MEDICAID MUST CONTINUE TO GUARANTEE NECESSARY CARE FOR CHILDREN

Children's Defense Fund

The Medicaid proposal of National Governors Association (NGA) would reduce the scope of Medicaid benefits now guaranteed to children through "EPSDT" (Early and Periodic Screening, Diagnosis and Treatment). The proposal would repeal the guarantee, enacted with bipartisan support in 1989, that children must receive all services that are medically necessary to treat their conditions.

EPSDT currently covers screenings to identify the physical, mental, dental, vision and hearing problems of children. Services required after a problem is diagnosed include physician and hospital care, eyeglasses, dental services, and hearing aids, and such other health care as is necessary to treat conditions discovered by the screening, whether or not all such care is covered for Medicaid-eligible adults in the state. Some state officials claim that this provision is costly. Others assert that such federal guarantees are unnecessary, since states are certain to protect children. Both claims are unfounded. Diluting the EPSDT guarantee would harm the health of children and the nation, without any good reason.

Those who would single out children for elimination of medically necessary care -- and only medically necessary care is required under EPSDT -- have a heavy burden of justification. Children are not small adults. They have unique developmental needs, and investments in their health are relatively inexpensive and uniquely cost-effective. If children are denied essential health care when they are young and growing, significant consequences can be felt for a lifetime.

Reducing children to the same mandatory benefits for adults, for example, would apply an adult-oriented package to the needs of children. Children and adults have different health care needs. Children need more preventive care (check-ups, screenings, vaccinations). Children also need less routine treatment of illness, such as physician visits, prescription drugs and hospital stays for heart conditions, ulcers, etc. But a small number of special needs children with serious conditions need much intensive care, such as rehabilitation, home health care and hospitalization. In a sense, children use more of the very "front end" and "back end" of the system; adults use more of the middle. A mandatory benefits package that emphasizes the middle disadvantages children and structures the program around adult needs, without any good reason.

1. EPSDT is not expensive or burdensome for states.

- EPSDT benefits for children are inexpensive. In 1994, the average annual cost for all children on Medicaid, including the severely disabled, was $1381 per child. By contrast, average annual costs per adult Medicaid beneficiary were $4907.
- The 1989 EPSDT law that is now under attack had very little effect on state costs. When health care inflation is taken into account, 1994 expenditures of state Medicaid funds per low-income child were only $54 higher than they were in 1988, before the EPSDT treatment guarantee was adopted.

2. Without federal safeguards, many states would eliminate essential health care for children.

<u>If the EPSDT treatment mandate is repealed, children would lose current guarantees of essential care</u>. Current law guarantees children many developmentally crucial services that are optional for adults and are not covered by many state Medicaid programs for adults, including:

- physical therapy, which 10 states do not cover for adults;
- speech therapy, which 13 states do not cover for adults;
- rehabilitative services, which 7 states do not cover for adults; and
- respiratory care services, which 40 states do not cover for adults.

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510

EPSDT also protects children from arbitrary limits on the amount, duration, and scope of services for adults. For example, according to the 1993 Medicaid Resource Book, Alabama limits inpatient hospital services to 14 days per year, and six other states have yearly limits ranging from 15 to 30 days. Seven states limit physician office visits to as few as 12 visits a year. Other states limit the number of prescriptions covered per month. While most children would never hit such service limits, these limits would be devastating to the sickest and most disabled children.

Many states sharply limit benefits under non-Medicaid, state health programs for children. This suggests what may happen to children covered by Medicaid if federal benefits standards are weakened. While the states with their own health programs that reach non-Medicaid children tend to be those most concerned with children's health, these programs that are unconstrained by any federal guarantees still include serious gaps in benefits. A National Governors Association survey found that, of 28 non-Medicaid, state health programs for children:

- 16 cover no physical therapy;
- 15 cover no mental health services;
- 16 cover no vision care;
- 19 cover no substance abuse treatment;
- 10 cover no care for hearing defects; and
- 20 cover no dental care.

Other state policies on children's health care show the need for federal safeguards. When states had freedom to set eligibility rules comparable to that now sought for services, states denied millions of poor children essential health coverage. For example, in 1989, before Congress finally stepped in and mandated coverage, states denied then-optional Medicaid coverage to more than 3 million infants and pregnant women in working families with incomes above state welfare levels (typically about 70% of the poverty line) and below 133% of poverty. There is no reason to believe states would act any differently today if federal standards on benefits are weakened.

Without the EPSDT treatment guarantee, a per capita cap would cause many states to cut necessary care for children. A per capita cap would force cuts in benefits or provider payments. In state capitals, poor children will compete with nursing homes, hospitals and HMOs -- extremely powerful provider groups -- for limited federal funds. Services newly optional for children could easily be cut to protect provider reimbursement levels.

Moreover, a "race to the bottom" is likely to result if states are allowed to deny more expensive services to the relatively few very ill and disabled children who need them. For nearly one million disabled children, Medicaid is a lifeline. While few families will change their state of residence to obtain routine health care, some families whose children have great medical needs will move if necessary to obtain care that determines whether their children can lead healthy, functional lives. States may "race to the bottom" to avoid the cost of caring for such children. Because relatively few children use these expensive services, states will not save very much, in the broader Medicaid context. But the children who desperately need this care will suffer grim consequences.

For more information, please contact either Stan Dorn (202) 662-3595 or Gregg Haifley (202) 662-3541 at the Children's Defense Fund.

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