

Providing Health Care for Low-income Children: Reconciling Child Health Goals with Child Health Financing Realities

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EVERY CHILD NEEDS ACCESS TO HEALTH CARE, including assessment and diagnostic services, preventive treatment, and medical care for episodic and chronic illnesses and conditions. We provide children with health care because it is both an ethical and moral social obligation (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983). We also provide health care for children because many pediatric health interventions are known to be both effective and cost-effective (Starfield 1982), and because when we invest in children we invest in our own futures.

Unfortunately, however, the goal of equitable access to health care for children has always been an elusive one in the United States. In recent years, it has grown more so, as rising poverty, changing employment patterns, and cutbacks in public health programs have left 35 million Americans—33 percent of whom are children and two-thirds of whom have family incomes below 200 percent of the federal poverty level—uninsured (Swartz 1985).

The purpose of this article is to examine health care financing for low-income children. Specifically, we will consider the Medicaid program and its special preventive health benefit for children, known as the

Early and Periodic Screening Diagnosis and Treatment program (EPSDT), in order to assess how well major child health goals are being served for low-income children.

Medicaid is the single most important public health program for low-income children, accounting for over 55 percent of all public health expenditures for children, compared to only 25 percent of public health expenditures for the elderly (Budetti, Butler, and McManus 1982). Medicaid has played a crucial role in reducing the disparity in access to health care between poor and nonpoor children (Davis and Schoen 1978).

The EPSDT program, added to the Medicaid program in 1967, ensures that all Medicaid-eligible children are covered not only for health care for acute and chronic medical problems but also for a wide range of preventive benefits, including health assessments, immunizations, vision, hearing and dental care, and medical treatment for episodic or chronic conditions disclosed during the screening process. Thus, the Medicaid program, in both its diagnosis-related and preventive health aspects, contains enormous potential for helping poor children secure access to the full range of health care they need.

However, Medicaid has substantially shortchanged the children it was meant to serve. Even prior to the dramatic 1981 reductions in federal eligibility standards, Medicaid provided only one out of three poor children with full-year coverage and left another one-third of all poor children completely uninsured (Butler et al. 1985). Despite the broad range of preventive and primary health services available to Medicaid-eligible children through the EPSDT program, over half of all black preschool children were inadequately immunized against various preventable childhood diseases in 1982 (Children's Defense Fund 1985b). Poor children continue to be at increased risk of death from all causes, including preventable factors, and are more likely to suffer greater and more severe and prolonged levels of many childhood illnesses (Egbuanu and Starfield 1982). Finally, when adjusted for health status, poor children have less access to medical care than their nonpoor counterparts (Kleinman 1981).

This article examines two separate but highly related issues. First, it analyzes Medicaid as a current source of health care financing for children. Second, it evaluates key structural decisions that states have made in implementing their EPSDT programs in order to determine whether the states' approach to EPSDT administration is compatible

both with the limitations of Medicaid and the needs of low-income children.

We focus particularly on EPSDT in this article because, as the component of Medicaid devoted exclusively to children, it provides insight into how adequately states finance a range of pediatric medical services for low-income children. Since EPSDT covers both assessment and medical treatment services, examination of EPSDT can identify how a variety of low-income children's health care service needs are met.

Finally, we conclude this article by exploring a series of possibilities for improving health care financing and service delivery arrangements for poor children.

Children and Medicaid: An Uneasy Relationship

Despite the fact that poor children have a disproportionately large stake in Medicaid, their relationship with the program has never been an easy one. Furthermore, children's link to Medicaid has deteriorated significantly over the last several years as a direct result of major federal restrictions imposed on the program by the Reagan administration and Congress.

Medicaid is a federal grant-in-aid program that entitles certain categories of poor individuals to coverage for a range of medical benefits (Rosenbaum 1983b). States are granted sizeable flexibility in fashioning their Medicaid plans. However, as a condition of participation in the program, states must cover certain groups of persons and must provide certain benefits to enrollees.

Payments for covered services are made directly by state Medicaid agencies to providers participating in the program for care furnished to enrollees. States maintain considerable flexibility in developing provider-participation standards, and establishing reimbursement rates, particularly in the case of outpatient services.

The federal government reimburses states for a certain percentage of the costs Medicaid agencies incur. The federal reimbursement level is based on a formula tied to a state's per capita income level.¹ While

¹ 42 U.S.C. sect. 1396d(b). By law, the federal medical assistance percentage rates range from 50 percent to 83 percent of funds expended by states.

federal funding for Medicaid is open-ended, as a practical matter a state will budget a set amount for a Medicaid program of a certain size and will control amounts expended by limiting the categories of persons served, restricting the definition of who is "poor" enough to qualify for Medicaid, limiting the range and depth of coverage, and limiting the level of reimbursement paid to providers. For example, in 1985 Medicaid financial eligibility levels for a family of three with no other income ranged from \$118 per month in Alabama to \$719 per month in Alaska.

Medicaid is the largest and most complex of all need-based federal grant-in-aid programs. Basically, however, it is an entitlement program that generally "piggybacks" onto two cash-assistance programs for the poor, including Aid to Families with Dependent Children (AFDC)² and the Supplemental Security Income (SSI)³ programs. The SSI program is a federally financed welfare program providing cash grants to aged, blind, and certain disabled persons, and its categorical and financial eligibility requirements are set by federal law. AFDC, on the other hand, is a federal grant-in-aid program that provides states with near total flexibility to establish financial eligibility criteria. In 1985 a single, noninstitutionalized SSI recipient received a living allowance of \$336 per month in addition to Medicaid coverage.

That same year, however, the average AFDC benefit for a family of three was approximately \$340 per month, or a prorated amount of approximately \$113 per month for each family member. As table 1 records, the 1985 monthly AFDC cash payment levels for a family of three were extraordinarily low.

The AFDC program represents the major test by which children's financial eligibility for Medicaid is determined. Over 95 percent of the more than 10 million children who received Medicaid in fiscal year 1984 were eligible as "dependent children." These children were covered by Medicaid either because they received AFDC or because they lived in families with countable incomes at or below AFDC payment levels (Health Care Financing Administration 1984a). Eighty-four percent of all children classified as "dependent" also received an AFDC cash grant. Another portion lived in families whose total

² 42 U.S.C. sect. 601, et. seq. (1985).

³ 42 U.S.C. sect. 1601, et. seq. (1985).

TABLE 1
 Monthly Medicaid Eligibility Levels* for a Family of Three, as a
 Percentage of the Federal Poverty Level**

State	Medicaid eligibility level	As a percentage of the federal poverty level
Alabama	\$ 118	16%
Alaska	719	97
Arkansas	192	26
California	555	75
Colorado	346	47
Connecticut	487	66
Delaware	287	39
District of Columbia	327	44
Florida	240	33
Georgia	223	30
Hawaii	468	63
Idaho	304	41
Illinois	302	41
Indiana	256	35
Iowa	360	49
Kansas	365	49
Kentucky	197	27
Louisiana	190	26
Maine	370	50
Maryland	313	42
Massachusetts	396	54
Michigan	372	50
Minnesota	524	71
Mississippi	120	16
Missouri	273	37
Montana	332	45
Nebraska	350	47
Nevada	285	39
New Hampshire	378	51
New Jersey	404	55
New Mexico	258	35
New York	474	64
North Carolina	246	33
North Dakota	371	50
Ohio	290	38
Oklahoma	282	38
Oregon	386	52
Pennsylvania	348	47
Rhode Island	409	55

TABLE 1—*Continued*

South Carolina	187	25
South Dakota	329	45
Tennessee	153	21
Texas	184	25
Utah	376	51
Vermont	531	72
Virginia	269	36
Washington	462	63
West Virginia	206	28
Wisconsin	533	72
Wyoming	360	49

Source: Social Security Administration, October, 1985: Data based on typical state maximum AFDC payments.

* Reflects categorically needy eligibility only for 1985 for families with no other income. Medically needy eligibility levels may be slightly higher in those states in which the actual AFDC payment amount is lower than AFDC payment standard.

** For 1985, annual federal poverty guidelines set poverty income levels for a family of 3 at \$8,850 (\$737.50 per month).

incomes were at or below AFDC eligibility levels. About one million children were enrolled in Medicaid because, after incurred medical expenses were deducted, their families had countable incomes between 100 percent and 133 percent of their state's AFDC payment level (Health Care Financing Administration 1984a). Such recipients are known as the "medically needy" (Rosenbaum 1983b). Only about a quarter million children received Medicaid on the basis of SSI eligibility.

Thus, insofar as financial eligibility is concerned, AFDC is the determinant of children's eligibility for Medicaid. Federal law mandates coverage for all poor children under age five whose families are categorically ineligible for AFDC. Federal law also provides state Medicaid programs the option of covering any child under age 21 whose family does not meet AFDC categorical eligibility standards. Thirty states have exercised this option (table 2). But even for children who are categorically ineligible for AFDC cash assistance, the AFDC program nonetheless provides the financial test by which their eligibility is measured.

Obviously, a program that incorporates financial eligibility criteria as restrictive as those found in the states' AFDC programs will result

TABLE 2
 Medicaid Coverage of Children under 18 and Medically Needy Children
 and Pregnant Women

State	State covers all poor children under 18 in 2-parent working families	State covers medically needy children and pregnant women
Alabama	No	No
Alaska	Yes	No
Arkansas	Yes	Yes
California	Yes	Yes
Colorado	No	No
Connecticut	Yes	Yes
Delaware	*	No
District of Columbia	Yes	Yes
Florida	Yes	**
Georgia	Yes	Yes
Hawaii	No	Yes
Idaho	No	No
Illinois	Yes	Yes
Indiana	No	No
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	No	Yes
Louisiana	No	Yes
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Minnesota	Yes	Yes
Mississippi	Yes	No
Missouri	Yes	No
Montana	No	Yes
Nebraska	Yes	Yes
Nevada	No	No
New Hampshire	No	Yes
New Jersey	Yes	Yes
New Mexico	No	No
New York	Yes	Yes
North Carolina	Yes	Yes
North Dakota	No	Yes
Ohio	Yes	No
Oklahoma	Yes	Yes
Oregon	No	Yes

TABLE 2—Continued

Pennsylvania	Yes	Yes
Rhode Island	No	Yes
South Carolina	Yes	Yes
South Dakota	No	No
Tennessee	Yes	Yes
Texas	Yes	Yes
Utah	Yes	Yes
Vermont	Yes	Yes
Virginia	No	Yes
Washington	***	Yes
West Virginia	No	Yes
Wisconsin	Yes	Yes
Wyoming	No	No

Source: State Medicaid plans and Children's Defense Fund survey, 1985.

* State provides Medicaid, under special waiver, to all children who receive state-funded general assistance, GA levels are lower than AFDC levels.

** Effective July 1986 (pending legislative approval).

*** Has a state-funded medical assistance program for all low-income persons receiving general assistance, and who do not qualify for Medicaid. Children under 21 are covered under either this program or under Medicaid.

in the denial of aid to millions of extremely poor children. For example, were an AFDC recipient with two children to find full-time, minimum wage employment, her gross salary of about \$575 per month, which equals two-thirds of the federal poverty level for a family of three, would give her a monthly income level greater than the 1985 AFDC payment level for a family of three in every state but Alaska (table 1). Even her take-home pay, which would be somewhat lower (the federal tax system unfortunately taxes poor as well as nonpoor workers), would still exceed nearly all states' monthly AFDC payment levels. Her gross salary would also have exceeded the so-called "standard of need" in 30 states (Children's Defense Fund 1986b). The "standard of need" is the threshold point for determining AFDC and Medicaid eligibility for applicants with outside income.

De minimus AFDC financial eligibility standards thus result in a built-in bias against Medicaid coverage of poor workers and their families. Prior to 1981, only 12 percent of states' AFDC caseloads included persons with earned income, and "excess" earnings, meager

as they might be, have traditionally been one of the primary reasons why a family loses its AFDC coverage (Congressional Research Service 1985).

The traditional bias in public assistance programs against poor working families is particularly disturbing since two-thirds of all poor children in 1984 lived in families in which at least one member was in the labor force (Children's Defense Fund 1986a) and since firms that primarily employ minimum wage earners are likely to offer no health insurance as a fringe benefit (Monheit et al. 1984). Not surprisingly, it has been estimated that three-quarters of uninsured Americans are either in the labor force (and disproportionately working at lower-wage jobs) or are dependents for persons in the labor force (Monheit et al. 1984). In 1980 poor children were over 3 times more likely than nonpoor children to be completely uninsured and only 33 percent of poor children had any private insurance coverage that year (Butler et al. 1985).

Since 1980 the limitations on children's Medicaid eligibility have been intensified by a series of congressional actions undertaken as part of the Reagan administration's fiscal year 1982 budget proposals. These proposals, which established new, mandatory federal limits on AFDC coverage for families with outside income were specifically designed to remove the working poor from the program. These limitations, which automatically apply to Medicaid, include the following:

- Prior to 1981 a working AFDC recipient had all necessary work-related expenses deducted from his earnings in calculating his or her eligibility for benefits. Since enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA)¹, states can now deduct only \$75 of an individual's work-related costs each month, regardless of a worker's actual expenses.
- Prior to 1981 a worker could deduct all child care costs in applying for AFDC. OBRA limited the child care deduction to \$160 per month, even for full-time workers.
- Prior to 1981 a set portion of a worker's wages were discounted.

¹ P.L. 97-35 (1981).

for as long as he or she worked, in computing his or her entitlement to AFDC benefits. After OBRA that portion of earned income could be disregarded only for a limited period of time.

- Prior to 1981 workers could apply for and receive AFDC and Medicaid no matter how high their gross earnings, so long as their countable earnings fell below payment eligibility levels. After OBRA a worker with gross earnings in excess of 150 percent of a state's "standard of need" could not even be considered for benefits, no matter how much his or her earnings might be reduced by work-related expenses.
- OBRA tightened the federal AFDC asset test from \$2,000 to \$1,000, thereby eliminating from coverage persons with more than \$1,000 in personal resources.

In 1984, Congress softened some of these 1981 penalties.⁵ First, the 150 percent "cap" on the "standard of need" was raised to 185 percent. Second, the period of time during which an AFDC-eligible worker could be credited with "disregards" earnings was slightly lengthened. Third, states were required to extend Medicaid for nine months for workers who lost coverage simply because certain AFDC disregards earnings expired (states were also given the option to extend this coverage for an additional six months).

However, these modifications by no means restored AFDC's (and thus, Medicaid's) federal eligibility standards to modest, pre-1981 levels. As a result, millions of poor workers who previously might have been assisted by the AFDC and Medicaid programs now fail to qualify for benefits.

The cumulative effects of the AFDC program's long-term financial stagnation and the federally imposed antiwork restrictions enacted in 1981 have been to limit severely the amount of time that a child's family can be expected to qualify for Medicaid (assuming that they can any longer qualify at all). Indeed, so severely have welfare stagnation and federal restrictions cut into children's Medicaid eligibility that had state Medicaid programs in 1983 performed at their 1976 eligibility

⁵ Sect. 2624 of the Deficit Reduction Act of 1984 (P.L. 96-369).

levels, two million additional children would have qualified for coverage that year (Children's Defense Fund 1985a). Moreover, in great measure because of fluctuating income, about one-third of all AFDC recipients lose eligibility within one year, and 50 percent lose eligibility within two years (McManus 1986).

Poor families with fluctuating earnings are extremely likely to be swept off the program for one or more reasons. A specialized study of the effects of the 1981 AFDC reductions found that, in five major cities surveyed, 66 to 86 percent of working AFDC recipients were affected by the reductions, compared to only 4 to 15 percent of those without earnings (U.S. General Accounting Office 1985). Among the employed, between 36 and 60 percent lost benefits outright. A year later half of these families had no health insurance. These five cities experienced approximately a two-thirds decline in the already low percentage of AFDC recipient families who had any earned income.

There can be no doubt as to Medicaid's impact on low-income children's access to and utilization of health care. One out of every three low-income children under the age of 6 with full-year Medicaid coverage, compared to one out of five uninsured low-income children received any preventive health services in 1980. Furthermore, adjusted for health status, low-income uninsured children were significantly less likely to see a physician for any reason that year than Medicaid-covered children (Rosenbach 1985).

Thus, the most important public health financing program for poor children offers them increasingly attenuated coverage for services. Children in poor families, particularly families that work, may be eligible for Medicaid for a few months, if at all, only to lose coverage because of a slight increase in the otherwise-uninsured family head's earnings.

Thirty-five states do provide Medicaid to medically needy children whose family incomes slightly exceed AFDC eligibility levels but are insufficient to meet the cost of necessary medical care (table 2). But these programs are of extremely limited usefulness. Like the basic Medicaid program, states' "medically needy" programs are tied to the AFDC payment level. Children living in minimum wage families would have to incur significant medical costs before their eligibility could begin—costs that in many instances far exceed the cost of a child's routine preventive and episodic health care needs.

The Early Periodic Screening Diagnosis And Treatment Program (EPSDT)

We are a young nation. . . . Much of the courage and vitality that bless this land are the gift of young citizens. . . . What [young people] are able to offer the world as citizens depends on what their Nation offered them as youngsters (U.S. Congress 1967).

With these words, President Johnson transmitted to Congress the Social Security Amendments of 1967, containing certain “Recommendations for the Welfare of Children.” These recommendations included a series of amendments to Medicaid and Crippled Children’s programs⁶ that were intended “to discover, as early as possible, the ills that handicap our children” and to provide “continuing followup and treatment so that handicaps do not go neglected.” By the end of that year, after remarkably brief consideration, Congress had amended both statutes to include a new required service for all individuals under the age of 21 and eligible for Medicaid. This benefit was known as Early and Periodic Screening Diagnosis and Treatment (EPSDT).⁷

Thus, one of the most sweeping health guarantees for disadvantaged American children ever enacted by Congress was launched: a program that would locate children suffering from health problems and ensure that they received the continuous and comprehensive medical care they needed. Congress envisioned that working together, crippled children’s agencies and other public agencies would identify children in need of care and would extend to them a program of preventive and remedial health benefits. The Medicaid program would finance the cost of the medical and remedial care provided by these agencies

⁶ The Crippled Children’s Program was originally codified as a separate authority within the Social Security Act. In 1967, however, it was consolidated with the Maternal and Child Health Program as Title V of the Social Security Act, 42 U.S.C. sect. 701, et. seq. In 1981 Title V was expanded to include a series of previously categorical maternal and child health services programs including the Title V Maternal and Child Health and Crippled Children’s Programs, and renamed the Maternal and Child Health Block Grant (P.L. 97–35, 95 Stat. 357 [1981]). (See also Rosenbaum 1983a).

⁷ 42 U.S.C. sect. 1396d(a)(4)(B); 42 U.S.C. section 705(a)(1968).

to Medicaid-eligible children.⁸ Ultimately, Medicaid agencies would also themselves become responsible for case-finding and supportive activities in addition to financing medical care.⁹

As a required benefit for Medicaid beneficiaries under age 21, EPSDT finances a broad range of primary and preventive health services for children. The purposes of EPSDT are to provide a comprehensive and periodic assessment of a child's overall health, developmental, and nutritional status, to treat conditions and illnesses disclosed during the assessment process, and to provide vision, dental, and hearing care. Services contained in the EPSDT benefit package include: a detailed and comprehensive health examination that consists of a health and developmental history, an unclothed physical examination, appropriate vision and hearing testing, appropriate laboratory tests, and a direct referral to a dentist for children over the age of three; immunizations; vision, hearing, and dental care; and diagnostic and medical treatment for conditions disclosed during the screening process, to the extent that such treatment services are otherwise included in a state's general Medicaid plan.¹⁰ Moreover, at their discretion, states may furnish special diagnostic and treatment services to children participating in the EPSDT program that are not otherwise made available to Medicaid-eligible persons.¹¹

⁸ S. Rep. 744 to accompany H.R. 12080, the Social Security Amendments of 1967.

⁹ The affirmative action requirement of the Medicaid EPSDT program was originally added to the Social Security Act in 1972 in response to growing congressional concern over states' failure to implement EPSDT. The original provision withheld 1 percent of federal AFDC payments from any state that failed to inform, screen, and treat eligible children, 42 U.S.C. sect. 602(g) (1972). In 1981 this so-called AFDC "penalty" provision was removed and the Medicaid statute was amended to incorporate these affirmative action provisions as a state plan requirement, sect. 2181 of P.L. 97-35, 95 Stat. 357 (1981), codified at 42 U.S.C. sect. 1396(a)(44) (1982).

¹⁰ 42 C.F.R. sect. 441.56(b) and (c) (1986).

¹¹ 42 C.F.R. sect. 441.57 (1985). The originally proposed EPSDT regulations would have required states to provide all medically necessary diagnostic and treatment services for conditions disclosed during the screening process, even if such services were not included in the state's basic medical plan. After intense opposition by states to this rule, however, the Nixon administration chose to limit the EPSDT enriched services package to vision, dental, and hearing treatment only, despite the fact that the statute itself contains no such limitation.

EPSDT assessment services must be furnished at periodic intervals specified in the state Medicaid plan (known as a periodicity schedule) that meet reasonable standards of medical care¹² (table 3). Thus, for example, a reasonable EPSDT dental examination schedule would at a minimum call for annual exams and treatment.¹³ Furthermore, each screening exam must meet reasonable content standards.¹⁴ For example, all laboratory tests and developmental assessments must be age-appropriate.

In addition to furnishing this package of basic medical services, state Medicaid agencies must also take affirmative action to ensure that EPSDT-eligible children know about, and are able to utilize, the benefits to which they are entitled. These affirmative action requirements include "effective" programs for informing families about EPSDT that combine oral and written informing procedures;¹⁵ provision of necessary scheduling and transportation assistance for both screening and treatment services;¹⁶ arranging for free or reduced-cost care for health services a child needs that are not covered by Medicaid;¹⁷ and the development of interagency agreements with agencies funded under the Title V Maternal and Child Health Block Grant and other agencies and institutions to ensure adequate screening, diagnostic, and treatment providers.¹⁸

The EPSDT program's successes and failures have been extensively reviewed during the two decades since its enactment. The program has assisted millions of children who otherwise might never have received comprehensive basic preventive health care. Children have received immunizations, eye exams, hearing tests, and dental care; and countless previously undiagnosed conditions have been disclosed and treated. EPSDT has contributed to a significant improvement in

¹² 42 C.F.R. sect. 441.58 (1985).

¹³ *Mitchell v. Johnston* 701 F2d 337 (5th Cir. 1983) holding that the Texas EPSDT dental program, which used a dental examination schedule that called for routine dental exams only once every three years was unreasonable, not in accordance with accepted professional standards of practice and therefore in violation of federal Medicaid and EPSDT regulations.

¹⁴ 42 C.F.R. sect. 441.58 (1985).

¹⁵ 42 C.F.R. sect. 441.56(a) (1985).

¹⁶ 42 C.F.R. sect. 441.62 (1985).

¹⁷ 42 C.F.R. sect. 441.85 (1985).

¹⁸ 42 C.F.R. sect. 441.85 (1985).

TABLE 3
State Periodicity Schedules

State	Infancy	Early Childhood	Late Childhood	Adolescence	Total
A.A.P. ¹	6	6	4	4	20
Alabama	1	4	1	2	8
Alaska	5	3	3	2	13
Arkansas	2	2	3	2	9
California	6	5	2	2	15
Colorado	6	7	2	3	18
Connecticut	5	3	3	2	13
Delaware	3	4	1	3	11
District of Columbia	5	3	2	2	12
Florida	5	6	3	2	16
Georgia	4	3	3	3	13
Hawaii	*	*	*	*	*
Idaho	1	1	1	1	4
Illinois	5	4	2	2	13
Indiana	5	6	7	5	23
Iowa	4	5	2	2	13
Kansas	3	5	2	3	13
Kentucky	5	5	4	3	17
Louisiana	2	3	2	3	10
Maine	6	5	3	3	17
Maryland	4	3	3	2	12
Massachusetts	*	*	*	*	*
Michigan	2	2	4	4	12
Minnesota	3	4	2	3	12
Mississippi	4	4	3	on request	12
Missouri	6	6	3	3	18
Montana	*	*	*	*	*
Nebraska	2	4	4	4	14
Nevada	*	*	*	*	*
New Hampshire	5	5	2	2	14
New Jersey	5	3	3	2	13
New Mexico	6	6	3	2	17
New York	6	6	4	4	20
North Carolina	6	5	2	3	16
North Dakota	1	4	7	8	20
Ohio	6	4	7	8	25
Oklahoma	1	1	2	1	5
Oregon	4	2	3	3	12
Pennsylvania	5	5	7	8	25
Rhode Island	4	5	4	3	16

TABLE 3—Continued

South Carolina	4	4	3	3	14
South Dakota	6	3	2	2	13
Tennessee	6	4	2	3	15
Texas	4	4	1	2	11
Utah	3	5	2	2	12
Vermont	*	*	*	*	*
Virginia	5	4	3	2	14
Washington	6	4	7	8	25
West Virginia	5	6	7	3	21
Wisconsin	3	3	3	3	12
Wyoming	2	2	0	1	5

Source: Children's Defense Fund Survey, 1985.

¹ American Academy of Pediatrics, Guidelines for Supervision.

* Information not available.

the health status of low-income children served by the program, and specialized studies have demonstrated its effectiveness and cost-effectiveness (Keller 1983; Irwin and Conroy-Hughes 1982).

At the same time, however, the program has faced serious problems. These problems have been extensively investigated by researchers (Foltz 1975; Children's Defense Fund 1977). No fewer than four separate sets of congressional hearings concerning the adequacy of the program have been held. No fewer than four major sets of federal rules have been issued.¹⁹ Repeated litigation efforts have sought to enforce the entitlement and affirmative action aspects of the statute.²⁰ Numerous states have designed and redesigned their programs, as new generations

¹⁹ 35 Fed. Reg. 18878 (December 11, 1970); 40 Fed. Reg. 3678 (August 20, 1975); 44 Fed. Reg. 29420 (May 18, 1974); and 49 Fed. Reg. 43654f (October 31, 1984).

²⁰ See, e.g., *Mitchell v. Johnston*, 701 F2d 337 (5th Cir. 1983); *Bond v. Stanton* 655 F2d 766 (7th Cir. 1981); *Bond v. Stanton* 630 F2d 1231 (7th Cir. 1980); *Brooks v. Smith* 356 A.2d 723 (Me. 1976); *Dominguez v. Milliken*, no. 9-198-72 (D. Mich. 1973) [reprinted at] C.C.H. Medicare/Medicaid Guide + 26,632; *Harris v. Candon*, no. 74-79 (D. Vt. 1978) [reprinted at] C.C.H. Medicare/Medicaid Guide 29, 099; *Philadelphia Welfare Rights Org. v. Schapp* 602 F2d 1114 (3rd Cir., 1979); cert. den. 444 U.S. 1026 (1980).

of policy makers and agency heads have “discovered” EPSDT and seized upon it as an attractive programmatic initiative.

A number of researchers have pointed to various factors that impeded effective program implementation, including: the ambiguous nature of federal EPSDT directives and the ensuing confusion they have generated; the poor design of EPSDT programs at the state and local level that has resulted in ineffective implementation; and a general lack of political commitment on the part of many state officials to the program’s aims (Foltz 1975; Children’s Defense Fund 1977).

While these are all certainly important considerations in assessing the success of EPSDT, perhaps the single most important factor is the fact that, since EPSDT is a Medicaid benefit, its effectiveness rests upon children being eligible for Medicaid or an equivalent financing source (such as the Crippled Children’s program) that incorporates all of the EPSDT standards and protocols. If there is no funding, then regardless of how committed or creative a program administrator is or how clear the federal directives, there will be no way to purchase the preventive, primary, and follow-up screening, diagnostic, and treatment services children need. Ultimately, Medicaid’s failure to insure more than one-third of poor children for even a full year (Butler et al. 1985) is the greatest single impediment to achieving EPSDT’s goals.

EPSDT has always been dependent upon the success of Medicaid. But the magnitude of the Medicaid program’s shortcomings in 1986 undoubtedly was never envisioned by the drafters of the 1967 child health amendments. Indeed, the complete text of the 1967 Social Security Amendments (of which EPSDT was only a small part) and their legislative history suggest an assumption on the part of Congress and the president that AFDC (and therefore, Medicaid) eligibility standards would remain relatively reasonable.

For example, the 1967 Social Security Amendments placed a ceiling on eligibility levels for state medically needy programs equal to 133 percent of the AFDC payment standard.²¹ In 1967 state AFDC payment levels were approximately the same as those used under programs for the aged, blind, and disabled. Thus, the medically needy elderly

²¹ Sect. 238 of P.L. 90-248.

would be left no worse off, and potentially slightly better off, than those elderly persons who received both cash and medical assistance.

Currently, however, most state AFDC payment levels are dramatically below the payment level under SSI (which was enacted in 1972 to replace prior, less generous state grant-in-aid programs for the aged, blind, and disabled). This discrepancy between AFDC and SSI has led to the anomalous situation in which medically needy eligibility levels for the elderly are significantly below those standards used to qualify the elderly for SSI. Elderly persons who receive welfare are often financially better off than medically needy elderly persons who do not receive cash assistance but who do need medical assistance to meet the high cost of health care. It is highly doubtful that the Congress would ever have used state AFDC payment standards to determine financial eligibility for the medically needy aged, had it anticipated how far behind cash assistance programs for the aged state AFDC benefits would ultimately fall.

State Response to EPSDT

Given poor children's tenuous insured status under the Medicaid program, the obvious question which arises is how can a state structure an effective EPSDT program that provides children with continuous access to the range of benefits EPSDT pays for if Medicaid itself is such an inadequate source of financing. Addressing children's volatile health financing dilemma is essential to EPSDT's success, not only because their uninsuredness frequently prevents them from securing EPSDT and other services, but also because low-income children who are not insured are less likely to receive preventive benefits at all (Rosenbach 1985). Medicaid has been shown to result in a greater use of preventive services and generally greater access to medical care (Rosenbach 1985).

Thus, for states to achieve EPSDT's objectives, as well as the broader goals of child health care, they must first stabilize poor children's health care financing arrangements. Low-income families who have health care coverage for their children on a continuous basis may prove to be more effective health care purchasers, and appropriate health outcomes for these children can be better assured.

During the summer of 1985, the Children's Defense Fund conducted a 50-state survey of EPSDT programs on a range of issues. A survey

instrument was prepared to achieve the objectives of the study, which were to determine:

- the extent to which states are in compliance with basic program requirements;
- what program changes, if any, had been put into place as a result of changes in the federal regulations;
- if states have developed innovative programs, particularly in the areas of outreach, provider participation, and case management; and
- how effectively states were integrating various health care programs for low-income children.

The questionnaire was pretested and then administered by telephone. In all, more than 50 specific program-related questions were asked of each state, and an attempt was made in each case to speak with the EPSDT program coordinator. Follow-up materials, including a sample of participation data, provider protocols and agreements, periodicity schedules, and outreach materials were requested by mail and received from most states. Additional information was obtained from the EPSDT Program Report, for fiscal year 1984 prepared by the Health Care Financing Administration, U. S. Department of Health and Human Services.

Several findings from this survey bear specifically on the issue of how adequately states have overcome Medicaid's financing dilemma for children and how adequately state supplemental financing mechanisms are integrated with the EPSDT program. Specifically, we sought information regarding the following: first, how many states have developed sources of funding to supplement Medicaid when a child in need of EPSDT screening, diagnostic, and treatment services is ineligible, or no longer eligible, for Medicaid coverage; and second, whether or not the EPSDT screening, diagnostic, and treatment protocols are incorporated into supplemental funding sources.

Supplemental EPSDT Funding for Children Who Are Ineligible for Medicaid

Our study revealed that no state has a uniform, statewide supplemental funding program to finance the range of EPSDT screening, diagnostic, and treatment services for low-income children who are ineligible for

Medicaid. Nearly all states use some portion of the funds they receive from the federal government under the Title V Maternal and Child Health Block Grant Act to underwrite health screening activities for children through local health departments, although it is not uncommon for such screening programs to be limited to very young children. Moreover, there is no guarantee that even early childhood screening services are uniformly available throughout the state.

Supplemental state funding for treatment services for Medicaid-ineligible children (vision, dental, and hearing care and treatment for conditions disclosed through the assessment process) is almost nonexistent. Treatment services for certain problems may be available through Title V-funded Children and Youth (C&Y) projects (special comprehensive health clinics serving children and funded under the Maternal and Child Health Block Grant), but in no state are C&Y projects available statewide.

Other sources of funding for medical treatment for children who are Medicaid-ineligible include state Crippled Children's (CC) programs, also funded through the Maternal and Child Health Block Grant. In 1983, however, state CC programs served only 620,000 children nationwide for selected medical problems, usually chronic and organic in nature (Association of State and Territorial Health Officials Foundation 1985). Crippled Children's programs are not commonly a source of funding for children's routine medical care needs, such as vision, hearing, and dental care. Furthermore, many state programs categorically exclude certain conditions, such as mental health problems, as treatable conditions.

Other residual sources of comprehensive health care for low-income children include Community and Migrant Health Centers.²² These centers provide a range of primary health services in the areas in which they are located. Nearly 40 percent of all center users are children, an indication of their poverty and uninsuredness (National Association of Community Health Centers 1986). However, in 1985 the centers served only 5 million people, while 20 million more were unserved (National Association of Community Health Centers 1986).

In short, states do not have comprehensive supplemental health care financing arrangements for Medicaid-ineligible low-income children which can be used to advance EPSDT's goals. At any given time,

²² Sects. 330 and 329 of the Public Health Service Act, respectively.

one-third of America's 12.9 million poor children are completely ineligible for EPSDT benefits, while another third will have Medicaid coverage for less than one year (Butler et al. 1985). Implementing a program whose main thrust is providing access to long-term preventive services in such a context is virtually impossible.

EPSDT's incompatibility with Medicaid takes on ironic overtones, given policy makers' expectations for the program. In 1984 the U. S. Department of Health and Human Services issued EPSDT regulations that encouraged states to develop EPSDT programs that utilized the services of providers who could provide "continuing care"—that is, both preventive services and medical treatment for periodic, episodic, or chronic health care needs—to Medicaid-eligible children. The goal embodied in this rule of incorporating EPSDT services with comprehensive health care arrangements for children is certainly a laudable one. However, it is doubtful that "continuing care" arrangements of reasonable duration can be successfully developed if there is no way to finance a child's care over long periods of time.

Given the problems inherent in implementing "continuing care" programs for such poorly financed children, we were interested in discovering what actions the states had, in fact, taken to develop arrangements. Our findings indicate that while some states were pursuing continuing care arrangements, none had tied such programs to supplemental funding sources. Instead, the states appeared to be entering into "continuing care" agreements as part of an overall effort to enroll Medicaid recipients in specialized primary care case-management arrangements, authorized under the Medicaid Act in 1981.

The primary purpose of these arrangements is to reduce state Medicaid expenditures, not to provide supplemental financing for poor families. Of 49 states responding to this survey question, 19 reported developing formal continuing care initiatives. However, none of these initiatives reported the inclusion of supplemental funding mechanisms that could be triggered to retain a child's enrollment in the continuing-care program if his or her Medicaid eligibility ceased. Some states are recruiting into their continuing-care programs publicly funded providers with a legal obligation to serve the poor (such as Community Health Centers, Children & Youth projects, or public hospital outpatient clinics). In this way, children who lose Medicaid might continue to remain with the provider on a subsidized basis. However, in most states, enrollment in private physician arrangements is emphasized.

These providers, of course, have no legal obligation to serve uninsured low-income children.

At least one state has now recognized that in the absence of a comprehensive supplemental financing program for poor children ineligible for Medicaid, it must more aggressively enroll public and quasi-public providers serving the poor into its EPSDT program. After an intensive review of its EPSDT program, a special task force in Massachusetts concluded that the Medicaid agency was doing an in-

TABLE 4
States Reporting Continuing Care Arrangements

State	Status	State	Status
Alabama	No	Missouri	No
Alaska	No	Montana	No
Arizona	—	Nebraska	No
Arkansas	No	Nevada	Yes
California	Yes	New Hampshire	Yes
Colorado	Yes	New Jersey	Yes
Connecticut	Yes	New Mexico	No
Delaware	No	New York	Yes
District of Columbia	No	North Carolina	No
Florida	Yes	North Dakota	No
Georgia	No	Ohio	Yes
Hawaii	—	Oklahoma	No
Idaho	No	Oregon	Yes
Illinois	Yes	Pennsylvania	Yes
Indiana	No	Rhode Island	Yes
Iowa	No	South Carolina	*
Kansas	No	South Dakota	No
Kentucky	*	Tennessee	Yes
Louisiana	No	Texas	No
Maine	Yes	Utah	No
Maryland	No	Vermont	No
Massachusetts	Yes	Virginia	No
Michigan	Yes	Washington	Yes
Minnesota	Yes	West Virginia	No
Mississippi	No	Wisconsin	Yes
		Wyoming	No

Source: Children's Defense Fund survey, 1985.

* Under development or under consideration.

adequate job of integrating its services with existing public health efforts, including Community Health Centers, school health programs, family planning clinics, and clinics providing general maternal and child health services, including supplemental food programs for women, infants, and children. Indeed, direct recruitment efforts by the Medicaid agency had been almost entirely limited to individual practitioners in private practice, rather than comprehensive, local agencies that could serve as a continuing-care provider's entity for uninsured poor children. The report recommended that integrated arrangements be developed with public health providers already furnishing health services to poor children in order to expand EPSDT's delivery system and to reach low-income children in their predominant health care entry points (Massachusetts Department of Public Welfare 1985).

Application of EPSDT Standards to All Supplemental Funding Programs

No state provides supplemental funding for all EPSDT services. However, all states do underwrite at least some screening, diagnostic, or treatment services to Medicaid-ineligible children, either through their Maternal and Child Health Block Grant programs or other state-funded efforts. We, therefore, sought to determine how many states apply EPSDT assessment standards and protocols to all public programs.

Use of common standards would better assure the provision of health exams that include all of the elements outlined in the EPSDT rules. Common standards would also ensure that children participating in any publicly funded program are recalled for periodic exams in a consistent fashion and that common immunization schedules are used. Moreover, states would be better assured that children receiving any publicly subsidized health services throughout a year are receiving the medical care and services that Medicaid agencies are legally obligated to provide. Finally, providers delivering pediatric services in several different public programs would be guided by a single, standard set of protocols.

Our survey revealed, however, that rather than using EPSDT standards to unify and guide the range of publicly funded pediatric programs, state Medicaid agencies in fact have seriously diluted the EPSDT program by permitting pediatric providers to claim Medicaid reimbursement for child health exams that may fall short of the content

and frequency requirements of the EPSDT program. Moreover, only a few states apply the EPSDT protocols to all publicly paid programs, such as Title V-funded well-child examination services furnished by local health departments.

We have termed these informal Medicaid provider-reimbursement arrangements that bypass the rigorous EPSDT requirements “shadow programs.” In general, Medicaid agencies believe that children treated under these “shadow programs” are receiving care equivalent to that required under EPSDT and can, therefore, be considered to be enrolled in “continuing care” arrangements. However, adherence to EPSDT protocols is not a prerequisite to reimbursement of these “equivalent” providers. Thus, the states, in fact, have no way of ensuring that complete assessment and referral services have been furnished.

Without adherence to the articulated standards and detailed protocols embodied in EPSDT, the states have no means of verifying that “shadow” care provided to children is, in fact, equivalent to that furnished under EPSDT. Among the 44 states responding to our question regarding whether EPSDT standards apply to all primary pediatric care reimbursed by Medicaid, most explicitly permit “shadow” billing arrangements. Furthermore, in most states, these “shadow” billing arrangements are available only to private physicians. Evidently, rather than negotiating with private physicians to implement the full EPSDT screening package (the federal regulations for which are based on the American Academy of Pediatrics *Guidelines for Health Supervision*) states have instead permitted physicians to bill for routine pediatric health services outside the EPSDT program. In return, Medicaid agencies frequently pay somewhat less for a routine “shadow” health exam than they pay for the full EPSDT complement of services.

We suspect that “shadow” billing is tolerated if not explicitly permitted in almost every state, since it may not be uncommon for a physician to perform a “well-child” exam on a child who is being seen for diagnosis-related reasons. Thus, even states that do not expressly and separately reimburse providers for routine health “shadow” services may, in fact, allow such reimbursement if it is part of an otherwise diagnosis-related visit.

Several adverse effects flow from “shadow” programs. First, health exams may not meet the EPSDT program’s quality and content protocols. For example, many state EPSDT screening protocols, in implementing the federal rules’ requirement of an age-appropriate hearing exam,

TABLE 5
States Reporting Shadow Programs

State	Status	State	Status
Alabama	Yes ¹	Missouri	Yes
Alaska	No	Montana	Yes
Arizona	—	Nebraska	Yes ³
Arkansas	Yes	Nevada	No
California	—	New Hampshire	Yes
Colorado	No	New Jersey	Yes
Connecticut	Yes	New Mexico	No
Delaware	Yes	New York	Yes
District of Columbia	Yes	North Carolina	No
Florida	Yes	North Dakota	Yes
Georgia	No	Ohio	Yes
Hawaii	—	Oklahoma	Yes ⁴
Idaho	Yes ²	Oregon	Yes
Illinois	Yes	Pennsylvania	Yes ⁴
Indiana	Yes	Rhode Island	Yes
Iowa	Yes	South Carolina	No
Kansas	Yes	South Dakota	Yes
Kentucky	No	Tennessee	No
Louisiana	Yes	Texas	No
Maine	Yes	Utah	No ⁵
Maryland	Yes	Vermont	—
Massachusetts	Yes ⁶	Virginia	No
Michigan	Yes	Washington	No
Minnesota	Yes	West Virginia	—
Mississippi	No	Wisconsin	Yes
		Wyoming	Yes

Source: Children's Defense Fund survey, 1985.

¹ one postpartum visit.

² birth to one year.

³ birth to age three.

⁴ one visit per year.

⁵ if medically necessary or subject to review.

⁶ limited to certain providers.

"Yes" indicates that state reports a shadow program without limitations on periodicity.

"No" indicates that state does not allow provider to bill for a well-child visit or examination outside of the EPSDT program.

recommend the use of an audiometer in conducting a hearing exam for children over age three. Yet, many physicians do not utilize audiometers in their practices. As a result, children being treated by "shadow" providers may not receive a complete hearing exam.

An even more serious example involves conditions particularly threatening to poor children, such as lead poisoning. In *A Guide to Administration, Diagnosis and Treatment, EPSDT*, the U. S. Department of Health, Education, and Welfare, in cooperation with the American Academy of Pediatrics, specifically noted that:

In the United States, 2.5 million children 1 through 5 years of age are at risk of undue lead absorption. Approximately 600,000 will be affected by the disease, generally as a result of living in old, deteriorated housing containing lead-based paint. Prevalence is lower in suburban areas and may be extremely low in areas with houses built after the 1950s and with little exposure to industrial sources of lead. Classical symptomatic lead poisoning is generally not seen. Approximately 6,000 will develop neurologic damage including slow learning, hyperactivity, and behavioral disorders even though the child is asymptomatic (HSM110-73-524).

Federal EPSDT assessment guidelines specifically call for lead poisoning testing as part of the basic exam. Yet, many physicians do not incorporate lead testing as part of their routine office practices. As a result, many children being seen by “shadow” providers may not be tested for lead poisoning.

A particularly serious problem has resulted in New York City, where plaintiffs, suing the city over its failure to identify and treat infants and children suffering from lead poisoning discovered that of all Medicaid-enrolled children in the city, only 5 percent could be certified as having received a full complement of EPSDT services, including lead poisoning exams.²³ With respect to the other 95 percent of Medicaid-eligible children, the city defendant noted that nearly all were under the care of an “equivalent” provider and were, therefore, not in need of EPSDT screens. However, according to affidavits of medical experts submitted in the case, it is not common practice outside of the EPSDT program for a physician in New York City to screen a child for lead poisoning. Therefore, because the state has failed to require adherence to the EPSDT protocol by all providers furnishing preventive Medicaid services to children, children potentially suffering from the effects of lead poisoning may be going unidentified and untreated.

²³ *New York City Coalition to End Lead Poisoning et al. v. Koch* (no. 42780 185, S.D.N.Y., 1985).

Second, the use of “shadow” programs means that states cannot assure that all children are up-to-date with respect to health exams and immunizations in accordance with state periodicity schedules. Federal EPSDT regulations require that all states establish schedules that identify the ages at which children should be screened and the screening and treatment services (such as developmental assessments, dental care referrals, and immunizations) that are to be provided at each periodic interval (table 3). However, “shadow” providers, who are not bound by state periodicity schedules may follow individual schedules that call for screening at greater or closer intervals than those called for in the official state periodicity schedule. This practice may, in turn, lead to overutilization or underutilization of needed services.

A third implication of permitting “shadow” billing is the potential for poor quality care. For example, health experts emphasize that pediatric practitioners should not attempt to measure a child’s overall health and development when the child is being seen for an acute or episodic illness, since a child’s responsiveness and capabilities may be depressed as a result of illness. Moreover, experts also underscore the point that immunizations should not be provided when a child is ill. Since these practices constitute poor medical care, a reasonable EPSDT program by law would not permit reimbursement for an EPSDT exam conducted on a sick child. Yet, these practices might occur under “shadow” programs, which, by definition, fail to regulate provider practices.

A final problem created by the existence of a “shadow” program is its spillover effect on other agencies. A health department may have no real incentive to conform its provider standards for non-Medicaid pediatric programs to those used by the Medicaid agency, if the Medicaid agency itself does not require adherence to rigorous protocols by all pediatric providers furnishing primary care and participating in Medicaid.

The problems created by the widespread use of “shadow” programs are complicated by the fact that not all states have developed detailed standards of practice even for providers willing to participate in the formal EPSDT program. In keeping with the tendency toward “shadow” billing, those that do maintain formal EPSDT protocols will frequently apply them only to selected groups of providers.

TABLE 6
EPSDT Provider Protocols

State	Written protocol*	Required applications
Alabama	manual	not all use
Alaska	manual	all use
Arizona	—	—
Arkansas	manual	all use
California	manual	not all components required all use not all components required
Colorado	—	—
Connecticut	yes	all use
Delaware	yes	all use
District of Columbia	yes	all use
Florida	no	—
Georgia	yes	all use
Hawaii	—	—
Idaho	yes	all use
Illinois	yes	all use
Indiana	yes	all use
Iowa	manual	only public providers use
Kansas	form	all use
Kentucky	yes	all use
Louisiana	yes	all use
Maine	no	rely on physician
Maryland	yes	all use
Massachusetts	yes	—
Michigan	yes	all use
Minnesota	yes	all use
Mississippi	form	all use
Missouri	form	all use
Montana	yes	all use
Nebraska	form	all use
Nevada	yes	all use
New Hampshire	revising	all use
New Jersey	yes	all use
New Mexico	yes	all use
New York	yes	all use
North Carolina	—	—
North Dakota	manual	all use
Ohio	yes	all use
Oklahoma	no	—
Oregon	yes	all use

TABLE 6—Continued

Pennsylvania	manual	all use
Rhode Island	yes	all use
South Carolina	partial	—
South Dakota	yes	all use
Tennessee	partial	all use
Texas	partial	all use
Utah	yes	all use
Vermont	—	—
Virginia	no	—
Washington	—	—
West Virginia	yes	all use
Wisconsin	no	—
Wyoming	form	all use

* Where states provided an actual sample of the protocol its status is described as form or manual or partial. In other cases, "yes" means a state reported having a protocol but did not send an example, and "no" means a state reported having no protocol.

Of the 45 states responding to our questions on provider standards, only 40 had developed provider standards that are to be used by all providers certified as formal EPSDT practitioners. Six states reported using no provider protocols at all.

Furthermore, of the 40 states using EPSDT provider protocols, 2 exempted private EPSDT providers from having to follow the protocols, even though health departments were required to follow written standards. Finally, the level of quality and detail in protocols varied greatly. For some states an extensive manual has been prepared; in others the standards may not include the full screening package. At least 5 of the 40 states are using only a claims form as a protocol, leaving the provider the discretion to interpret the requirements for which no details were provided. For example, officials in Maine report that they rely on physicians' judgments about the most appropriate manner in which to provide an EPSDT screen. Similarly, although the Texas agency requires all providers to use written protocols for the medical portion of the screen, it has developed no protocol for the dental exam.

In Wyoming and several other states, the claims form is the only written EPSDT guideline supplied to providers. The form is a single

column listing beside which a provider might check off items such as “family health history/parents” or “physical examination/hearing.” Such a form, while useful for determining the completeness of a provider’s screen, does not tell the provider that an EPSDT hearing screen is to be conducted to certain specifications, such as with an audiometer.

Conclusion

Achieving the goals of high-quality health care for low-income children requires both adequate financing and adherence to sound standards of practice. The Medicaid program with its broad range of preventive, diagnosis and treatment-related services, and its open-ended financing mechanism, represents a powerful tool to reduce significantly uninsuredness and improve access among children. However, Medicaid suffers from serious limitations, some federally imposed and some created by the states. Years of stagnation in AFDC, whose eligibility methodology is used to determine nearly all children’s eligibility for Medicaid, have seriously limited the program’s reach. These limitations have been exacerbated since 1981 by federal restrictions designed to remove from Medicaid working-poor families who are least likely to be privately insured.

In recent years state and federal government response to Medicaid and children has been mixed. On the one hand, since 1980 about a dozen states have expanded categorical coverage of children under Medicaid to include all children under age 18 in families satisfying AFDC income and resources criteria. Another six have added coverage for “medically needy” children. Similarly, in 1984, Congress mandated Medicaid coverage of all children under age five whose families meet state AFDC financial eligibility standards; additionally, Congress softened somewhat the antiwork amendments incorporated into AFDC and Medicaid in 1981. All of these actions are particularly notable in an era of great fiscal constraint.

On the other hand, the financial criteria used to determine children’s Medicaid eligibility remain extraordinarily depressed, and punitive measures against the working poor have permanently disinsured millions of families from Medicaid. These highly restrictive eligibility conditions seriously undercut Medicaid’s utility as a direct and stable insurer of

poor children, thereby rendering such crucial programs as EPSDT far less useful than they might otherwise be. EPSDT's utility is further undercut by apparent state dilution of this all-important benefit.

We believe that two things must happen. First, the states must develop better public financing mechanisms for poor children. There are several ways this might be done. First and most obviously, the states might improve their Medicaid coverage significantly. Twenty states still do not extend benefits to all children under age 18 living in families with incomes below AFDC eligibility levels (table 2). All should do so. The Health Care Financing Administration has recently estimated that such a program might add 4 percent to a state's annual Medicaid outlays (Health Care Financing Administration 1984b).

Fifteen states also currently fail to cover medically needy children (table 2). In 1981 Congress amended Medicaid to permit states to establish limited medically needy programs only for pregnant women and children under 18, without having to cover other categories of medically needy individuals, as required under prior law.²⁴ Medically needy coverage of pregnant women and children only has been estimated to add no more than 4 percent to a state's annual Medicaid outlays (Wulsin 1984).

Most important, however, states should raise their AFDC payment levels. An AFDC increase would automatically increase Medicaid penetration rates. AFDC payment increases are vital not only because they improve children's access to Medicaid but also because of the strong link between children's overall standard of living and child health outcomes (Starfield 1982). In an era when the rate of progress in reducing infant mortality is declining and, even more important, the nation is experiencing an actual nationwide rise in postneonatal mortality, standard of living issues become particularly pressing (Children's Defense Fund 1986b).

We recognize, however, that AFDC increases are not easy to accomplish. The nation's conservative retrenchment and the widespread misconception that welfare benefits led to the explosion during the 1970s of out-of-wedlock births to teenage women (even though, in fact, the value of welfare declined dramatically as the out-of-wedlock

²⁴ Sect. 2171 of P.L. 97-35, replacing 42 U.S.C. sect. 1396a (a) (10) (C) (1980).

birthrate grew) mean that the stigma of welfare is as strong today as it was 20 years ago.

Moreover, since by law Medicaid must be provided to anybody who receives AFDC, an AFDC increase means increased Medicaid coverage for adults as well as children and, therefore, a potential sizeable increase in Medicaid expenditures. Additionally, in states whose Medicaid plans include coverage of the medically needy, increased AFDC payments automatically push up medically needy eligibility standards, since AFDC serves as the basis for the states' medically needy eligibility levels. Many of these persons, including young adults, the elderly, and the disabled, have relatively high per capita costs (Health Care Financing Administration 1984b).

Thus, increasing Medicaid coverage by increasing AFDC may prove to be a politically and financially unpopular avenue for change. While state lawmakers might be persuaded to enact modest AFDC improvements, they may resist sizeable across-the-board AFDC increases, especially in those states with medically needy programs.

Given the political and financial difficulties in substantially increasing coverage of children under Medicaid by improving the program's eligibility criteria, we believe that states should explore several other approaches. First, states might supplement Medicaid with a state-financed public medical assistance entitlement or quasi-entitlement program for children whose family income falls between state AFDC payment levels and some outer limit (for example, 125 percent of the federal poverty level). Children failing to qualify for or maintain Medicaid eligibility could be shifted onto coverage under this supplemental public-insurance program. Moreover, such a program could develop a more reasonable asset test than the one employed under the AFDC program (although welfare officials estimate that less than 5 percent of AFDC applicants are denied eligibility on the basis of excess resources).

A supplemental public-benefit health program for children makes both health and economic sense. Children who are stably insured could be enrolled over long periods of time with cost-effective providers, such as community health centers, HMOs, cost-efficient private group practices, or comprehensive public clinics. There is evidence that long-term enrollment in a stable preventive and primary health care system may actually reduce overall Medicaid costs (Keller 1983). Massachusetts has already established a supplemental public-benefit program for

pregnant women with family incomes between that state's Medicaid eligibility level and 185 percent of the federal poverty level. This type of program could be extended to poor and near-poor children. Additionally, the Governors of Arizona and New Jersey have included such plans for children in their fiscal year 1987 budget proposals, and Maryland lawmakers are considering a similar type of plan for pregnant teenagers.

Alternatively, states might consider making more aggressive use of their Medicaid flexibility more generously to finance public and quasi-public health care providers (such as community health centers) that are legally obligated to serve low-income children. Currently, many such clinical providers are poorly paid. Indeed, a number of state Medicaid programs fail to reimburse free-standing clinics for preventive, diagnostic, and treatment services rendered to Medicaid children unless the provider is a physician. These restrictive practices effectively give Medicaid agencies a "free ride" on the backs of health department clinics, community health centers, and other publicly obligated providers desperately in need of revenues to help offset their large caseloads of uninsured poor patients.

Instead of financially starving these providers, Medicaid agencies should include in their state plans coverage for all clinic services, not just those furnished by selected clinical staff. Reimbursement should be set on the basis of clinics' reasonable charges for the comprehensive health care they provide. This higher level of Medicaid reimbursement could provide clinics with greater revenues, thereby enhancing their operations.

Third, states might provide direct grants to providers giving ambulatory services to large numbers of low-income children. Massachusetts, Connecticut, Texas, Florida, South Carolina, Ohio, Rhode Island, and New York all currently provide direct grants to one or more types of comprehensive clinics serving the poor. Were such supplementation combined with enhanced Medicaid reimbursement a more comprehensive public health system for low-income children might be developed.

In the long run, states might consider establishing a program to provide publicly subsidized insurance coverage for poor and near-poor working families. A number of states, including New York, South Carolina, Florida, and West Virginia, have established revenue policy mechanisms for underwriting specific types of medical care, such as

hospital services for poor and uninsured persons. Revenues for these pools are collected from a variety of sources, including taxes on hospitals, insurers, other types of taxes, and state and local contributions.

These pools might ultimately be used to underwrite a public insurance plan under which poor and near-poor families could buy coverage on an income-adjusted, sliding premium basis. Were such pooled money used simply to purchase private insurance for these families, problems might develop, since many private plans have poor coverage of preventive health benefits, utilize high coinsurance and deductibles, involve costly premiums, and provide coverage on an indemnity basis (which presents an impossible situation for low-income families, who cannot lay out cash first and collect from their insurer later). Publicly controlled plans would be less expensive to states and would permit states to control plan features. Massachusetts is currently considering such a plan.

We also strongly urge that *all* public child health financing mechanisms, whether Medicaid or supplemental public programs utilize EPSDT protocols. While remedying the basic financing dilemma is crucial, equally as important is the quality and content of the care that is purchased with public funds. EPSDT is an enduring articulation of sound medical practice, and its provisions should be adhered to, not undercut.

We hope that some day all child health financing mechanisms, whether public or private, will incorporate a complete EPSDT-level schedule of preventive and primary health benefits. Congress is now, in fact, considering legislation, known as the Child Health Incentive Reform Plan (CHIRP) which would require all employer-purchased health insurance plans to include coverage for certain preventive pediatric services such as health examinations and immunizations, in order to qualify for federal tax treatment. There is precedent for legislation imposing conditions on the deductibility of employer-financed coverage. Recently enacted federal legislation requires employers to extend coverage at group rates to families of deceased or divorced workers as a condition of tax deductibility. Furthermore, many states now mandate minimum benefits for insurance plans.

We are hopeful about the potential for reform. Policy makers are increasingly recognizing the need to come to grips with the health care financing gap that confronts low-income children. Indeed, the National Governors Association has recently recommended a major

expansion of federal Medicaid eligibility requirements for low-income women and children, with financing to be shared by the federal government and the states. This organization's commitment to maternal and child health, in an era of major fiscal retrenchment at all levels of government, is remarkable.

Without doubt, reshaping the health care financing and service delivery system for low-income children is one of the most sophisticated tasks facing state and federal policy makers. But we believe that the task of reconciling child health goals with program realities is one that can be successfully undertaken with patience, inventiveness, and relatively modest outlays.

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