

Medicaid: Health Promotion And Disease Prevention For School Readiness

Comprehensive well-child care is a good investment for society.

by Edward L. Schor, Melinda Abrams, and Katherine Shea

ABSTRACT: Medicaid's child health program, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), emphasizes health promotion and disease prevention as vehicles to ensure that children are ready for school and able to succeed in life. Required components of preventive care can be mapped to specific health outcomes that are important attributes of school readiness and prerequisites for educational success. The federal government and states can take specific action to assure that children receive all of the health care services, including preventive services, necessary to promote their optimal health and development and, thus, to maximize their future productivity. [*Health Affairs* 26, no. 2 (2007): 420–429; 10.1377/hlthaff.26.2.420]

AT ITS INCEPTION, MEDICAID'S Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the child health portion of Title XIX of the Social Security Act, intended preventive and child health care services to focus not only on children's current health care needs, but also on their future health. It recognized the contribution that health care could make to enable children to become contributing members of society. In a special message to Congress, President Lyndon Johnson said:

Recent studies confirm what we have long suspected. 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. Our nation must rid itself of this bitter inheritance. Our goal must be clear—to give every child the chance to fulfill his promise.¹

The legislation that he subsequently signed recognized that the nation's highest-risk children (Medicaid now covers about one-quarter of all children, most of whom live in low-income families and many of whom have special health care needs) were being held back by unidentified, untreated health problems.

Especially noteworthy was that the EPSDT program defined *health* broadly, emphasizing the promotion of both the physical health and the cognitive, social, and

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emotional development of children. In keeping with those objectives, it adopted a definition of *medical necessity*, a standard of care that recognized that health promotion, disease prevention, and timely treatment in the short term will allow young children to be ready to enter school and, ultimately, ready to succeed in life. The EPSDT program is also unique in that it provides the only major insurance benefit package designed explicitly to meet the needs of children.

This paper examines the contribution of good-quality well-child care, based on children's development, to children's school readiness; identifies the relationship between health insurance benefits and child health outcomes at school entry; and recommends actions that Medicaid programs can take to ensure that young children receive necessary services.

Investing In Services For Young Children

There is no longer any serious debate over the importance of early life experiences and environments in setting the stage for future development and achievement. Research has shown that at least half of the eventual educational achievement gaps among children exist at kindergarten entry and that these gaps widen rather than diminish as children move through the educational system.² Economists have concluded that the returns to human capital investments are greatest for the young.³ Although much of the evidence is derived from research on educational and social interventions with young children and their families, there is a growing body of evidence that lifelong patterns of health and well-being are established early in life.⁴ Consequently, assuring that young children and their families have access to resources and services that can promote early health and development is likely to pay large dividends over the life course.

■ **Special burden of poor children.** Children living in low-income households are at increased risk for poor health.⁵ Factors contributing to this disparity include less access to timely medical care and increased risk of accidents and illness. These same children also exhibit disproportionately poor developmental outcomes, possibly because of a lack of opportunity for stimulating interactions and experiences in their homes, such as reading, playing, having a daily schedule, and eating meals with the family.⁶ Since such risk factors are linked to poverty and early life experiences, there is much overlap of children's health and developmental morbidity.⁷

■ **Public programs for low-income children.** In response to the finding that health and developmental problems frequently co-occur, especially among children from low-income families, a number of public programs—most notably Head Start, Early Head Start, and Medicaid—were structured to promote comprehensive, multidisciplinary interventions and collaborative care.

School Readiness And The Goals Of Well-Child Care

In the larger policy arena, the child outcome of greatest current interest is school readiness, as the public has come to accept that the first five years of life are

critical to a child's lifelong development. Federal legislation, action by governors, and a variety of other efforts have emerged to ensure that children are ready for school.⁸ A three-year initiative of seventeen states reached consensus on a limited number of indicators of children's readiness for school in five domains: (1) physical well-being and motor development; (2) social and emotional development; (3) approaches to learning; (4) language development; and (5) cognition and general knowledge.⁹ Underlying these domains is the central belief that families need to be supported and strengthened, since child development is directly linked to how well the family functions.¹⁰

■ **Pediatricians' domains.** These domains are familiar to pediatricians who monitor and promote children's development, including their physical well-being and social and emotional development, through the provision of well-child care.¹¹ Developmental services—such as developmental surveillance and screening, parent education and counseling, referral to needed services, and care coordination—are core preventive child health care services that are specified in both American Academy of Pediatrics (AAP) policy statements and clinical guidelines.¹² Most pediatricians see themselves as responsible for identifying and addressing developmental problems and are well positioned to do so.¹³

Surveys of pediatricians reveal their belief that they should be responsible for identifying a variety of emotional and behavioral problems among children, and first among their goals in child health supervision is “to ensure normal development of children.”¹⁴ They report routinely discussing preventive care topics such as nutrition, physical and cognitive development, substance use, exercise, and safety with parents of their patients.¹⁵

■ **Demonstrated impact of preventive care.** Despite opinions to the contrary, the impact of a large number of the components of pediatric preventive care has been demonstrated. The U.S. Preventive Services Task Force has supported the provision of immunizations, oral fluoride supplementation, vision screening, and blood screening for elevated lead levels and a number of congenital metabolic disorders.¹⁶ A review of developmental services by researchers at the University of California, Los Angeles (UCLA), found evidence of the efficacy of the following developmental services: (1) structured inquiry into parents' concerns about development and behavior; (2) questionnaires to identify psychosocial risk factors children's environment that could impair their development; (3) parental education to increase sensitive and responsive parenting of infants; (4) parental education on infant temperament and how to manage challenging infants; and (5) parental education about healthy sleep habits, sleep problems, excessive infant crying, effective discipline, and book sharing to promote language development.¹⁷

The Healthy Steps for Young Children intervention, a controlled, randomized trial of structured, developmentally oriented well-child care, resulted in major improvements in the provision of recommended services, parents' approaches to discipline, and practice staff's responding to signs of parental depression.¹⁸

■ **Prevalence of developmental disorders in children.** There is much evidence that good-quality preventive care for young children is needed. An estimated 12–16 percent of all children have developmental and behavioral disorders.¹⁹ Thirty-nine percent of young children enrolled in Medicaid are estimated to be at risk of developmental, behavioral, or social delay.²⁰ Thirty-seven percent of all parents and 40 percent of parents of children on Medicaid worry that their child has a learning, behavioral, or developmental problem.²¹ Data from the Early Childhood Longitudinal Study, Kindergarten Class of 1998–1999 (ECLS-K) demonstrate that a large number of children entering school have health (31 percent), cognitive (20 percent), or social/emotional (31 percent) problems, and a large proportion lag behind in more than one of these developmental domains.²² Studies over the years have found an association between poor health, especially when poor health limits functioning, and school absence, special education placement, and diminished academic performance.²³

EPSDT Services And Structure: Designed For Children

■ **Correlation between EPSDT benefits and desired outcomes.** The EPSDT statute mandates the provision of a package of preventive services intended to address the child health and development issues discussed above. Exhibit 1 provides a side-by-side mapping of those benefits to the desired outcomes of well-child care for children during their first five years of life—that is, prior to school entry.²⁴ It is apparent that achieving each of these outcomes, and consequently achieving school readiness, requires the provision of one or more EPSDT services and that detection without treatment is incomplete care and cannot meet children’s needs.

■ **EPSDT’s unique standard of care.** Not only is EPSDT comprehensive in its benefits, but it also applies a different standard from that ordinarily used by private insurers—a preventive standard—to determine the medical necessity of care for children. Under this standard, treatment is considered to be necessary not only once a child is seriously ill but also “at the earliest possible time that an intervention is deemed to be medically beneficial to prevent the onset or worsening of a disabling condition.”²⁵

In 2001 the Bush administration affirmed Medicaid’s preventive standard in Medicaid managed care regulations, which state that health services related to “the ability to achieve age-appropriate growth and development” are considered medically necessary.²⁶ Health plans contracted to provide Medicaid services to children are also explicitly prohibited from restricting the preventive standard as a means to limit the scope of services provided to children. This standard is not found in any other health insurance program; it sets EPSDT apart as being uniquely able to promote children’s health and optimal development.

■ **Structural features of EPSDT.** Three structural features of EPSDT—the periodicity schedule of preventive care, the inclusion of care coordination services, and the mandate to obtain input from professional medical organizations—further illus-

EXHIBIT 1 Early And Periodic Screening, Diagnosis, And Treatment (EPSDT) Benefits And Recommended Health Care Outcomes

| Core EPSDT benefit | Health care outcome |
|--|--|
| Periodic and as-needed screening services Unclothed physical examination Comprehensive health history Mental health assessment Developmental assessment Immunizations Health education and anticipatory guidance | All developmental delays (emotional, social, cognitive, communicative) detected All congenital anomalies/birth defects detected All risks assessed, including maternal depression, family violence, family substance use, and signs of abuse or neglect Immunizations complete for age Parents able to anticipate and meet children's developmental needs All lead poisoning detected |
| Vision services | All vision problems detected and corrected optimally |
| Dental services | All dental caries treated |
| Hearing services | All hearing problems detected and actively managed |
| Other necessary health care to correct or ameliorate physical and mental illnesses and conditions | Management plans in place for all chronic health problems Parents knowledgeable about child's physical health status and needs All developmental problems treated and actively managed |
| Administrative services Informing of eligible children Transportation, scheduling, and other assistance in securing covered services and assistance in securing uncovered services Linkages to other agencies (special education, Title V, WIC, child welfare, etc.) Reporting | Parents understand and are able to fully use well-child care services Parents feel valued and supported as their child's primary caregiver and function in partnership with the child health care provider |

SOURCES: American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, "Recommendations for Preventive Pediatric Health Care," *Pediatrics* 105, no. 3 (2000): 645–646; M. Green and J. Palfrey, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 2d ed. (Arlington, Va.: National Center for Education in Maternal and Child Health, 2000); Center for Medical Home Improvement, "Medical Home Index," 2001, <http://www.medicalhomeimprovement.org/assets/pdf/MHIK-tools.pdf> (accessed 12 December 2006); and Rhode Island KIDS COUNT, *Getting Ready: Findings from the National School Readiness Indicators Initiative, A Seventeen-State Partnership* (Providence: Rhode Island KIDS COUNT, February 2005).

NOTE: WIC is Women, Infants, and Children.

trate the value of the EPSDT program for children's development.

Periodicity schedule. Federal guidance instructs states to establish a periodicity schedule in which services are provided "at intervals which meet reasonable standards of...practice and be established after consultation with recognized medical and dental organizations involved in child health care."²⁷ If health concerns arise in between scheduled well-child visits, federal Medicaid law requires states to provide screening "services at other intervals" to identify physical or mental illnesses or conditions.²⁸ This mandated flexibility for the interperiodic screen shows an appreciation for the diversity among children and the difficulty of detecting sometimes subtle health and developmental problems in preschool children.

Care coordination and case management. Care coordination and case management are also EPSDT services that are integral to promoting the healthy development of

children. Although many questions exist about the current scope, definitions, and financing of case management as a result of recent Medicaid reform legislation, the service remains a core element of the program.²⁹ Care coordination and case management help ensure that various medical services are linked, service providers and agencies are in communication, and, most importantly, children obtain the services they need.

Consultation with recognized medical organizations. The EPSDT requirement that state Medicaid programs consult with “recognized medical organizations involved in child health care” acknowledges that children’s health care needs are different from those of adults, especially in terms of their need for comprehensive health promotion and disease prevention services.³⁰ For the EPSDT program to realize its mission to promote child well-being and prepare children for school and future work, Medicaid policy officials—at both the federal and state levels—need to work closely and collaboratively with child health clinicians whose expertise is in health promotion and child development. Such collaboration will help ensure that children enter school healthy and ready to learn.

Medicaid Reform And Protecting Our Nation’s Future

■ **Deficits of current child health plans.** The future of U.S. child health coverage is a topic of great interest, but greater attention needs to be paid to the content and quality of that coverage. First, the benefit packages of typical private-sector insurance plans—those that are recommended as “benchmark plans”—are not designed for growing and developing children, and especially not for low-income children, who have rates of health care need that are higher than those of their higher-income peers. Frequently, such plans limit their scope of services to children inappropriately, do not apply a preventive standard of medical necessity, and do not have child health specialists consistently accessible.

Second, unlike EPSDT policies, some consumer-directed models of health insurance effectively cause preventive health care to be an out-of-pocket expense for families, encouraging them to forgo these services, whose value might not be apparent in the short term. Further, if states opt to charge beneficiaries premiums and coinsurance, children and families will lose Medicaid coverage or disenroll from the program because of the burden of these fees.³¹

Third, especially for children with complex health and developmental problems and limited social resources, the EPSDT case management service is especially valuable. Recent legislation expands the definition of *medical case management* but leaves unanswered exactly which conditions and services qualify for payment by Medicaid and which are the responsibility of unspecified third-party payers. States might lose access to federal dollars that now support much-needed case management services that help make the extremely fragmented system of child and family services work to promote and improve child development.

Finally, the current quality of preventive pediatric care is quite variable, often

not meeting expressed standards of care or the needs of children and families.³²

■ **Recommendations for reform.** The importance of Medicaid and other publicly funded child health insurance programs in identifying problems early and ensuring treatment can hardly be overstated. State EPSDT programs now have great flexibility and can take a number of actions to increase the likelihood that young children will obtain needed services. These actions include the following.

Ensure that the covered child health care services, at a minimum, conform to AAP recommendations. The periodicity schedule adopted by state Medicaid agencies should be consistent with that of the AAP as articulated in various committee statements and Bright Futures guidelines.³³ In addition, states should step up efforts to work collaboratively with private pediatric organizations to ensure that the state's policies are in fact consistent with the intended program design and likely to meet the health and developmental needs of children.

Supplement "benchmark" benefit packages with wraparound benefits designed to meet the developmental needs of low-income children. Medicaid covers a disproportionate number of children in poor health, many with complex medical problems. Especially for these children, the current scope of EPSDT benefits meets their needs better than benchmark packages do. If states choose to adopt a benchmark plan, the wrap-around benefit should be carefully crafted so that families can obtain needed services easily. Providers need to understand and be informed of the available wrap-around services to effectively counsel patients and refer them for related services. Families also need to be explicitly informed about which services are included in the supplemental package and how to access them. Further, the adoption of a benchmark package—that is, a commercial insurance model—for EPSDT services increases the risk of erroneously applying a commercial standard of medical necessity, instead of maintaining the preventive care standard that is a hallmark of the EPSDT program.

Implement structured approaches to service linkage within communities. Many of the interventions to address developmental risks and problems require the services of professionals outside the health sector, especially those in education and social services. States and communities should create integrated systems of early childhood services. Short of that ideal, payment mechanisms should be developed to support practice-based as well as centralized, community-based care coordination systems and care integration.

Undertake efforts to actively improve the quality of preventive pediatric care. As the largest single purchaser of children's preventive health services, Medicaid has the leverage to promote improvements in quality. A number of approaches exist: (1) Medicaid should routinely measure the quality of preventive care, especially that relating to child development, such as screening and surveillance, parental education, and care coordination and follow-up. (2) Medicaid should base its contracts and payments on quality and performance. (3) State agencies should jointly monitor Medicaid quality indicators, tying that process to their efforts to measures and as-

sure school readiness. (4) Medicaid should provide explicit definitions of developmental services tied to billing codes. (5) Medicaid should offer guidance and training to health care providers in their choice and use of screening or assessment instruments, and it should provide additional reimbursement when that guidance is applied to patient care. (6) Medicaid should work with other state agencies to strengthen the medical component of the state's early education and early intervention services for young children with or at risk for developmental problems.

Federal Medicaid officials should encourage and support states to strengthen preventive services for children prior to school entry. Such opportunities might include the following: (1) provide guidance to state officials on the meaning of various case management provisions in federal statute and clarify for which services states may claim a federal Medicaid match; (2) offer financial incentives or other inducements based on the percentage of children receiving developmental screening, referred for early intervention services, and followed up by a primary care provider; and (3) provide guidance to states on developing their quality review and improvement strategies, with an emphasis on preventive care and developmental services.

WELL-CHILD CARE SEEKS TO OPTIMIZE children's health and development, preparing them for school and life beyond. The child health component of Medicaid, EPSDT, was designed with a similar objective, which is reflected in the EPSDT program's comprehensive benefit package, its preventive standard of care, and its case management functions. Given the vulnerability of young children from low-income families to poor health, poor educational attainment, and low lifelong productivity or social dependence, comprehensive well-child care represents a good investment for society. EPSDT plays an essential role helping low-income children be ready for school and life beyond. National and state health policies should not lose sight of this role. Any modifications in publicly funded child health programs should not only preserve but maximize these contributions; that is, they should ensure that children have access to a full array of high-quality preventive and developmental services to promote their optimal development and future contribution to society.

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An earlier version of this paper was presented at the National Initiative for Child Healthcare Quality (NICHQ) meeting on the Future of Medicaid and SCHIP, Washington, D.C., 17-18 August 2006.

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