that the local EFMP staff assist service members in determining their eligibility for Medicaid and in completing Medicaid applications and associated documentation. While potentially eligible service members must go to the local Medicaid agency to submit their applications, the assistance provided by the EFMP and BCAC staff increases the chances that they will have all correct and necessary information prepared before applying for Medicaid coverage.
- *Higher income levels typically disqualify service members for Medicaid eligibility.* Interviewees noted that the single most important reason why Medicaid is not more often used is that almost all service members have incomes that are above the states' income eligibility thresholds. Having a child with high-cost intensive health care needs is not in and of itself a sufficient reason for accessing Medicaid: income is the determining eligibility factor.
- *As with the civilian sector, military CSHCN may encounter shortages of specialty providers.* TRICARE primary care providers (PCPs) authorize referrals to specialists, first within the Prime contractor's network, and if available only out-of-network, to others in the local community.

TRICARE PCPs assume responsibility for overall case management and communicate on an ongoing basis with specialists, including those provided through Medicaid. At one base, the PCPs rely on EFMP and special needs coordinators to assist in case management. While the ECHO rules state that families enrolled in the program must first attempt to access public sources for some of its covered services, it is typically the case that those sources are not available, due to public program and/or specialist provider shortages (e.g., child psychiatrists).

Conclusion

This analysis shows Medicaid's importance to children in military families, all of whom have basic health insurance coverage through TRICARE. Medicaid covers one in 12 military children, and one in 9 military children with special health care needs. Compared to civilian children with special health care needs who have private health insurance, military children are more dependent on Medicaid. Among the former group, 9 percent have Medicaid, while among the latter, the figure stands at 11 percent.

Whether compared to military children with special health care needs who are not enrolled in Medicaid, or to dually enrolled civilian children with special needs, dually enrolled military children with special needs are disproportionately low-income and minority and disproportionately burdened by severe health needs. This special sub-group of children with special needs is also far more likely to also be enrolled in Supplemental Security Income and to depend on the services of Title V agencies in addition to the supplemental health care financing assistance they receive from Medicaid.

It is also apparent from the evidence presented in this study that this special subgroup of children with special needs stands out in other respects. Compared to special needs military children who do not receive Medicaid, these children are less likely to receive the care they need, particularly in the case of mental health services. Despite significant reliance on Title V programs, these children continue to face access problems.

The findings from this analysis also suggest a clear awareness of Medicaid's importance on the part of the military health system. Although none of the sites at which we conducted interviews has outstationed Medicaid enrollment personnel located at bases, military personnel at all sites are equipped to assist families with Medicaid enrollment as well as identify other federal, state and community services important to the management and treatment of children with special health care needs. Even the ECHO program depends on the services of states and communities.

Whether ECHO reduces Medicaid's role for military children with special health care needs cannot be known for some time. ECHO is structured to offer expanded coverage for children with the most severe disabilities, and since Medicaid enrollment among military children with special needs appears to be tilted toward children with the most serious disabilities, ECHO may have a decided impact on Medicaid enrollment. On the other hand, ECHO is designed to address certain specific conditions, and coverage is subject to monthly limits as well as a \$30,000 annual dollar limits. For children with catastrophic and complex physical and/or mental conditions, out-of-pocket expenses may well exceed this \$30,000 annual cap, thus imposing a significant burden on military families, particularly those in the lower ranks with limited incomes. Furthermore, ECHO conditions coverage on the exhaustion of public resources, a hurdle that may create added barriers to coverage.

Since Medicaid contains no similar coverage limitations or exhaustion requirements, it may well continue to play a key role in health care financing for military children with special needs.

This analysis raises a series of important questions that merit additional exploration. To what extent will ECHO lessen the need for Medicaid, and how do ECHO's limitations affect its ability to compensate for the underlying limitations of TRICARE? Which children are aided by ECHO and which children continue to require the services of Medicaid? Do the barriers that confront dually enrolled military children resemble those that confront Medicaid enrolled children with special needs who are not members of military families? Does children's military status add further complexity to the location of appropriate sources of care in communities and what interventions may ease barriers to care?

Finally, this analysis underscores a less analyzed aspect of Medicaid: its capacity to supplement basic coverage for special needs children. Clearly, whether the focus is on children in the military or civilian sector, Medicaid plays an important role for children with significant health risks. This hidden side of the program merits especially close attention as an element of longer term Medicaid reform. It also suggests the importance of reconsidering existing federal SCHIP policy, which prevents under-insured children from qualifying for SCHIP in order to fund supplemental benefits.