At Risk: Medicaid's Child-Focused Benefit Structure Known as EPSDT

by Tricia Brooks and Kelly Whitener

The federal benefit standard in Medicaid ensures that low-income and vulnerable children receive the health care services they need to grow and thrive. But this standard is at risk. Proposed cuts to Medicaid and CHIP funding could make EPSDT unaffordable to states, and in turn, proposed changes to federal policy, including legislative and administrative action, could potentially give states the option to eliminate the standard except as it applies to children with disabilities. Such a move would be shortsighted as children with serious disabilities make up only a small share of children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) who benefit from EPSDT.

Introduction

Medicaid and CHIP provide health coverage to more than one third of all children and an even larger share of the country's most vulnerable children: children living in or near poverty; infants, toddlers and pre-schoolers during formative early development years; children with special health care needs; and children who have suffered neglect and abuse leading to placement in foster care. These children have a higher need for health care and live in families with a lack of resources to pay for it.

Medicaid's comprehensive, child-focused benefit standard, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, was enacted in 1967 as part of a broader effort to improve pediatric health care quality.[1] Its focus was to improve the capacity of the health care system to identify, assess, and treat children with early signs of physical and mental health conditions that may affect growth and development. The initiation of EPSDT was precipitated by research from early Head Start demonstrations and the health exams of young Vietnam War draftees highlighting the need for improvements in health care delivery for children.[2] EPSDT stands as the single most important public policy effort ever undertaken to define an appropriate health services coverage standard embedded in developmental pediatric practice. It remains as relevant today as it did 50 years ago.[3]

Thirty years after EPSDT was introduced, the Children's Health Insurance Program (CHIP) was enacted by Congress to encourage states to build on the success of Medicaid and expand coverage to moderate-income uninsured children. As an incentive, states were granted more leeway in designing their CHIP programs but many states use Medicaid or provide EPSDT benefits to some or all CHIP-funded enrollees, as discussed in more detail below.

This brief describes the federal benefit standards for Medicaid and CHIP and the importance of EPSDT services in meeting the health care needs of the low-income and vulnerable child populations served by these critical safety net programs. Eliminating EPSDT would mean that millions of children with ongoing special health care needs, as well as children who experience an acute need for EPSDT's developmentally-focused benefits, would no longer be guaranteed access to the services they need to succeed in school and in life.

Key Findings

- Medicaid serves the lowest income and most vulnerable children who have higher health care needs than the general population and live in families without the resources to pay for needed care.
- Medicaid's comprehensive, child-focused benefits are uniquely designed to meet these higher health care needs and to maximize a child's potential by addressing developmental delays and health conditions that affect school performance and success in life.
- Restructuring Medicaid financing or cutting funding for Medicaid or CHIP would shift costs to states and likely result in cuts to eligibility or benefits for children, including the potential elimination of EPSDT standards. Without EPSDT's child-focused, pediatrician-recommended benefits, Medicaid coverage could fall short of meeting the health care needs of millions of children, particularly those with special health care needs.

Federal Medicaid Benefit Standards for Children

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guarantees that all children enrolled in Medicaid receive comprehensive services to assure their healthy development. EPSDT addresses a full scope of child health services, including screenings for physical and mental health, growth, and development, as well as nutritional status. In practice, EPSDT means that children covered by Medicaid must be screened regularly for healthy development and a comprehensive range of conditions, and treatment must be provided as needed.

Under EPSDT, states must assess and identify health problems and developmental delays early by checking children's health at periodic, age-appropriate intervals developed in consultation with recognized medical organizations. These intervals are defined through a schedule of recommended screenings and diagnostic tests, such as Bright Futures—the periodicity schedule developed by the American Academy of Pediatrics that more than two-thirds of states have adopted or adapted.[4] The periodic checkups must include assessments of physical, mental, social, and emotional development, as well as dental, hearing, and vision screenings and any other evaluations and tests necessary (such as lead screenings) to detect potential problems.

If a screening indicates that further evaluation is needed, children must be provided all medically necessary services to diagnose and treat conditions discovered or reduce the burden of illness. Medical necessity is determined on a case-by-case basis, taking into account a particular child's needs and physician's recommendation. As long as federal law allows Medicaid to pay for the services, they must be provided to children who need them—even if the state does not include the services in their Medicaid state plan or offer the services to adults in Medicaid. Although states may set provisional limits on services (like 20 speech therapy visits per year), they cannot impose an absolute limit on pediatric benefits if the service is medically necessary.

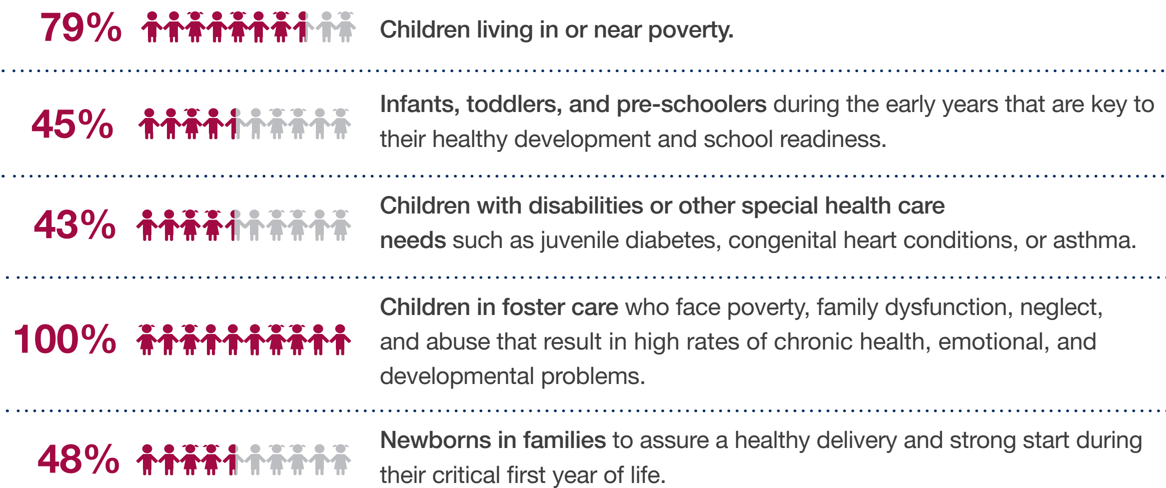
Medicaid also covers dental services for children as part of EPSDT, which requires a separate periodicity schedule. While oral screening may be done as part of a physical exam by a medical professional, dental examinations performed by a dentist are also required in accordance with the state's dental periodicity schedule. The dental periodicity schedule must be developed in consultation with recognized dental organizations involved in child oral health care. Dental services must include relief of pain and infections, restoration of teeth, and maintenance of oral health. Screenings and dental services must be provided at regular intervals that meet reasonable standards of dental practice and more frequently if medically necessary.

Children's Health Needs

Children served by Medicaid and CHIP can be distinguished primarily by family income, with Medicaid serving the lowest income children (minimally below 133 percent of the Federal Poverty Level (FPL) or about $27,000 per year for a family of three). CHIP stands on the shoulders of Medicaid, serving children in families with low- to more moderate-income (the income eligibility threshold varies across states but the median is 255 percent FPL). Medicaid also serves other vulnerable children—namely infants born to women covered by Medicaid, children in the child welfare system, and children with disabilities and other special health care needs (see Figure 1).

Figure 1. Medicaid and CHIP serve the United States' most vulnerable children.

A large share of at-risk children rely on public coverage, as reflected by the percentage of United States children in each group below that depend on Medicaid and CHIP for health care they need to thrive:



Low-Income Children

Children of all income levels may have disabilities or special health care needs but studies show a direct correlation between income and health status: the lower one's income, the greater likelihood of disease and premature death. This fact extends to children, with infant mortality and children's health strongly linked to family income among other factors.[5] Although it may be intuitive to understand how health is tied to income for the very poor or the very rich, there is a gradient relationship between income and health—the two are connected step-wise at every level of the economic ladder.[6] It is important to recognize this correlation to fully appreciate the importance of Medicaid's more defined and wide-ranging benefits in meeting the needs of the low-income children served.

Lower income children experience higher rates of asthma, heart conditions, hearing problems, digestive disorders, and elevated blood lead levels. Poor children also have more risk factors for disease, such as childhood obesity, which is a strong predictor of obesity as an adult.[7] Based on the National Survey of Children's Health, parents with incomes below the poverty level are more likely to report that their child is in poor or fair health; has a high risk of developmental, behavioral, or social delay; and has one or more conditions that consistently affects their daily activities compared to children in families with higher income families (see Table 1). Moreover, because of their low-incomes these families cannot afford the cost of services that might be excluded if Medicaid benefits did not encompass the full scope of EPSDT services.

Table 1. Parent-Reported Children's Health Care Needs by Family Income Level[8]

Federal Poverty Level (FPL)	Fair/Poor Health Status (Overall health status)	High risk of developmental, behavioral or social delay	Daily activities, consistently affected, often a great deal	2 or more chronic conditions	Condition of child's teeth fair/poor
<100% FPL	7.1%	18.6%	37.5%	13.1%	15.4%
100 - 199% FPL	3.5%	10.7%	30.4%	9.9%	9.8%
200 - 399% FPL	2.0%	7.4%	24.8%	9.0%	4.8%
> 400% FPL	0.8%	7.2%	18.4%	7.3%	2.6%

Pregnancy and Newborn Care

Rates of low birth weight are highest among infants born to low-income mothers, and these children often need extra care and services in order to catch up developmentally and be ready to enter school. Medicaid and, in some states, CHIP help to assure a healthy start in life for newborns by covering women during pregnancy. All states provide Medicaid coverage to pregnant women with incomes up to at least 133 percent FPL, although the median eligibility across the states is just over two times the poverty level. Additionally, six states use CHIP funds to cover more moderate-income pregnant women.[9] Medicaid and CHIP coverage helps to assure a healthy birth by providing prenatal care, labor and delivery services, and postpartum care. Moreover, infants born to a woman covered by Medicaid or CHIP are guaranteed coverage during the critical first year of life.

Foster Care Children and Youth

Medicaid serves virtually all children in foster care. These children face poverty, family dysfunction, neglect, and abuse, and they have high rates of chronic health, emotional, and developmental problems.[10] Approximately 35-60 percent of children placed in foster care have at least one chronic or acute physical health condition that needs treatment, including growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, sexually transmitted diseases, and complex chronic illnesses.[11] An estimated 30-40 percent of foster adolescents face mental health issues, including posttraumatic stress disorder.[12] Youth who age out of foster care are more likely than their peers to report having a health condition that limits their daily activities and to participate in psychological and substance abuse counseling.[13] The research sharply illustrates that physical and mental health care issues persist over time. Given these statistics, it is clear that the need for access to physical and mental health services continues as youth strive to attain independence and self-sufficiency in transitioning to adulthood.

Children with Special Health Care Needs

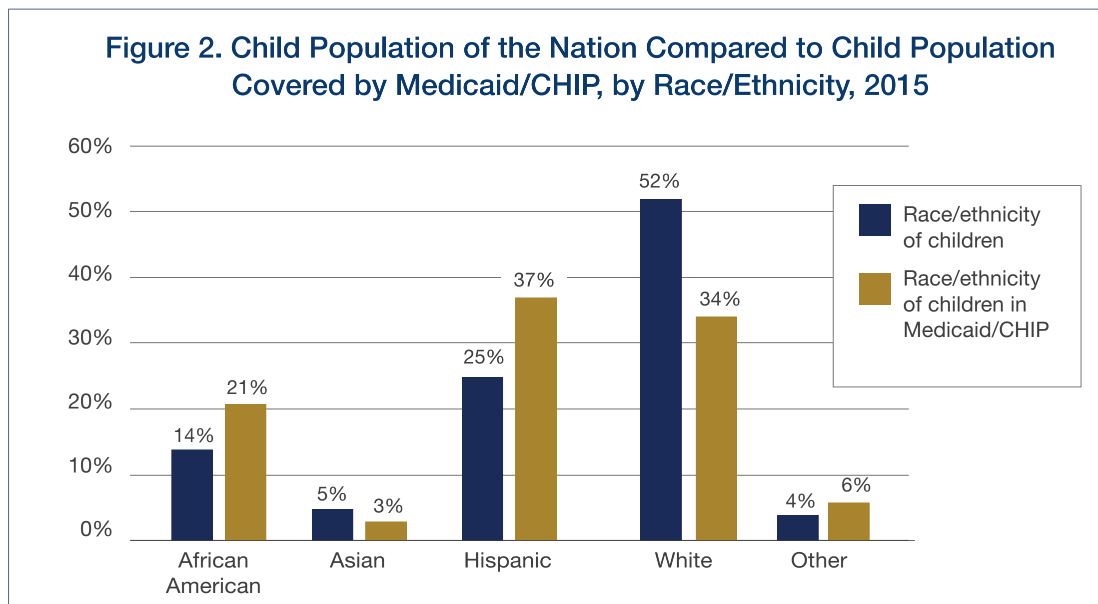
In the 2011-12 National Survey of Children's Health, parents reported that nearly 6.3 million children enrolled in Medicaid or CHIP have special health care needs.[14,15] These children have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and require health services of a type and amount beyond that required by children generally. It is important to note that the vast majority of children with special health care needs qualify for Medicaid on the basis of age and income, not disability.

Children with Disabilities

All states must cover low-income blind or disabled children, and most states base eligibility on the Social Security Administration's definition of disabled.[16,17] In 2012, approximately 1.3 million children were qualified as disabled and receiving Supplemental Security Income (SSI),[18] which results in automatic enrollment in 35 states.[19] Additionally, all but one state has used flexibility in the federal rules to extend optional Medicaid to children with severe disabilities who would qualify for institutional care through a program named Katie Beckett or through other home and community based waiver programs.[20] Importantly, these children have more extensive health care needs than those who are non-disabled but only those receiving SSI are guaranteed Medicaid coverage as a disabled child under federal rules.

Children of Color

Medicaid serves a disproportionate share of children of color who are often economically disadvantaged (see Figure 2). For example, African American children represent 14 percent of the child population but 21 percent rely on Medicaid for health care. The share of Latino/Hispanic children relying on Medicaid is even higher at 37 percent, while these children make up only one-quarter of the U.S. child population.[21] Addressing racial and ethnic health disparities is a critically important goal and EPSDT helps to provide the wide-ranging benefits children of color may need to thrive in school and in life.



Medicaid Benefits Are a Model for Many CHIP Programs

States have options in designing and limiting benefits covered under CHIP but may also use CHIP funds to expand Medicaid. States that cover CHIP-funded children in Medicaid must follow all of the Medicaid benefit rules described above, including providing EPSDT benefits. In 2015, more than half (56 percent) of the 8.4 million children enrolled in CHIP received EPSDT benefits through Medicaid expansion programs.[22, 23, 24] Additionally, 11 of the 36 states with separate CHIP programs have recognized that Medicaid's comprehensive benefit structure is uniquely designed to meet the full scope of children's health and developmental needs by providing the EPSDT benefit package in CHIP as Secretary-approved coverage.[25] And two other states provide an EPSDT-like benefit to some CHIP enrollees. This means that, in addition to all Medicaid eligible children, approximately two-thirds of all CHIP-eligible children are receiving EPSDT services.[26]

The Impact of Federal Financing on Children's Benefits in Medicaid and CHIP

Policy and financing changes at the federal level could have a significant impact on Medicaid and CHIP coverage for children going forward. While the nation's historic gains in coverage for children—more than 95 percent of all children have health coverage—illustrates the positive impact of Medicaid and CHIP, coverage is not all that is at risk. States would have limited choices in offsetting reductions in federal Medicaid support: raise taxes, cut eligibility, reduce benefits, or decrease provider payments. And with children representing over 50 percent of all Medicaid enrollees, there is simply no way states can absorb significant cuts in Medicaid without impacting children.

Medicaid is widely viewed as a cost-effective program with annual cost increases that are notably lower than private insurance.[27] Among all Medicaid eligibility groups, children are the lowest cost.[28] The fact that children have access to a broad array of EPSDT services does not mean that Medicaid pays for unnecessary services. All services are based on medical necessity. And even when capitation rates are established for managed care, they are based on actual utilization of services. If a state were to opt not to provide EPSDT services or be forced to reduce benefits as a result of cuts in federal funding, it would do so at the risk of neglecting children's needs. If states are not required to provide all medically-needed services, they could essentially discriminate against children with pre-existing conditions, which is not allowed under current law.

Restructuring Medicaid Financing

The legislative proposal (the American Health Care Act (AHCA)) recently passed by the U.S. House of Representatives repeals and replaces the Affordable Care Act (ACA), as promised. But it also proposes a radical restructuring that would cap the federal investment in Medicaid and essentially end coverage for newly eligible adults, culminating in a 25 percent cut in federal Medicaid funding by 2026.[29] To make that bitter pill more palatable to cash-strapped states, the AHCA, among other policy changes, would make EPSDT benefits optional for all but disabled children.[30] An alternative proposal crafted by four Governors would have accomplished the same result for EPSDT.[31] Under both proposals, politicians—not pediatricians—would be empowered to decide what benefits children should receive. There would no longer be a guarantee of the comprehensive services to ensure the healthy development of the nation's lowest-income and most vulnerable children; instead, geography could play a larger role in determining the status of child health.

Administrative Action

The new executive branch of the federal government has also signaled its willingness to accommodate state requests to waive federal Medicaid standards. In a letter to Governors, the HHS Secretary and CMS Administrator have promised to work with states to revamp the federal and state Medicaid partnership.[32] If the majority in Congress is unable to accomplish its goal of limiting future funding for Medicaid through the AHCA, the administration could step in and allow states to limit EPSDT through waivers. Additionally, the Secretary has the authority to approve or waive some CHIP benefits. If federal funding for Medicaid or CHIP is limited in any way in the future, states could seek fiscal relief through this path.

Federal Financing for CHIP

CHIP is currently financed through September 2017. Unless Congress acts to extend funding, some states will exhaust their current allotment of funds in 2017, jeopardizing the coverage of over a quarter of CHIP children by the end of the calendar year. While all states will run out of funds in 2018, funding for almost two thirds of CHIP children will run out by March 2018.[33] Ultimately, all CHIP benefits for the nearly 9 million children and pregnant women it serves would be at risk.

Conclusion

Proposals to limit EPSDT benefits to children with disabilities fail to recognize that most children with special health care needs do not qualify for Medicaid based on a disability status. As previously discussed, approximately 6.3 million children enrolled in Medicaid have special health care needs. Yet only approximately 1.3 million qualify for mandatory Medicaid coverage as a disabled child. This illustrates that if EPSDT were limited to “disabled” children, millions of children with special health care needs could experience gaps in needed services.

And even healthy children can experience a temporary need for EPSDT’s comprehensive screening, diagnostic, and treatment services. Take for example a child with delayed language skills. Appropriate screening and treatment could uncover the need for a simple remedy such as fitting the child for hearing aids to correct a hearing loss problem, plus speech therapy to help language skills develop. Without adequate services, the child could suffer longer-term language delays leading to poor performance in school or more permanent hearing loss. Parents know that their children could encounter a serious health problem at any time and EPSDT protects them against that unknown risk.

Moreover, cuts to Medicaid and CHIP could have a chilling effect on emerging efforts to address the social determinants of health more broadly through EPSDT. Specifically, a recent update to Bright Futures incorporated screenings for poverty, caretaker depression, and other social determinants of health. A lack of federal financing support could suppress innovation in health care such as New York’s efforts to test the use of a value-based purchasing to improve school readiness.[34] The pilot project is aimed at increasing the percentage of children who are developmentally ready when they enter kindergarten, a useful predictor for third-grade literacy, which in turn is a predictor for high school graduation, incarceration, and employment.

There were clear and compelling reasons when EPSDT was adopted as a federal standard in Medicaid—half of young men drafted to serve in Vietnam failed the baseline health exam.[35] It would be shortsighted of the federal government to lower Medicaid benefit standards for the nation’s children or cut funding that forces states to reduce coverage and benefits for children. Medicaid is a long-term investment in children’s academic achievement, health as adults, and economic success in life. As stated by the American Academy of Pediatrics in their pre-election blueprint for children: “The next administration must preserve these successes, build upon this progress, and create a stronger foundation for future generations—which will reap benefits for the nation’s workforce, productivity, military readiness, and economic performance.”[36]

Endnotes

[1] S. Rosenbaum, S. Wilensky, K. Allen, "EPSDT at 40: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System," Center for Health Care Strategies, July 2008.

[2] Ibid.

[3] Ibid.

[4] Georgetown University Center for Children and Families analysis of state periodicity schedules obtained from the Center for Medicaid and CHIP Services.

[5] S.H. Woolf, et al,, "How are Income and Wealth Linked to Health and Longevity?," Virginia Commonwealth University Center on Society and Health and the Urban Institute (April 2015), available at http://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.

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[7] Ibid.

[8] National Survey of Children's Health 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved April 21, 2017 from www.childhealthdata.org.

[9] T. Brooks and K. Wagnerman, Georgetown University Center for Children and Families, and S. Artiga, E. Cornachione, and P. Ubri, Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey," January 2017, available at http://ccf.georgetown.edu/wp-content/uploads/2017/01/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-1.pdf.

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[11] E. P. Baumrucker, A. L. Fernandes-Alcantara, E. Stoltzfus, et al., "Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues," Congressional Research Service (February 27, 2012).

[12] P. Jaudes, et al., "Policy Statement: Health Care of Youth Aging Out of Foster Care," American Academy of Pediatrics, December 2012. Accessed online on May 5, 2015, at http://pediatrics.aappublications.org/content/130/6/1170.full.pdf.

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[14] National Survey of Children's Health 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved April 21, 2017 from http://childhealthdata.org/browse/survey/results?q=2546&r=1&g=466.

[15] The National Survey of Children's Health uses the CSHCN Screener© to identify children with special health care needs. The Screener is a five item, parent-reported tool designed to reflect the federal Maternal and Child Health Bureau's consequences-based definition of children with special health care needs. It identifies children across the range and diversity of childhood chronic conditions and special needs, allowing a more comprehensive and robust assessment of children's needs and health care system performance than is attainable by focusing on a single diagnosis or type of special need. This instrument has been used in several national surveys including the Promoting Healthy Development Survey, the CAHPS-CCC, the NSCH, the NS-CSHCN, and MEPS. The CSHCN Screener was developed by the Child and Adolescent Health Measurement Initiative (CAHMI).

[16] Under the Supplemental Security Income program, a child is considered disabled with s/he has a physical or mental condition that very seriously limits activities, and is either terminal or expected to last more than year. For more information, see https://www.ssa.gov/pubs/EN-05-10026.pdf.

[17] In 35 states, children with disabilities or who are blind and qualify to receive Supplemental Security Income (SSI) are automatically enrolled in Medicaid. Eight states (AK, ID, KS, NE, NV, OK, OR, and UT) use the same eligibility rules for SSI and Medicaid but a separate Medicaid application is required. Eight states (CT, HI, IL, MN, MO, NH, ND, and VA) use their own eligibility rules for Medicaid and require a separate Medicaid application. Source: MACPAC, https://www.macpac.gov/publication/medicaid-income-eligibility-levels-as-a-percentage-of-the-fpl-for-individuals-age-65-and-older-and-people-with-disabilities-by-state/.

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[22] Medicaid and CHIP Payment and Access Commission, "Exhibit 31. Child Enrollment in CHIP and Medicaid by State, FY 2015," available at https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-31.-Child-Enrollment-in-CHIP-and-Medicaid-by-State-FY-2015.pdf.

[23] States may design their CHIP programs in one of three ways: 1) as an expansion of Medicaid where the state receives CHIP funding to cover uninsured children in Medicaid above the Medicaid income eligibility level; 2) as a separate program where states receive CHIP funding to cover children in a standalone program; or 3) as a combination of the two approaches. Most states have a combination program, with some children paid for by CHIP but covered through Medicaid and some children covered in a standalone CHIP program.

[24] Centers for Medicare & Medicaid Services, Children's Health Insurance Program Plan Activity as of May 1, 2015, available at https://www.medicaid.gov/chip/downloads/chip-map.pdf. Forty states have combination programs, 8 states and D.C. have a Medicaid-expansion CHIP program only, and 2 states have a standalone CHIP program only.

[25] A. Cardwell, et al., "Benefits and Cost Sharing in Separate CHIP Programs," National Academy of State Health Policy and the Georgetown Center for Children and Families, May 2014, available at http://ccf.georgetown.edu/wp-content/uploads/2014/05/Benefits-and-Cost-Sharing-in-Separate-CHIP-Programs.pdf.

[26] CCF analysis of enrollment in CHIP enrollment in states that have adopted EPSDT benefits for CHIP enrollees.

[27] Georgetown University Center for Children and Families analysis of National Health Expenditure "Age and Gender Tables" from the Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/2012GenderandAgeTables.zip. Totals for the age group 0-18 were analyzed from tables 25 and 27.

[28] C. Truffer, C. Wolfe, and K. Rennie, "2016 Actuarial Report on the Financial Outlook for Medicaid," Office of the Actuary, Centers for Medicare & Medicaid Services, and the Department of Health & Human Services (January 2017).

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[30] American Health Care Act, as reported in House March 24, 2017: CR H2393-2405. See page 2398 creating a new §1903A(i)(2)(A)(iii), available at https://www.congress.gov/crec/2017/03/24/CREC-2017-03-24-pt1-PgH2393.pdf.

[31] See page 10 of letter from J. Kasich, R. Snyder, B. Sandoval, and A. Hutchinson to Senator McConnell and Speaker Ryan, dated March 16, 2017 and available at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=S_gEqkALBFY%3d&tabid=160.

[32] See March 14, 2017 letter from HHS Secretary Price and CMS Administrator Verma to Governors, available at https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

[33] Medicaid and CHIP Payment and Access Commission, "Federal CHIP Funding: When Will States Exhaust Allotments?," March 2017, available at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-CHIP-Funding-When-Will-States-Exhaust-Allotments.pdf.

[34] As part of New York's Delivery System Reform Incentive Payment (DRSIP) Program, the state has embarked on a pilot program aimed at providing incentives to providers to meet specific standards for development screenings as a way to improve school readiness. For more information, see https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/clinical_advisory_group.htm.

[35] S. Rosebaum, et al., "National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT," George Washington University Department of Health Policy, April 2005, available at http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/mil_prep042605.pdf.

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