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The Medicaid program, through its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit package, requires states to provide comprehensive preventive, acute, and chronic care services for low-income children who are eligible for Medicaid. The benefit extends to one in four children in the United States.

The promise of Medicaid's EPSDT program to benefit children and adolescents is once again being tested. Two parts of the recent federal Balanced Budget Act (BBA) of 1997 (P.L. 105-33) particularly concern EPSDT:

The BBA authorizes each state to implement a "State Children's Health Insurance Program," to provide health insurance to uninsured children and makes federal funds available to do so. States have the option of expanding their Medicaid programs (and thus extending EPSDT benefits to more children) or creating new health insurance options (in which the benefit package can be based on EPSDT). [\(1\)](#)

The BBA calls for a study of the EPSDT program to be conducted by the Secretary of HHS, in consultation with Governors, State Medicaid directors, the American Academy of Actuaries, and representatives of provider and beneficiary organizations. The legislation authorizes a broad look at EPSDT, to include an examination of the actuarial value of treatment services. The study is to be completed within a year from enactment of the BBA. [\(2\)](#)

This issue brief provides snap shots of the EPSDT benefit which help to explain why the program is a key element in providing necessary health care for low-income children. [\(3\)](#)

EPSDT Snap Shots

EPSDT benefits are comprehensive in scope and are based on the physical, mental, and developmental needs of children.

- Children's health care needs are different from adults' and require a benefit package

tailored to the needs of children. [\(4\)](#)

- Children experience many health problems that cut across physical, mental developmental, and psycho-social domains (e.g., family and neighborhood violence, drug and alcohol problems). [\(5\)](#) Thus, they require a range of services available through EPSDT to address these problems (e.g., comprehensive assessment, case management, mental health care, or rehabilitative therapies).

Poor children have the greatest need for the comprehensive EPSDT benefits but can least afford them.

- Children living in poverty are more likely than non-poor children to suffer from ill health--including vision, hearing and speech problems, dental health problems, skin lesions, elevated lead blood levels, sickle cell disease, behavioral health problems, anemia, asthma, and pneumonia. [\(6\)](#)

- Children of color are more likely to be poor, and they experience significant disparities in health status, when compared with white children. The infant mortality rate of African Americans babies exceeds that of whites; young African Americans more frequently die as a result of homicides, suicides, and accidents. Immunization rates of nonwhite, one-year-old children trails that of whites (and of children in about 70 other countries). [\(7\)](#)

- Children in foster care are particularly needy: Almost 35 percent of 1,407 children examined over a five day period had a chronic illness; 18 percent were on medication. Of children under age six, 31 percent had delayed immunizations. Physical exams showed that 92 percent had at least one abnormality. One quarter of children older than three years had vision problems; 16 percent had hearing problems. Assessments indicated that 75 percent were at risk of developing mental health problems. [\(8\)](#)

- Privately insured children live in families where the average family income is about \$50,000 a year. These families have this income available to them to purchase health care services, such as eyeglasses, hearing aids, and speech therapy, that poor families cannot afford to purchase. Poor families depend on Medicaid EPSDT.

The Medicaid program, including the EPSDT benefit, plays a critical role for children living in poverty by increasing their access to health services.

- Children on Medicaid receive preventive care services at significantly higher rates than other poor children who do not have Medicaid coverage. [\(9\)](#)
- Disabled children who are poor and uninsured have half as many ambulatory care visits as non-poor children with similar problems. But if the poor child has Medicaid, he is about as likely to use physician services as the non-poor child. [\(10\)](#)

Children are not the Medicaid program's "big ticket" items.

- Poor children *and* their parents comprise 73 percent of the Medicaid population, but account for only a third of Medicaid expenditures. According to the HHS Office of Inspector General, "Overall, the younger Medicaid patients require less care and less costly services than the aged and disabled, and very little long term care." [\(11\)](#)
- In 1995, children under age 21 represented half of the Medicaid population. Yet, expenditures for children represented only 17 percent of overall Medicaid spending. [\(12\)](#)
- In 1995, Medicaid spent an average of \$1,175 per low income child who used services and \$6,421 for children who qualified for Medicaid on the basis of disability. By contrast, spending per adult enrollee was \$1,731; for disabled adults, \$8,542; and for persons over age 65, \$9,233. [\(13\)](#)
- In a five year period when Medicaid spending more than doubled, children only accounted for one-fifth of the increase, even though they represent half the Medicaid population. [\(14\)](#)

Of the small percentage of expenditures for children, the costs are disproportionately attributable to caring for newborns--needs that can be reduced with adequate prenatal care.

- In FY 1993 (the last year for which HCFA has released national data for the EPSDT program), 56 percent of eligible children were screened through the EPSDT program, nationally. Most were healthy and did not require follow-up treatment. Of the children screened, 28.6 percent were referred for corrective treatment. Notably, nearly 70 percent of this corrective treatment was for infants and children under age six. [\(15\)](#) This percentage may reflect the increased medical needs of infants and young children born at low birth weight and with congenital problems--needs which could have been reduced with adequate prenatal care. Each additional dollar spent on prenatal care saves \$3.00 in medical care costs. [\(16\)](#)

EPSDT provides dependable federal funding for services that states are already obliged to provide to children with disabilities.

- EPSDT, through its comprehensive treatment package, has meant a dependable source of federal dollars to assist states and local hospitals that serve neonatal intensive care needs and disabled preschool and school-age children. In many instances, states and local hospitals already are obligated to provide these services under other federal, state, or local laws, such as Part H and Part B of the Individuals with Disabilities Education Act, the federal emergency room anti-dumping protections, Hill-Burton community service obligations, and local and state indigent care laws. Without the current EPSDT program, state and local governments would be forced to provide these services with solely, or increased, state and local funds.

EPSDT services are effective.

- There are few studies on the cost effectiveness of the comprehensive EPSDT benefit. This is not surprising, given the paucity of cost effectiveness studies for pediatric and adolescent medical services generally. Children have less opportunity to participate as research subjects; and public and private funding for research on medical outcomes and cost effectiveness for children's services has been quite limited. ⁽¹⁷⁾ Many of the specific services that EPSDT helps children receive have been shown to be cost-effective. Also, other factors such as the appropriateness of a benefit package to address the full range of children's needs should be used to evaluate the effectiveness of EPSDT.

- Immunizations: According to the Office of Technology Assessment, virtually all of the numerous studies on the topic conclude that immunizations are beneficial and cost effective. ⁽¹⁸⁾

Studies have shown their prevention of illness, disability, and death saves an estimated \$10 to \$14 in health care for every \$1 spent.

⁽¹⁹⁾

EPSDT helps children get these immunizations.

- Eye care: Children can develop vision loss from conditions that are not detected and treated early on. ⁽²⁰⁾ Studies, which include children and adolescents, have estimated that routine eye care would achieve annual savings exceeding \$100 million annually.

⁽²¹⁾

Children get these benefits through EPSDT. In 1995, for example, over 3 million children,

nationwide, received vision services through EPSDT.

[\(22\)](#)

- Dental care: Baby bottle tooth decay, the only serious dental problem common in children under age three, can be avoided through health education and treatment during checkups during the first years of life. Left unaddressed, the problem can cause premature tooth loss, tooth decay, infection, pain, increased risk of cavities, and even failure to thrive. [\(23\)](#) EPSDT helps children get dental care. In 1995, over 4.6 million children, nationwide, received dental care through EPSDT.

[\(24\)](#)

- Annual check ups: Accrediting organizations increasingly recognize the importance of annual check ups in helping children and adolescents realize their full potential. For example, the National Committee for Quality Assurance's *Health Plan Employer Data and Information Set (HEDIS) 3.0*, requires participating plans to report well-child visits, specifically the number of enrollees in the plan between ages of 12 and 21 who had at least one well-child visit with a primary care provider during the past year.

[\(25\)](#)

- School-based care: Of 75 students who received EPSDT screens in a school-based setting, 30 had abnormal laboratory tests while 14 children received 29 immunizations to counter immunization deficits. Even children who look healthy need EPSDT. [\(26\)](#)

- Community-based care: Community-based prenatal care programs specifically designed for adolescents have been shown to involve only 41 percent of the costs of traditional prenatal care, which is not adolescent focused. [\(27\)](#)

- EPSDT: Studies of the EPSDT programs in Michigan, North Dakota, Virginia, and Pennsylvania have documented the effectiveness of the EPSDT program in improving children's health status and lowering their medical costs. [\(28\)](#) In Southeast Pennsylvania, researchers found their study of EPSDT to "attest to the beneficial effects of EPSDT on the health status of children served." In particular, EPSDT was associated with a 30 percent decrease in the prevalence of abnormalities requiring care on re-screening.

[\(29\)](#)

- According to the National Governor's Association: "The importance and cost-effectiveness of primary and preventive health care are well documented in the literature. Preventive care, early treatment of acute illnesses, and amelioration of chronic illnesses early in life may prevent more costly health problems later." [\(30\)](#)

CONCLUSION

Early and periodic screening is essential to identifying childhood illnesses before they worsen. The EPSDT benefit package can work to identify health problem early and to correct and ameliorate illnesses and conditions that are diagnosed during the screen. Society must decide what value it places on children's and adolescents' health, broadly defined, and whether to provide a comprehensive set of health benefits designed to promote the health of children and adolescents. Congress, federal agencies, states, insurance carriers, health care providers, advocates, families, and individuals all have a role to play in determining the future of EPSDT.

State Medicaid programs should work to improve the delivery of EPSDT benefits to children and adolescents. And, state child health insurance programs should adopt a benefits package that is as close to EPSDT as possible.

The National Health Law Program and the National Center for Youth Law have just published a joint issue of *Health Advocate* and *Youth Law News* that analyzes the Medicaid and State Children's Health Insurance Program provisions of the BBA. The National Health Law Program has received funding from The Annie E. Casey Foundation to report on the states' implementation of EPSDT. A state-by-state report will be issued in February 1998. We also are working with the University of North Carolina School of Social Work to develop a teaching module on EPSDT and Managed Care, which will be available early next year. The National Center for Youth Law has been conducting an "EPSDT Implementation Project" funded by The California Wellness Foundation. Both organization are collaborating on a project, *Adolescent Health Care in Transition: Medicaid, Managed Care, and Health Care Reform*, funded by the Carnegie Corporation of New York.

We will continue to make available periodic updates on child health insurance and Medicaid issues. Please keep us informed about activities in your state, and let us know how we can help.

End Notes:

1. BBA, § 4901-4923, 111 Stat. 251 (creating a new Title XXI of the Social Security Act).
2. BBA, § 4744.
3. For a detailed analysis of the EPSDT program, see Jane Perkins and Susan Zinn, *Toward a Healthy Future -- Ensuring Early and Periodic Screening, Diagnosis and Treatment for Poor Children* (April 1995) (available from the National Health Law Program's Los Angeles office).
4. Elizabeth Wehr and Elizabeth J. Jameson, *Beyond Benefits: The Importance of a Pediatric Standard in Private Insurance Contracts to Ensuring Health Care Access for Children*, 4 The Future of Children 115 (Winter 1994).
5. Haggerty, RJ, *Child Health 2000: New Pediatrics in a Changing Environment of Children's Needs in the 21st Century*, 96 Pediatrics 804 (Oct. 1995).
6. Clinical studies documenting these problems are cited in Newacheck, *et al.*, *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).
7. U.S. Dep't of Health and Human Services Nat'l Ctr. for Health Stat., *Health United States: 1995* (May 1996); Children's Defense Fund, *The State of America's Children: 1997*

(1997).

8. Chernoff, *et al.*, *Assessing the Health Status of Children Entering Foster Care*, 93 Pediatrics 594 (April 1994).

9. Newacheck, *et al.*, *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).

10. Newacheck, *et al.*, *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).

11. HHS Office of Inspector General, *Medicaid Managed Care and EPSDT* at 1 (May 1997).

12. Kaiser Commission on the Future of Medicaid, *Medicaid's Role for Children* (May 1997).

13. Kaiser Commission on the Future of Medicaid, *Medicaid's Role for Children* (May 1997).

14. Newacheck, *et al.*, *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (Nov. 8, 1995).

15. HCFA, *EPSDT Program Indicators* (FY 1993). We can provide you with the state-specific information.

16. Committee to Study the Prevention of Low Birthweight, Division of Health Promotion and Disease Prevention, Institute of Medicine, *Preventing Low Birthweight* (1985: National Academy Press, Washington, DC).

17. Steve Berman, M.D., American Academy of Pediatrics, in *A Pediatric Perspective of Medical Necessity*, 151 Arch. Pediatr. Adolesc. Med. . 858 (Aug. 1997).

18. U.S. Congress Office of Technology Assessment, *Healthy Children: Investing in the Future* (Feb. 1988).

19. Wagner, *et al.*, *Insurance Coverage for Preventive Immunizations in Childhood*, 326 New Eng. J. Med. 768 (March 12, 1992).

20. American Academy of Pediatrics, *Your Child's Eyes* (1993).

21. Ackerman, *Benefits of Preventive Programs in Eye Care are Visible on the Bottom Line*, 15 Diabetes Care 580 (April 1992).

22. National Health Law Program, *EPSDT Chart Book* (forthcoming Feb. 1998).

23. Acs, *et al.* *Effects on Nursing Caries on Body Weight in a Pediatric Population*, 14 Pediatric Dentistry 302 (1992); Johnson, *The Role of the Pediatrician in Identifying and Treating Dental Caries*, 38 Pediatric Clinics of N. America 1173 (1991).

24. National Health Law Program, *EPSDT Chart Book* (forthcoming Feb. 1998).

25. National Committee for Quality Assurance, *HEDIS 3.0* (Jan. 1997).
26. Nativio, *et al.*, *A Team Approach to Delivery of EPSDT Services in Pittsburgh, Pennsylvania Schools*, 65 J. of School Health 38 (Jan. 1995).
27. Kay, *et al.*, *Process, Costs and Outcomes of Community-Based Prenatal Care for Adolescents*, 29 Medical Care 531 (June 1991).
28. Keller, *Study of Selected Outcomes of the Early and Periodic Screening, Diagnosis, and Treatment Program in Michigan*, 98 Pub. Health Reports 110 (March-April 1983)(summarizing study results).
29. Irwin and Conroy-Hughes, *EPSDT Impact on Health Status: Estimates Based on Secondary Analysis of Administratively Generated Data*, 20 Medical Care 216 (Feb. 1982).
30. National Governors' Association, *Caring for Children* 8 (1991).