

Op-Ed

When Old Is New: Medicaid's EPSDT Benefit at Fifty, and the Future of Child Health Policy

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IN 2017, MEDICAID'S SPECIAL CHILDREN'S BENEFIT—KNOWN AS early and periodic screening, diagnosis, and treatment (EPSDT)—turns 50. The rationale for the legislation establishing EPSDT as a mandatory benefit for children resonates as strongly today as it did in 1967. Given what we now know about the impact of poverty on health during childhood and beyond, we owe our poorest children and adolescents no less than what EPSDT guarantees.¹

The original Medicaid statute contained no special children's coverage rules. Like adults, children enrolled in Medicaid were entitled to a range of benefits and services necessary to treat acute and long-term health conditions. Preventive services were an optional benefit category that states could cover if they chose. However, because of a basic Medicaid requirement that similarly situated beneficiaries be treated similarly, any state that tried to add more benefits for children likely would have been barred from doing so.

This changed in 1967, when 2 years after Medicaid's enactment, Congress amended the law to draw an exception to the comparability rule and to fundamentally alter the terms of children's coverage. Enacted as part of the 1967 Social Security Amendments (Pub. L. 90–248), the legislation restructured Medicaid's terms to include what ultimately came to be understood as a special children's coverage standard with no counterpart in either public or private insurance. Congress further strengthened the EPSDT standard in 1972 under the Nixon administration and again in 1989 under President George H. W. Bush.

Ironically, the original 1967 amendments were aimed primarily at what was then known as the Title V Maternal and Child Health and Crippled Children's Program (renamed the Maternal and Child Health Services Block Grant in 1981); the initial Medicaid legislation was

understood simply as conforming public insurance to the screening, diagnostic, and treatment requirements made part of all state Title V programs.² Ultimately, as the full meaning of the Medicaid entitlement became increasingly clear, and as Congress moved to strengthen the Medicaid EPSDT provisions directly, the Medicaid reforms completely eclipsed those directed at the far smaller Title V program.

The EPSDT amendments were a policy response to two distinct developments, both of which had a profound impact on President Lyndon B. Johnson, who proposed the reforms to Congress. The first was research—carried out in connection with the early Head Start demonstrations—documenting the extent to which impoverished preschool children already were exhibiting signs of physical and mental health conditions carrying lifelong consequences if untreated.³ The power of the research was captured in President Johnson's Letter to Congress transmitting his child health proposal:

In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder, these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation.

The second development, which occurred several years earlier, was a study conducted by the Task Force on Manpower Conservation, established by President John F. Kennedy only weeks before he was assassinated; its charge was to investigate the astounding 1962 failure rate of 49.7% among young Selective Service draftees, whose documented physical and mental disabilities disqualified them from service.⁴ The 1964 report, which linked health and poverty data, presented heart-breaking findings: disqualification resulting from "bones and organs of movement diseases and defects" (1,571/10,000); disqualification resulting from vision disorders (974/10,000); disqualification based on hearing defects (628/10,000); disqualification based on psychiatric disorders (1,223/10,000). The list went on and on. In effect, the study offered evidence of the terrible consequences for national security of child health neglect. President Johnson viewed the report as "dramatic evidence" of poverty's impact on American life and called for reforms to ensure that "no young person, whatever the circumstances, shall reach the age of 21 without the health, education, and skills" essential to "effective" citizenship.

The 1967 EPSDT amendments were fully intended to reverse these conditions. The government would not simply pay for health care; it would undertake affirmative efforts to find, examine, and treat children in need of care, thereby ensuring not just coverage but access. Under the terms of the legislative text, Title V agencies were directed to provide for the “early identification of children in need of health care and services, and for health care and treatment needed to correct or ameliorate defects or chronic conditions discovered thereby, through . . . periodic screening and diagnostic services, and . . . treatment . . . to correct or ameliorate defects or chronic conditions as may be discovered thereby.” Virtually identical language was used to define the mandatory Medicaid coverage itself. In 1972, in response to the Nixon administration’s refusal to implement the Medicaid amendments, Congress directly established case-finding and access as a formal Medicaid duty. Although the statute initially gave the secretary of the Department of Health, Education, and Welfare (renamed Health & Human Services in 1979) latitude to define the scope of EPSDT, Congress modified the statute in 1989 to directly codify its scope in legislation, mandating coverage of physical, mental, and developmental assessments; all necessary laboratory services, including assessment of blood lead level; all recommended immunizations, vision, dental, and hearing care; and all necessary treatments for physical and mental health conditions falling within the definition of “medical assistance,” even treatments not covered for adults aged 21 and older.

The course of implementation was challenging. Early on, systemic federal and state resistance was the norm. Later, numerous lawsuits were mounted to enforce EPSDT’s extraordinary coverage guarantee.⁵ Despite these struggles—hardly unusual in efforts to fundamentally change the way the health system operates—EPSDT has prevailed as the nation’s seminal policy statement regarding the health and health care obligations government owes its poorest children.

More than 30 years have passed since the federal government last updated its EPSDT regulations, which now lag badly behind not only the 1989 expansion amendments, but more importantly perhaps, the wealth of evidence regarding the role that health care should play in the lives of low-income children. Today, with nearly 1 in 3 American children insured through Medicaid, the transformative potential of EPSDT never has been stronger, given Medicaid’s sheer reach into pediatric health care

nationally. A comprehensive, inclusive effort to update and modernize federal EPSDT policy would require no additional legislative reforms. Given all we now know regarding the link between poverty and health, as well as Medicaid's ability to shape pediatric practice, an initiative to translate knowledge into action must be a priority.

References

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