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ABSTRACT

This Congressional hearing records the testimony of administration and public witnesses on H.R. 9434 and S. 1392 and includes the texts of the legislation. H.R. 9434 is an act to amend the social security act to increase the dollar limitation and federal medical assistance percentages applicable to the medicaid programs of Puerto Rico, the Virgin Islands, and Guam. S. 1392 is the Child Health Assessment Act, which provides for the strengthening and improvement of the early and periodic screening, diagnosis and treatment program and broadens medicaid eligibility. Discussions focus on the populations to be covered, in terms of age and condition and cost efficiency of programs. The 65-page final report of the American Association of Psychiatric Services for Children to HEW on developmental review in the early and periodic screening, diagnosis and treatment program is included in the publication. In contrast to simple screening procedures, periodic review of the ways in which development is occurring and the forms it takes is advocated. Also included is a Research Digest Series report titled "Uncertainties of Federal Child Health Policies: Impact in Two States", which reviews two federally supported child health care programs from the original statement of Congressional intent to its questionable delivery at the local level. (RH)

CHILD HEALTH ASSESSMENT ACT AND INCREASED MEDICAID FUNDING FOR PUERTO RICO

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 9434

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO INCREASE THE DOLLAR LIMITATION AND FEDERAL MEDICAL ASSISTANCE PERCENTAGES APPLICABLE TO THE MEDICAID PROGRAMS OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

S. 1392

A BILL TO STRENGTHEN AND IMPROVE THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND FOR OTHER PURPOSES

AUGUST 14, 1978

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1978

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CONTENTS

ADMINISTRATION WITNESSES

PUBLIC WITNESSES

COMMUNICATIONS

APPENDIX

ADDITIONAL INFORMATION

CHILD HEALTH ASSESSMENT ACT AND [illegible]CREASED MEDICAID FUNDING FOR PUERTO RICO

MONDAY, AUGUST 14, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m. in room 2221, Dirksen Senate Office Building, Hon. Abraham Ribicoff presiding.

Present: Senators Ribicoff and Dole.

[The press release announcing this hearing and the [illegible] H.R. 9434 and S. 1392 follow:]

[Press Release]

U.S. SENATE, COMMITTEE ON [illegible],
SUBCOMMITTEE [illegible] HEALTH,
[illegible] 1978.

SUBCOMMITTEE ON HEALTH ANNOUNCES HEARINGS ON: S. [illegible]—CHILD HEALTH ASSESSMENT ACT, AND H.R. 9434—INCREASED MEDICAID FUNDING FOR PUERTO RICO

The Honorable Herman E. Talmadge (D., Ga.), chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold a hearing on the Child Health Assessment Act (S. 1392). S. 1392, introduced by Senator Abraham Ribicoff (D., Ct.), is intended to improve the administration of and benefits under the Medicaid program for screening and treatment of children.

The Health Subcommittee of the Interstate and Foreign Commerce Committee of the House of Representatives has completed action on a companion bill (H.R. 13611).

The hearing on the Child Health Assessment Plan will begin at 9:00 A.M., Monday, August 14, 1978, in Room 2221 of the Dirksen [illegible] Office Building.

The Subcommittee will hear initially, beginning at [illegible], from the Administration and the Resident Commissioner of Puerto [illegible] regarding H.R. 9434, a bill to increase Federal Medicaid funding for [illegible] the Virgin Islands and Guam.

Requests to testify.—Chairman Talmadge stated that [illegible] desiring to testify during these hearings must make their requests [illegible] to Michael Stern, Staff Director, Committee on Finance, Room 2227 [illegible] Senate Office Building, Washington, D.C. 20510, not later than the close of [illegible] on Tuesday, August 8, 1978.

Witnesses will be notified as soon as possible after this [illegible] when they are scheduled to appear. If for some reason the witness [illegible] to appear at the time scheduled, he may file a written statement for [illegible] in lieu of the personal appearance.

Consolidated testimony.—Chairman Talmadge also s[illegible] that the Subcommittee strongly urges all witnesses who have a common [illegible] to consolidate their testimony and designate a single spokesman to pre[illegible] common viewpoint orally to the Subcommittee. This procedure will e[illegible] Subcommittee to receive a wider expression of views than it might otherwise obtain. All witnesses were further urged to exert a maximum [illegible] inate their statements.

Additionally, because of the extensive hearing record established by the House Interstate and Foreign Commerce Committee on the Child Health Assessment Act, witnesses are asked not to repeat that testimony since the House record will be carefully reviewed by the Committee on Finance.

Legislative Reorganization Act.—The Legislative Reorganization Act of 1946 requires all witnesses appearing before the Committees of Congress to "file in advance written statements of their proposed testimony and to limit their oral presentations to brief summaries of their argument." In light of this statute, and the number of witnesses who desire to appear before the Subcommittee, and the limited time available for the hearings, all witnesses who are scheduled to testify must comply with the following rules:

1. A copy of the written statement must be filed by noon the day before the witness is scheduled to testify.
2. All witnesses must include with their written statements a summary of the principal points included in the statement.
3. The written statements must be typed on letter-size paper (not legal size) and at least 75 copies must be submitted before the beginning of the hearings.
4. Witnesses are not to read their written statements to the Subcommittee, but are to confine their 10-minute oral presentations to a summary of the points included in the statement.
5. No more than 10 minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.—Persons not scheduled to make an oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Senate Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510, not later than Monday, August 21, 1978.

95TH CONGRESS
2D SESSION

H. R. 9434

IN THE SENATE OF THE UNITED STATES

FEBRUARY 8 (legislative day, FEBRUARY [illegible]), 1978
Read twice and referred to the Committee on Finance

AN ACT

To amend the Social Security Act to increase the dollar limitations and Federal medical assistance percentages applicable to the medicaid programs of Puerto Rico, the Virgin Islands, and Guam.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

ADJUSTMENT OF DOLLAR LIMITATION ON MEDICAID PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

SECTION 1. (a) Subsection (c) of section 1108 of the Social Security Act (42 U.S.C. 1308(c)) is amended to read as follows:

"(c) The total amount certified by the Secretary under title XIX with respect to—

"(1) the fiscal year ending September 30, 1978, for payment—

"(A) to Puerto Rico shall not exceed $50,000,000,

"(B) to the Virgin Islands shall not exceed $1,600,000, and

"(C) [illegible] Guam shall not exceed $1,475,000;

"(2) the fiscal year ending September 30, 1979, for payment—

"(A) to Puerto Rico shall not exceed $60,000,000,

"(B) to the Virgin Islands shall not exceed $2,000,000, and

"(C) to Guam shall not exceed $1,800,000; and

"(3) each subsequent fiscal year, for payment to Puerto Rico, the Virgin Islands, and Guam shall not exceed the amounts specified [illegible] subparagraphs (A), (B), and (C), respectively, of paragraph (2) increased by a percentage equal to the percentage increase in the Consumer Price Index (published monthly by the Bureau of Labor Statistics of the Department of Labor) between October 1, 1979, and the first day of such fiscal year.".

(b) The amendment made by subsection (a) shall apply to fiscal years beginning after September 30, 1977.

ELIMINATION OF SPECIAL LIMITATION ON THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

SEC. 2. (a) The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking out "(1)", and

(2) by striking out ", and (2)" and all that follows through "shall be 50 per centum".

(b)(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall apply with respect to care and services provided, under a State plan approved under title XIX of the Social Security Act, in a calendar quarter beginning after September 30, 1978.

(2) Each of the agencies administering or supervising the administration of the State plan, approved under title XIX of the Social Security Act, for Puerto Rico, the Virgin Islands, or Guam may elect not to have the amendments made by subsection (a) apply to any care or

services provided in its jurisdiction to an individual over a period of time beginning before October 1, 1978, and ending after October 1, 1978.

Passed the House of Representatives February 6, 1978.

Attest: EDMUND L. HENSHAW, JR.,
Clerk.

95TH CONGRESS
1ST SESSION

S. 1392

IN THE SENATE OF THE UNITED STATES

APRIL 26 (legislative day, FEBRUARY 21), 1977

Mr. RIBICOFF (for himself, Mr. HATHAWAY, and Mr. KENNEDY) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To strengthen and improve the early and periodic screening, diagnosis, and treatment program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be known as the "Child Health Assessment Act".

DECLARATION OF PURPOSE

SEC. 2. The purpose of this Act is to modify the early and periodic screening, diagnosis, and treatment program and broaden medicaid eligibility—

(1) to continue and expand the availability of health care to children whose families do not have adequate resources to cover the cost of such care and to

strengthen efforts to assure adequate child health assessments, diagnosis, treatment, and periodic reassessment of all eligible children;

(2) to increase the number of children eligible for such care;

(3) to assure the continuity of care for a period after a child would on account of income become ineligible for medical care under title XIX of the Social Security Act;

(4) to increase immunization levels of children; and

(5) to provide further incentives to States to arrange for and encourage quality health care for children.

REQUIREMENT FOR ASSESSMENT AND TREATMENT OF ALL INCOME ELIGIBLE CHILDREN

SEC. 3. Section 1902(a)(13) of the Social Security Act is amended by inserting "and" at the end of subparagraph (E), and by inserting after subparagraph (E) the following new subparagraph—

"(F) effective October 1, 1977, in the case of any individual under the age of six who is a member of a family who would, on the basis of income and resources, be eligible for aid under the State plan approved under part A of title IV of this Act, but who is not a dependent child as that term is defined in section 406 (a) of this Act, for the inclusion of the care and services specified in section 1905 (a) (4) (B); and

"(G) effective October 1, 1977, in the case of any individual under the age of twenty-one who has received his periodic assessment pursuant to section 1912 (b) (1), for the inclusion of all care and services appropriate for individuals under age twenty-one (but not necessarily including (i) those for the treatment of mental illness, mental retardation, or developmental disabilities, and (ii) dental care when not for the treatment of conditions discovered during an assessment) for which payment is available under this title, whether or not under the State plan such care and services are provided to individuals who have not been periodically assessed pursuant to section 1912 (b) (1);".

MEDICAID ELIGIBILITY OF CERTAIN CHILDREN UNDER SIX

SEC. 4. (a) Section 1902 (a) (10) of the Act is amended by striking out "and" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by adding after subparagraph (B) the following new subparagraph:

"(C) for making medical assistance available to any individual under the age of six who is a member of a family who would, on the basis of income and resources, be eligible for aid under the State plan approved under part A of title IV of this Act, but who is not a dependent child as that term is defined in section 406 (a) of this Act; and".

(b) (1) Section 1902 (a) (10) of the Act is amended by inserting "or clause (C)" after "clause (A)" each place it appears in that section.

(2) Section 1902 (a) (10) (I) of the Act is amended by inserting "or pursuant to clause (C) of this paragraph, clause (F) or (G) of paragraph (13), or section 1912" after "section 1905 (a)".

CHILD HEALTH ASSESSMENT PROGRAM

SEC. 5. Title XIX of the Act is amended by inserting at the end thereof the following new section:

"CHILD HEALTH ASSESSMENT PROGRAM

"SEC. 1912. (a) Effective October 1, 1977, each State with a plan approved by the Secretary under section 1902 (b) must include the provision of child health assessments and primary care pursuant to this section to any individual under the age of twenty-one and eligible for such services pursuant to section 1902 (a) (13) (B), any individual under the age of six and eligible for such services pursuant to section 1902 (a) (13) (F), and any other individual under the age of twenty-one who is eligible for such services under the State plan approved under this title.

“[illegible] Child health assessments under this title may be provided only by a health care provider who enters into an agreement with the State agency responsible for administering or supervising the administration of the State plan under this title to—

“(1) provide to individuals specified in subsection (a) periodic health assessments, as required by regulations of the Secretary;

“(2) provide to individuals assessed a minimum range of diagnostic and treatment services (including immunization against childhood diseases) as required by regulations of the Secretary, except that in lieu thereof (A) during the period beginning October 1, 1977, and ending September 30, 1978, a State may enter into an agreement with any health care provider who agrees to refer such individuals for such diagnostic and treatment services; (B) during the period beginning October 1, 1978, and ending September 30, 1980, a State may enter into an agreement with any health care provider who has written arrangements for the referral of such individuals to appropriate providers for such diagnostic and treatment services; and (C) after September 30, 1980, the Secretary may, with respect to any geographic area in a State, continue to allow agreements pursuant to clause (B) if he determines that a State has made reasonable efforts to assure provider participation, but the number of providers who have agreed with the State to provide directly diagnostic and treatment services is insufficient to serve the number of children who are eligible pursuant to this paragraph for such services;

"(3) refer such individuals to appropriate providers for any corrective treatment the need for which is disclosed by an assessment but which is not available directly from the provider who has the agreement with the State, and follow-up to assure the provision of such treatment;

"(4) take responsibility for the management of the medical case of each individual assessed to assure that all medical services which are offered under the State plan (pursuant to section 1902(a)(13)(G)) and which are found to be necessary pursuant to an assessment are made available in a timely manner and that reassessments are performed as required in regulations of the Secretary;

"(5) be reasonably accessible on an ongoing basis to individuals who have been assessed to assure the continuing availability of medical care; and

"(6) make reports which the State or the Secretary may require to assure compliance with the requirements of this section.

"(c) Any individual under the age of twenty-one who has received an assessment pursuant to this section shall, notwithstanding any other provision of this section or the State plan approved under this title, remain eligible for all care and services provided under the State plan to individuals who have been assessed for a period of six months following the date on which the income and resources of his family first exceeded the eligibility limits specified in the State plan for such care and services, or, if the individual was eligible for aid to families with dependent children under part A of title IV of this Act, for a period of six months following the date on which he became ineligible for such aid, except that in no case shall an individual be eligible for such care and services by reason of the application of this subsection (1) who has attained the age of twenty-one or (2) who has not been reassessed in a timely manner.".

ADDITIONAL STATE PLAN REQUIREMENTS

SEC. 6. Section 1902 (a) of the Act is amended by striking out "and" after paragraph (35), by striking out the period after paragraph (36) and inserting instead "; and" and by adding after paragraph (36) the following new paragraph—

"(37) provide that the State will encourage participation by physicians and health care centers in the program described in section 1912 of this Act; will assure coordination between State and local agencies participating in that program and community health centers funded under section 330 of the Public Health Service Act; and will assure the availability of appropriate support services (including case tracking and outreach), in accordance with regulations of the Secretary, to individuals and health care providers participating in the program described in section 1912.".

FEDERAL REIMBURSEMENT

SEC. 7. (a) Section 1903(a) of the Act is amended by redesignating paragraph (6) as paragraph (7) and by adding after paragraph (5) the following new paragraph—

"(6) an amount equal to a per centum of so much of the sums expended during such quarter as are attributable to child health assessments performed pursuant to section 1912(b)(1) and to diagnosis, treatment (other than dental and inpatient care), referral, follow-up, and medical case management of individuals who have been assessed pursuant to that section and regulations of the Secretary promulgated thereunder; which per centum shall be equal to one-half of the sum of the Federal medical assistance percentage (as calculated for purposes of paragraph (1) of this subsection) and 90 per centum or 75 per centum, whichever is greater; plus".

(h) Section 1903 of the Act is amended by adding at the end thereof the following new subsections:

"(l) Notwithstanding any other provision of this title, beginning October 1, 1977, whenever the Secretary determines that a State does not have a program, which meets such standards as he shall specify in regulations, for the purposes of—

"(1) informing families of children eligible pursuant to subparagraph (B) or (F) of section 1902 (a) (13), for services under the State plan pursuant to section 1912 of the availability of such services;

"(2) assuring the provision of child health assessments in a timely manner in cases where it is requested and required under the State plan;

"(3) assuring the provision, in a timely manner, of any medical care or service the need for which is disclosed by an assessment; or

"(4) assuring compliance with the terms of the agreements it has with providers of services under section 1912;

the Secretary shall notify the State of such failure and that the amount otherwise required to be paid to such State with respect to each succeeding fiscal quarter following such notification pursuant to paragraphs (2), (3), (4), and (7) of this section for the [illegible] of the State plan shall be reduced by 20 per [illegible] that amount until the State shows to the [illegible] the Secretary that the failure with respect to [illegible] reduction applies has been corrected. Until the Secretary is so satisfied, he shall make any reduction referred to in the preceding sentence, except that if the Secretary is satisfied that the State intends to correct such failure, the Secretary may withhold the imposition of the reduction referred to in the preceding sentence for a period of time, not exceeding six months, to allow the State to fully comply with the requirements of this subsection, and where, at the end of any such period he determines that the failure with respect to which the reduction would apply has been corrected, he may waive the imposition of the reduction entirely. Nothing in this or any other section of this title shall be construed to require the Secretary to review a State's activities to assure compliance with this subsection more frequently than he determines is necessary based upon the State's previous performance in meeting the requirements of this subsection. Each State shall cooperate with the Secretary by providing appropriate documentation of its performance pursuant to this subsection.

"(m) Notwithstanding any other provisions of this title, with respect to any quarter beginning after September 30, 1977, for which the Secretary determines that a State has met the criteria for good performance applicable to the program required by section 1912 which he shall specify in regulations pursuant to this subsection, he shall pay, in addition to any other payments he is required to make to the State pursuant to this section, an amount equal to 25 per centum of the remainder specified in section 1903(a)(7). The standards the Secretary shall specify for determining good performance under this subsection may include criteria such as the percent of children eligible for assessment under the State plan who are assessed; the percent of conditions identified during an assessment which are treated; and the percent of children eligible for assessment who are fully immunized following assessment.".

CONFORMING AMENDMENTS

SEC. 8. (a) (1) Section 403(g) of the Act is repealed.

(2) The amendment made by paragraph (1) of this subsection shall be effective with respect to quarters beginning after September 30, 1977.

(b) (1) Section 1905(a)(4)(B) of the Social Security Act is amended to read as follows: "(B) child health assessments, diagnosis, treatment, referral, and medical case management of individuals under the age of twenty-one who are eligible for such services under the State plan in accordance with the requirements in section 1912;".

(2) The amendment made by paragraph (1) of this subsection shall be effective beginning October 1, 1977.

(c) Any individual who has been screened pursuant to section 1905(a)(4)(B), as in effect prior to October 1, 1977, and who meets the criteria pertaining to age and date of previous screening which the Secretary shall specify in regulations, shall, for purposes of the amendments made by this Act, be deemed to have been assessed according to section 1905(a)(4)(B), as amended by subsection (b) of this section, on the date when he was screened.

Senator RIBICOFF. The committee will be in order.

The first matter before us is H.R. 9434. The Honorable Balasar Corrada and Robert Derzon.

You may proceed, sir. I understand you have a summary, but your entire statement will go into the record as if read.

STATEMENT OF HON. BALTASAR CORRADA, RESIDENT COMMISSIONER FROM PUERTO RICO; ACCOMPANIED BY DR. JAIME RIVERA-DUENO, SECRETARY OF HEALTH, PUERTO RICO

Mr. CORRADA. Good morning, Mr. Chairman and members of the committee. I am accompanied by Dr. Jaime Rivera-Dueno, Secretary of Health for the Commonwealth of Puerto Rico, and it is a pleasure for me to appear before you today.

This bill provides for an increase in the ceiling of Federal expenditures for the medicaid program in Puerto Rico, Guam, and the Virgin Islands. It is a very simple and I believe noncontroversial piece of legislation. As you probably know, this bill passed the House under suspension of the rules, which means that a two-third majority was required for its passage.

Mr. Chairman, one of the priorities of Governor Romero's administration is to provide the best possible health care to the people of Puerto Rico, but unless we are afforded a better treatment under the medicaid program, most of our efforts will be seriously hampered.

The medicaid program was designed to provide medical care to those in our society who are medically indigent. By placing ceilings and restrictions on the applicability of the program in Puerto Rico, we have been seriously constrained in carrying out the spirit of the law.

The public health care system in Puerto Rico is a very extensive one and it provides services to approximately 1.3 million persons who are eligible for medicaid and an additional 400,000 persons who receive services at 100-percent State cost. To keep this expensive system operating at adequate standards and servicing this large clientele, the Government of Puerto Rico spends around 10 percent of its total budget for health care.

For example, in the 10-year period from 1965 to 1975, the Government of Puerto Rico's appropriations for health care were increased from $37.8 million to $109 million or by 188.4 percent. For fiscal year 1977–78, this figure was increased to $141.2 million.

During this same period, the municipalities of Puerto Rico increased the health care costs from $24.2 million to $53.8 million for an increase of 122 percent. Governor Romero-Barcelo in his testimony before the House Subcommittee on Health assured the members of that subcommittee that the dollar commitment to the improvement of health care in Puerto Rico will continue to increase and that no reductions will be made in the health budget if we receive additional Federal funds under the medicaid program. I would like to make that same pledge to this subcommittee.

Attached to my testimony, you will find table A, which I make part of this testimony, and I request that it be made part of the record, showing the constant increase in the local appropriations.

Puerto Rico has also invested heavily in physical facilities. Approximately $210.5 million have been spent during the last 6 years from local funds for the construction of diagnostic and treatment centers to provide services to the medically indigent.

When Congress established in 1965 the medical assistance program through title XIX of the Social Security Act, Puerto Rico was included in the same manner as the States except that the matching formula applied to the island was 55 percent. But in 1968, Congress established an annual ceiling of $20 million for the program and reduced the Federal share to 50 percent. In 1972, the ceiling was raised to $30 million, which is still the applicable ceiling for medicaid expenditures in Puerto Rico.

Title XIX of the Social Security Act, as it applies to Puerto Rico, does not entirely fulfill the intent of Congress of helping low-income families in the Nation to avail themselves of high-quality medical care on an equal basis with those who can afford to pay for it. The constraints imposed by the inflexibility of the statutory limitation of $30 million and the requirements that the island comply with virtually the full range of legislative and administrative conditions for the receipt of these funds, as they apply to the States, are the key factors that limit the full implementation of the program in Puerto Rico.

The medicaid program in Puerto Rico has to provide the same services to welfare and health clients, and to engage in various administrative actions as required from the States, despite the statutory financial limitation to the island.

The range of required services includes medical and hospital services; early and periodic screenings; diagnosis and treatment for children; home health services; nursing home services; family planning services; and reimbursement for certain emergency and other health services provided in other States to participants while traveling in the mainland. These service requirements alone imply costs far in excess of the available State and Federal financing.

To aggravate the problem, we find that the government of Puerto Rico has been sued in court by the Puerto Rico Legal Services, Inc., which is funded by the Federal Government, because we are not able to comply with Federal regulations under the medicaid program. One of the main reasons, Mr. Chairman, that makes it difficult for us to comply with these regulations is that we do not receive adequate funding from the Federal Government. Certainly we are anxious to provide more and better services.

Mr. Chairman, as I mentioned before, the public health care system in Puerto Rico is quite extensive. Due to the severe limitations of funds we are providing only in a very limited scale nursing home services and we are unable to reimburse other States for emergency and other services provided to the residents of Puerto Rico.

During the last few years, most of the Federal legislation related to the delivery of health services to the medically indigent population has been based on the third-party reimbursement concept. In the United States the main source of third-party reimbursement for these programs is medicaid. This is obviously not true in the case of Puerto Rico and, therefore, any program depending on third-party reimbursement is doomed to failure.

This is so because most of these programs provide only for "seed money" with a phaseout schedule providing the projects enough time to become self-sufficient through third-party funds. In Puerto Rico, we cannot foresee that this will ever be feasible because of the absence of third-party payors, especially medicaid. If this trend continues, the medically indigent in Puerto Rico would not be able to benefit from any of the new legislation their counterparts in the United States are benefiting from.

Although Puerto Rico has made efforts of its own to expand the health budget it has been unable to effectively upgrade the quality and expand the services to our indigent population.

Most of the increases in funding have been offset by the annual increase in population, the high cost of living, and inflation in health care costs.

As I have stated before, approximately 1.7 million persons in Puerto Rico are considered to be medically indigent, 57 percent of these, or 975,000, are children. This low-aged group places increasing demands on the financial resources of the Government of Puerto Rico if we are to provide them all the health care services they need.

The cost of living in Puerto Rico is higher than in most areas of the United States. As a matter of fact, the U.S. Civil Service Commission has established a 12.5-percent cost-of-living allowance for Federal employees working in the San Juan metropolitan area, and 5 percent for those working outside the metropolitan area. A recent report for the Puerto Rico Department of Labor shows that there has been a 67-percent increase in the cost of living in Puerto Rico over the past 8 years. This same report indicates a cost-of-living index for medical care of 190.7 percent.

As an example, Mr. Chairman, the average annual medicaid payment per eligible recipient in 1972 was $21.21. In 1975, that was equal to $12.85; an effective drop of $8.40 due to the decrease in the purchasing power of the dollar.

As you can see, the $30 million ceiling, unfair as it is, becomes more burdensome because of inflation and the high cost of living in medical care.

In conclusion, Mr. Chairman, it is unfortunate that after 9 years, in spite of a considerable State effort, Puerto Rico has not been able to reach the commendable goals set by medicaid legislation due to insufficient funding. In order to prevent further deterioration of the services and to treat as equal the medically indigent U.S. citizens residing in Puerto Rico, we urge this committee to recommend the lifting of the $30 million ceiling for medicaid expenditures in our island. I believe that the House-passed bill takes a sensible approach and I hope that this committee will concur with the House on this matter. Mr. Chairman, I have provided the subcommittee with a series of tables containing data relative to my testimony and I would appreciate it if they could be made part of the record.

Senator RIBICOFF. Without objection.

[The material referred to follows:]

TABLE A.—STATE AND LOCAL APPROPRIATIONS FOR HEALTH IN SELECTED FISCAL YEARS

Sources	Appropriations (millions)	
	Fiscal year 1965	Fiscal year 1975
Puerto Rico (State)	$37.8	$109.0
Municipal	24.2	53.8
Total	62.0	162.8

TABLE "B"

(*a*) Hospitalization at regional hospitals: Admissions—100,000 per year; cost per unit [1]—$702 (average) per patient; total cost—$70,200,000; and medicaid estimate (66 percent of total cost), $46,332,000.

(*b*) Out-patient care at regional hospitals: Visits—900,000 per year; cost per unit [2]—$37 (average) per patient; total costs—$33,300,000; and medicaid estimate (66 percent), $21,978,000.

(*c*) Services at area hospitals: 1976 experience—$16,555,747; and medicaid estimate (66 percent), $10,890,000.

(*d*) Services at health centers: 1976 experience—$24,691,386; and medicaid estimate (66 percent), $16,236,000.

(*e*) Services provided by the San Juan Health Department: 1976 experience—$26,000,000; and medicaid estimate (66 percent), $17,160,000.

(*f*) Services provided by other municipalities: 1976 experience—$12,000,000; and medicaid estimate (66 percent), $7,920,000.

Total estimate of medicaid funds required, $120,516,000.

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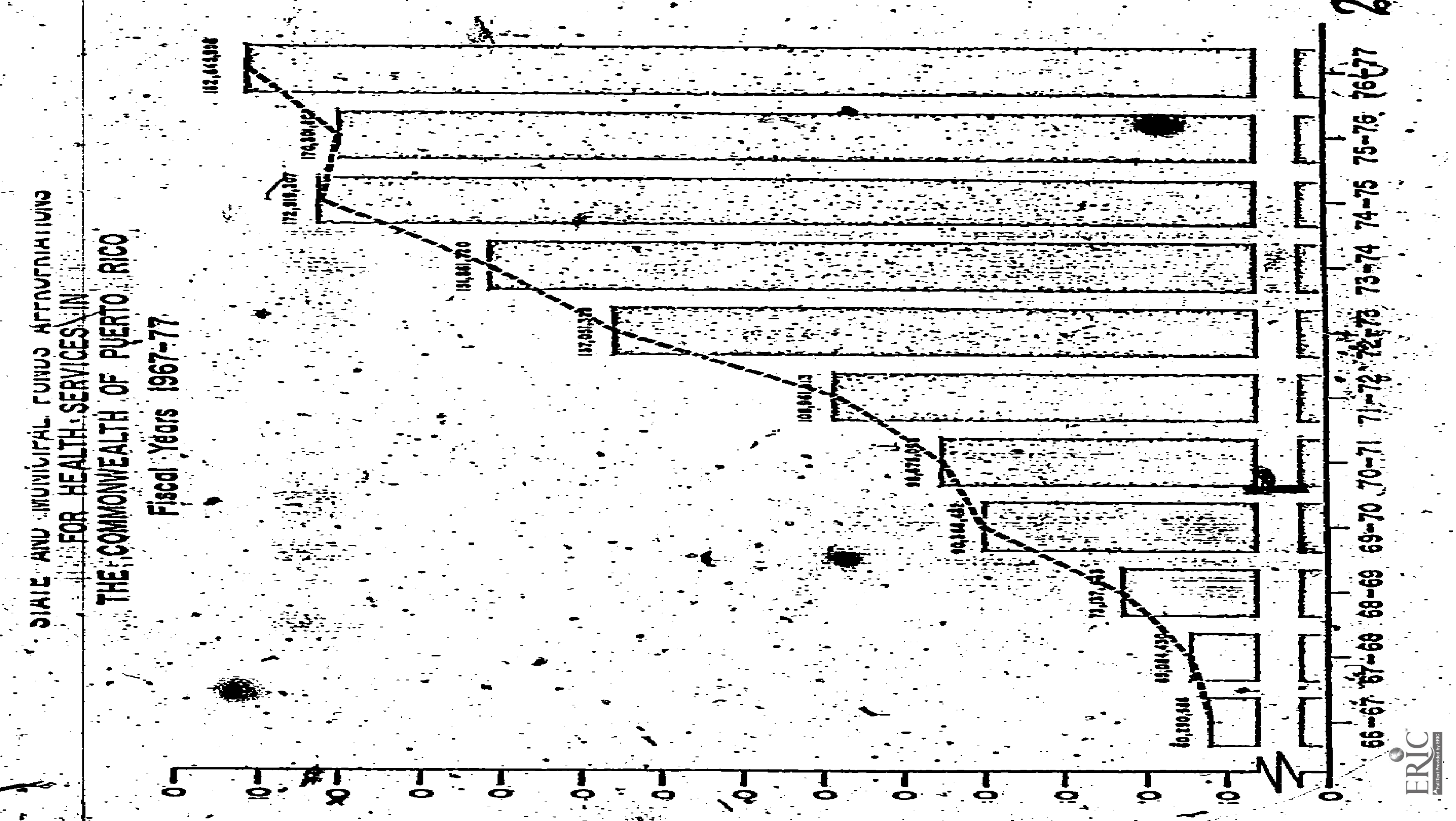
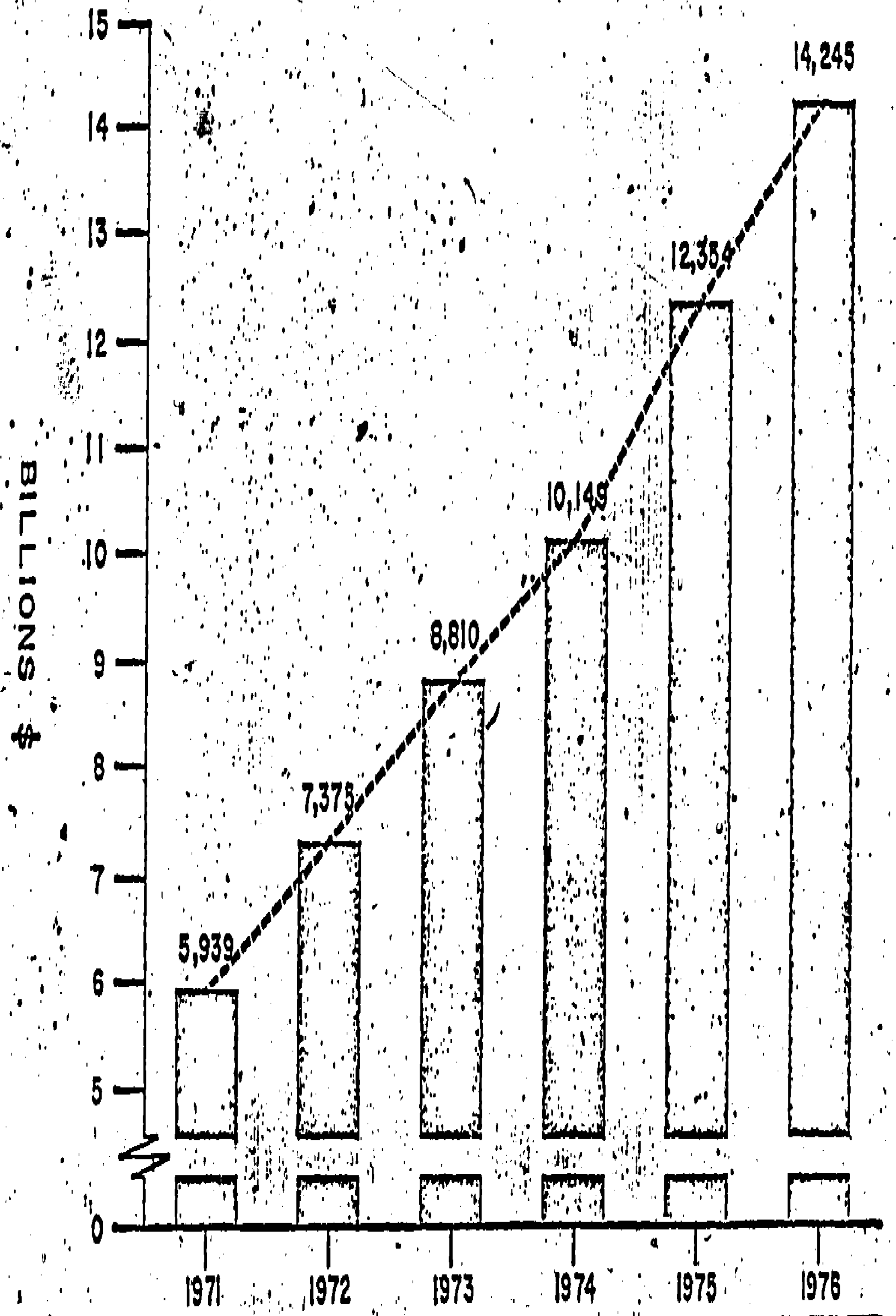
[1] Includes all services rendered during patient's stay, until his discharge.
[2] Includes all services rendered during patient's visit.



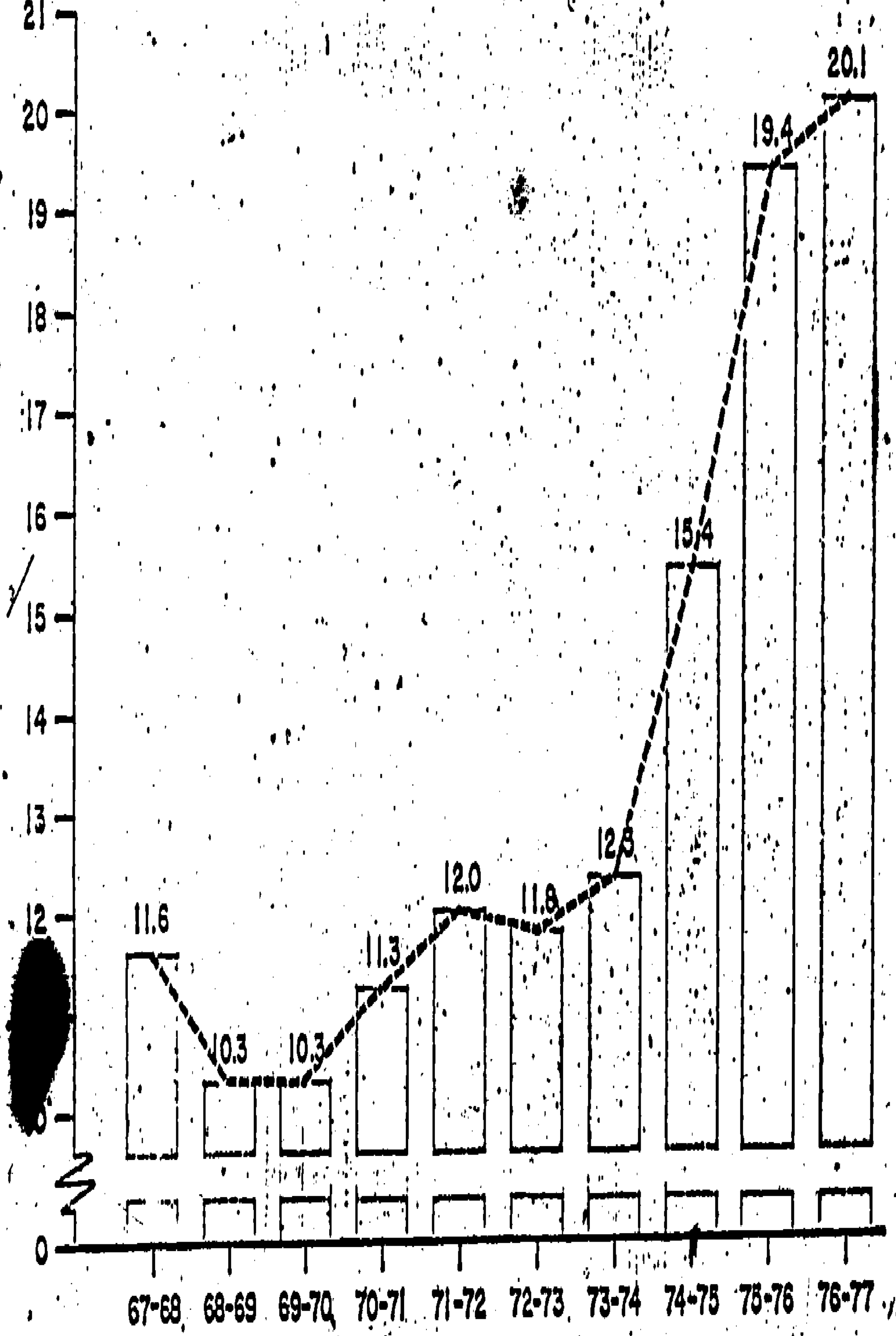
STATE AND MUNICIPAL FUNDS APPROPRIATIONS FOR HEALTH SERVICES IN THE COMMONWEALTH OF PUERTO RICO
Fiscal Years 1967-77

TOTAL VENDOR PAYMENTS UNDER TITLE XIX
Fiscal Years 1971–1976 (U.S.A.)

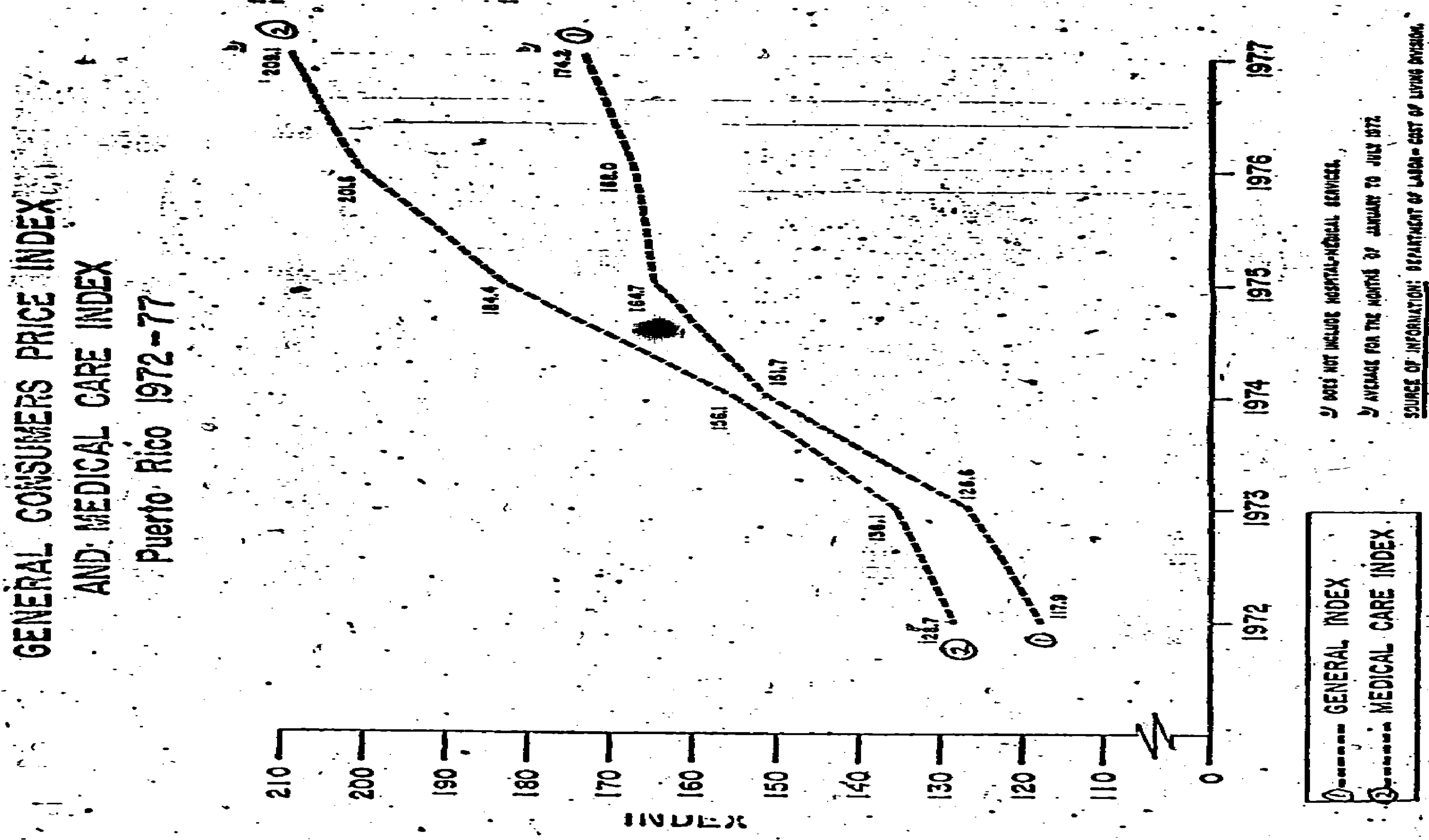


MEDICAID STATISTICS, FISCAL YEAR 1976
U.S. DEPARTMENT OF H.E.W.
SOCIAL AND REHABILITATION SERVICE

UNEMPLOYMENT RATES IN PUERTO RICO
YEARS 1968—1977



PUERTO RICO DEPARTMENT OF LABOR


GENERAL CONSUMERS PRICE INDEX AND MEDICAL CARE INDEX Puerto Rico 1972-77

a/ DOES NOT INCLUDE HOSPITAL-MEDICAL SERVICES.

b/ AVERAGE FOR THE MONTHS OF JANUARY TO JULY 1977.

SOURCE OF INFORMATION: DEPARTMENT OF LABOR— COST OF LIVING DIVISION.

Puerto Rican estimated average annual expenditure for a family of 5 members, summary table:[1] 1970

Item	*Average annual expense*
Food	$1,954.68
Clothing and other personal items	1,179.76
Housing, equipment, electricity, water, gas	1,556.13
Transportation	447.00
Recreation, schooling, and printed material	213.00
Other consumption expenditures	114.00
Insurance	139.00
Donations and presents	99.00
Total	5,702.57

[1] Basic Needs of the Puerto Rican in 1970 Division of Planning Research and Evaluation.

Considering a rate of inflation of 7 percent annually, during the last 7 years, the level of medical indigency should be raised considerably. Rate of inflation of medical care exceeds other items.

PERCENT OF ELIGIBLE MEDICAID PATIENTS BY TOWN

Town	Population	Percent eligibles
Adjuntas	20,240	61.9
Aguada	33,300	78.4
Aguadilla	60,660	59.5
Aguas Buenas	21,800	67.6
Aibonito	23,200	71.4
Añasco	24,060	53.1
Arecibo	86,690	65.3
Arroyo	14,580	74.8
Barceloneta	13,220	63.7
Florida	9,920	---
Barranquitas	24,840	68.0
Bayamon	183,590	42.0
Cabo Rojo	29,740	60.2
Caguas	109,370	57.8
Camuy	21,410	74.6
Canovanas	25,030	58.8
Carolina	140,950	36.7
Catano	30,150	74.0
Cayey	42,290	74.2
Ceiba	12,940	40.2
Ciales	16,570	66.5
Cidra	25,520	88.3
Coamo	26,320	82.2
Comerio	21,250	68.8
Corozal	30,310	66.7
Culebra	870	---
Dorado	23,570	50.3
Fajardo	27,080	38.5
Guanica	16,770	62.8
Guayama	43,600	63.4
Guayanilla	19,970	72.2
Guaynabo	76,810	51.2
Gurabo	20,760	73.9
Hatillo	23,620	89.2
Hormigueros	12,500	44.9
Humacao	41,550	58.6
Isabela	35,390	67.0
Jayuya	14,120	79.1
Juana Diaz	43,950	68.3
Juncos	24,060	70.5
Lajas	18,980	54.7
Lares	29,080	70.3
Las Marias	10,890	51.7
Las Piedras	20,340	60.4
Luquillo	11,230	66.8
Manati	33,420	64.2
Maricao	6,650	59.6
Maunabo	10,690	86.7
Mayaguez	99,010	43.6
Moca	29,870	68.3
Morovis	18,530	83.5
Naguabo	20,320	63.4
Naranjito	23,300	74.2
Orocovis	20,460	89.9
Patillas	19,770	76.1
Penuelas	18,380	63.0
Ponce	175,690	56.1
Quebradillas	17,370	60.5
Rincon	10,570	70.9
Rio Grande	26,610	52.0
Rio Piedras	363,060	21.8
Sabana Grande	18,470	64.0
San German	31,360	62.8
Salinas	25,090	66.2
San Juan	[1] 147,890	73.8
San Lorenzo	34,390	78.2
San Sebastian	37,470	67.1
Santa Isabel	17,670	63.3
Toa Alta	25,150	66.3
Toa Baja	60,910	35.1
Trujillo Alto	40,280	57.9
Utuado	39,470	64.4
Vega Alta	27,780	55.9
Vega Baja	37,600	72.6
Vieques	9,040	---
Villalba	19,320	82.3
Yabucoa	36,210	56.7
Yauco	37,640	69.0
Loiza	18,370	45.0
Total	3,120,900	56.1

[1] Includes San Juan I, II, III, and IV.

Mr. CORRADA. These tables and charts show the State and local appropriations for health in selected fiscal years, hospitalization, individual costs.

They also show State and municipal funds, appropriation for health services in Puerto Rico for fiscal year 1967 through 1977; total vendor payment under title XIX for fiscal years 1971 through 1976; unemployment rates in Puerto Rico through the years 1968 through 1977; and general consumer price index and medical care index, Puerto Rico, 1972 through 1977; Puerto Rico estimated annual expenditure for a family of five members; and a summary table; percent of eligible medicaid patients by island municipalities. All this information will be of help to the subcommittee.

Further, Dr. Rivera and I will be glad to answer any questions you may have.

Senator RIBICOFF. Thank you very much.

Mr. Derzon?

STATEMENT OF ROBERT DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. DERZON. Thank you very much, Mr. Chairman. I am Robert Derzon, Administrator of the Health Care Financing Administration, and to my right is Mr. Richard Heim, Director of the Medicaid Bureau. We are pleased to be here today to strongly support the objectives of H.R. 9434, increasing Federal aid to the territories.

I think it is self-evident from the testimony you have already heard that [an] extraordinary increase in inflation and health care costs is taking place in Puerto Rico, Guam, and the Virgin Islands as it has throughout the rest of the United States. The ceilings on Federal assistance have not been adjusted since 1972, and we strongly concur that adjustments need to be made so that, in fact, we can have a fair program for all citizens of the United States, wherever they might be.

I simply want to strongly urge the committee's support of the thrust of H.R. 9434. We would like the effective date to be after October 1 of this year so that we can make proper provisions within the budget of the President, and we would like future increases in the ceiling to be tied, as they are in the proposed bill, to the Consumer Price Index so that there can be adjustments each year, without going through an additional legislative process.

The administration's proposal transmitted to Congress June 7, would increase the proportion of Federal matching from 50 to approximately 75 percent. This seems more reasonable for these territories, where the per capita incomes are very low, than the approach proposed in H.R. 9434.

I think that summarizes pretty fully our statement. We would be pleased to answer any questions.

Senator RIBICOFF. Does the administration support adding the Marianas to this bill?

Mr. DERZON. Our draft bill would also extend the medicaid program to the northern Marianas, and would permit Federal financial participation in medicaid costs of up to $1,500,000 per fiscal year. As is proposed for Puerto Rico, Guam, and the Virgin Islands, the match rate would be established at 75 percent.

Senator RIBICOFF. Thank you very much, gentlemen.

[The prepared statement and letter of Mr. Derzon follow:]

STATEMENT OF ROBERT A. DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, I am pleased to share with you and the committee the Department's views on H.R. 9434, which would increase Federal Medicaid funding for Puerto Rico, Guam, and the Virgin Islands.

The Department is sympathetic to the problems which this legislation seeks to alleviate. Medicaid was enacted to help all low-income U.S. citizens to have access to quality medical care, and these territories, which have a high poverty level and substantial unemployment, rely on that commitment.

The ceilings established by the Congress on Federal medical assistance to Puerto Rico, Guam and the Virgin Islands have not been adjusted since 1972. I need not remind this committee of the change in health care costs since that time. The price tag of the Medicaid program alone has nearly tripled in six years. Although this legislation could be viewed as contributing to this trend, we do not believe that low-income recipients of medical care should be penalized because of widespread inflation in the health care field, intolerable as that inflation is.

In this connection, I am pleased to note that Governor Romero-Barcelo of Puerto Rico has stated that the public health care system serving the indigent population of Puerto Rico has built-in controls on expenditures to keep costs down. He can be proud of a system which is predominantly ambulatory and which has shifted its focus from acute care to a preventive approach to assuring good health.

I believe it is also appropriate this morning to note that the Commonwealth has invested heavily in maternal and child health care.

The Department supports the objectives of H.R. 9434. The fiscal 1979 budget included a proposal to provide fiscal relief to these jurisdictions along the lines of H.R. 9434. The Department formally transmitted this proposed legislation to Congress on June 7, 1978.

Because funds are not included in the fiscal year 1978 budget, however, we would urge you to ensure that the changes made by this legislation do not take effect until after October 1. H.R. 9434 provides for increased expenditures beginning in this fiscal year, which could result in unbudgeted increases of $21 million.

Our recommendation to double the ceiling in fiscal year 1979 conforms to the House bill. In future years we propose, as does H.R. 9434, to tie the increases in the ceiling to the Consumer Price Index. Accordingly, the impact of the bill on budget outlays is within the amounts projected in the President's budget for the next five years.

We also propose increasing the Federal match rate from 50 to 75 percent. We view this as equitable and preferable to the provision in H.R. 9434 which would set the Federal share in the same manner as is determined for the 50 States. These jurisdictions are exempt from Federal income taxes; they are exempt from the usual Medicaid requirement that recipients be given their free choice of qualified providers, and they are exempt from the ceiling on income levels for the medically needy. These arrangements reflect the special status of these jurisdictions and the special nature of their health care systems. We believe a flat percentage Federal share, as well as the ceiling on funding, is consistent with our recognition of this unique system and the need to preserve a certain amount of flexibility.

With the changes mentioned above, we would be pleased to support the bill.

Thank you.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
August 14, 1978.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This is to follow up on and provide a formal response to Senator Ribicoff's question during this morning's hearing on H.R. 9434. The Senator asked for the Department's views on extending the legislation to the Northern Marianas.

As you are aware, the Trust Territory of the Northern Mariana Islands has not previously participated in the Medicaid program. The Department's draft bill to provide increased funding to Puerto Rico, Guam, and the Virgin Islands, which the Secretary transmitted to the Congress on June 7, 1978, would also extend the Medicaid program to the North Marianas. This amendment is required by section 502(a)(1) of Public Law 94-241, the Joint Resolution to approve the covenant to establish a Commonwealth of the Northern Mariana Islands in political union with the United States. The Department's draft bill would permit Federal financial participation in Medicaid costs of up to $1,500,000 per fiscal year and, as is proposed for Puerto Rico, Guam, and the Virgin Islands, the Federal matching rate would be established at 75 percent.

Sincerely,

ROBERT A. DERZON,
Administrator,
Health Care Financing Administration.

Senator RIBICOFF. We will now go to S. 1392, the Child Health Assessment Act.

The first witness will be Ms. Wendy Lazarus. Without objection, your opening statement will go into the record, as if read.

STATEMENT OF WENDY LAZARUS, HEALTH SPECIALIST, CHILDREN'S DEFENSE FUND

Ms. LAZARUS. Thank you, Mr. Chairman. My name is Wendy Lazarus, and I am representing the Children's Defense Fund. I directed CDS nationwide study of the EPSDT program. I am grateful to have the opportunity to comment on 1392, the CHAP bill.

No proposal currently being acted on by Congress has greater significance for the health of children in this country. We appreciate the willingness of the subcommittee, and the leadership exhibited by you, Mr. Ribicoff and Chairman Talmadge, to schedule these hearings at a time when Congress is confronted with a full agenda of pressing issues. We are joined by a number of other organizations who are committed to passage of a strong CHAP bill this year, and we are pleased the Senate is taking action.

The Children's Defense Fund is a national, nonprofit, child advocacy organization created in 1973 to gather evidence about the conditions of American children and to address their needs systematically. We seek to correct problems uncovered by our research through Federal and State policy changes, public information, and a variety of other means.

S. 1392 contains many good and extremely important provisions. Although, we will not use limited time this morning to discuss them. I do want to underscore our support for the administration's efforts to make legislative improvements in EPSDT. We are submitting today extensive written testimony on the bill that sets forth the value of CHAP, the provisions we support in 1392, the amendments we believe are essential to make CHAP effective and the rationale for each. We request that this be submitted into the record.

Senator RIBICOFF. Without objection, the entire statement and exhibits will go into the record as if read.

Ms. LAZARUS. I will summarize briefly here why a strong CHAP bill should be passed now, and which changes in S. 1392 we consider unexpendable.

For 2 years, between 1975 and 1977, we studied the operation of EPSDT. In addition to reviewing statistics and reports of the program nationally, we went out and looked at programs in a number of localities. Unfortunately, we saw far too many instances where chil-

34

dren were simply not getting EPSDT services. The consequences are extremely severe.

Archie Douglas is now 8 years old and has already failed the first grade twice. His problem is a hearing loss which developed as a result of an ear infection he suffered when he was 2 years old. Archie would have been spared much of his suffering had he received EPSDT services within a year after he had his infection. The hearing loss could have been identified much earlier, before it seriously affected his language skills.

Once his problem was identified, Archie could have gotten a hearing aid and services in school suited to his special needs.

Millions of poor children like Archie cannot do without health services. For every three screenings done through the EPSDT program nationally, two health problems requiring followup care are found. A vast majority of these problems have never been found or treated, yet, they are the kind of troubles that interfere with a child's ability to learn in school, eat properly, and lead a productive life.

For instance, vision and hearing disorders, serious dental needs, and a lot of anemia are found. All you have to do is see firsthand what EPSDT can do for children to become convinced that if it can be made to work better, that it must be done.

To make this happen requires relatively simple legislative and administrative changes. I would like to emphasize that CHAP is not a major new program. It is an attempt to face squarely and resolve the deficiencies in a program which has been in existence more than 10 years.

CHAP's goals, while absolutely crucial, are modest. No. 1, to modify EPSDT so it will enroll all needy low-income children in a system of health care which assures them complete preventive services and necessary subsequent care. No. 2, to correct the most serious inequities in eligibility and benefits policies for children and youth under medicaid.

Certain modifications in S. 1392 are necessary to accomplish these two purposes. Most of them are administrative changes which are doable and which cost no money at all. The remainder do require funds, but only a modest increase, particularly given the evidence that preventive care actually brings costs savings when properly provided to children.

Let me begin discussing the changes that would require no, or minimal, new funds. These amendments are intended to deal with the sad fact that only a small portion of medicaid children now receive EPSDT services.

We found, for instance, in 1976 only one-quarter of the number of screenings needed by eligible children were provided. Three of the major reasons for this inadequate record are not addressed sufficiently by S. 1392, and we urge that they be corrected.

First, few States have set up the kind of public education or outreach program, which properly informs eligible families about EPSDT and how to secure its services. Obviously, this is the first crucial step in the program, and if it is not done effectively, no children will benefit from CHAP, regardless of how good the rest of the program is.

Like EPSDT, S. 1392 fails to promote the methods of outreach that have been shown to work best by every serious study of this program. To be effective, CHAP must shift outreach activities in a state away from heavy reliance on welfare agencies. It should promote community organizations that employ trained paraprofessionals who are known and trusted by medicaid families.

Second, few States have involved the full range of providers qualified to offer EPSDT services. As a result, in some places, children wait as long as 6 months for an appointment for screening or treatment services. Often, too, children cannot receive EPSDT services from the providers which can meet their needs best. At the time of our study, 19 States relied primarily on country health departments to the exclusion of a host of other qualified providers. S. 1392 does not correct this problem. Provisions must be added setting out explicitly the States' responsibilities to actively solicit provider participation in CHAP.

Third, EPSDT program standards and the mechanism for insuring adherence to them are inappropriate and weak. S. 1392 is deficient here as well.

We have, therefore, recommended that several administrative changes be made: that outcome-oriented standards be used for determining penalties as well as bonuses, that CHAP implementation plans be developed by States, and present loopholes in Federal compliance procedures be eliminated. Lastly, we urge that States be required to maintain at least their current eligibility and services policies for the under-21 population so these new Federal funds expended by CHAP result in strengthened and expanded health services.

We and many others, know that EPSDT shortcomings have been due, in part, to the very poor peformance by HEW in administering this program. While many of the failures occurred in past administrations, the performance of this administration has been unimpressive as well. Screening levels are not increasing as they should. Badly needed new regulations and reporting requirements have been under review for a year and a half and have not been issued yet.

In light of the Department's commitment to cut medical costs, it is all the more intolerable that it has made little progress to improve this preventive care program for children, which does save money in the long run.

EPSDT and CHAP can be administered well, but it will require an understanding by the Health Care Financing Administration of the program's uniqueness, and a Federal commitment and leadership which EPSDT simply has not, and still does not, enjoy.

We urge Congress to build in certain assurances of constructive Federal leadership.

First, we recommend that Congress ask the Secretary to submit an annual report on the progress made by States in enrolling children in CHAP and providing them with high-quality services.

Second, we recommend that CHAP be administered by an identifiable unit. The office should have clear authority and sufficient staff to set programs standards, devise reporting requirements, work with States to promote proper implementation, and monitor program quality.

It is not acceptable to spread these functions through various parts of medicaid. CHAP's charge requires a special focus in the agency, as well as support from the highest levels in carrying out its unique mission. The reason is that it is unlike other parts of medicaid and medicare, CHAP is concerned not only with financing, but also with setting up a delivery system to actually reach a targeted population with a standard of care.

I would like to summarize the changes we urge which do entail additional costs. Our written statement contains the rationale and implications of each.

We recommend coverage of routine dental care for all medicaid youngsters. In addition, a CHAP health assessment should include a referral to a dentist for any child not receiving routine dental care.

No. 2, we recommend coverage of all health care for which medicaid payment is available for each child enrolled in the CHAP program. If cost considerations dictate any limitation on care subsequent to an assessment, these limitations should be confined to expensive services affecting the least number of children.

Three, we recommend expansion of medicaid eligibility to all children under age 21 in families which meet State income requirements, which should be at least set at an established minimum.

No. 4, we recommend extension of medicaid eligibility to low-income pregnant women who meet income requirements.

The total package of our amendments to S. 1392 would cost roughly $300 million in fiscal year 1979. This may sound like a lot of money in these times, but CDF believes the expenses are entirely justified, given the cost savings which will accrue to taxpayers eventually and the very real physical and emotional relief that children will derive. We believe it would be shortsighted and mistaken to enact a package which excludes any of these amendments.

EPSDT has a track record by now, and hard data are coming in which demonstrate cost savings. It is very interesting, Mr. Chairman, that in North Dakota, for instance, Federal medicaid expenditures were significantly lower—36- to 44-percent lower—for children who were in the EPSDT program than for those who were not. Expenditures for in-hospital services were 47- to 58-percent lower for those who had been screened.

In conclusion, I would like to talk for a moment about a legislative matter related to CHAP. Based on conversations with congressional staff and other persons interested in child health, we have become aware of a growing interest in considering changes this year in title V, maternal and child health programs.

CDF agrees that title V warrants serious examination. After more than 40 years of program operation, it is time to reassess what title V's focus should be and how to accomplish it best. But the issues are complex; and we believe it is unlikely that the fundamental kind of reevaluation needed can be done before Congress adjourns.

While certainly title V and CHAP are related in some ways, we believe the CHAP program we have recommended should be enacted this year and that title V should receive consideration by the 96th Congress. Children need the benefits of CHAP now. Low-income children who were not yet born when EPSDT was enacted in 1967 are now nearly 11 years old.

The proposal we have just described is justified, and has broad support. We urge you to pass CHAP before adjournment in October so that these children do not go any longer without basic health services.

Senator RIBICOFF. Thank you very much, Ms. Lazarus. Staff will submit some questions to you, and you may answer them as soon as possible.

[The prepared statement and attachments of Ms. Lazarus follow. Oral testimony continues on p. 47.]

STATEMENT OF THE CHILDREN'S DEFENSE FUND

Chairman Talmadge and members of the subcommittee, the Children's Defense Fund appreciates the opportunity to appear before this Subcommittee to express our views on the child health assessment program (CHAP): "a bill to strengthen and improve the early and periodic screening, diagnosis and treatment program and for other purposes." There is no proposal currently being acted on by the Congress which has greater significance for the health of children in this country. This important bill deserves prompt and careful consideration by the committee.

The Children's Defense Fund (CDF) is a national, nonprofit, child advocacy organization created in 1973 to gather evidence about the conditions of and to address systematically the needs of American children. We have issued reports on specific problems faced by large numbers of children in this country, in the areas of health care, education, juvenile justice, and foster care. We seek to correct problems uncovered by our research through Federal and State policy changes, monitoring, litigation, public information and support to parents and local community groups representing children's interests.

CDF has recently published an in-depth report of the progress and problems of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT: Does It Spell Health Care For Poor Children?, issued in June, 1977, describes the way the program is operating, documents the extent to which it is failing to meet the basic health needs of poor children, and sets out the concrete steps needed to make EPSDT work better.

Because many of the necessary reforms require legislative changes, CDF is delighted that the Congress is developing a plan to modify EPSDT. We are pleased, too, that members of the Senate have taken an increasingly active interest in the important question of how to improve the EPSDT program. We appreciate the willingness of the subcommittee to schedule these hearings at a time when the Congress is confronted with a full agenda of pressing issues, and we are standing by to help in any way we can to expedite consideration of this legislation. This increased interest in EPSDT is reflected not only in the scheduling of the hearings, but in the work of Senators Chiles and Cranston who have actually developed legislative proposals. We would be pleased to work with the Subcommittee and any other interested members of the Senate and House to shape all of the proposals into a bill which can be enacted this year.

During the course of this testimony we will summarize briefly the principles we support in S. 1392 and the amendments to it introduced by Senator Cranston. We will devote the remainder to setting out our views on the issues which are treated differently by S. 1392 and the House bill, H.R. 13611, as reported out of the Committee on Interstate and Foreign Commerce. Our recommendations on these unresolved issues are crucial to make the plan effective.

We urge the Committee to act expeditiously to amend the bill accordingly. Children need the benefits of CHAP now. And because we believe that much of the Committee's attention next year should be devoted to other issues of national health policy, it is essential that needed reforms in EPSDT and Medicaid be made before the Congress recesses this year.

POOR CHILDREN'S IMMEDIATE NEED FOR BETTER HEALTH CARE

As EPSDT has documented. children in low income families have a host of unmet health needs. Nationally in fiscal year 1976, for every three children screened, two conditions were found needing follow-up care. Between 60 and 80 percent of these problems were previously unidentified or uncared for. Fewer than 1 percent of children screened in EPSDT had ever received a complete physical examination. Screening uncovered such conditions as incomplete immunizations, dental problems, low hemoglobins, vision and hearing disorders, high levels of lead in the blood, genitourinary and respiratory infections, parasites and skin diseases.

Most of the problems uncovered by EPSDT can be corrected or at least eased by providing children with basic health services. The consequences of not doing so are monumental. Children suffer needless pain; they encounter difficulty in school and in jobs; and society expends billions of dollars treating problems which could have been prevented.

"Archie Douglas" is a child now living in the District of Columbia. His story shows the frequent results of inadequate health care.

Archie Douglas is now eight years old and has already failed the first grade twice. He has always avoided going to school whenever possible. Last year his teacher reported that when in class, he had a short attention span, misbehaved frequently and was generally disruptive. After two years of first grade instruction, his language skills are those of a five year old. This is true despite the fact that he excels in the nonverbal portion of standardized intelligence tests. Archie comes from a stable, intact, lower-income family.

Archie was a full-term, normal healthy baby. He received his health care during infancy from a city clinic. When he was 18 months old, he had a fever and an earache. His mother, relying on her mother's advice, rocked him to soothe his crying and ease Archie's pain, gave him an aspirin every few hours and used a commercial ear-drop preparation. While rocking him, his mother noticed that some fluid began draining from his ear. Archie seemed less distressed after the fluid drained, and he recovered completely within a few days.

Three months later the fever and the earache recurred. This time both ears were affected. Home remedies brought no relief and Archie was taken to the clinic. The doctor diagnosed bilateral otitis media. This is a common childhood illness, easily diagnosed, and easily and effectively treated by antibiotics. Mrs. Douglas was able to pay $15 for antibiotics only by deferring her rent payment. Because Archie seemed to recover in a few days, his mother discontinued the medication prescribed by the doctor before the full antibiotic regimen was completed. Within a month, the condition returned, and this time rocking, ear drops and a few leftover antibiotic pills were administered and Archie seemed to recover.

With the exception of these illnesses, Archie was a healthy, active child. Other than visits to the clinic for immunization, his mother was grateful that he never needed to see a doctor.

This year Archie has a new first grade teacher. On his recommendation, Archie's mother took him to a speech and hearing center for an evaluation. They found that Archie has a bilateral hearing loss that probably resulted from his early bouts with otitis media. He has slightly more hearing in his left ear (30 dB) than in his right (45 dB).

Archie's hearing loss is considered significant. He has frequent difficulty with normal speech sounds, and his difficulty has probably been the cause of his school problems. Archie's hearing problem can be alleviated by a hearing aid, but at this point, he also needs remedial education and his mother needs counseling and support. Even with help, it will be difficult for Archie to overcome his initial impressions that school is incomprehensible, that he cannot keep up and that he is a failure.

Archie could have been spared much of his suffering through a program of early screening and follow-up care. While it is unlikely that screening could have identified his ear infection when it first developed (unless his screening appointment happened to be scheduled when he was sick), screening within the next year or so would have identified the hearing loss much earlier, when he was two or so years old, long before it seriously affected his language skills. Once his problem was identified, Archie could have gotten a hearing aid and services in school suited to his special needs.

Millions of children like Archie need the basic health care which they currently do not get. According to projections by the Congressional Budget Office, among Medicaid-eligible children in one year alone, 3,200,000 need immunizations, 2,184,000 need treatment for anemia, and 2,210,000 need care for vision or hearing impairments. If the health problems of children who are poor but not eligible for Medicaid were considered, the numbers would, of course, become much larger.

WHY IMPROVE EPSDT?

Numerous reports, experts, and other organizations have pointed up the shortcomings in the performance of EPSDT. In nearly every respect, this program has failed to realize the promise which many believed it held for poor children when it was enacted back in 1967. Our own findings have convinced us that the only way poor children will receive truly effective health care is through a national health program designed to assure comprehensive care to all Americans. The enactment of such a program is our principal goal. However, poor children cannot go without basic health care until a national health program is enacted. Experts agree that even if national health legislation were introduced immediately, it would be at least four years until services become available. This delay is due to the time required to legislate, plan and implement any major new program.

The first reason to improve EPSDT now is that, until a new national program is in place, there are no other sources of health care to which many poor children can turn for primary care services.—Other federally-financed health programs for children—including Community Health Centers, comprehensive programs under Title V, and Migrant and Indian Health programs—reach only a fraction of the children on Medicaid. According to recent figures, these programs were estimated by HEW to have reached 1.7 million children. This compares to an estimated 13 million children certified for Medicaid.

These programs have been effective and their expansion is necessary to fill the gaps in the delivery system through which EPSDT and a national health program operate. Therefore, we urge that they be expanded immediately. However, it is unrealistic to expect them to gear up to meet the needs during the next year or two of the millions of children who do not presently have access to their services. As new resources are being developed, reforms in EPSDT can bring improved services to poor children now. Thus we do not hesitate to recommend an increased investment in EPSDT despite our clear awareness of its limitations.

During the next few years, EPSDT can provide services which many poor children have not and will not receive unless provided through EPSDT. Data show that most children reached by EPSDT had never received comparable services elsewhere. For instance, the EPSDT Demonstration Projects found that fewer than one percent of the almost 7,500 children screened had had a previous examination comparable to what is called for by the program. Sixty to eighty percent of the health problems found in these children were previously unknown and untreated, even though 80% were chronic. In Baltimore, physicians from the University of Maryland screened 361 children; 335 of them had referrable conditions. In their view, "not one of these conditions would otherwise have been recognized so early in its course" without the program.

The second reason to strengthen the program is that EPSDT can improve the health status of children reached and reduce the amount of money spent on health care.—In North Dakota, total expenditures under Medicaid were compared for children who had been screened and for those who had not. Per capita expenditures were 36–44 percent lower for those screened than for the unscreened children. Expenditures for in-patient hospital services were 47–58 percent lower for those who had been screened. In Michigan where children are on the second cycle of EPSDT screening, diagnosis and treatment, the rate of referrals for health problems found through screening has dropped significantly for those returning for re-screening. The referral rate has dropped overall by 13 percent. The most significant reduction is found in the rates of referral for immunizations (from 26 percent–18 percent), as a result of physical assessments (42 percent–31 percent), and review of health histories (10–7 percent).

The third reason to improve EPSDT is that, in the process of making EPSDT function more effectively, we will confront and help to resolve some of the key problems that any national health program will have to address in order to be effective.—If we are not to duplicate the mistakes of wasteful, piecemeal and inadequate health care programs of the past, we must (a) develop effective ways to reach out to families currently outside the health care system; (b) establish standards for complete, quality care and methods to monitor and enforce these standards; (c) involve more doctors and clinics as providers in publicly-financed programs; and (d) provide incentives to develop health resources where they currently do not exist—in urban centers and remote rural areas. Reforms in the EPSDT program will strengthen the foundations on which a new universal program can be built.

PROVISIONS CURRENTLY IN CHAP WHICH CDF SUPPORTS

S. 1392, including the Cranston amendments to it, includes certain significant improvements which CDF supports:

Inclusion in Medicaid of additional children and youth aged 0–21 who are not currently on welfare but would qualify as "income eligible" children.

Inclusion in Medicaid of low income pregnant women.

Provision of a clearly defined, comprehensive health assessment, rather than a screening.

Provision of an expanded package of health services to children who have been assessed.

Extension of a child's eligibility for Medicaid to help assure that needed followup care is received.

Defining providers' responsibilities under the program to include provision of health assessments and provision or at least arrangement for followup care.

Encouragement for providers to offer routine forms of treatment as well as assessment, within a reasonable period of time.

Increased federal share of CHAP costs.

Provision of a financial bonus to states which provide assessments, treatment, and immunizations to an especially high proportion of eligible children.

Withholding a share of states' Medicaid administrative funds rather than of AFDC payments for failure to meet program requirements (assuming Congress includes a financial penalty for non-compliance).

While we endorse the many good provisions listed above, nonetheless we believe other crucial elements must be added, without which the package will not be nearly as effective as it can and must be. During EPSDT's ten-year history, a great deal has been learned about how best to meet the needs of children and in what respects the current EPSDT program is deficient. These lessons should certainly be applied to the design of CHAP.

SUMMARY OF CDF RECOMMENDATIONS ON KEY UNRESOLVED ISSUES IN CHAP

Some of our recommendations require only nominal increased costs. The costs of others are slightly greater but extremely modest in the context of Medicaid as a whole. According to projections by HEW, the total federal program cost for these changes would be roughly $265 million over the cost of the administration's bill and within the medicaid budget authority approved by Congress for fiscal year 1979; $235 million represents less than 2 percent of last year's medicaid expenditures.

Below is a summary of CDF's positions on key unresolved issues, followed by a discussion of each recommendation.

I. AMENDMENTS WHICH INVOLVE NO COST OR MINIMAL COSTS

A. Encouraging all qualified providers to participate in CHAP

CHAP should require states to identify all qualified providers (including dental providers) and to encourage their participation in CHAP by offering administrative arrangements which can be expected to elicit their involvement. These include adequate reimbursement rates and prompt payment of claims.

The criteria in the bill defining a CHAP provider should be modified to make clear that providers which can take responsibility for assessing children and assuring that they receive complete CHAP services should qualify. The listing of such providers should explicitly include community health clinics, private practitioners, day care or Headstart programs, rural health clinics, public health departments, maternal and child health centers and any other entity that can meet the responsibilities assigned to providers.

B. Assuring that CHAP services get to needy children

As a program requirement, CHAP should establish outcome standards which states are expected to meet. The standard should measure performance in enrolling a reasonable proportion of eligible children in the program and providing them with needed assessments and treatment.

CHAP should require that the Secretary gather data to assess states' performance in enrolling eligible children in CHAP and in providing a reasonable proportion of eligible children with health assessments and needed treatment.

CHAP should be modified to require that states meet key program requirements including outcome standards, and that the "penalty sanctions" be used by the Secretary for an infraction of program responsibilities.

CHAP should require that the Secretary review every state's program at least twice annually. The Department should complete its review within 6 months of the close of the quarter under review. If the Secretary determines that a state is not meeting CHAP's program requirements, he must levy the

41

financial penalty and require the state to take necessary steps to meet the Congressional mandate. Before any order of the Secretary becomes effective, the state can seek administrative review on the appropriateness of the Secretary's finding. The process for reviewing a state's appeal should be carried out expeditiously.

C. Developing States' capacity to deliver CHAP services

Under CHAP, States should submit plans to HEW which show how the requirements of CHAP are met and which demonstrate the capacity to carry them out as described. There should be substantial public input in the development of the plan.

CHAP should require that Medicaid agencies report to the Health Planning and Title V Maternal and Child Health agencies identified health shortage areas for children so a strategy can be developed for building the necessary resources.

D. Building accountability in HEW's administration of CHAP

S. 1392 should specify that Congress expects 80 percent of eligible children to be enrolled in the program five years following CHAP's enactment. On an annual basis, the Secretary should report to the Congress on the Department's progress in reaching this goal.

S. 1392 should require that within 6 months of CHAP's enactment final implementing regulations should be in effect.

S. 1392 should establish that, on a biennial basis, an independent evaluation of HEW's administration of the program be conducted and submitted to the Congress by an outside panel of experts representing the interests of recipients.

II. AMENDMENTS WHICH INVOLVE ADDITIONAL COSTS

A. Assuring effective outreach

CHAP should require states to allocate a certain minimum portion of funds (.2 percent of total Medicaid expenditures or 5 percent of CHAP expenditures) for public education and for efforts to enroll children in the program. The exact amount should be in proportion to the percent of eligible children not currently enrolled in CHAP. Nonprofit organizations located in the target community as well as public agencies should qualify for reimbursement to perform outreach.

For outreach performed by nonprofit organizations located in the target community, states should receive 90 percent Federal reimbursement for the expenses of enrolling new children, up to a reasonable level for the cost of each child enrolled.

States which fail to attract to the program a reasonable proportion of eligible children should be required to develop a new outreach program emphasizing the use of organizations located in the target community.

B. Covering health services following an assessment

The language in S. 1392 should be clarified to make explicit CHAP's intent: that children in the program (i.e., who have been assessed) receive health care needed for problems found during the assessment as well as for problems which arise in between the times they are assessed.

The provision exempting states from treating children with "mental illness, mental retardation, or developmental disabilities" should be eliminated. CHAP should provide health services, including mental health services, for all conditions found and should refer children, as appropriate, for needed educational and social services.

C. Providing dental care

The dental provision in CHAP should be replaced by a requirement that states provide such dental care as is necessary for relief of pain and infection, for restoration of teeth, and maintenance of dental health. CHAP should not allow the receipt of dental care to be predicated on medical or dental screening.

The level of federal reimbursement for dental care under CHAP should be modified to make it the same as for other health services.

D. Maintaining State effort in the program

The federal CHAP expenditures should pay for expansion of services beyond what is currently provided under EPSDT. To accomplish this, states should be expected to maintain at least their current services and eligibility levels for children.

E. Extending medicaid to "income eligible" youth, aged, 0–21

Medicaid eligibility should be extended to children and youth between the ages of 0 and 21 who meet income qualifications for welfare but do not presently qualify for Medicaid because they fail to meet other welfare requirements (e.g., they are poor but live in intact families). States' income criteria for eligibility should meet a minimum national floor.

The criteria for eligibility should allow children to meet the income standard by deducting the family's out-of-pocket payments for medical care.

SUMMARY OF IMPROVED BENEFITS CHAP PROVIDES

Medicaid eligibility for approximately 2.5 million low income children and youth.[1]

Provision of medicaid services for approximately 64,000 low income pregnant women aged 22–44.[2]

Provision of health assessments to 600,000 more children in fiscal year 1979 than would receive them through EPSDT.[3]

Coverage of a comprehensive treatment package of benefits for an estimated 4.1 million children, projected by HEW to be up to date on health assessments, fiscal year 1979.

Coverage of routine dental care for all medicaid eligible children.

Increased federal share of the cost to states of providing expanded benefits and eligibility.

Financial bonus to states for good performance in CHAP.

RATIONALE FOR CDF'S RECOMMENDED AMENDMENTS

Our EPSDT report includes extensive justifications for the changes we recommend in the program. Here we will describe briefly why they are necessary.

1. Encouraging all qualified providers to participate in CHAP.—CHAP's clear intent is to make sure that poor children have ready access to CHAP services by involving the range of providers who are acceptable to poor families and qualified to give needed care. These include Community Health Centers, Children and Youth programs, Head Start programs, solo and group practice physicians, outpatient departments of hospitals and the like. While we strongly support this goal, we believe that CHAP, as it now stands, lacks adequate provisions to attract all qualified providers' participation.

Medicaid law presently calls for EPSDT programs to make the maximum use of existing resources. However, the intent has not been carried out because the language is too general and the federal monitoring has been lax. As a consequence, for instance, last year, 10 States relied primarily on county health departments, at the exclusion of other qualified providers, to screen eligible children. CDF found that in other states, qualified providers are effectively excluded from participating in EPSDT due to low reimbursement levels or inappropriate standards for certifying providers. Thus, children are denied access to comprehensive health centers and other providers which are often best suited to attend to their needs. Hopefully during these hearings the Subcommittee will hear the testimony of providers who have encountered first hand the barriers or disincentives to providing EPSDT services.

Although S. 1392 currently requires states to "encourage participation by physicians and health care centers," this provision can be expected to be no more effectual than the similarly vague requirement under EPSDT. Based on

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[1] According to projections by HEW, office of the Deputy Assistant Secretary for Planning and Evaluation/Health. Assumes coverage for children and youth aged 0–21 and a national minimum income standard for $4200 for a family of four.

[2] According to projections by HEW, office of the Deputy Assistant Secretary for Planning and Evaluation/Health. Assumes a national minimum income standard for $4200 for a family of four.

[3] According to projections by HEW, office of the Deputy Assistant Secretary for Planning and Evaluation/Health.

what is now known about the reasons qualified providers do not participate in EPSDT, a more explicit provision can and should be written. Therefore we recommend that language be added requiring states to offer provider agreements to any qualified provider. These should include community health clinics, dentists, solo and group practice medical practitioners, day care or Headstart programs, rural health clinics, public health departments, maternal and child health centers, and any other entity that can meet responsibilities assigned to CHAP providers. CHAP should explicitly require states to identify all qualified providers and to encourage their participation in the program by offering administrative arrangements (including reimbursement rates and prompt payment of claims) which can be expected to elicit their involvement. HEW should be charged with monitoring state performance in this regard and with reporting to Congress on provider participation in CHAP and the steps being taken to use all qualified providers in the program.

2. *Assuring effective outreach.*—When the Congress enacted EPSDT in 1967, it recognized that "organized and intensified casefinding procedures" were among the essential first steps in getting basic health care to needy children. Since then, nearly every study of EPSDT has concluded that outreach (or public education about services and assistance in using services) is most effectively carried out by community residents who are known and trusted by the target population.[1] Organizations which frequently perform outreach in this manner are community clinics, Headstart programs, church groups and the like. Although S. 1392 charges states with "assuring the availability" of outreach, it fails to include provisions which guarantee that sufficient funds and effective methods of outreach will be employed.

The outreach provisions under EPSDT currently, including the financial support available, have not been adequate to effectively inform the majority of eligible children and assist them to get health care. CDF found that EPSDT outreach usually consists of sending welfare recipients a written notice (which families often cannot understand or read) and sometimes having a welfare caseworker explain the program to the family during certification or recertification for welfare benefits. We found no organization other than the welfare department reimbursed by Medicaid for EPSDT outreach.

The results have been poor. In fiscal year 1976, for the 13 million children who were eligible. EPSDT provided only about one-quarter of the screenings children needed, according to minimum standards set by the American Academy of Pediatrics. Unless provisions for effective outreach are included in the CHAP program, the same inadequate situation can be expected to prevail: although CHAP will pay for essential services, few children in need will receive them.

While we believe states need flexibility to design outreach programs suited to particular needs in the state, we believe CHAP must contain certain minimal guarantees for effective outreach. Therefore, we recommend that states be expected to earmark at least a certain portion of the program budget for outreach, totaling approximately .2% of total Medicaid expenditures or 5 percent of CHAP expenditures; that non-profit organizations located in the target community (e.g., community clinics, and Head Start programs) qualify for reimbursement, and that states receive a financial incentive for outreach activities known to be effective (90 percent Federal reimbursement for outreach by non-profit organizations located in the target community, up to an amount of approximately $6 per child enrolled.) If with this incentive, however, states do not attract a reasonable proportion of eligible children into CHAP, they should be required to establish a new outreach program emphasizing the use of organizations located in the target community.

3. *Covering health services following an assessment.*—According to HEW staff who developed the proposal, CHAP seeks to provide comprehensive health services to children who are in a program of ongoing health supervision. Thus, S. 1392 calls for providing to "any individual under the age of 21 who has received his periodic assessment . . . all care and services appropriate for individuals under age twenty-one . . ." We strongly support the principle underlying this provision—that states should make available to children basic health services as needed. The fact that some states currently opt not to cover needed treatment services and primary care services (as is the case under EPSDT) is unconscionable. After all, the purpose of preventive and ongoing health care for children is to provide them with the services needed for the problems found.

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[1] See "EPSDT: Does It Spell Health Care For Poor Children?" p. 90 and following.

While we strongly support CHAP's thrust regarding coverage of health services following an assessment, we find S. 1392 deficient in two major respects. First, the bill must make explicit that CHAP entitles children in the program (i.e., who have been assessed) to receive health services needed for problems found during the assessment as well as for problems which arise in between the times they are assessed, regardless of what services are covered under the State plan. It make no sense for Medicaid to pay for penicillin only if a child is found during a health assessment to have strep throat, but not pay for the drug if the child comes to the pediatrician with strep throat two months later. (Eligible children can, of course, receive other Medicaid services as well.) In sum, the language should make clear that CHAP provides children with a range of essential health services for needs which occur while they are in the program. This concept is clearly a step forward from EPSDT's narrow concept of a program which screens and is concerned with treatment only for problems found at the time of screening.

Second, we oppose the provision in S. 1392 which allows states to avoid providing treatment for children with "mental illness, mental retardation, or developmental disabilities." Such an exemption runs counter to the coverage for children with all other conditions and is unacceptable for several reasons.

A significant proportion of children in CHAP will be denied important health services. As data on health conditions found through EPSDT screening show, roughly 10 percent are related broadly to growth or development. In our view, this exclusion may signal to states that one acceptable way of dealing with new financial demands of an expanded EPSDT program is to limit treatment coverage in these areas. As a result, states which opt to cut back on Medicaid coverage are likely to cut out the services needed by millions of children.

Writing an exclusion based on a particular health condition is extremely damaging to recipients. That approach requires that one determine the reason a child needs a particular service. Does, for example, a mentally retarded child need a medical and dental service as a result of the mental retardation or for some other reason? Because it is usually impossible to determine the cause, we fear that states will simply decide not to provide most health care for children who have the specified conditions. In addition to discriminating against children with certain kinds of special needs, an exemption tied to etiology encourages labelling and overclassification of children (with the excluded condition) in order to avoid payment for services.

We can find no acceptable rationale for denying needed health care to children with developmental conditions. While it is true that several other federal programs provide services to handicapped children (e.g., Developmental Disabilities, Crippled Children), they reach only a small portion of the children in CHAP who need such services. For instance, the largest program of health care for handicapped children, the Crippled Children's Program, serves roughly one-half million children each year. Yet of the 13 million children currently on Medicaid, a projected 2.6 million require health services for developmental needs.

The cost considerations, which in large part dictated establishing this exclusion, can be accommodated in other ways. First, if CHAP is amended to clarify that it provides for needed health care (as we recommended above), CHAP will not be required to pay for related services, such as educational and social services, which children with handicaps may need. In addition, there is considerable evidence that cost considerations can be accommodated by instituting careful quality control standards and peer review. Such measures must be established and enforced vigourously before we would find it acceptable to consider limiting coverage for essential children's services.

We therefore urge that the service exemption now in S. 1392 be dropped. Needed health services, including mental health services, must be provided. EPSDT, as well as other sources of data about children, show that mental health services constitute a vital part of health care for some children. They can be helped immensely by relatively inexpensive and short-term mental health interventions, mental health services which must be covered at the very least. If cost considerations dictate some limitations on care subsequent to an assessment, limitations should be confined to expensive services affecting the least number of eligible children (e.g., services in a psychiatric hospital).

4. *Providing dental care.*—Dental care represents one of the few respects in which the CHAP requirement is potentially a step backward from present practice in the states under EPSDT. EPSDT requires states to provide the dental services available under the state's Medicaid plan and "at least such dental care

as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health." [1] States have interpreted this regulation flexibly with the result that some pay for needed dental care for children who have not had a dental screening while others predicate coverage of dental care on being referred during an EPSDT screen. Under EPSDT, the federal government reimburses states for EPSDT dental care at the same level as for other medical services.

CHAP's provisions for dental care are inappropriately restrictive on two counts: (1) CHAP would reimburse states for dental care at a lower rate than for other CHAP services, thereby demoting the importance of the services; and (2) states would be required to pay only for treatment of conditions discovered during an assessment or on referral to a dentist at the time of an assessment. Coupled with the lower federal match and the fact that dental services are viewed as relatively expensive, we fear there will be minimal provision of dental care in the states. This is unacceptable.

There is wide consensus that children need routine dental care to avoid pain and subsequent problems, including the development of speech impairments and malnutrition. Because of the almost universal need for dental care, experts agree that it is unnecessary to screen children for dental problems but imperative that routine dental care be provided. Routine dental care for children should include an emphasis on the preventive measures which are known to be effective.

Based on the needs of children, the most sound dental policy under Medicaid would be to require states to cover routine and emergency dental care. While it would be more costly than the dental portion of EPSDT currently, HEW's estimates show that the costs are modest because if all eligible children were entitled to such care, the experience under EPSDT and Medicaid suggests that a relatively small portion of those eligible would actually use the services (particularly during the first few years of the program). In addition, the cost per child would decline as more children receive dental benefits and their dental health improves. Therefore, we support coverage of routine and emergency care as Medicaid benefit for children. Children not receiving routine dental care should be referred to a dentist as part of the health assessment. Dental expenditures should be matched at the same level as other health services under CHAP.

5. *Assuring that CHAP services get to needy children.*—The Congress expressed its desire to make sure that children get EPSDT services by enacting the EPSDT penalty provision in 1972. The experience with the EPSDT penalty points up the inadequacies of current enforcement activities, certain of which are not corrected by S. 1392.

Existing provisions have not guaranteed that children receive assessments and treatment. CDF found, for example, that during the first quarter the penalty was in effect, 20 states or territories which met the requirements under the penalty provisions performed fewer than one-third of the screenings required according to the AAP's standards. The nature and administration of the penalty requirements have led to the failure to achieve Congressional intent,

One element which must be built into CHAP is a requirement that States meet minimum outcome standards; enroll a reasonable proportion of eligible children in the program and provide them with needed assessments and treatment. S. 1392 includes such standards as the basis for giving states a bonus for food performance; however, using performance standards for this limited purpose will not assure that all states perform at a satisfactory level. Because of the built in financial disincentive to provide care, under medicaid (for every service the state provides, including CHAP, the state bears a portion of the cost), there must be minimum expectations related to outcomes for children. The exact standard may vary for each state but it should represent a reasonable increase over performance each year, until an acceptable level is met. The Secretary should be specifically authorized to gather data to assess states' progress. Unless such standards are penalty issues which are monitored and apply as minimum expectations in each State, it is predictable that many will continue to function at their current unacceptable level.

We are pleased that S. 1392 includes incentives for states to meet outcome standards. In addition, there must be measures capable of eliciting compliance when states fail to do so. The financial penalty established in S. 1392 is an important tool. However, based on an examination of EPSDT's enforcement history,[1]

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[1] 45 C.F.R. 249.10(a) (3) (iv).

[1] For discussion, see Chapter 2 of "EPSDT: Does It Spell Health Care for Poor Children?"

we have concluded that the financial penalty alone is not always effective in bringing about the desired improvements in the program.

Thus, we recommend that the Secretary be given an additional enforcement tool: to require that, so long as states receive federal funds for CHAP, they take steps (set out by HEW and agreed to by the state) to meet Congressional mandates. More specifically, if the Secretary determines that a state is not meeting CHAP program requirements, he should issue a notice of non-compliance and an order which sets out the outcomes the state is expected to meet and the corrective steps to be taken to bring the state into compliance. States should have the option of entering into a binding agreement to meet the terms of the corrective order within an agreed upon period of time or of seeking administrative review of HEW's finding of noncompliance. If at the end of the correction period or the administrative review, the state is found not to be in compliance with CHAP requirmeents, the corrective order is immediately enforceable. A portion of Medicaid administrative funds could be withheld as an additional inducement for states to take needed remedial action.

Finally, for the sanctions to promote compliance with CHAP requirements, application of them must work more expeditiously than is the case under EPSDT. HEW has taken an unjustifiably long time to complete compliance reviews of each state's program. In addition, because of the cumbersome process which now exists for appealing a finding of non-compliance, no funds have yet been withheld from any state even though one penalty provision has been in effect more more than four years. It is essential that Congress set timetables to assure prompt review of state programs, appeals by states, and application of the sanctions.

6. *Maintenance of State effort.*—The primary purpose of CHAP is to encourage states to strength and expand health care for poor children. Because current state expenditures are minimal in relation to the amount necessary to fill the unmet needs of children, we believe that federal CHAP dollars should be programmed to expand services beyond what is currently provided. Although we do not oppose fiscal relief to states, we cannot accept it at the expense of an improved, expanded program which children vitally need and are not now receiving.

We recommend that a state maintenance of effect provision be added to CHAP. After examining various proposals, we have concluded that the most effective approach is to require that states maintain at least their current services and eligibility levels for the under 21 population. Such a provision would help assure that new federal funds contribute to services for children not now served and that Medicaid services currently covered for children are maintained.

7. *Medicaid eligibility for "income eligible" youth aged 0–21.*—While S. 1392 takes a much needed step by making children under age 6 who live in extreme poverty eligible for Medicaid, it fails to include children in the same family who are older. Yet, as EPSDT data show, children and adolescents aged 6–21 have as high or higher rates of problems found in screening and are as much in need of basic health care as younger children. In order to reach the most needy poor children and to avoid discrimination among children of different ages in the same family, we recommend support for the amendment to S. 1392 which extends Medicaid eligibility to all children (up to age 21) in families which meet income but not welfare requirements.

Using income as the sole basis for Medicaid eligibility for children any youth, aged 0–21, will go a long way in removing the barriers standing between the neediest children and basic health services. However, the exceedingly low income standard used to determine eligibility in some states will still operate to exclude from the program some of the poorest children in the country. In 1977, in ten states or territories, children in families of four persons where the family income is only $3,000 would not qualify for Medicaid. To bring state standards up to an acceptable level, we believe that CHAP should establish a standard income floor which states must meet at the very least. We find the level recommended by the House bill—$4200 for a family of four—acceptable. According to HEW's projections, the provision would entitle approximately 2.5 million additional children and youth to Medicaid services.

Finally, we urge that the income standard be applied to allow families to qualify by meeting it outright or by spending down to meet the established level. The intent of an income based eligibility standard is to reach children most unlikely to get needed care because their family lacks adequate income. Assume a standard of $4200. A child in a family earning slightly more than $4,200 but with large medical bills is far more needy (in terms of income available to meet the child's health needs) than children in families based on income alone. Not taking into account the cost of medical care incurred, as well as basic income results in excluding some of the neediest youngsters in the more than 20 states which do not cover "the medically needy" for Medicaid services.

8. *Medicaid eligibility for low income pregnant women.*—We strongly support the amendment to S. 1392 which would extend Medicaid coverage to low income women during the term of their pregnancy and for two months following its termination. Currently, only nine states provide Medicaid coverage to low income pregnant women who have no children. While these women are likely to qualify for Medicaid as members of families with dependent children once the child is born, they are unable to receive pre-natal care through Medicaid during their first pregnancy.

The inclusion of coverage of prenatal care for low income pregnant women by all state Medicaid programs would have a significant and positive effect on the health of children and would bring considerable cost savings in the long run.[1]

Prenatal care helps prevent fetal and neo-natal health problems and prematurity, conditions strongly associated with birth defects, mental retardation, and later health and developmental problems. For example, one extensive study found that prematurity rates among mothers who made their first prenatal visit in the first trimester averaged 6.5 percent while prematurity rates average 23.6 percent among mothers who made no visits at all.

Adequate prenatal care reduces the particularly high incidence of problems associated with teenage pregnancy: problems such as toxemia of pregnancy and premature labor as well as low birth weight. These are responsible for a variety of health problems in infants and children.

Despite the dramatic benefits of prenatal care, women who are most likely to have complications in their pregnancy are the least likely to receive early prenatal care. For example, seven out of ten mothers under 15 years of age receive no prenatal care during the first trimester while one-fourth never receive any prenatal care or delay receiving it until the end of pregnancy. Low income women, particularly, go without needed prenatal care. During 1975, while 69.4 percent of all U.S. women began prenatal care in the first trimester, only 53.8 percent of all Black women began prenatal care during the first trimester. Furthermore, 5.8 percent of all women in the U.S. received no care or received care only in the final trimester while 8.9 percent of all Black women were in this category.

The necessity of adequate prenatal care for the future health of a child is unquestionable. Including an eligibility provision for low income pregnant women in S. 1392 would help to insure that no important omission has been made in the attempt to assure the continuing health of all low income children.

9. *Developing States' capacity to deliver CHAP services.*—Unlike other Medicaid Services, CHAP charges states with putting in place a host of services and seeing that children receive them. This calls for a kind of planning and administrative capability different from other Medicaid provisions. S. 1392 does not adequately address these affirmative aspects of the program; nor does EPSDT as it is now administered.

To carry out an effective CHAP program, states must set out a strategy capable of meeting program goals, build a statewide system for delivering the services, and gain broad based cooperation from a range of personnel who work with children. Under EPSDT, there has been little and in some places no attention to these activities. We therefore recommend that states develop an annual state plan demonstrating the capacity to meet program requirements. We urge, too, that there be public hearings as well as other mechanisms needed to assure substantial public input in the development of CHAP plans.

CHAP must also begin addressing problems of the inadequate number or the inappropriate kinds of health providers for children. While Medicaid, with its reimbursement approach, cannot single-handedly address resource problems, it can do a lot to help identify shortage areas and work with other health delivery and health planning programs to begin filling gaps. CHAP should require that Medicaid agencies report to the Health Planning and Title V Maternal and Child Health agencies identified health shortage areas for children so a strategy can be developed for building the necessary resources.

10. *Building accountability in HEW's administration of CHAP.*—As this Subcommittee is well aware, the history of EPSDT has been characterized by foot dragging at the federal and state levels and a pronounced failure by HEW to

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[1] The following data are derived from materials prepared by the Institute of Medicine for its Conference on Prevention, February, 1978.

provide the necessary support and leadership.[1] We are extremely hopeful that this Administration is committed to vigorous action to see that children receive the benefits to which CHAP entitles them. At the same time, we believe it important for the Congress to institute certain minimal forms of accountability. CHAP, as presently written, does not include such measures.

Had EPSDT included benchmarks against which the Congress could monitor the progress in providing children with needed care, EPSDT's poor performance would not have persisted these ten years. We believe it essential that they be established under CHAP. Therefore, we recommend as a target that 80 percent of eligible children be enrolled in the program within five years of enactment. Our summary of recommended amendments includes two measures for keeping the Congress apprised of the Department's progress in meeting these goals. In addition, we recommend that CHAP require the Secretary to issue final program regulations within six months of passage.

BEYOND EPSDT REFORM: ADDITIONAL LEGISLATIVE CHANGES

1. *Resource development funds.*—Our work has convinced us that changes in EPSDT can bring rapid and widespread payoff for poor children. But because of built-in limitations in what Medicaid can accomplish, measures beyond reforming EPSDT are called for. One crucial measure is the development of new health care providers in the many areas where children do not have appropriate sources of care close by. Based on a preliminary analysis by HEW, an estimated 16 percent of children on AFDC children live in counties designated as shortage areas; the percent is slightly higher when all children are taken into account.

We are extremely pleased that the roughly $25 million in the original CHAP budget was allocated for the purpose of developing primary care resources in underserved areas. But while it signals attention to a very important problem, $25 million cannot begin to provide assistance in many of the communities across the country in need of it. We hope the Congress will see fit to undertake a significantly expanded program of resource development to make available start up funds, technical assistance, and continuing subsidies as needed in shortage areas.

2. *Reforms in title V.*—We believe that Title V, the Maternal and Child Health provisions of the Social Security Act, provides an excellent vehicle through which a variety of needed changes in health care delivery for children can be effectuated. However, carefully thought out legislative revisions would be needed for Title V to function in this way. We are in agreement with the growing number of groups and organizations which suggest that a serious consideration of Title V reform is needed. We believe that consideration of legislative changes in Title V should be a high priority, and we are strongly committed to a thorough examination of the problems and remedies as soon as possible.

One of the biggest deficiencies in the program is that there is no administrative apparatus (operating between the federal level and providers of service at the community level) which is capable of assuring that high quality care is provided to all needy children. Improvements should be considered for key aspects of the program including: the mandate of Title V, allocation and programming of funds under Title V, and methods of assuring accountability for program funds. Changes in these aspects of Title V must be taken into account in designing an efficient administrative structure to carry out Title V's charge.

We believe it is unlikely that the kinds of fundamental reform needed in Title V can be made before Congress adjourns this year. The changes are complex and inter-related. Major reviews of Title V are underway currently by HEW, the Congress, and non-governmental organizations. With information gained from these studies, Title V reform can and should be placed at the top of next year's legislative agenda in the area of health.

An amendment to S. 1392 proposed by Senator Chiles (Amendment No. 1029) would modify Title V to set up a system of "lead agencies" to coordinate and develop child health services at the local level. We strongly support setting up an administrative structure capable of remedying the gaps and inequities in health resources for children. Medicaid and CHAP currently lack the capacity to create a rational delivery system (to develop services where needed, coordinate existing fragmented services, etc.) The function is an essential one, and until it is performed properly, many children will not receive needed care even though CHAP entitles them to it. While legislative changes in Title V seem to us a

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[1] See "EPSDT": Does It Spell Health Care for Poor Children?," pp. 54–59.

logical means to define and assign the needed responsibility, in our view the proposed "lead agency" proposal is unlikely to fulfill its intended purpose.

We find the proposal to be deficient in several respects:

Lead agencies lack staff and funds to assess what the problems are and provide technical assistance to remedy them.

Lead agencies lack the power to bring about necessary change. They lack the ability to review the allocation of funds and to reprogram funds going into the area. In addition, they have no new funds to fill gaps.

Lead agencies have no leverage to elicit from providers in the area necessary information regarding funds spent and services delivered.

Lead agencies are given neither the authority nor the charge to monitor the quality of care given children and assure that acceptable standards are met.

The proposal lacks necessary clarification of the lead agencies' powers in relation to other entities with a similar charge, such as HSAs.

It would be a serious mistake to embark on a new administrative scheme which is likely to fail. Particularly at this time when there is public skepticism about new federal directives, it is essential that changes made be workable and effective in meeting agreed upon goals. For this reason we oppose passage of amendment No. 1029, and recommend instead that the "lead agency" issue be taken up next year as part of a broad reform of title V.

We look forward to working with all interested parties to examine and improve the Title V program.

Thank you.

CHILDREN'S DEFENSE FUND,
Washington, D.C., August 15, 1978.

Senator HERMAN TALMADGE,
Chairman, Subcommittee on Health Finance Committee, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: As you know, the Children's Defense Fund prepared extensive testimony on S. 1392 which we submitted to the Committee, and also had the opportunity to present oral testimony. However, we would like to add for the record our support of a provision in the House CHAP bill, as reported out of the Interstate and Foreign Commerce Committee, related to Medicaid eligibility. This is the provision in H.R. 13611 which allows states to extend Medicaid eligibility to children who have been in foster care and who are hard-to-place because of a condition requiring medical care and services.

It is estimated that at least 100,000 children are lingering in foster care who have not been adopted because of their special needs. A large number of these children have handicapping conditions—often multiple handicaps—which require continuing care and treatment. Although often eligible for Medicaid while in foster care, these children frequently lose such eligibility when adopted and may be ineligible for coverage under the insurance policies of adoptive parents because their handicaps constitute a pre-existing condition. The absence of Medicaid coverage for such children following placement for adoption serves as a fiscal disincentive to finding permanent adoptive homes for these children and keeps them in foster care at public expense. The purpose of covering hard-to-place adopted children under Medicaid is to encourage and facilitate adoption of these children with special needs.

For this reason we would appreciate your careful consideration of and support of this amendment to S. 1392.

Yours sincerely,

WENDY LAZARUS,
Health Specialist.

QUESTIONS SUBMITTED TO MS. LAZARUS BY SENATOR RIBICOFF AND HER ANSWERS TO THEM

Question No. 1. In order for any screening and treatment program for children to succeed, qualified providers must participate. This has been a problem with EPSDT. What are your recommendations for overcoming this problem in CHAP?

Answer. Medicaid law presently calls for EPSDT programs to make the maximum use of existing resources. But the intent of this general language has not been carried out in the program. Although S. 1392 requires states to "encourage participation by physicians and health care centers," this provision can be expected to be no more effectual than the similarly vague requirement currently in EPSDT. Unlike EPSDT, CHAP must require states to solicit actively the cooperation of providers. This will involve informing providers about the program, urging their participation in it and working out contractual terms which are acceptable.

We therefore recommend the following changes in S. 1392:

(1) Language should be added requiring states to offer provider agreements to any qualified provider. Qualified providers should specifically include community health clinics, dentists, solo and group medical practitioners, day care or Headstart programs, rural health clinics, public health departments, maternal and child health centers, and any other entity that can meet responsibilities of CHAP providers.

(2) States should explicitly be required to identify all qualified providers and to encourage their participation in the program by offering administrative arrangements (including reimbursement rates and prompt payment of claims) which can be expected to elicit their involvement.

(3) HEW should be charged with monitoring state performance in this regard and reporting to Congress on provider participation in CHAP and the steps being taken to use all qualified providers in the program.

Question No. 2. EPSDT has reached only a small fraction of eligible children with services. Why? Do you think that the provisions in S. 1392 are adequate to solve this problem?

Answer. In fiscal year 1976. for the 13 million children who were eligible, EPSDT provided only about one-quarter of the screenings children needed. Poor showings such as these are explained by three critical problems which plague the EPSDT program:

First. the outreach provisions under EPSDT including the financial support available, have not been adequate to effectively inform the majority of eligible families about the program and assist them to get health care. CDF has found that EPSDT outreach usually consists of sending welfare recipients a written notice (which families often cannot understand or read) and sometimes having a welfare case worker explain the program to the family during certification or recertification for welfare benefits. These have proved to be ineffective measures. CDF found no organization other than the welfare department reimbursed by Medicaid for EPSDT outreach.

Second. EPSDT programs have failed to encourage the participation of a range of providers despite the fact that Medicaid laws calls for EPSDT programs to make the maximum use of existing resources. As a consequence, for instance, last year 19 states relied primarily on county health departments to the exclusion of other qualified providers. to screen eligible children. CDF found that in other states qualified providers are effectively prevented from participating in EPSDT due to low reimbursement levels or inappropriate standards for certifying providers. Thus, children are denied access to comprehensive health centers and other providers which are often best suited to attend their needs. Often, too. they wait as long as six months to get an appointment for screening or treatment.

Third. throughout the history of EPSDT. the federal government has failed to provide the necessary support and leadership to assure that children receive the benefits of the program. A chronology of federal action in the implementation of EPSDT shows that more than four years after the program's enactment. and more than two years after its effective date of implementation. HEW had not promulgated regulations so critical for guiding states to begin EPSDT programs. Final regulations and guidelines when eventually published, deferred requiring full implementation for yet another year and a half. HEW did not conduct reviews of state programs until two-and-one-half years after EPSDT's effective date. Once having conducted such reviews. HEW failed to act on its findings and to date. HEW has not issued final regulations to clarify states' obligations in complying with the requirements of EPSDT's penalty provisions.

Without a number of amendments. S. 1392 will not overcome EPSDT's failure to reach eligible children with services. CDF recommends that S. 1392 be amended to address directly the problems of outreach. provider participation. and federal leadership.

(1) Although S. 1392 charges states with "assuring the availability" of outreach it fails to include provisions which guarantee that sufficient funds and methods of outreach be employed. We recommend states be expected to earmark at least a certain portion of the program budget for outreach, totaling approximately .2 percent of total Medicaid expenditures or 5 percent of CHAP expenditures; that non-profit organizations located in the target community (e.g., community clinics, and Head Start programs) qualify for reimbursement; and that

states receive a financial incentive for outreach activities known to be effective (90 percent Federal reimbursement for outreach by non-profit organizations located in the target community, up to an amount of approximately $6 per child enrolled.) If with this incentive, however, states do not attract a reasonable proportion of eligible children into CHAP, they should be required to establish a new outreach program emphasizing the use of organizations located in the target community.

(2) Although S. 1392 requires states to "encourage participation by physicians and health care centers", this provision can be expected to be no more effectual than the similarly vague requirement under EPSDT. The explicit provisions we have included in Question 1 above should be added to S. 1392.

(3) We believe it essential that benchmark's be established against which the Congress can monitor CHAP's progress in prvoiding children with care. S. 1392, as presently written, does not include such measures. Therefore, we recommend as a target that 80 percent of eligible children be enrolled in the program within five years of enactment. The Secretary should report to Congress on an annual basis the Department's progress in meeting these goals. In addition, we recommend that CHAP require the Secretary to issue final program regulations within 6 months of passage.

Question No. 3. Why do you think it is important for Congress to act on S. 1392 this year rather than wait for a total overhaul of the title V MCH program?

Answer. First, the health needs of poor children cannot wait. An estimated 13 million children now on Medicaid could get vitally needed health services over the next few years through CHAP. As our testimony explains in greater detail, most of these children have not and will not receive basic health services unless provided by an improved EPDST program.

Second, there is wide consensus about how EPDST can be made to work better. Numerous studies have pointed to the same deficiencies. These can be corrected through relatively simple legislative and administrative changes. And there is broad politcal support to make these changes now.

Third, overhaul of Title V need not be done at the same time as CHAP. Although the two programs are related in some ways, any necessary conformities can be made through Title V later. In addition, to decide whether or not and how to overhaul Title V will take considerable time to do properly. In the meantime, many children from low income families will remain without access to or ability to pay for necessary health care which CHAP can provide.

Senator RIBICOFF. Ms. Katz, please.

STATEMENT OF MARILYN K. KATZ, CONNECTICUT LEGAL SERVICES, INC.

Ms. KATZ. Thank you, Senator. My name is Marilyn Katz and I am an attorney with Connecticut Legal Services. In that capacity, I represent the people who are the intended beneficiaries of the CHAP legislation, poor children and their parents who want health care for them.

There are many aspects of this bill, as Ms. Lazarus has pointed out, which deserve close consideration, but one of the greatest concerns to my clients is dental care, for three reasons.

First, it is an inexpensive service that all children need and want, and they invariably suffer if they do not get the care. It has proven results. Parents and children see the benefits of dental care immediately, as well as over the long run. It is something that the children and their parents can participate in directly. It is within their means.

Unfortunately, this bill that is now in front of your committee fails to recognize the importance of such care to my clients. It does not include dental care as a mandatory service. Rather, it requires that an assesment be provided before children can get dental care.

Ther is less reason to predicate dental care on a prior assessment than there is with most services, because we know all children need the service.

An assessment can serve a useful purpose, however. It can be the opportunity to refer children to a dentist who might not otherwise get there on their own.

Before covering each of these points in a little greater depth, I would like to ask you to look at the medicaid program from the point of view of my clients.

Most of them get very, very little care under medicaid, even though the medicaid budget grows—as does the rest of the health care system—phenomenally every year. In Connecticut, we have a $300 million medicaid program. Only $15 million of that program goes to the noninstitutional care.

That is less than 5 percent, or $75 per recipient.

Of course, it is important that people who need institutional care get it, but that covers very few individuals. In Connecticut, 7 percent of the medicaid recipients get 50 percent of the medicaid dollars for nursing home care. This leaves very little for all the children and all the parents for preventive care.

Most institutional services are provided to people, not by choice, but because they have reached the end of the line; they have no choice. They are compelled by the necessity of their condition.

Unfortunately many of the services are of dubious efficacy. Studies done by your sister subcommittee, the House Subcommittee on Health, have uncovered abuses in surgical techniques and nursing home care.

But dental care is something that is of virtually universal applicability. Almost every single child needs dental care, and those who qualify for medicaid need it most.

As a Legal Services attorney, I am astonished by the number of clients I see as young adults who have lost teeth as lack of dental care. This loss is tragic because it is completely unnecessary. Preventive dental care is one of the most universally effective health care services.

Not only does it result in improvement in children's health, but it is one that the children and their parents can see immediately and can appreciate. They can understand the connection between the dental care they get and the results. This experience is a very good one in itself, and it is also important as a lesson in regular health care.

This lesson continues because dental care involves my clients in a way that they find within their resources to perform. Unfortunately, there are many necessary medical treatments that simply are beyond the means of my clients to participate in, that require special living arrangements, regular appointments, transportation.

But dental care, between two regular visits a year, requires only a simple toothbrush and some dental floss. A child can be taught to care for himself.

All this makes dental treatment the ideal service to include and emphasize in a child health program devoted to comprehensiveness and prevention. But rather than encouraging dental care as a cornerstone of a child health care program, the administration treats dental care like a stepchild.

Section 3(G)(ii) of the bill broadens the responsibility of the States to provide most health services, whether the condition necessitating the service is discovered in an assessment or not. However, this section makes an explicit exception for dental services by requiring only "the treatment of conditions discovered during an assessment."

Senator, this is a fundamentally mistaken approach to dental care. It just makes no sense to require an assessment before preventive dental services are provided, just as we would not screen children before we give them vaccinations. Dental care should be considered a public health measure. Dental disease is just not like diseases where the incidence is limited and unpredictable and where you have to have mass screening in order to single out the children who are afflicted so that they can be treated.

Moreover, when dental assessments are not done by dental professionals very few children are assessed as needing dental care. In Connecticut, less than 6 percent of the children who received screenings under EPSDT were identified as having dental problems, though we know that 95 percent, by HEW's own figures, need dental care.

To predicate the receipt of dental care on an irrelevant assessment is simply irrational and the effect can only be to reduce the number of children who get the care they need.

However, such assessments, CHAP assessments, can serve a useful purpose. They can be an opportunity to further increase the number of children getting dental care.

Simply requiring reimbursement if the child finds his way to a dentist is not enough. In Connecticut, our experience proves that without referral and followup, many children still do not get care. Connecticut is one of the richest States in the Nation. It provides one of the broadest ranges of medicaid services, including coverage of all dental care without the requirement of a prior assessment. Yet, less than 20 percent of medicaid-eligible children received any dental care this past year.

The administration approach does not respond to this problem either. It does not require that children who do receive a screening package under CHAP are automatically referred to a dentist for examination and treatment and followups to see that care is received.

Instead, the current bill includes that meaningless assessment I talked about as a part of a regular screening process. The administration is now proposing an amendment to the bill which will allow a State to have a child who has been assessed for other conditions referred to a dentist, but would not require a State to follow this procedure. This "choice" makes no sense.

But if limitations on dental services are to be imposed, if Congress is worried about costs, do not attempt to control costs by putting artificial barriers, meaningless assessments, in the way of children getting care. Instead, choose which dental care services you want to cover by considering the need for and the efficacy of each service.

I would suggest to you that the current definition in the medicaid regulations is a good one, and this is one that I notice Senator Childs used primarily in the amendment he offered before your committee to the administration bill. Another good definition related to need and efficacy is found in the House bill.

After specifying coverage in such a definition I would then propose that you amend the bill to include dental care as defined in the definition in the list of required medicaid services.

In addition, the bill should be amended to require that assessed children be referred automatically to a dentist and CHAP followed up to assure that treatment is received.

On behalf of my clients, who are low-income children who depend on your decisions for their future dental health, I respectfully request your careful consideration of these recommendations.

Senator RIBICOFF. Thank you, Ms. Katz. The staff will submit some questions and we would appreciate your responding to them at your earliest convenience.

[The following was subsequently supplied for the record:]

ANSWERS TO QUESTIONS SUBMITTED TO MARILYN KATZ, ATTORNEY WITH CONNECTICUT LEGAL SERVICES

Question 1. Ms Katz, you obviously believe strongly in the need for basic and comprehensive dental coverage under CHAP. Cost estimates for mandating this coverage range widely. What has been the Connecticut experience? What is the reimbursement rate for dental providers? How is their participate rate?

Answer: Total expenditures are, of course, based on the cost of the services per child times the number of children using the service. The Administration has estimated a total expenditure of $78 million for the first year of mandatory comprehensive dental coverage and automatic referrals of CHAP-screened children. This total figure is based on a cost estimate of $107 per child and a user estimate of 35% of eligible children being screened under CHAP and referred to dentists and half of these actually receiving treatment and of 25% unscreened children receiving dental care.

The House Budget staff came up with a lower total estimate for the initial year, $21.5 million, based on a similar cost per child estimate ($100), but projecting only 6 months of operation and lower (and we believe unfortunately more realistic) user rates. The House estimate of $88 million for fiscal 1980 is more similar to the Administration's projection for the initial year. It depends on using the $100 per child annual cost for each child receiving dental treatment for the first time and $40 per child annually for each child after his or her initial year.

The assumption of the House Budget staff that costs will decrease once years of neglect are corrected and preventive maintenance is instituted is supported by recent experience in Connecticut. Connecticut's state plan provides coverage for dental services for all Medicaid eligible children, regardless of whether they have undergone an EPSDT screening. Yet because the State was trying to control costs by excluding certain preventive services from coverage and by maintaining unreasonably low fees, very few children were receiving care and the number was declining.

Just this past year, the false economy of such a policy was manifested. From fiscal 1976–1977 to fiscal 1977–1978, total expenditures for children's dental care in Connecticut increased only slightly from $1.3 million to $1.6 million. However, because the number of children receiving care declined 20% from 20,000 in 1976–1977 to 16,000 last year, the average cost per child receiving dental care rose from $65 to $100. There was also a significant change in the types of services rendered: for the first time expenditures for the most expensive restorative services exceeded the expenditures for preventive care and routine work such as simple fillings.

The Department of Social Services which administers the medicaid and current EPSDT Programs in Connecticut shared our concern that the cost per child was going up while the number of children being served was declining. They concluded that limitations on preventive services and the fee levels for covered services which had become increasingly too low were causing dentists to refuse to provide preventive dental care. When children did not get the preventive care they needed, their dental health worsened. Those who finally did get to the dentist came in an advanced stage of dental disease, often when pain had become unbearable, and usually then required more extensive, expensive restorative work.

It was the decision of the Department of Social Services, aided by consultation with myself and other attorneys from Connecticut Legal Services and with representatives of the Connecticut Society of Dentistry for Children, to raise the fees and add coverage for the necessary preventative services.

The following chart summarizes the changes in the program:

Service	Before May 1978	After May 1978
1. Prophylaxis	$6	$6
2. X-Rays:		
Bite wings	5	5
Additional front teeth	[1] 1	[1] 1
3. Examination		6
4. Topical fluoride		6
5. Single filling	6	8

[1] Up to $3.

Thus the average cost for a child who is being seen for the first time is now between $23 and $27, plus additional fees for any necessary fillings. The second of the two annual visits which would include only the cleaning and x-ray service costs $11 to $14, plus any necessary fillings.

Along with the additions to services and fees, the Department has added about 30 EPSDT outreach workers in its District offices who provide direct referrals to children and their parents from a list of dental providers in each geographic area and who follow up to see that the services are received. The districts are just beginning their reporting system so no statistics are available yet. However, the Department expects total expenditures to rise initially as more children are reached for the first time, and then to level off as more children need only preventive and maintenance care, and the incidence of the more expensive restorative work declines.

Connecticut's recently increased fees and expanded services should help expand the availability of dental providers for poor children. The State reports that more dentists have expressed an interest in participating in the program and have signed up as providers to receive direct referrals from the State. Currently only 1,600 of the 4,000 dentists in Connecticut submit claims for medicaid reimbursement and it is not knon how many of these providers do not see children. More significantly, although 1.600 had at least one claim for dental care reimbursement under medicaid, only about 300 dentists submitted over $2.500 worth of claims. (An amount one would expect to be billed if all medicaid eligibles were receiving care and all dentists were seeing such patients in equal numbers).

Of course, it is unrealistic and unnecessary for adequate care to be available for every dentist to treat medicaid eligible children. And medicaid fees do not have to equal fees for private patients (in Connecticut the current fees are less than one-half the Blue Cross rate). But the State medicaid agency should be required by explicit Federal regulations, if not by statutory language, to devise a proper fee structure and to affirmatively enlist a sufficient number of providers to adequately serve poor children under CHAP.

In conclusion, even assuming the Administration's estimate of $100 annually per child is correct, dental care is a relatively low cost service compared with other child health care services. One visit to an emergency room can cost more than a year of dental care. Furthermore, as Connecticut at least has begun to recognize, foregoing these preventive services will lead to increased direct costs later for more expensive restorative care.

And a total cost of $78 million for dental care coverage for all the medicaid eligible children in our nation for a year is also a very, very small amount of money. It is less than the amount spent annually for only 7,000 adults receiving nursing home care in a small state like Connecticut. It is less than one week's worth of care for hospitalized medicaid recipients in this country. It is surely a small investment for the possible returns in health care for our children.

Question 2. Anytime a new service is added to a federal health program on a fee-for-service basis, we hear horror stories about fraud. There would seem to be some potential for abuse if dental services were mandated without safeguards. Could you address this question?

Answer: As your question indicates, the cost-effectiveness of any service can be diminished by fraud and abuse. Fraud usually refers to a provider's claim for reimbursement for a service which has not actually been performed: it can also include duplicate billing for the same performed service. Abuse on the other hand, usually refers to a claim for reimbursement for a service which was actually performed but which was unnecessary.

Fortunately, preventive dental care is one of the health services least subject to abuse. Like innoculations, the need for the service is universal; all children need a dental examination, x-rays, cleaning, topical flouride application and instruction. For simple restorative work such as fillings, the fees are generally low enough that there is no incentive to do unnecessary work. According to Steven Press, the Director of the Connecticut Medicaid Program, a dentist will not spend half an hour of his valuable time doing an unnecessary filling for a small fee. Connecticut has concluded that it is not cost-effective to use abuse-prevention procedures such as prior authorization for preventive or simple restorative work.

Connecticut used to require dentists to submit requests for prior authorization for all dental services; the submission ordinarily included x-rays in support of the request. Earlier this year, a study was undertaken which demonstrated that no abuse of simple restorative services was being uncovered by the prior authorization system, but it was costing the State a significant amount to pay dental consultants to examine all the requests. Such a system was also unduly burdensome to dentists and patients who would have to wait weeks for approval; many patients became so discouraged they never returned for treatment.

Therefore, Connecticut first eliminated prior authorization for all dental services under $50 and subsequently (as of July 15, 1978) extended that exemption to all services under $100. The dental consultants continue to require requests for prior authorization (supported by accompanying x-rays) for more expensive serivces where it is also more appropriate to have a second opinion from the client's point of view, e.g., extensive bridge work, dentures, etc. Of course, x-rays are generally available in a patient's file if the State wants to check that routine restorative work was indeed necessary.

Dental care is also one of the health services where the detection, and therefore the deterrence, of fraud is easiest. Unlike many services, dental services produce a visible, identifiable result. Paid dental consultants and x-rays can be used to check that work for which reimbursement is claimed has indeed been performed.

Connecticut is currently programming its computer system to institute HEW's Project Integrity. Project Integrity is based on programming a state's computer to supply the names of providers who have a higher than average number of services billed per patient. The State can also detect double billing by checking the service codes on the bills to see if more than one claim for reimbursement has been made for more than one filling claimed in the same part of a patient's tooth.

The State will then run audits on providers for whom it has questionable profiles. Part of the audit will include the examination of patient files and x-rays and part will consist of requesting the patients to submit to open-mouth examinations. It will be easy for a dental consultant to tell if the claimed work has actually been performed and whether it has been done satisfactorily. It is estimated that the majority of states have the computer capability to run the Project Integrity programs. Even without pin-pointing particular providers, a state could economically conduct an effective number of spot checks on dental providers, especially if the number of significant providers is limited as it is in Connecticut.

In conclusion, I submit that our experience in Connecticut demonstrates that neither considerations of cost or of abuse and fraud control weigh against mandatory comprehensive dental care for poor children under Medicaid and automatic referrals to dentists of children screened under CHAP.

Senator **Ribicoff**. Senator Dole?

Senator **Dole**. I will follow the same procedure if I have questions.

Senator **Ribicoff**. Dr. Barber, please.

STATEMENT OF DR. JESSE B. BARBER, PRESIDENT, NATIONAL MEDICAL ASSOCIATION, ACCOMPANIED BY DR. ROSELYN PAYNE EPPS, NATIONAL CHAIRMAN, NMA PEDIATRICS SECTION; AND DR. GERTRUDE T. HUNTER, PROJECT DIRECTOR, NATIONAL IMMUNIZATION PROGRAM OF THE NMA

Dr. **Barber**. Senator Ribicoff, Senator Dole, I am Jesse Barber, M.D., president of the National Medical Association, which represents approximately 8,000 black physicians in our Nation. Our organization has traditionally been concerned about the health care of all children but particularly about that of the low income, minority, and other underserved population.

We are pleased to have this opportunity to present testimony on Senate bill 1392, Child Health Assessment Act. With me today are: Dr. Roselyn P. Epps, chairman of the pediatric section of the National Medical Association and Dr. Gertrude T. Hunter, project director, national immunization program of the National Medical Association.

By virtue of our traditional and historic role in the urban and rural communities, we view the enactment of this legislation as having a potentially positive impact for improving the health status of the children and youth who will be entitled to benefits under this act.

We have reviewed the companion bill H.R. 13611 and endore several improvements over the original bill. We believe that the following should be included in the final legislation; namely:

No. 1, the assurance that appropriate prenatal and postpartum care be made available for needy pregnant women;

No. 2, efforts be made to increase immunization levels of children which is consistent with National Medical Association's immunization projects;

No. 3, the inclusion of adopted children with special needs as participants;

No. 4, provision for routine dental services; as defined in 13511;

No. 5, removing some of the financial barriers to participation in the program;

No. 6, no enrollment fee, premium, deduction, cost sharing or similar charge with respect to any of the care and services will be imposed under the plan; and

No. 7, study and demonstration projects on provider participation.

There are other areas about which we have concerns, and it is to these issues we now wish to speak.

No. 1, continuity of care. Although the bill speaks to comprehensiveness of care, there is no assurance that fragmentation, duplication, and omission of services will not continue. For instance, there is no provision for continuity between assessment, diagnoses, treatment, and followup. In order for these activities to occur with continuity provisions for education for recipients and providers, outreach and tracking are essential.

No. 2, nutrition. The National Medical Association was struck by the glaring omission of nutrition as an identifiable component of this legislation. Although it may be implied in the term "preventive health care," for persons defined as "low-income," nutrition-education and appropriate food services are absolutely essential for growth and development, maintenance of health prevention of disease and recovery from illness. We would strongly urge that provision for nutrition services be included in this act.

No. 3, utilization of all health resources. Although the act permits participation by all health care providers—public and private—there is no assurance that they will be utilized or will be able to participate in the program. Deterrents to full utilization of all health resources include State regulations that prohibit participation by some providers, unrealistic reimbursement for costs of health care delivery, and exclusion of malpractice premiums as a factor in determining reimbursable costs.

These factors are critical to providers in underserved areas with large concentrations of low-income families. Some providers are unable to absorb these additional costs and are forced to relocate—further contributing to the maldistribution problem. Prior to passage of this bill, consideration should be given to this problem and remedial action taken.

No. 4, eligibility for services. Although provision is made for eligibility for services from the prenatal period to age 21, in reality numerous restrictions and qualifications exist which can interfere with adequate health care at the many crucial periods for this high-risk population. In reality, the act does not reflect appreciation for the life long consequences of poverty and inadequate health care and the dynamics of growth and development.

The National Medical Association believes that any individual who becomes eligible for this program at any point in time prior to reaching age of majority should remain eligible without restrictions until the age of 21. Only then can we effectively break the cycle of disease and poverty and raise the overall health status of the citizens of the United States reflective of the level of which we are capable and of which we can be proud.

Thank you for the opportunity of appearing before you.

Dr. Epps and Dr. Hunter, would you like to add anything?

Dr. EPPS. We would answer any questions you may have.

Senator RIBICOFF. I have no questions at this time. We might submit some questions to you and we would appreciate a response at your earliest convenience.

Senator Dole?

Senator DOLE. I will do the same.

I want to agree with the second point you made on nutrition. As a member of the Nutrition Committee, we have been having some success, finally, in the food stamp program and the school lunch program of getting some nutrition component. I think that is an excellent point, and I will certainly focus on it.

We have spent $50 a year for driver training for children and 50 cents for a child for nutrition education.

Senator RIBICOFF. I would say to my distinguished colleague, if we would transfer the nutrition program to the Department of Education instead of Agriculture, we might maybe be in a position to do something about education in the field of nutrition, but it is going to be a tough road to hoe over Senator Dole's opposition in the Senate.

Thank you very much. We may have some questions to submit to you.

Dr. Noshpitz?

Dr. Levitas?

Dr. LEVITAS. Senator Talmadge asked me to express his personal regrets that he could not be here this morning. The President asked the Senator to be with him in Missouri today, so he is accompanying President Carter to Missouri. Senator Talmadge has informed me that you are the brother of Congressman Elliott Levitas who represents Georgia's Fifth Congressional District.

We welcome you here today, and are pleased to have your testimony, Doctor.

STATEMENT OF DR. THEODORE LEVITAS ON BEHALF OF THE AMERICAN DENTAL ASSOCIATION

Dr. **Levitas.** Thank you, Senator. I accede to the President's priority over my Senator being here, and I respect Senator Talmadge's decision to accompany him.

Senator **Ribicoff.** I do not know if that is always wise.

Dr. **Levitas.** Mr. Chairman and members of the committee, I am Dr. Theodore C. Levitas of Atlanta, Ga., where I am engaged in the practice of pediatric dentistry. I am here today representing the American Dental Association, the American Academy of Pedodontics, of which I am a past president, and the American Society of Dentistry for Children.

It is a privilege to appear before you, and I am acutely aware of the personal, significant contributions to the American governmental progress that both you distinguished gentlemen have made.

In view of the constraints upon the time of the committee, I will be as brief as possible in summarizing our problems with S. 1392 the Child Health Assessment Act as proposed by the administration. A longer, more detailed statement, has been submitted for the record.

First, I would like to point out that it probably would not be necessary for us to appear here today if the House of Representatives had been willing to adopt an amendment proposed by Senator Ribicoff in 1965 which would have mandated dental care benefits for poor children under the original medicaid legislation.

At that time, Senator Ribicoff, you made an eloquent plea for the amendment and concluded with the statement that: "The need for including dental care as one of the required benefits for needy children is clear."

Senator **Ribicoff.** Doctor, what contribution does dental care make to the overall health of a child?

Dr. **Levitas.** I think that it would be fairly obvious, Senator, that the omission of dental care is going to produce severe pain for children who are susceptible to dental disease. Statistically, we know that an excess of 95 percent of the population of America has some type of dental disease. There is nothing more painful than seeing a 3-year-old, as I see on a fairly regular basis, who is suffering from dental pain.

If you extend this, perhaps, into the school-age period, a child who is suffering from dental disease simply cannot concentrate on his studies. Aside from that, it can lead into other medical problems by becoming a serious physical ailment, serious disease processes.

The difficulty, or the most important thing to me, is that dental disease is preventable No. 1: and, correctable, No. 2, relatively easy, if we see the children at the right age.

Senator **Ribicoff.** What are the consequences of the failure to provide dental care at an early age? You say that dental disease is preventable and you can check it, but what are the consequences for the person if it is not provided at an early age?

Dr. **Levitas.** There can be serious problems resulting from infection, abscessed teeth, that will extend to other areas of the face and neck and other parts of the body. This should be obvious.

It means a premature loss of primary teeth, and even permanent teeth. This can cause developing malocclusions that ultimately can have a psychological effect on a child if he presents an unsightly appearance to his classmates and, as he gets older, when he goes out to seek employment.

Strange as it may seem, the mouth is one of the first things that is seen by a person appraising a candidate for a job, and decisions can be made not on the person's ability to work, but on what his physical appearance may look like. So this is going down the road a bit.

Senator RIBICOFF. Taking preventive dental care, if you fail to undertake this at an early age, what are the monetary consequences, the cost in later life, to try to remedy or to correct a bad dental situation that could have been corrected in early years?

Dr. LEVITAS. At the moment, I do not have the exact figures. These can be supplied to you, I am certain, by our association.

Senator RIBICOFF. Would you do that?

Dr. LEVITAS. Yes, sir, we certainly will.

[The following was subsequently supplied for the record:]

The cost savings attributable to a sound, preventive dental health program for children are difficult to establish in precise dollar amounts. It is not difficult to establish the fact, however, that such savings are substantial. Bringing a generation of children to adulthood with good oral health is far less expensive than attempting to repair or restore the consequences of years of neglect. Statistics compiled by the Armed Services indicate that for every 100 recruits, it is necessary to perform or supply 500 fillings, 80 extractions, 25 bridges, and 20 dentures.

Most of these conditions can be prevented with proper diagnosis, care and dental health education with significant monetary savings in the cost of remedial treatment.

Dr. LEVITAS. I would follow up on your comments by saying that, in any instance, preventive care is going to be less expensive to the Government, to the country, to the individual, than corrective procedures at a later time, so that it makes sense to devote our energy and our expense of the moneys that are available to providing preventive dental care as opposed to worrying about corrective procedures later in life.

Senator RIBICOFF. You may proceed, Doctor.

Dr. LEVITAS. Senator Ribicoff was absolutely correct at the time of that statement, and the need is equally clear today.

In our written statement, we have recounted the association's support of that amendment and subsequent efforts by the Senate to improve dental care programs for poor children.

When the EPSDT program was adopted in 1967 with the support of the American Dental Association, dental care was to be included as a mandated benefit, but the program languished for more than 2 years until a lawsuit was brought to require HEW to carry out its provisions. Even today, it is characterized by indifferent and faltering implementation and the regulations, seemingly requiring dental care, are applied on a piecemeal, fragmented basis, if at all.

That brings us to S. 1392, and the situation is historically unique for us because it is the first time we have been faced with a bill that proposes incentives to reduce the minimal dental care benefits currently being offered to poor children. In the past, our testimony in behalf of children's dental health bill has been directed toward improving the status quo. Today, it appears that we are struggling to maintain a status quo that everyone admits is grossly deficient.

Preliminary to outlining our objections to certain sections of S. 1392, I would like to say that we recognize the importance of a health care needs of children and support provisions of the bill broadening the definition of dependent children as well as the emphasis in the bill on immunizations and other necessary services.

Mr. Chairman, under the existing EPSDT law and regulations, States are required, on paper at least, to provide:

> Such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health.

Section 3 of S. 1392 in practical effect would repeal this provision by the following language which requires:

> The inclusion of all care and services appropriate for individuals under age 21, but not necessarily including dental care when not for the treatment of conditions discovered during an assessment.

Senator RIBICOFF. One of the problems and one of the objections to covering preventive dentistry is the potential for abuse, and there have been some abuses. How do you monitor this to assure that there are not abuses—overchange, care that is not really necessary in certain localities. How would your organization handle that situation?

Dr. LEVITAS. Senator, you ask a loaded question, as I am sure you appreciate. There are abuses in every facet of life that involves human people, individuals, and to a large degree the responsibility must be placed upon the shoulders of the person involved. That notwithstanding, however, there will be people who will take advantage of situations and who will abuse them.

We would like to think that the professional peer review committees that are existent in all types of organizations, perhaps, are the best ways of monitoring these abuses, by calling them to the attention of the peers of the professionals, the fellow professionals, and having these particular situations examined.

Frankly, I am not a Solomon to give you specifics as to how to control an individual who would choose to violate the law, or to take advantage of a situation.

It has been a problem in our profession, and every profession, including these hallowed halls in which I sit today, and I respectfully suggest that it is something that we, as humans, will have to struggle with, perhaps until the end of time, because it involves individuals as opposed to ones who would attempt to do the right thing, and frankly, I am very pleased to tell you that the vast majority of practitioners do subscribe to honest methods of treating their patients and submitting their claims for fees.

Senator RIBICOFF. When you are talking about dentistry and young children, the difficulty of getting them downtown or in the neighborhoods to the dental office looms large. How about the clinics in schools where the children are anyway and where they can be examined? What about a time allotted for dental care with private practitioners coming in early in the morning or at a certain designated time to do the work under supervision in the schoolhouse?

Dr. LEVITAS. It has been my experience that this is simply not the way to do mass dental treatment for the children. I practice in an area removed from downtown Atlanta, that is removed from the residential areas where the majority of the medicaid patients might be expected to live. Yet I see large numbers of medicaid children in my private office who come to me by bus or by private car.

I firmly believe that where there is a will, there is a way for patients to come to the offices. Just as some patients who are able to pay their own way in dental offices or for dental care choose not to accept dental treatment, there will be a certain number of medicaid patients also who will not accept it.

The prospect of treating in clinics, first of all, I think you have to understand—as I will mention a little bit later—that perhaps three-quarters of the dentists in this country practice in private offices. I go to a clinic for indigent children on a regular basis in Atlanta to provide services. These are children who are not eligible for medicaid and children who are not eligible for any other type of assistance, so through our local welfare agencies there is a private clinic where we provide free services for the children.

But I feel that the practice of dentistry should be in the hands of the private practitioners in their offices where they are able to see more patients because they are following the daily, normal routine procedures. To do it in the school setting simply does not seem to me to be the place where dental treatment should be offered.

Senator RIBICOFF. Where you have a situation—where it is Atlanta, New York, Washington—where you have poor children who have little motivation, or a lack of knowledge by the parents or themselves, and the difficulty of getting to a dental office, but they are in the schoolhouse, are not so many children going to miss preventive dental care by having to go to a dentist's office?

Most dentists I know are very busy men and women.

Dr. LEVITAS. I choose to think they can get that care. I give that care, if I may be so bold to interject.

Senator RIBICOFF. Do you think you are the norm?

Dr. LEVITAS. I would certainly like to think so. I am sure there are people who would question whether I am the norm, or normal. But that is beside the point. I would like to think that I am.

Perhaps my vision is clouded a bit because of my concern in this matter.

I think if you separate the two things you mentioned a moment ago, preventive and instruction in contrast to treatment, if you are talking about instruction, home care procedures for preventive care, procedures for instructing children how to take care of their teeth; perhaps this very well could be done in a school setting by auxiliary personnel who are trained in dental offices or in dental schools to provide this type of instruction.

I think perhaps there is a way to do that. The administration of fluoride mouth rinses could be done in these places. But I am not sold, in my own mind, on the idea of trying to create clinics. The amount of money that would be spent in establishing a dental clinic in enough schools—how many schools are you going to provide a dental clinic in? Are you going to establish a dental office in every school in a medicaid neighborhood, for example?

Senator RIBICOFF. If you were really going to make it work, the answer is "Yes"—by the local health departments, the State, or the localities. I am trying to think of the different dentists I have gone to in my lifetime, personally, and I am trying to envision those dentists taking a lot of poor kids from the ghettos of our big cities and treating them.

To be very, very frank with you, I could see almost all of these dentists whom I know, going to a schoolhouse and spending an hour or two early in the morning, 8 to 9 or 8 to 10. I could see them doing that in cooperation with the local dental society.

I think you have a very big problem.

Dr. **Levitas.** Senator, we in the dental profession are aware of the fact that we have a major problem. There are some dentists—and I am not saying this in a critical sense at all—there are some dentists who simply choose not to see children, and this I respect. There are certain physicians who choose not to see children, for whatever their reasons. It may be their training or personalties or desires. It can be a lot of things.

I believe if some of the redtape, if some of the hassle that is given to the providers in the profession were eliminated, there would be a lot more private practitioners who would be willing to see patients within the walls of their private offices as opposed to having to make a trip across town, for example, which is not just one hour from 8 to 9, as you put it, but it very well could involve 2 or 3 hours of time away from the office where they might be productive in seeing other patients.

Senator **Ribicoff.** You may proceed.

Dr. **Levitas.** I was saying, inclusion of section 3 of S. 1392, in practical effect, would repeal this provision by the language which requires the inclusion of all care and services appropriate for individuals under age 21, but not necessarily including dental care, when not for the treatment of conditions discovered during an assessment.

Parenthetically, Senator, just call up a dental supply man or a detail man and ask him what it would cost to establish a reasonable dental office in a clinical facility. It becomes astronomical; it is incredible. The amount of money, if we are talking about cost effectiveness in dollars, we are getting into an entirely different ball game, if you are going to build clinics throughout the country in schools.

The provision just mentioned is wholly unrealistic unless its purpose is to deny needed dental care to most of the medicaid eligible children in the country.

Had the administration's authors of the bill taken the time and effort to review the information available from their own sources—and perhaps they did—they would have discovered studies that show, for example, that as many as 97 percent of poor children examined were found to require dental care before age 6. Further, they would have found that in the early days of Headstart, significant amounts of money were ill-spent or wasted by requiring dental assessments or screenings without followup treatment.

Other, more recent data show that only a small percent of children who are assessed actually are referred for needed treatment.

This unfortunate state of affairs would become the rule under S. 1392 because there is no requirement that persons trained in the detection of dental disease participate in the assessment program. This will assure that only the most gross conditions will be found. This omission is compounded by the failure to recognize that much dental disease will occur and remain untreated during the period between assessments.

This approach is cost-ineffective but more importantly, it ignores the long-range health benefits to be gained by continuing preventive dental programs during the formative years of childhood.

We strongly recommend that the bill be amended to provide for direct referral for dental care and otherwise correct the deficiencies we have noted.

Another serious defect and perhaps of more long-range detriment than any other is the exclusion of dental care from the higher Federal matching contribution provided in section 7. As we understand the proposal, services "other than dental and inpatient care" would henceforth be matched at a rate between a minimum of 75 percent and a maximum of 84 percent as compared to the current range of 50 to 78.

This, of course, is an open invitation to the States to reduce even further the inadequate level of dental care now provided to poor children and an encouragement to them to refrain from broadening coverage of such care in the future. Although it would seem difficult to take a step backward from the present EPSDT program under which only 1 in 5 eligible children receives services, the administration has succeeded in designing one of giant-sized proportion.

We strongly recommend that section 7 of the bill be amended to include dental care in the higher contribution rate that is proposed.

We also must disagree with the reliance that is placed in S. 1392 upon the utilization of so-called health care centers for assessment and treatment. This is particularly inappropriate and probably unworkable for dental care since more than three-quarters of all dentists practice alone in private office settings. Our organizations believe that the medicaid population should have the same access to care as the population in general.

Emphasizing a delivery mechanism not widely used by the public serves to set the medicaid-eligible children apart, clearly an undesirable effect and we would urge corrective amendment.

Based upon considerable years of experience, we anticipate that HEW will attempt to defend the exclusionary dental care provisions of S. 1392 on budgetary considerations. We believe their estimates can be shown to be high, but in any event, we think the Government should be willing to make a reasonable humanitarian commitment to the improvement of the health care of poor children, for general health and dental health are inextricably intertwined. Let me assure you that dental care is too expensive not to be provided.

As you can see, Mr. Chairman, we have some serious concerns with this legislation. At the same time, we strongly support the purpose of improving health care for children of low-income families. We have prepared amendments that would remedy the deficiencies we have mentioned and we would be pleased to submit these and work with the committee toward further improvements.

We are pleased with the support given us by the Children's Defense Fund and the Connecticut Legal Services, and we are appreciative of the amendments already introduced by Senator Childs which are directed toward the same objective. We subscribe to the theory that the lack of dental treatment is too expensive not to provide it for those less fortunate than we.

The American Society of Dentistry for Children has, as its model, the words of the philosopher Goethe: "Little can be done for grown-up people. The intelligent man begins with the child."

Mr. Chairman, members of your committee, so, too, should we begin with the child.

Thank you for your time and consideration.

Senator RIBICOFF. Thank y[illegible]ery much.

[The prepared statement o[illegible]. Levitas follows.]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman, I am Dr. Theodore C. Levitas of Atlanta, Georgia where I am engaged in the practice of dentistry specializing in Pedodontics. I am also representing the American Academy of Pedodontics, of which I am past president, and the American Society of Dentistry for Children.

I am pleased to have this opportunity to present the views of these organizations on S. 1392, the Child Health Assessment Act.

As I believe this committee is well aware, the American Dental Association has traditionally placed its highest priority on the dental care of children. The development during childhood of effective regimens of diet, professional treatment, and home care is the foundation for a lifetime of sound oral health.

Dental care for the children of indigent families and families that are minimally self-sustaining is frequently neglected. This occurs for several reasons, but certainly severely limited finances is a significant factor. Because of this situation the Association has long advocated the inclusion of dental services in health care programs aimed at these children and also has promoted the introduction of separate legislation to the same effect.

With the indulgence of the committee, I would like briefly to review some of these efforts:

In 1964, when the association testified on medicaid, we urged that if resources would not permit coverage of all needy persons, at least dental care for children should be mandated. Such an amendment was introduced by Senator Ribicoff, and was approved by this Committee and passed by the Senate. Unfortunately, it was dropped in the House-Senate conference on the bill.

In 1967, at the urging of the Association, the then administration submitted to Congress a bill authorizing among other things pilot dental projects under Title V of the Social Security Act. The bill was passed but no funds were allocated for such projects during fiscal years 1968, 1969 or 1970. In 1971, $500,000 were allocated to seven dental projects serving about 10,000 children. The next year about $860,000 were allocated and by the terms of the law the program was merged into other title V projects.

The association vigorously supported the 1967 amendments to the Social Security Act which established EPSITD and included dental care among the mandated benefits. The program languished for more than 2 years until a lawsuit was brought to require HEW to carry out its provisions. Even then and up to the present, progress has been painfully slow, which of course is one of the reasons we are here today.

In 1971, following a comprehensive hearing in the Senate, a Children's Dental Health Act introduced by Senator Warren G. Magnuson and strongly supported by the Association was passed by the Senate by a vote of 88 to 1. It provided grants for children's dental health care projects, fluoridation grants on a one-time voluntary basis, dental health education and other programs to develop effective preventive dental programs for children. The bill was not considered in the House.

In 1975, Senator Magnuson introduced a revised version of the Children's Dental Health Act, again with the Association's support, which was designed specifically to augment the floundering EPSDT program by authorizing dental project grants for dental care and services for children of pre-school and school age who qualify for Medicaid. The bill passed the Senate as an amendment to the National Consumer Health Information and Health Protection Act of 1976 but was not included in the final bill reported to the floor of the House.

That brings us down to the present, Mr. Chairman, and the situation is historically unique for us because it is the first time we have been faced with a bill that proposes incentives to reduce the minimal dental care benefits currently being offered to poor children. In the past, our testimony in support of children's dental health bills has been directed toward improving the status quo. Today, it appears that we are struggling just to maintain a status quo that everyone admits is grossly deficient.

Before getting into the specifics of our objections to certain provisions of S. 1392, I wish to make clear that we recognize the importance of all health care needs of children, none of which should be neglected. We therefore support the broadening of the definition of "dependent child" and the assurance of continuing care for children whose families' income increases beyond the level of eligibility as provided in the bill. The increased emphasis on immunization also is desirable and necessary.

The new penalty provisions in section 7(b)(1) appear to be an improvement, but we believe Congress should continue to seek methods of assuring compliance without reducing a state's health care funds. The monetary incentive for good performance also is an important innovation. While section 6 speaks vaguely to encouraging provider participation in Medicaid under regulations of the Secretary, the crux of this matter lies in the unrealistic reimbursement schedules that are in effect in many areas, an issue that should be addressed directly.

To turn now to our specific concerns with S. 1392, Mr. Chairman, it is our opinion, with all respect to those in the administration who drafted the bill, that its preamble would more accurately describe its provisions related to dental care if it said "To weaken and emasculate the early and periodic screening, diagnosis and treatment program".

Although the EPSDT program in many respects has been seriously deficient because of faltering and indifferent implementation and underfunding, its weaknesses do not lie in its underlying intent or in the scope of its benefits. CHAP, on the other hand, represents a step backward, if that is possible, in its exclusion of benefits, its disincentives to the provision of comprehensive care and its reliance upon delivery settings that do not exist in many areas or do not lend themselves effectively or economically to meeting the total health needs of the children to be served.

Mr. Chairman, under the existing EPSDT law and regulations States are required on paper at least, to provide "at least such dental care as is necessary for relief of pain and infection and for restorations of teeth and maintenance of dental health. . ." (CFR 239.10(b)(3)(IV)).

Section 3 of the CHAP legislation in practical effect would repeal this provision by the following language which requires " * * * the inclusion of all care and services appropriate for individuals under age twenty-one (but not necessarily including * * * dental care when not for the treatment of conditions discovered during an assessment)."

This provision is wholly unrealistic unless its purpose is to deny needed dental care to most of the medicaid-eligible children in the country. Had the administration's authors of the bill taken the time and effort, and perhaps they did, to review the information available from their own and other independent sources, they would have discovered from a report on the health status of children of low-income families in the maternal and child health program that in 1969 dental patient visits for all children from families with incomes of $7,000–$10,000 was four times that of children from families with incomes of $3,000–$5,000; that only 40 percent of children under age 17 from low-income families had ever been to a dentist; that 97 percent of such children were found to require some dental care before age 6. From a report of the American Academy of Pediatrics on the Delivery of Health Care to Children they would have read that "Dental disease is nearly universal in children and 50 percent of preschool children have one or more decayed teeth. Poverty intensifies neglect so that children from low income families have five times as many untreated decayed teeth as the average child". From another report they could have found that when black teenagers' health status was examined in Harlem in 1972, dental disease was found to be overwhelmingly the most common problem.

Further they would have found from their own records that in the early days of the Headstart program significant amounts of money were ill-spent, or wasted by requiring dental screenings which many times produced a well-intended chart that collected dust instead of resulting in needed follow-up dental treatment. They also could have found from more recent experience under EPSDT that in states requiring screening by nondentists as a prerequisite to dental treatment only a small percentage are actually referred for care and those often include only children with the most visible or gross conditions, usually involving severe pain. According to data gathered by the Congressional Budget Office only 25 percent or 500,000 of the 2,000,000 (children) projected to be screened may actually be referred for dental care because some states are reluctant to "find" dental problems they would be required to treat. This unfortunate state of affairs will become the rule under S. 1392 because there is no requirement that persons trained in the detection of dental disease participate in the child assessment program. an omission that is compounded by the failure to recognize that much dental disease will occur and remain untreated during the intervals between assessments.

This litany of the easily discoverable and obvious could be continued to include notice to the Department of Health, Education and Welfare that children with seriously diseased mouths do not perform well in school or in work, that oral disfigurements are handicapping to youths seeking employment, that thousands of man-hours of work per year are lost because of oral disease, and, perhaps most importantly that dental disease is among the most preventable of all maladies.

It is for these and other reasons that the dental profession has repeatedly urged state agencies to conserve resources and get to the business at hand by foregoing dental screening in favor of automatic referral to a dentist for diagnosis and treatment. This is the most cost effective way of meeting the dental health needs of eligible children and we srongly urge that the bill be amended to this effect.

In this same connection we strongly object to the requirement in S. 1392 for utilization of comprehensive health care providers for assessment and treatment. This requirement is particularly inappropriate, and almost certainly unworkable, for dental care since more than three quarters of all dentists practice alone in a private office setting. Provisions which result in restrictions on the types of providers which can participate in the CHAP program run totally counter to the basic intent of this legislation. One of the key elements which will determine the success of the CHAP program is the ability to attract providers who are willing to participate in the program. A reliance on a single type of entity, particularly one which is not generally available and certainly is almost unavailable in dentistry; will inevitably limit the number of providers who participate.

The American Dental Association believes that the medicaid eligible population should have the same access to care as the population in general. Emphasis upon a delivery mechanism which is not widely used by the public serves to set medicaid eligible children apart, clearly an undesirable effect. The Association believes it is imperative that all providers be eligible to participate in the program and to provide care to eligible children.

One of the most serious defects in S. 1392 and perhaps of more long-range detriment than any other to the provision of needed dental care for poor children is the exclusion of dental care from the higher federal matching contribution provided in Section 7 of the bill. Under existing law the federal contribution for dental and other health services ranges from 50 to 78 percent and averages 55 percent. As we understand the proposed formula under S. 1392, services "other than dental and inpatient care" would henceforth be matched at a rate between a minimum of 75 percent and a maximum of 84 percent.

This, of course, is an open invitation to the states to reduce even further the inadequate level of dental care now provided to poor children and an encouragement to them to refrain from broadening coverage of such care in the future. Although it would seem difficult to take a step backward from the present EPSDT program under which only one in five eligible children receives any service, the Administration has succeeded in designing one of giant-size proportions, insofar as access to dental care is concerned.

Mr. Chairman, our association has some specific recommendations for amendments which should be made to S. 1392. Initially we believe that the medicaid program must be amended to clearly mandate dental care for eligible children. This is an amendment which was introduced by Senator Ribicoff and agreed to by the Senate in 1965 when the medicaid program initially was enacted. Adoption of that amendment very likely would have eliminated the necessity for our discussion today of the inadequacies of the medicaid program in providing dental care for children. I am taking the liberty of appending Senator Ribicoff's statement in behalf of that amendment which is as appropriate today as it was then. Establishment in the law of a requirement that all state medicaid plans provide dental care for children will be a significant step toward finally assuring that these children receive necessary dental care.

We also believe strongly that it is time to formally eliminate requirements, that there be a dental screening as part of the assessment process. As we have stated, the needs of low-income children for dental care are so widespread there must be direct referral to a dentist fo rnecessary diagnosis and treatment.

Inclusion of a direct referral requirement as part of the CHAP program will help assure this.

Third Mr. Chairman we believe that there would be a tremendous increase in the incentives to the States to see that dental care is provided to eligible children if the Federal level of matching to the States for this care for children who are in the CHAP program is at the higher level proposed for other forms of health care. Unless the states are shown that the Federal government is finally committed to assuring the availability of dental care through its offering of the higher matching level of assistance for this care, there will be a continuing threat that the States will not develop this priority on their own.

Our fourth recommendation for amendment to S. 1392 is to eliminate the restrictions on the types of practice in which providers of care must engage in order to participate in the program. All practitioners, no matter what their form of practice, should be able to participate in the program. As we have said this is the way to help assure the maximum level of practitioners' participation, a level which must be increased in order to have a successful effort.

Senator Chiles has introduced an amendment to S. 1392 to help correct the dental deficiencies in this bill. We are most grateful for his concern. We would be more than pleased to work with the Committee and staff in developing the appropriate additional language to accomplish our suggested amendments.

Finally, Mr. Chairman, based upon a considerable number of years of experience, we anticipate that the Department of Health, Education and Welfare will attempt to defend the exclusionary dental care provisions of S. 1392 on the basis of budgetary considerations. In this regard, the Department's estimates of costs as reported to us appear to be based upon questionable assumptions and are significantly inflated. We would be glad to analyze the Department's latest projections and provide our cost estimates for the record. In any event, the government should be willing to make a reasonable, humanitarian commitment to the improvement of the dental health of poor children.

Mr. Chairman, as you can see we have some serious concerns with this legislation. At the same time, we support the basic philosophy of the bill which is to improve health care for low-income children. We hope that a final bill can be developed which will improve the availability of dental care for low income children without overburdening the administrative aspects of the program or increasing the regulatory burdens associated with it. We would like to assist in this development.

Thank you for your time and your consideration.

[Congressional Record, Washington, D.C., Tuesday, May 18, 1965]

AMENDMENTS NOS. 189 AND 190

Mr. RIBICOFF. Mr. President, I submit, for appropriate reference, two amendments to H.R. 6675, the Social Security Amendments of 1965 now before the Finance Committee.

The first amendment extends equal treatment under the bill to the dentists of the Nation. As written, the bill would deny the right of a patient to select an oral surgeon to perform oral surgical procedures that would be covered if performed by a physician or an osteopath.

Now, many dentists who have completed internships and residencies in oral surgery regularly remove oral tumors, take biopsies, reduce jaw fractures, and perform other services not involving what might be described as routine dental work. Throughout the country, there are hundreds of dentists admitted to hospital practice. Nearly 40 percent of the Nation's hospitals have formalized dental services and virtually all hospitals permit dentists to admit patients for oral surgical services. All contracts under the Federal Employees Health Benefits Act recognize the rights of dentists in this regard as do other private insurance plans.

It is only simple equity to allow patients to have their oral surgery performed by qualified oral surgeons, and that is what this amendment would accomplish.

The second amendment relates to dental care for needy children under part 2 of title I. grants to States for medical assistance.

In its present form, the bill requires State plans to include five kinds of services for persons eligible for medical assistance in order to qualify for Federal participation. Dental care is not one of these five services. I believe strongly that in the case of needy children it should be.

Not too long ago the Director of the poverty program described the care received by a youngster from one of the great cities of this Nation who joined the Job Corps. During the first days he was there, the boy simply refused to eat. The officials of the center were, naturally, concerned and did their best to find out what caused the boy to act in this way. They believed, I suppose, as most of us would have, that the boy was apprehensive or lonely or confused by the changes that had taken place in his life. The explanation was simpler than that—simpler but in many ways more tragic. The boy wouldn't eat because it hurt him to eat. His mouth was so diseased, his teeth so riddled with cavities that it pained him to eat nourishing food.

What a sad story. Even sadder, I believe, are the studies which show that this boy's problem is shared by many others. Just a few statistic document this. For example, 60 percent of the children between the ages of 5 and 14 who are members of families whose income is below $2,000 a year have never seen a dentist. Even if you go up the income scale as high as $4,000 a year, there are still 40 percent of the children who have never received dental care.

And irrespective of income, 24 percent of urban children between the ages of 5 and 14 have never seen a dentist; nor have 29 percent of the same age group in rural nonfarm families or 42 percent of those in rural farm areas.

Think of the huge sums spent on dentifrice advertising. Yet hundreds of thousands of our children are without dental care. A society that can afford toothpaste ads can afford a dental care program for needy children.

The need for including dental care as one of the required benefits for needy children is clear. In his health message of January 7, President Johnson asked Congress to adapt the Kerr-Mills program "to permit specific Federal participation in paying costs of medical and dental care for children in medically needy families." I believe we should honor the President's recommendation and the amendment I am submitting would do so.

I ask unanimous consent that the amendments be printed at this point in the RECORD.

The ACTING PRESIDENT pro tempore. The amendments will be received, printed, and appropriately referred; and, without objection, the amendments will be printed in the RECORD.

The amendments were referred to the Committee on Finance, as follows:

AMENDMENT NO. 189

On page 127, line 17, after "State plan" insert "(except to the extent required by Clause (A) (ii) of paragraph (13))".

On page 129, line 7, strike out "clauses (1) through (5)" and insert in lieu thereof "(i) clauses (1) through (5), and (ii) in the case of dependent children, clause (10)".

AMENDMENT NO. 190

On page 64, line 18, strike out "Association" and insert in lieu thereof "Association, or, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association".

On page 82, line 2, immediately after the period insert "Such term, when applied to professional services performed by a dentist, shall be limited to dental services and oral surgery of the following types: (A) prompt repair of accidental injury to natural teeth; (B) reduction of fractures of the jaw or facial bones, (C) removal of stones from salivary ducts, (D) excision of oral cysts or tumors, torus platinus, and leukoplakia, and (E) other cutting surgery on tissues of the mouth, other than gums, when not performed in connection with the extraction of teeth."

On page 82, line 6, after "surgery" insert ", or dentistry,".

On page 83, line 5, after "(6)" insert "(A)".

On page 83, line 7, strike out "and'.

On page 83, between lines 7 and 8, insert the following:

"(B) dental prosthetic devices, but only under circumstances when such devices are required for the prompt repair of accidental injury; and".

On page 88, line 21, strike out "or".

On page 88, line 24, strike out the period and insert in lieu thereof a semicolon followed by the word "or".

On page 88, between lines 24 and 25, insert the following:

"(12) where such expenses are for dental services other than those described in the second sentence of section 1861 (q)."

Senator RIBICOFF. Dr. Noshpitz?

STATEMENT OF JOSEPH D. NOSHPITZ, M.D., PROFESSOR OF PSYCHIATRY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER ON BEHALF OF AMERICAN ACADEMY OF CHILD PSYCHIATRY, AMERICAN PSYCHIATRIC ASSOCIATION, NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, MENTAL HEALTH ASSOCIATION AND ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Dr. **Noshpitz.** Mr. Chairman and members of the subcommittee, my name is Joseph D. Noshpitz. I am past president of the American Academy of Child Psychiatry. I am here to present the joint testimony of the academy, the American Psychiatric Association, the National Association of Private Psychiatric Hospitals, the American Association of Psychiatric Services for Children, the Mental Health Association, and the Association for the Advancement of Psychology on S. 1392, the Child Health Assessment Act.

I am accompanied here by Miss Ludie White, president of the North Carolina Mental Health Association, and a member of its National Committee on Childhood and Adolescent Mental Health.

We wish to address the clause in section 3 of this bill which limits provision of treatment for those children who have been screened and diagnosed as being mentally ill, mentally retarded, or developmentally disabled. Specifically, we refer to lines 10 through 12 on page 3 of S. 1392 as introduced which read: "(but not necessarily including (1) those for the treatment of mental illness, mental retardation, or developmental disabilities . . ." The result of this parenthetical clause is the exclusion of such treatment altogether. The failure to mandate such services for these children is disturbing to the membership of each of the organizations I represent.

We know how difficult it is to treat children afflicted by mental illness, mental retardation, or development disabilities. Much time, much money, much skill and human effort are entailed. The paradoxical outcome has been that traditionally, these children were excluded from service programs. In the past, such discrimination, regrettable as it may be, has taken place through an act of omission. However, this bill is unconscionable. The legislation explicitly authorizes the denial of treatment to this entire group of children in need.

Such a deliberate omission stands in direct contradiction to the recommendations of the Report of the President's Commission on Mental Health. Stating that "helping children must be the Nation's first priority in preventing mental disability," the Commission recommends that:

> A periodic, comprehensive, developmental assessment be available to all children with consent of parents and with maximal parental involvement in all stages of the process.

In its explanation of this recommendation, the Commission explicitly mentions the child health assessment program. Noting that, at present:

> The Early and Periodic Screening, Diagnosis and Treatment Program of Title XIX of the Social Security Act does not include the availability of treatment and service provisions to cover mental illness, mental retardation, and developmental disability when these conditions are diagnosed—

71

The Commission states that:

> The proposed child health assessment program should mandate that these services be available.

As it stands now, S. 1392 excludes mandatory treatment for children diagnosed as mentally ill, mentally retarded, or developmentally disabled. The implications of this provision need to be clearly faced. Optional treatment is tantamount to exclusion. There is a history to this, and the sum of its teaching is that optional coverage for mental illness means no coverage.

This stands in radical contrast to the bill's declaration of purpose:

> To continue and expand the availability of health care to children whose families do not have adequate resources to cover the cost of such care and to strengthen efforts to assure adequate child health assessments, diagnosis, treatment, and periodic reassessment of all eligible children.

That statement of purpose says one thing: the language in which legislation is couched says something quite different. In essence, the bill states that if you are a poor child whose health has been assessed, and you are found to be mentally ill, mentally retarded, or developmentally disabled, then care and services need not be provided.

In effect, S. 1392 declares that a 3-year-old diagnosed as having diabetes or kidney disease will be treated while that same child found to have psychosis, neurosis, or depression will be labeled, but not treated.

We have received conflicting messages from the administration in this area. The President's Commission on Mental Health has been a very visible force in advocating treatment of mentally ill children. At the same time, the Secretary of the Department of Health, Education, and Welfare is on record as supporting optional coverage for children with mental illness, mental retardation, or developmental disabilities. We look to the Senate to assert its leadership role in bringing the needed services to these special children.

Diagnosis and treatment of mental and emotional illnesses among children are the first line of prevention. Experience indicates that the failure to do so has already had severe consequences and will continue to have a profound effect in future years. However, if a child's mental and emotional illness, mental retardation or developmental disability is attended to as nearly as possible to the time of its inception, the result will be more normal development throughout childhood and a far better chance for later entry into society as a productive adult.

Neglect at this early age is not only wicked, but from the standpoint of a healthy and productive society, it is also stupid. The early treatment of emotional and intellectual disorders benefits not only the individual and the family, but also society as a whole. More than that, the cost of treatment at an early age is far less than the cost of lifelong disability, social services, unemployment or delinquency.

The fact is that America is presently underserving its mentally ill children. There are approximately 88 million children and youth in the United States, who constitute about 40 percent of the population. If one uses the commonly acknowledged figure of 10 percent of the population requiring services for mental or emotional illness, we would estimate that close to 9 million children have demonstrable psychiatric problems. Only about 10 percent of this population, or about 900,000 children, receive any treatment at all.

Thus, this program offers Congress the potential to provide a system of active treatment for children in need who are presently being seriously neglected.

The proponents of optional coverage advance the argument that children diagnosed as mentally ill, mentally retarded or developmentally disabled are adequately served through other means, such as the community mental health centers program. Originally, most of the CMHC system omitted children's services entirely. Later, they were phased in only after a congressional mandate.

Regrettably, the pattern of such service delivery has been very sporadic and disorganized.

Senator RIBICOFF. It is obvious that the administration does not want to go as far as you think that they ought to go.

I would like to go far, I am not so sure that a majority of Congress is willing to face up to mandating complete coverage of mental health problems and developmental disabilities.

If that is the case, would you have a suggestion as to a midway point, a big step forward, if we cannot get it all?

I would like to get it all, but I happen to think that I am in the minority.

Do you have a step that you would recommend that we take?

Dr. NOSHPITZ. Well, there is a curious emphasis on hospitalization as coverable versus outpatient treatment as less worthy, or less necessary or less immediate.

Senator RIBICOFF. Personally I am for more and more outpatient and home-patient care in every phase of the health cycle, but again, you are talking to one who is very sympathetic to your point of view.

By now, we have to face the realities, both from the executive and the legislative branches. Do you have any suggestion of where we could go meaningfully if we cannot go all the way?

Dr. NOSHPITZ. Let me address two points. In the legislation as it stands, a provision is made for coverage of hospitalization of children in general hospitals that have psychiatric units. This is a curious paradox.

If one looks at the actual figures, it costs more to treat the children in general hospitals than it does in the private, psychiatric hospitals. You can check this out with Children's Hospital right here in the District of Columbia.

Second, the general hospital's psychiatric division does not have to meet the standards for psychiatric facilities set by the Joint Commission on Accreditation of Hospitals, JCAH. That standard does not have to be met by the psychiatric division of a general hospital. It does have to be met by all psychiatric hospitals.

So that is one illustration of where careful attention to some of the kinds of details of service delivery can make a difference in the cost of these things, as well as in the efficiency.

The second point that I would like to underline is that there are many, many ways of building outpatient services. One can do it via HMO's, one can do it in a variety of ways.

I know the outpatient services at Children's Hospital where I am a full-time staff person now, right here in the District; the outpatient service expenses for an hour of psychiatric time, my time, are greater than I would charge as a private practitioner sitting in my office.

If I were in just plain private practice, no connection with the hospital, my charge per hour is less than what is billed for a medicaid patient there.

Senator RIBICOFF. In other words, what you are saying your charge for a private patient in your office is less than a hospital charges the medicaid patient for the same service?

Dr. NOSHPITZ. That is correct. Less by over $12 an hour.

Senator RIBICOFF. That is a very interesting figure.

I would suggest that you or your colleagues at your mutual convenience might have a conference with Mr. Constantine of our staff about whether or not we can find a middle ground to achieve some of these objectives.

Dr. NOSHPITZ. We would be delighted to do so. We will work on making the arrangements.

Senator RIBICOFF. This is one of the great problems in all health care, the mounting costs. The costs are really what keep us from getting more and more into the whole health care field. And I think we should be examining more and more how to lower overall health costs. This is the basic argument now between President Carter and Senator Kennedy over the impossibility—in an inflationary period—of covering all the health costs when you have skyrocketing health needs.

I see that the Secretary just walked in, and Mr. Secretary, Dr. Noshpitz was just saying that the amount of money he charges for a patient in his office is $12 less than a general hospital will charge to medicaid for the same service.

You have this basic problem where you avoid certain treatment and pay more money under the regulations. I think this is an ongoing problem to which we have to address ourselves.

I understand the President's point of view, and what he is trying to achieve, and the Secretary's point of view. but I think we do have the problem of examining all the delivery of health services and determining why a hospital charges more for a medicaid patient than you—and look at your credentials; you are a professor of psychiatry at George Washington University. You appear here on behalf of the American Academy of Child Psychiatry. the American Psychiatric Association, the National Association of Private Psychiatric Hospitals, the American Association of Psychiatric Services for Children. the Mental Health Association. and the Association for the Advancement of Psychology. So I am assuming that you have reached a status among your peers as a leader, and here a private patient comes to you and your charge is less to them than the charge under medicare and medicaid in a general hospital. That is hard to take.

The staff has asked me to ask you. is it generally true that the professional service that the average psychiatrist charges is less than the charge—the professional charge—in a hospital for the same type of psychiatric service?

Dr. NOSHPITZ. I would like to look into the generality of that. I know it is true in a number of instances. Whether it is generally true in the sense of surveying every general hospital in the country——

Senator RIBICOFF. Let's take the one you know.

I would say that would probably be the norm, generally, around the country. It is similar, but here you are in Washington. You are a professor of psychiatry, but you are also allowed to see private patients?

Dr. **Noshpitz**. The patients pay the hospital, but I am allowed to see private patients.

Senator **Ribicoff**. That is an interesting point.

I would hope that members of your association might sit down with Mr. Constantine and I would suggest that probably while the Secretary is here, that he assign a member of his staff to sit in on that conference.

I know what the Secretary is trying to achieve; he is trying to get the best service that we can give in the health field at the lowest cost. He recognizes the difficulty that we are all under, but this is a very challenging thing that you have just said, and I think that we ought to pursue it.

I think the Secretary walked in in time to get the interchange. Did you?

Secretary **Califano**. I did, Mr. Chairman.

Senator **Ribicoff**. Thank you very much for being with us. Your entire statement will go into the record as if read.

The fact that you have dropped in here is of importance and I am very pleased that the Secretary is with us, and the staff, so we can pursue it. Thank you very much, Doctor.

[The prepared statement of Dr. Noshpitz and the American Association of Psychiatric Services for Children follows. Oral testimony continues on p. 177.]

STATEMENT OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY, AMERICAN PSYCHIATRIC ASSOCIATION, NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, MENTAL HEALTH ASSOCIATION AND THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, JOSEPH D. NOSHPITZ, M.D., AMERICAN ACADEMY OF CHILD PSYCHIATRY

Mr. Chairman, and members of the subcommittee, my name is Joseph D. Noshpitz, M.D. I am past President of the Amercian Academy of Child Psychiatry, and I am here to present the joint testimony of the Academy, the American Psychiatric Association, the National Association of Private Psychiatric Hospitals, the American Association of Psychiatric Services for Children, the Mental Health Association, and the Association for the Advancement of Psychology on S. 1392, the Child Health Assessment Act.

We wish to address the clause in Section 3 of this bill which limits provision of treatment for those children who have been screened and diagnosed as being mentally ill, mentally retarded, or developmentally disabled. Specifically, we refer to lines 10 through 12 on page 3 of S. 1392 as introduced which read: "(but not necessarily including (i) those for the treatment of mental illness, mental retardation, or developmental disabilities * * *." The result of this parenthetical clause is the exclusion of such treatment altogether. The failure to mandate such services for these children is disturbing to the membership of each of the organizations I represent.

We know how difficult it is to treat children afflicted by mental illness, mental retardation, or developmental disabilities. Much time, much money, much skill and human effort are entailed. The paradoxical outcome has been that traditionally, these children were excluded from service programs. In the past, such discrimination, regrettable as it may be, has taken place through an act of omission. However, this bill is unconscionable. The legislation explicitly authorizes the denial of treatment to this entire group of children in need.

Such a deliberate omission stands in direct contradiction to the recommendations of the Report of the President's Commission on Mental Health. Stating that "helping children must be the Nation's first priority in preventing mental disability," the Commission recommends that "A periodic, comprehensive, developmental assessment be available to all children, with consent of parents and with maximal parental involvement in all stages of the process." In its explanation of this recommendation, the Commission explicitly mentions the Child Health Assessment Program: Noting that, at present, "The Early and Periodic Screening, Diagnosis and Treatment Program of Title XIX of the Social Security Act does not include the availability of treatment and service provisions to cover mental illness, mental retardation, and developmental disability when these conditions are diagnosed," the Commission states that *"The proposed Child Health Assessment Program should mandate that these services be available."* (Emphasis added.)

As it stands now, S. 1392 excludes mandatory treatment for children diagnosed as mentally ill, mentally retarded, or developmentally disabled. The implications of this provision need to be clearly faced. Optional treatment is tantamount to exclusion. There is a history to this, and the sum of its teaching is that optional coverage for mental illness means no coverage.

This stands in radical contrast to the bill's declarations of purpose: "to continue and expand the availability of health care to children whose families do not have adequate resources to cover the cost of such care and to strengthen efforts to assure adequate child health assessments, diagnosis, treatment, and periodic reassessment of all eligible children." (Emphasis added.) That statement of purpose says one thing: the language in which legislation is couched says something quite different. In essence, the bill states that if you are a poor child whose health has been assessed, and you are found to be mentally ill, mentally retarded, or developmentally disabled, then care and services need not be provided. In effect, S. 1392 decrees that a 3-year-old diagnosed as having diabetes or kidney disease will be treated, while the same child found to have psychosis, neurosis, or depression, will be labeled, but not treated.

We have received conflicting messages from the Administration in this area. The President's Commission on Mental Health has been a very visible force in advocating treatment of mentally ill children. At the same time, the Secretary of the Department of Health, Education, and Welfare is on record as supporting optional coverage for children with mental illness, mental retardation, or developmental disabilites. We look to the Senate to assert its leadership role in bringing the needed services to these special children.

Diagnosis and treatment of mental and emotional illnesses among children are the first line of prevention. Experience indicates that the failure to do so has already had severe consequences and will continue to have a profound effect in future years. However, if a child's mental and emotional illness, mental retardation, or developmental disability is attended to as near as possible to the time of its inception, the result will be more normal development throughout childhood and a far better chance for later entry into society as a productive adult. Neglect at this early age is not only wicked, but from the standpoint of a healthy and productive society, it is also stupid. The early treatment of emotional and intellectual disorders benefits not only the individual and the family, but also society as a whole. More than that, the cost of treatment at an early age is far less than the cost of lifelong disability, social services, unemployment, or delinquency.

The fact is that America is presently underserving its mentally ill children. There are approximately 88 million children and youth in the United States, who constitute about 40 percent of the population. If one uses the commonly acknowledged figure of 10 percent of the population requiring services for mental or emotional illness, we would estimate that close to 9 million children have demonstrable psychiatric problems. Only about 10 percent of this population, or about 900,000 children, receive any treatment at all.

Thus, this program offers Congress the potential to provide a system of active treatment for children in need who are presently being seriously neglected.

The proponents of optional coverage advance the argument that children diagnosed as mentally ill, mentally retarded, or developmentally disabled are adequately served through other means, such as the Community Mental Health Centers Program. One can only seriously question those who advocate this as a solution. Originally, most of the CMHC system omitted children's services entirely; later, they were phased in only after a Congressional mandate (Public Law 94–63). Regrettably, the pattern of such service delivery has been very sporadic and disorganized. Indeed, the Task Panel Report on "Mental Health and American Families," which accompanied the Report of the President's Commission on Mental Health, noted that the CMHC program has failed to meet children's mental health needs. It stated: "Part F of the CMHC Act, which began to provide discrete services for children, is being dismantled. In many centers, identifiable children's programs are not evident; and children and adolescents with serious mental health problems are being inadequately serviced." (See "Task

Panel Reports Submitted to The President's Commission on Mental Health," Volume III, Page 627.)

The statistics speak for themselves. The CMHC catchment areas serve 40 percent of the population. Several years ago, the Mental Health Association estimated, very conservatively indeed, that of the disturbed children in this country only 2 million fell within catchment areas. In 1975, however, only 300.000 children were seen in the CMHC system. The rest were not seen because of lack of staff, lack of funding, not enough specifically trained clinicians, inappropriate facilities, etc. From these figures, it is all too obvious that the program does nto adequately serve the children in need.

But it is not just this one system that fails these children. Today, only 29 states provide Medicaid options to cover the care of child patients in psychiatric hospitals. In 1976, the Office of Education, DHEW, suggested that only 55 percent of 7.8 million handicapped children were served by educational programs. Moreover, the same study noted that only 13 percent of emotionally disturbed children are ever reached.

Another argument for refusing to mandate these services is advanced by the Medical Services Administration (now the Health Care Financing Administration). According to their view, there are no adequate cost controls and the treatment is too costly. In point of fact, this same MSA has stated repeatedly it does not have data on the cost of treatment of the mental or emotion disturbances of Medicaid children. Hence the argument is fallacious to begin with: in any case, it would be a sorry reason to deny treatment to ill, retarded, or disabled children.

The American Academy of Child Psychiatry, the American Psychiatric Association, the National Association of Private Psychiatric Hospitals, the American Association of Psychiatric Services for Children, the Mental Health Association, and the Association for the Advancement of Psychology urge [illegible] Senate Finance Committee to eliminate all language that makes it optional for the states to extend treatment to the mentally ill, menally-retarded, or developmentally disabled child. In addition, we recommend strongly that the CHAP program be required specifically to assess all child health and mental health needs, and then to provide all subsequent active treatment that may be necessary.

The House Committee on Interstate and Foreign Commerce has taken a first major step; it has mandated treatment for children screened and diagnosed with mental illness, mental retardation, or developmental disability for all but inpatient treatment in psychiatric hospitals. We hope that the Senate Committee will go beyond this to insure that all treatment modalities are available on a mandatory basis, and that exclusion by diagnosis or type of treatment will be eliminated in the legislation.

I respectfully request that the article, "Toward a National Policy for Children," be included in the record of this hearing. I will be pleased to answer any questions you may have, and wish to thank you again for the opportunity to testify.

TOWARD A NATIONAL POLICY FOR CHILDREN

(By Joseph D. Noshpitz, M.D.[1])

The most obvious thing about our national policy for children is the fact of its absence. This is a phenomenon that has troubled many child psychiatrists for a long time. I would like to share with you some of the ways in which I and other colleagues have thought about it, and some suggestions that we have gradually developed. I plan to present these views in two parts: first, to explore how it comes about that we have no stated national policy for children, and to review briefly some of what we have and have not done for our young; and second, to suggest in an experimental way what we can try to do.

Curiously, the major hazard in approaching this topic is a knowledge of history. Santayana was probably quite right when he cautioned that we would repeat history if we would not remember it: in this instance, however, as a nation, we seemed compelled to redo it in spite of remembering.

When it comes to our children, we are a singular people. Our best known cradle song is Rock-A-Bye Baby, and our first prayer, Now I Lay Me Down To Sleep.

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[1] Dr. Noshpitz is President of the American Academy of Child Psychiatry and delivered this speech at the Annual Meeting of the Academy, October 18, 1973, in Washington, D.C. Reprints may be requested from the auther at 3141 34th St., N.W., Washington, D.C. 20008.

Thus, before our child is 2½ we have thrown him out of a tree every day, and killed him off every night.

Here in Washington we have also managed to kill off our Children's Bureau, and seem to be in the process of dismantling the Office of Child Development. About five to eight years ago our nation invested in a very major effort, the Joint Commission on the Mental Health of Children, and more recently still, we held a White House Conference on Children and Youth. We wait in vain for their many explorations and recommendations to appear in the form of new agencies, or new legislation. Could we say, conservatively, that there appears to be a certain ambivalence in our relationship with our children?

Let us stay with Santayana a bit and look at our history. Back around the turn of the century Freud's work first came into view. Clifford Beers wrote "A Mind That Found Itself" (1908), the first Juvenile Court was established in Chicago, and the mental hygiene movement was launched in America. Within the same decade Theodore Roosevelt called together the first White House Conference for Children, and, in large measure because of its recommendations, the Children's Bureau was established in Washington.

Thereafter, the press of history, the first World War, the stock market crash, and the Great Depression sucked up the energies of our nation, and attention turned away from programs for children. The White House Conference continued to meet every tenth year, and the 1930 Conference produced a set of recommendations that could readily have been transformed into a national policy, which indeed could still serve in that way. But no one listened, and thereafter the White House Conferences seem to have functioned as gratifying encounter groups, and little else. On the other hand, the Depression produced its own demands, the Social Security Act was passed, and welfare legislation in the form of Aid to Dependent Children did become established.

The Supreme Court decision of 1954 opened the floodgates on the racial issue, and the long pent-up torrent roared forth. In its wake came a host of concerns with the minority child: the impact of poverty on development; the many questions about "cultural deprivation," and the significance of different educational variables on how children grew and learned. All this was associated with a postwar baby boom that successively inundated the schools, the social agencies, and the correctional institutions with myriads of youngsters needing, well, just about everything, shattering categories, disrupting the established ways of doing things, and sharpening the sense of social need and social response. To make matters worse, people poured out of the farmlands and into the cities, and out of the cities and into the suburbs, so that the very fabric of social relationship, of rootedness in place, of unity of family, of ongoing connectedness with a matrix of practice, value, and tradition—all these were rent asunder and swept away as the numbers of people grew and as they changed their site and mode of life. And television came.

It should come as no great surprise that children felt much of the brunt of all this; there were so many more of them than ever before, and no one was quite ready for them. The family was forever on the move, society was far more unsettled than before, and grandpa and grandma no longer came over, comforted you, and baby-sat. Rather, you talked to them on the phone, long distance.

Everywhere there was social ferment and an effort to deal with the huge new problems, all manner of theories were advanced, and all manner of legislation passed, every cabinet department in the U.S. federal system developed some program to try to do something for children, and each of them focused on a different group of children in a different way. Presently a ragged, crazy-quilt pattern of patchwork services and agencies came into being. All types of things were to be done for children, but often the programs clashed and jostled against one another; they overlapped in some areas, or failed in their totality to cover other areas. Somehow they often did not reach children and families who needed their services, or they did reach needy people whom they could not serve because of some quirk in legislation or in regulations. And there was chaos in the land.

his stae of affairs in turn heralded he establishment of the Joint Commission on the Mental Health of Children. That is not quite accurate—one could devote an essay to the peculiar impact of the individual variables of great men on the establishment of children's legislation. In this case, Kennedy's contribution came bizarrely enough through the manner of his death, and the Congressional bill which created the Joint Commission was actually nicknamed the Oswald bill. As Rexford (1969) has noted, some of our legislation for children seems to happen because we want to defend ourselves against them.

In any case, the Commission worked for three years and produced a set of recommendations which, under the basic rubrics of child advocacy, community services, research, and manpower and training, covered a very wide range of areas and activities. Superficially, it would seem that such a statement could have served as a nucleus around which to build a national policy. In fact, however, it did not, and perhaps it is worth pausing for a moment and considering why things took the course they did.

The first, and clearly the most important of the recommendations of the Joint Commission, was for advocacy. This word has become both a rallying point and a target; it remained undefined and, perhaps for that reason, multidefinitional, and it continues to be an uneasy, oft-quoted, suggestive, evocative, but elusive idea in the field. It generates much ferment, and several advocacy proposals and offices of advocacy were initiated; somehow, however advocacy never moved off center, it did not quite catch on. For one thing, the advocate was supposed to unify the activities of the several fractionated services and agencies dealing with children, to find where they were, and what they were, learn what they could do, and then coordinate them and bring them to bear on the children and families that needed them—a logical mission, even a noble one, but one of considerable complexity.

I remember a presentation by Edward Zigler, a former Director of the Office of Child Development, in which he describes his experience when he came to Washington. He had been given to understand that he was to be the advocate for children in the federal government, that it was to be his task to coordinate the activities of the several agencies which had established children's programs or which contributed in some way to meeting children's needs. He soon discovered that to career civil servants, when someone came up to you and said he was going to coordinate your activities, it means that he was going to take away your money; thus he encountered a rash of broken appointments, delegations of meetings to underlings, and cold receptions, when he set about trying to advocate and coordinate programs for children. Logically, advocacy is a good idea; politically, it is hard to make it work.

Another problem aspect of advocacy was described in a Group for the Advancement of Psychiatry Ad Hoc Committee Report (Noshpitz et al., 1972). It can also be seen in the history of advocates of the past. Let us look at the Juvenile Court Judge. He, too, is an appointed advocate of children, chosen to see to it that they are protected from the punitive aspects of law and that they are viewed instead as misguided individuals in need of treatment, protection, supervision, nurture, education, and training and guidance. The judge's task is to decide how much of each is necessary, and to assign the services to the child and family, however it went, and another soul would be saved. The problem was and still is: where are all these therapists protectors, supervisors, educators, trainers, and guides to be found? The answer comes mostly: "Nowhere." The probation personnel attached to the court, be they ever so skillful, soon had far, far too many cases to handle; the foster placements which were implicit in such a mission did not exist; and the back-up agencies such as the training school, hospitals, or treatment centers were destructive, regressive, or full. The result we know: the court became a well-intentioned agency which worked ineffectively, often hopelessly, against impossible odds, and succeeded chiefly in producing a high level of professional discontent and client recidivism.

Whose fault was it? Whose fault is it today? Well, nobody's exactly, or, more precisely still, everybody's. The System. Overtly we set up a good program, covertly we make it fail. We. You and I. Everybody.

I believe that this illustrates an essential part of the problem which will face any child-serving agency, one which a national policy must address. All of the money, all of the good work of any one part of the system will come to naught if there are not the necessary elements present to handle the full range of problems which arise. Or, [illegible] in this imperfect world not the full range; then the large bulk of the needs, for if these are not met, then the untreated case sits among us. Some child, some family in the midst of us, proclaims his or her need, perhaps by piteous pleas, perhaps by delinquent assault, but saying through his presence and his suffering that "things" are not working, that something more has to be done, and this will act as a small focus of demoralization and dismay for neighbors and relatives, for professionals and agencies, for everyone who contacts the situation, and it will cast its cloud on all the good work done about it. Given many, many such instances, given, in short, the state of affairs in the total field of child care today, the whole system falls under the shadow of disquietude and uncertainty and begins to question its worth. The result, often enough, is chronic demoralization and high staff turnover, or a regrouping on a lower level of expectation, where failure is the expected outcome of one's efforts, and the worker, or the team, or the agency is sustained only by the uncertain reassurance that he and others are doing the best they can, that they are helping some children. And indeed, there is always the occasional and unpredictable success that comes from God alone knows where.

Such unhappy systems are, alas, not uncommon. In addition to the court, they include the more backward state hospital programs for children, some of the institutions for the retarded, most of the training schools for delinquents, quite a few public schools in poverty areas, many a special education class and, in sum, all too many of our child-serving agencies.

How are we ever to deal with all this need and with our system? No easy answer is currently available. In fact, we do not know how to solve the basic problem, and one symptom of our ignorance is that we spin so many theories, and offer so many answers. The system will not respond to further patching: it really needs redoing, conceptually and empirically. Unless it is approached that way, with a certain total overview in mind, it is very doubtful if it can be made to work well. That is not to say that it will not work at all. It works today, for example, sloppily, inefficiently, and inadequately, but it does work: quite a few youngsters are seen and moved about, and some of them are helped. Many, many are not, and all too many end up more hurt than otherwise by their education, their institutionalization, or their unfortunate unsupervised placement. In so many of these instances it seems that neither the youngster nor the system can win. The only genuine choice is among different ways of losing—one can make some decisions there.

What would it take for a system to work? First of all, I believe that it needs an idea: an axiomatic idea, no proof available, but an idea that everyone subscribes to. This is peculiarly important. From the idea we can generate a policy. And from the policy can flow technique and method. But unless there is some sort of underlying, unifying concept, it is difficult to create a really workable policy. In one White House Conference after another, in the report of the Joint Commission on the Mental Health of Children, and in many other areas, ringing formulations have been advanced about our children's needs, our children's rights, our stated ethics, and our cultural responsibilities. Sad to relate, none of this seems to accomplish very much. Maybe it is my personal scotoma, or perhaps it is a very American reluctance to accept ideologies of whatever kind, I do not know. Perhaps it is simply that these ethical imperatives enter too directly into our areas of cultural ambivalence.

I would therefore like to propose a rather simple formulation which I will call the Principle of Conservation of Development Potential. This principle states, in brief: a culture succeeds or fails in direct proportion to the way it enhances or impedes the development of its children. In other words, a culture that encourages, protects, and furthers development will do better than one that does not. A culture can conserve developmental potential, or waste it. If it does conserve it, it will make more money, produce more inventions, achieve higher artistic levels, provide its children better parents, be more just to its citizens, fight better wars if it has to, and have more solidarity as a people. More than that, as individuals, its people will know more joy.

This, then, is the underlying principle, the philosophical set. I think of it as a pragmatic principle, the fruit of observation and a basis for action. It is a principle with admittedly parochial origins; to the child psychiatrist, development is the heart of his work. He knows how complex development is, with its many critical dimensions. He knows that there is a universe of discourse covered by this one word, and that we are a long way from being able to realize all its implications. Nonetheless, he also knows that we do know something about it, and that it should be our national business to design our civilization so as to give the maximum stimulus, support, and opportunity to the development of each individual. The policy which emerges from this principle is that it should be the stated commitment of the United States Government to endeavor by every means at its command to preserve the developmental potential of every child in the land.

As we observe children, we can see that each stage of childhood is comprised of a set of moving elements that form a complex wave front. All in all, development is a dynamic movement of intricately patterned interrelated sequences that advance together, now to enhance, now to confuse, and occasionally to cancel each other out. But the larger resultant of all their varied interactions is growth, a progressive unfolding, all through the life cycle so that you and I too are not static, never cross sections, we grow always, and we shall continue to do so until we arrive at what may be the greatest growth step of all, the moment we die.

At no time, however, is the rate of such growth, and its vulnerability to insult, so great as in childhood. And this in turn begets the need for societal concern, societal protection, societal help, to see to it that within our children those delicate, intangible, fragile, weblike processes unfurl with all their richness and complexity preserved, and that each stage builds securely on the health and integrity of what has gone before.

This is society's task, and from this viewpoint then must flow program, method, and practice. How does one go about conserving development? Please note the language usage here—to "conserve." I employ this verb advisedly, because I seek here to ally myself with the conservationists rather than the educators, or the sociologists, or even the therapists. I do so for two reasons. The first is that I think of the potentials of our children as an immense wellspring of uniquely precious quality, a realizable asset that is peculiarly human in character; that is not primarily economic, although it undoubtedly has extraordinary economic implications; that is all too easily and quite typically wasted, exploited, or destroyed; that is given much lip service and insufficient support; and that will reap us an abundant harvest if nourished, preserved, and protected. In effect, I am trying to slip the preservation of child development past our cultural ambivalence. I might add that this approach has an interesting precedent. It may be apocryphal, but it is an oft-quoted story out of American history that over a century ago there were several attempts to bring brutal parents to book for mistreating children, but they were all failures. In those days, no statute could be written that would interfere with a parent's right to correct his offspring: no matter what a parent did, he was within the law. Finally, a case of child abuse was brought in under a then-existing code that decreed humane treatment for animals. The court ruled that children were indeed animals and so came under the protection of the statute. Only then could some of these abuses be approached.

Today, there is a series of events unfolding in the country which, while different in character, are nonetheless reminiscent of this same style of approach. Heretofore, there has been no way to force a state to educate or to treat its young. Currently, however, a group of inspired and determined young lawyers is opening up a whole new battlefront with the culture over the question of children's rights. In effect, these attorneys are using the adversary approach that is so deeply rooted in our legal mores to challenge the culture, saying, in effect: if our professed standards and legal codes state that people have certain inalienable rights, what about the rights of our children to humane care, to treatment, to education? Again, please note, the plea is not for children *qua* children: it is for civil rights of a particular group as a legal matter. If you stop to think of it, there's something schizophrene about the fact that a state would have to be taken to court to give children these basic supports to their development: from the point of view of the student of societal ambivalence toward children, one can only sigh. Q.E.D., and all hail to our lawyers.

So I feel I am in line with established precedent when I focus on conservation. And indeed, where children are concerned, we have something very important to conserve. We know that there are critical intellectual capacities that are failing to unfold, multipotential stages of emotional development that are not being achieved, boundless capacities to grow both physically and emotionally that are not being realized, towering levels of psychosexual maturity that are not being attained, and capacities to love and work that are being stifled and atrophied. We have but to look about us and we see all manner of snuffings out and suffocatings of the conceptual, the creative, and the humane in our developing youngsters, with resultant withering of some portion of their potential humanity. All this because of our failure to throw the full weight of our efforts and energies into the kind of work necessary to protect and preserve these nascent and unachieved fruitions! I take it for granted that behind any conservation program there is likely to be a good deal of love, a measure of genuine caring for what is preserved; or if not, then there should be at least some self-love, an enlightened self-interest that can see beyond the immediacies of cost and expense. It is self-evident that children who are better able to love are going ot make for a better society; children who are better able to learn, to remember, and to work are going to make for a more productive society; children who are better able to control their impulses and keep their emotions in check are the long-range answer to our common yearning for a safe society; and children who are able to develop tenderness, compassion, and feeling for other people will surely make for a happier socie[illegible]. I propose a problem to our economists. If you could raise the average IQ level of our society two IQ points, what would be the effect on our gross national product? My prediction is that it would be considerable. More to the point, however, is the fact that while children as entities are not rare, full psychosocial maturity is so uncommon that we are not likely to meet more than two or three truly fully mature, completely integrated human beings in a lifetime; the potential for such an outcome is within us all, but most of us never approach it. I am talking here of conserving something that is in fact infinitely precious.

The second reason for invoking the concept of conservation is that it is an action-oriented idea; it speaks to things to do, of tasks and programs and channels for endeavor. Certainly that is exactly what we do need now. We need a policy that will lead to action. How, then, do we begin? How, to repeat the question, does one go about conserving development? Well, to conserve it, we have to worry about it. We have to consider its vagaries, its vicissitudes, its multiple potentialities in the face of inherent difficulties. We have to devise preventative methods to avoid trouble, growth-enhancing tactics to maximize potential, and therapeutic and rehabilitative practices to cope with troubles that do appear. We have to pay attention to details.

As I see it, there are two levels at which the work of conservation must go on. One is the conservation of family potential; the other, of individual capacity. Family potential implies a host of action programs: housing, income protection. legal services, community organization, rat control. disease prevention, nutrition, population control, city planning, coping with racism, women's rights, adult education, marital counseling, and a whole universe of adult services that protect family function, enhance family feeling, and prevent family disruption. It implies that we teach parents parenting, that we cope with child abuse, that we teach corporations to think twice before they move families around, that we teach hospitals how to maintain dignity in waiting rooms, that we teach police how to approach family difficulties, that we teach politicians what they lose when they vote down family-support legislation—and so on and on for an immense variety of programs.

Today, however, we want to look more closely at the other leve[illegible]e level of the individual child, and to talk about how society can cup its hand[illegible]round each young grower, and preserve and protect and enhance this fledgling till he or she reaches his fullest stature, his most fruitful being.

From the moment of conception to the moment of death, we are all of us woven about with the living strands of our culture, fibers that can become wings with which we may fly, or manacles to hobble us, or a noose to destroy us. It is our burden, then, and our mission to strive to shape our culture to our larger ends.

Let me repeat the three dimensions of care with which society must approach each stage in the life cycle of each developing child: it must seek to p[illegible]ent whatever harm can be prevented, to enhance whatever capacity is there, and to straighten and heal whatever hurts.

During the work of the Joint Commission on the Mental Health of Children, the question of service delivery models commanded a great deal of attention. Dane Prugh developed an initial model which a Group for the Advancement of Psychiatry Ad Hoc Committee on the Report of the Joint Commission on the Mental Health of Children later elaborated into a mental health grid. I was a member of that committee, and I would like to repeat something of what was in that Group for the Advancement of Psychiatry report. This concept of service delivery was built on a notion of plotting the child's age against his levels of functional competence, so that for each age there was a built-in statement of what services he would need.

In effect, we can begin by drawing a diagram. We draw a line, the line of growth. Along its length we mark a series of points. These points each represent a moment of development; they could be labeled: pregnancy, infancy, the transitional child, toddler, pre-schooler, early latency, prepuberty, puberty, mid-adolescent, and young adult. This, the ordinate.

Next, we draw a line at right angles to the growth line. What shall we plot as our second dimension? Clearly, children are many things, joys and problems, talented and retarded, average and deviant—how shall we regard them most usefully so that we can plan for them? The proposal is that we think of a spectrum with two end points. At one extreme is the child with unusual talents. He is musical, or has an extraordinary memory, or is cognitively precocious, or a mathematical marvel, or whatever. At the other end is a group I would call the tragic children, the severe organic retardate, the lifelong nuclear schizophrenic, the victim of massive brain trauma, the child whom we can ease, but whom we cannot otherwise help. In between there is a wide range of possibilities, and I propose we list them as a series of closely demarcated categories in order of decreasing competence and increasing need for help.

This, then, becomes our abcissa; its points: gifted child, competent child, vulnerable child, stressed child, troubled child, disturbed child, and tragic child. Now we take out our rulers and draw lines from each point, lines vertically and lines horizontally, and lo, we have a grid, a checkerboard of intersecting lines. Our assertion is that wherever these lines meet and cross, a set of appropriate social institutions must be created to provide the tripartite response that is necessary for that age group with that level of need.

A few examples should illustrate how this grid works. Let us consider the early latency child and the services he would need. We follow along our grid line for this age group, and the first point we come to is the gifted child. What does such a gifted 7-year-old require? Since unusual talents expose children to novel stresses and unique social pressures, there may be need for parental counseling to help the parents protect the child's emotional development. Often enough, the pressures are felt most keenly within the child's own family. Along with this, the school would have to have an array of special adaptations for the precocious or exceptional youngster. For some children these would include specific, talent-enhancing programs such as special tutoring; for others, it might mean a planful avoidance of special training, a minimum emphasis on difference. In short, talent needs carefully designed educational and emotional supports for its full conservation.

Now let us extend our early latency line across to the next point, where we encounter the competent child. The great socializing and facilitating agency for this youngster is the primary school, and our culture has indeed addressed that issue; most of our children do get an exposure to that level of education. What is lacking, however, and what we hope we are approaching but have not yet achieved, is a sort of quantum jump in how to teach, a beginning appreciation that all learning is a cognitive-affective process, and not just a matter of rote, or conditioning, or compliance, or intellectual mastery. Our schools and our teachers are grasping this slowly today, and precious capacities in our children that could have been kept open and preserved are still being shut off and aborted by the failure of our educators to address the affective component of the learning process.

What we also are only beginning to deal with it the fact that every competent child may shift columns on our grid and become a vulnerable one. A parental illness, a serious medical or surgical challenge to the child himself, the all too common experience of family breakdown, a move to a new and more demanding environment—a variety of factors can transform a youngster who is growing well into one who is at risk. A series of social responses in depth can help and preserve the growth potential here: the presence of a guidance counselor or a mental health professional on the school staff; the preparation of the family doctor and the pediatrician to recognize the impact of emotional stresses on the developmental processes and to know how to intervene; the availability of mental health consultation to families and to agencies serving the competent child, such as camps, and playground personnel, and training programs for scout leaders, and librarians and various kinds of neighborhood workers; the use of adult education techniques to sensitize and inform parents about children's needs; and so on, for a wide range of problems.

Let us advance another point on the grid, from the vulnerable child to the stressed child. He or she is having some trouble. Minor neurotic symptoms or predelinquent behavior are beginning to be evident. Here is the prime site of action for short-term play therapy, for family intervention, for belief group activity therapy. Major aids can come from the police athletic league, the foster grandparent program, or the Big Brothers. In some areas these youngsters need probationary or supervisory support. These may be backed by properly designed group involvements, along with a whole host of reaching-out patterns like neighborhood workers and special camp programs. In the schools, mental health classes can be of help with additional tutorial or special education approaches and with opportunities to maximize the child's available skills or to find channels for his or her interests—in short, to do the work of preremediation or early remediation necessary for youngsters at this level of disequilibrium.

If we proceed to the next point, the troubled child, we encounter the need for intensive psychotherapy, pharmacotherapy, child analysis, day care, or group home care. The disturbed child would, in turn, require long-term residential treatment or other forms of institutional care. Finally, we come to the tragic child with the special lifelong settings he or she requires. At each point in our grid there is a need for providing the patterns of intervention and support which that stage of child development needs at that level of function.

For contrast, let us jump up to mid-adolescence and see what happens along that grid line. First, we encounter the talented adolescent. It is a challenge worthy of any great culture to provide for the special abilities of gifted youngsters so that their talents are known, channeled, refined, and rewarded. It strengthens both the individual and his society when such a youth grows and flourishes in his or her areas of competence and obtains the richest fruit from his endowment. All types of specialized and advanced training, tutorial programs, work opportunities, specific camp and school settings, a chance to meet and work with leaders in their fields, along with emotional supports when and as needed (i.e., an open-ended group the youth could attend if he wished to, in which coping with talent is the focus of the work, and with the back-up of individual therapy or psychoanalysis, if indicated) : all of these would be at least part of the picture.

To proceed to one more point on the line, the competent teenager might need a puberty rite, along with his education and his social experience. Many youngsters seek out such events, for instance, by joining a gang, or getting a driver's license, or getting into a particular college, or starting to work, or through a first heterosexual encounter. They experience enormous anxiety and tension about this initial event, and they get profound symbolic as well as realistic satisfaction because they have endured the ordeal. Instead of letting the puberty rite just happen, there might well be a planned cultural response in keeping with this adolescent need, e.g., a year of preparation for the driver's license, with courses in social behavior, dating in a car, temptation and control on the highway, and all sorts of associated topics which would bring a youngster into contact with social mores and practices via the ceremony of becoming a driver. The ceremony itself could be made a rich and rewarding experience taken very seriously by the whole social structure.

These are a few illustrations taken out of the grid. One basic characteristic inherent in this pattern is that of assigning a child to a particular category which has nothing to do with his diagnosis, merely with the level of treatment required. This is clearly a medical decision and should be made by the child psychiatrist. Thus a child with school phobia can be classified as "vulnerable" and require some brief therapy, consultation to school, and work with the guidance counselor, or he or she can be diagnosed as "disturbed," and be a candidate for institutionalization. Such distinctions are important for planning service delivery programs and computing the economics of care: it could help insurance companies plan coverage in terms of functional level. Hopefully, it would make the whole social management of a given child clearer and more consistent. The point of this grid is that it can be superimposed on any community and the hard questions can then be asked in terms of our policy, what services for children are present and what absent? What more is needed, what is potentially available, what needs yet to be striven for?

Often enough, we are told we must make choices, determine priorities, get first things done first. Sometimes this has taken the form of which age group needs the most help. At various times in the past, the focus of public interest has been on adolescence; not long ago, the emphasis fell on the preschool child; more recently still, it has been on the first three years of life.

But one cannot emphasize any one point in development and say, "That's it—we'll protect that!" There is plenty of evidence that such a course simply does not work. For better or for worse, all the stages of development are important, and they all need maximum support.

Let us take an example. A few years ago, one of the most creative and imaginative programs yet to be devised to help this nation's children was organized by Julius Richmond and his colleagues. It was called Head Start. Richmond recognized that there was a whole universe of preschool children who lacked an adequate supply of many ingredients essential for development. He devised a program that brought these chidlren a goodly diet of prevention, enrichment, stimulation, and education. Many of the children who were entered into this program responded beautifully and began to make evident and measurable progress. By the time they were ready to enter school, they were doing well, working at a relatively good level. The investigators connected with Head Start waited a year and retested the children along with a group of controls, children who had not had the benefit of Head Start. Lo and behold, by the end of the year, all the initial gain of the Head Start children had been lost; the two groups tested alike.

The response to this was twofold. One form took the direction of seeking to continue enrichment and stimulation into first grade. Evidently, the gains needed to be given continuous support if they were to be maintained. The other took the tack of throwing the weight of help and research into the earlier years of life, the infancy and toddler periods. In other words, the attempt to deal with one point in development gave only limited success, and the efforts then spilled over into both collaterals, both the stage ahead and the stage behind.

As I see it, there is a crucial need to support development all up and down the line. There is no one phase that is THE one, the critical one. Or, if you like, each phase is critical in a different way. If your priority is to prevent the most serious organically based disturbances, then you must concentrate on genetic, intrauterine, and neonatal events, for most such children are formed in that set of crucibles. If you wish to deal with the severe narcissistic problem, the borderline child, or certain forms of psychosis, then it is the first year of life with its undifferentiated, autistic, symbiotic, narcissistic preobject and early object formations that must become the focus of your efforts. If, on the other hand, it is delinquency and the impulse disorders you would avoid, concentrate on the anal phase; the toddler is the father of the delinquent, and the delinquent so often really an outsize 2-year-old. Again, to prevent or ease the burden of the neurotic, or to try to head off so many character problems, the focus of the work shifts to the oedipal period when this set of disorders is forged. Or, if it is work difficulties that concern you, learning problems, peer relationship disturbances, and habit-training disorders, the latency child is your proper target . . . and so on and on.

But it seems to me it makes little sense to choose in this way. On the contrary, it would be the counsel of wisdom to develop a model for a pattern of services, a matrix, that would begin to meet the needs of families and children at every level.

There has been a good deal of thinking about how to do this. The authors of advocacy in the Joint Commission drew up a master plan involving multiple levels of government and a bureaucracy that extended from the White House to the community. There were careful descriptions of advocacy councils at every level. Unfortunately, one did not hear much response to this idea. Other overall approaches have been contemplated, and today perhaps the most widely touted long-range answer to needed services is the concept of national health insurance. This may be an answer of sorts. It seems to be based on the presumption that if money is available to pay for services, and people want services, why, services will spring up. And, indeed, they might, probably will, but I must confess this kind of thinking worries me. It is like saying, if we want housing, and people can afford it, builders will come forth and build it. That, in fact, is just what happened, and that is how we obtained the worst features of polluted suburban sprawl. I wonder if something similar is not happening in response to Medicare? Many people are receiving many services, and new arrangements for service delivery are springing up. But it remains to be seen if the emerging patterns are optimal. One hears that waiting around the corner may be kiddicare, where a similar system for funding services for maternal and infant care will be enacted. Well, it is good to know that patterns of financing are being thought through and are reaching fruition. But that does not necessarily mean that the best pattern of services will thereby emerge, any more than it did with housing in suburbia. Indeed, even though most people who wanted houses and could afford them were able to buy them, many questions remain about the quality of the houses and of the community life that ensued.

It is noteworthy, I think, that even in the housing area our culture is trying a new approach. Here and there we have started planning, designing, and building new towns, planned communities. We are not just using money; we are using our ability to create. We are doing a little looking ahead, a bit of thinking through before we build. I submit that if we were interested in conserving developmental potential, some such thinking might well go into our approach to services. Insurance can do a great deal to help people get services, but it is not the only answer, and perhaps not the best answer. Alongside the coverage, we had better do the hard job of thinking through who needs what services and how we deliver them. This is the direction I would see our future thinking go.

In recent years, there has been an attempt to think this way about mental health services for the entire country. The Community Mental Health Centers were devised in order to do just that. Unfortunately, they were never given a chance to expand to the planned-for coverage, and, more to the point, they left out the services for children. Up until today, no one knows quite how to put the children back in. In each place which elects and engages in such a program, however, I would build in a grid completely: all the necessary services and their missions to conserve developmental potential. I would hope that each such site would become a catalyst for quickening the interest and exciting the desire for emulation in adjacent areas. Each community will certainly be an experimental site, a sociological research project, wherein to study linkages, overlaps, social impact, and long-range implications. Given adequate backing and support, a lot of effort, and a lot of luck, such an idea can take root, can survive, and can grow. Basically, it means that one has to sell an idea; if that can be accepted, the pattern of services and their implementation will follow.

But, when all is said and done, this notion of a grid of services for children and families is only one model, perhaps a poor one. Surely, there are many ways of approaching the matter of conserving developmental potential.

The basic point here, however, is that as a culture we need to find *some* way to do this. It is worth society's efforts and energies to try to devise such a way. Indeed, to strive toward such a goal should be an urgent governing mission of a culture such as ours; to achieve it would be one of our proudest and most magnificent accomplishments.

Perhaps this is an ephemeral vision I spin for you out of the cobwebs of my own mindsubstance. Nonetheless, I can only state that I firmly believe that locked away in most of us are very considerable riches, a wealth of creativity, and love, and constructive energy that in fact are never fully realized. To strive to unlock this and allow these potentials their maximal realization are goals fully worthy of our common humanity.

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STATEMENT OF THE AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN

Mr. Chairman, distinguished colleagues, as the largest organization of children's mental health services in the country, the American Association of Psychiatric Services for Children, whose member services employ over 8,000 child mental health professionals from all the disciplines, wishes to commend the stated intent of this legislation, S. 1392.

It is unnecessary for us to reiterate the declaration of purpose contained in section 2 of the bill. We certainly agree on the goal of making quality health care available to those children whose families do not have such care. In many respects the CHAP bill does improve and expand upon the early periodic screening diagnosis and treatment program. In fact, the legislation appears to be responsive to many of the criticisms that have been leveled against EPSDT in the few years it has been operational. It adds to the medicaid and EPSDT eligible population those children under the age of 6 (although we would like to see this amended also to include children from 6 to 21) whose family structure presently makes them ineligible for services. It speaks to the issue of continuity of care by continuing eligibility for medical assistance for 6 months after the family is no longer medicaid eligible because of higher income. It increases the financial incentives for the States by augmenting the Federal match. It attempts to improve upon the quality and continuity of care by asking the States to enter into agreements with comprehensive care providers for health resource, development, in areas with a shortage of comprehensive care providers. And it mandates treatment for all conditions found in the assessment of children with certain notable and shortsighted exceptions; namely, mental illness, mental retardation, developmental disabilities, and for certain kinds of dental care.

1. *Nonmandatory Coverage of Treatment for Mental Illness.*—The limitation on the treatment of mental illness poses an obvious problem to those of us engaged in the provision of mental health services to this group of particularly vulnerable children. The bill as written in fact takes a regressive step from the original enabling legislation for EPSDT, which, although not mandating federal financial participation in the treatment of mental illness, did mandate referral for treatment services. As the present legislation reads, only treatment services presently available in the individual State's Medicaid plans would be covered by CHAP. Since inpatient services are now a State option, as are clinic services, mental health treatment services will not be available to the CHAP children in those states that do not include clinic and inpatient services in their medicaid plans. Only 2[illegible] States presently include inpatient services; 42 include clinic services, but not all of the 42 include mental health clinic services.

The AAPSC has questioned many of the DHEW officials who participated in the drafting of the S. 1392. We were told that the exclusion of mental health treatment services from the mandatory provisions of the Bill was due to the lack of available data on cost and utilization of mental health treatment services by persons under 21 years of age. We find this reasoning untenable. In fact, we would like to suggest that it places us in a "Catch 22" situation. AAPSC has attempted to get data from the Medical Services Administration about the current experience with mental health services to individuals under 21 in the title XIX program for many years. We have asked: "How many children are being served in the inpatient program and what are the costs? How many children are being served on an outpatient basis through clinic, outpatient, hospital, and individual provider services and what are those costs?" What we have been told in the past is that HEW doesn't know, that the data are not broken down this way.

Up until July of 1977, we were also told that HEW didn't care about collecting such data, that there were too many other concerns about the operation of the medicaid program to bother with taking a look at the experience in the mental health area. When the inpatient option became law we even suggested to the Department, that it would be relatively simple to collect the inpatient data on mental health services to individuals under the age of 21 at the time of the initial implementation of the program, but our requests always fell on deaf ears. In July, 1977, we received from the acting director of the Medicaid Bureau, written assurance that the collection of outpatient cost and utilization data would become a high priority in their fiscal year 1978 evaluation plan. This assurance comes a little late for us to answer HEW's insistence that the reason for the exclusion of mental health treatment is the fact that so little is known about the costs of treating mental illness in children. Actually, not a great deal of data are available, but that is only because no one has been interested in funding studies that would permit the collection of such data. A policy paper prepared by a public health analyst on the staff of the Assistant Secretary for Planning and Evaluation cites the lack of research resources as one of the primary reasons for the scarcity of prevalence studies in the area of children's handicapping conditions (John Dempsey, "Handicapped Children and Disability: A Policy Overview Paper," October 1976). In fact, this same paper states that there is very little accurate data on the entire population of handicapped children in the Nation, but that data in the area of the mentally ill are most lacking. One can take the argument outlined in Dr. Dempsey's paper one step further: there have been no resources available for the collection of prevalence data and there have been no resources available for collecting cost and utilization data.

The AAPSC has attempted to gather, both from its own membership and from other sources known to us, what prevalence and cost/utilization data we could, given the resources we could muster to collect it. What we have found are contained in the tables appended to this statement. What little is available does confirm what we have been saying for many years based on our own humanitarian instincts, namely, that emotional disabilities are widespread among the high risk children served by the EPSDT program, that the bulk of these children can be served by relatively short term intervention, and that for the very small percentage who need the lengthier and more costly inpatient and residential care, the utilization and cost experience in the small sampling of States participating in the program, does not merit HEW's decision to remove treatment of mental illness from the mandatory provisions of the bill (see appendix I).

In fact, we would suggest to the distinguished members of this committee, that ~~S. 1392 as presently constituted provides an incentive to those States who are~~ not presently participating in the inpatient and clinic options to place children who have been assessed by the program in the diagnostic categories where States need not be financially responsible for treatment. This categorical approach to what is heralded to be a program promoting "more comprehensive, continuing primary and preventive health care," is contradictory to the stated purpose of the legislation. It would appear to us that it would be far more rational to consider the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) experience of limiting costs through quality assurance measures such as peer review and standard setting, rather than arbitrarily delegating the health services relative to emotional disabilities as unnecessary and too costly components for inclusion in a comprehensive health care program. The exclusion makes no sense to us either from a humanitarian or from a cost effective point of view.

Our experience in the field, our participation in preventive as well as diagnostic and treatment activities have led us to conclude that for *any* illness it is far more costly in the long run not to treat it when it is first uncovered through screening assessment and diagnosis. Good mental health *is* a part of good comprehensive health care. To consider it as a separate and distinct entity from the entire spectrum of health is to contradict what has become a truism today: that in dealing with prevention, primary and comprehensive health care for any individual, you must deal with the whole person. To be a little facetious, this bill attempts to separate the head from the body. Our experience has demonstrated the devastating impact emotional disability in a family member has on an entire family. If the resources were made available to collect such data, we would be able to demonstrate that mental illness in a child leads to loss of productivity in an entire family. Parents miss days from work because school systems cannot deal with disruptive children and someone must be home to supervise the child.

Untreated disabilities can lead to severe acting out problems in the adolescent years, problems which can tie up the juvenile justice system for months, even years on end. The average cost of a one year's stay in a juvenile detention facility in the State of New York is $25,000 a year. Society is bearing the cost of those placements, now. Many future placements could be avoided if the children were given access to treatment resources at an early age.

We pay a lot of lip service to the fact that children are our most precious resource and that the guardianship of their health is one of the most important activities we as a society can pursue. To say then, as this bill as presently written appears to say, that we don't care about their mental health, is tantamount to saying that we care about our most precious resource only so long as we don't have to deal with the uncomfortable fact that we may have to channel some of our fiscal resources in new directions if we are to insure the future health of our Nation.

We would suggest, then, that this Committee drop the present exemptions for mandatory treatment services from this legislation. We would like to see Federal reimbursement available for all health services for problems uncovered through screening and assessment.

There are several other areas of the Bill to which we would like to call your attention.

2. *Strengthening the Outreach component of the program.*—Our own experience in providing services to the low income population has taught us that an effective outreach program is one of the most important pieces in insuring access to care. Currently, States must inform families with Medicaid eligible children about EPSDT and encourage and help them to utilize services.

However, inadequate outreach is demonstrated by the extremely low rates of participation in EPSDT. Approximately 25 percent of eligible children were screened in the last year. Few states use the method of outreach known to be most effective in reaching low-income facilities: personal contact by those people in their communities known and trusted by them. For a relatively small cost, the CHAP program could be greatly strengthened by: (a) establishing performance standards for outreach which require States to assess a reasonable proportion of eligible children; (b) providing financial incentives for outreach by increasing the Federal match to 90 percent to States for outreach services performed by private, non-profit organizations or individuals with strong community ties (e.g. Head Start programs, community clinics, etc.); (c) requiring States to earmark a small proportion of funds for public education and for efforts to enroll children in the program. Those States which fail to attract to the program a reasonable proportion of eligible children should be required to develop a new outreach program that mandates the use of workers and/or organizations from the local communities.

3. *Encouraging Qualified Providers to Participate in CHAP*—One of the problems identified in the studies of the operation of the EPSDT program is that many of the qualified providers have chosen not to participate in the program. The reasons for this are varied but S. 1392 as written provides few incentives to participation. The AAPSC recommends that CHAP be amended to require States to identify qualified providers, including child mental health practitioners and to encourage their participation in CHAP by offering satisfactory administrative arrangements such as adequate reimbursement rates and prompt claims payment. We would urge that the Secretary be required to review each State's performance in this area on an annual basis.

The criteria in the bill defining CHAP providers should be modified to clarify the fact that providers such as Head Start programs, mental health clinic programs, etc. which can assure that children receive CHAP services do qualify, even though they themselves do not provide all services.

4. *Requiring Performance Criteria*—CHAP should be amended to establish performance criteria that States are expected to meet. The criteria should include the enrollment of a reasonable proportion of eligible children in the program and the provision of the required assessment and treatment services. The Secretary should be required to gather data on an annual basis in order to assess States' performance in enrolling eligible children in CHAP and in providing a reasonable proportion of eligible children with health assessments and treatment services. CHAP should require that all States meet all program requirements and that the sanctions available to the Secretary be used for any lapse in program responsibility.

5. *Developing State's Capacity to Deliver CHAP Services*.—The CHAP provisions of title XIX can be distinguished from the rest of the medicaid program by the fact that States are charged with seeing that children are served by the program. If the program is to be effective, then States must see to it that the requisite services are in place for the children in need. This requires a planning and administrative component which is not adequately addressed in S. 1392. States should be required to submit to HEW an annual plan, developed with the opportunity for substantial public input, that indicates how the requirements of CHAP are to be met. It should be required that this plan be utilized by the State Health Planning Agency to facilitate the integration of planning for adequate health services for children with the planning for the State population as a whole.

We realize that medicaid in general and CHAP in particular are reimbursement mechanisms and not what are usually considered to be health service programs. Nevertheless, we submit that with this requirement, CHAP can become an effective vehicle for identifying shortage areas, and with proper and adequate administrative support and monitoring can be utilized in conjunction wth other health delivery and health planning programs to aid States in identifying and filling gaps in the delivery system.

We would like to conclude our statement by affirming our support for the intent of the CHAP legislation. As one of the participants in the AAPSC Conference on Developmental Screening and Assessment in the EPSDT program observed in a working paper prepared for the Conference, one of "EPSDT's significant contribution[s] to the field of child health has been to uncover the present health system's inability to provide comprehensive and continuous health service for poor children, even given a financing mechanism." (Anne-Marie Foltz, "The Policy Dilemma, Screening and Cost-Effectiveness," February 1977). Many of the reasons [illegible] this failure can be dealt with if the Committee accepts our suggestions for modification of HR 6706.

As AAPSC [illegible] emphasized in the Prologue to its report on Developmental Review in the EPSDT program, a copy of which is appended to this statement. (Appendix II),

"The legislation authorizing EPSDT (CHAP) makes it national policy that the development of our children, our future citizens, be safeguarded so as to insure that each child reaches maturity functioning at a maximum level of development. This goal is more than the finding, the study, and the treatment of disease. The guardianship of the health of children is in the national interest as well as in the interest of the individuals; this is the essence of EPSDT (CHAP)."

Mr. Chairman, this Committee has the opportunity to translate this statement into reality. It is our hope that you will do so on behalf of all children and youth in need. Thank you very much.

APPENDIX I

TITLE XIX STATE INPATIENT DATA

Wisconsin

State and County Mental Health Inpatient $'s (1976).

	Total	Federal
Increase county hospitals	1,600,000	[illegible]000
State hospitals	1,531,700	919,020
Prior plan	3,766,200	2,259,720
Total title XIX	6,897,900	4,138,740

Pennsylvania

12 State-owned and operated hospitals. (1 specifically for children and adolescents).

March 1977. 300 children and adolescents in the hospitals projected annually, $6,500,000 Federal assistance ($21,666.67/child).

Eastern State Hospital (Trevose), average length of stay:

Length of time:	*Percent*
3 months to 1 year	25
1 to 2 years	50
2+ year	25

Reference: Correspondence to AAPSC from State Departments of Public Welfare.

AAPSC SURVEY OF MEMBER SERVICES—1975 STATISTICS

[Data based on 70 respondents]

Setting	Total number	Children seen — Percent by sex: Boys	Girls	Percent by age: 0 to 5	6 to 13	14 to 18
Outpatient	43,707	62.1	37.9	9.9	[illegible]	35.4
Partial hospital/day care	2,001	69.1	30.9	26.2	[illegible]	11.3
Residential care	704	77.8	22.2	.5	55.1	44.4
Inpatient care	1,621	61.3	38.7	3.7	34.6	61.7
Total	48,033	62.6	37.4	10.2	54.4	35.4

Income of caseload

	Percent
$3,000 and under	16.8
$3,001 to $7,000	23.9
$7,001 to $10,000	21.9
$10,001 to $13,000	16.8
$13,001 to $20,000	13.1
More than $20,000	7.4

Number of visits required for diagnosis:	*Percent*
1 to 4	65.3
5 to 8	33.3
9 plus	1.4

LENGTH OF TREATMENT

	Percent served in	Percent terminated after
A. Outpatient (hours):		
1 to 6	20.2	20.2
7 to 12	20.2	40.4
13 to 30	26.7	67.1
30 to 90	25.2	92.3
Over 90	7.8	100.0
B. Daycare (months):		
0 to 3	11.0	11.0
3 to 6	12.2	23.2
6 to 12	37.4	60.6
12 to 24	3[illegible]	92.8
Over 24	[illegible]	100.0
C. Inpatient hospital (weeks):		
0 to 1	11.3	11.3
1 to 3	25.4	36.7
3 to 12	29.9	66.6
Over 12	33.4	100.0
D. Residential center (months):		
0 to 3	10.0	10.0
3 to 6	13.6	23.6
6 to 12	23.5	47.1
12 to 24	44.0	91.1
Over 24	8.9	100.0

NEEDED SERVICES IN DECREASING ORDER

	All ages	0 to 5	0 to 12	13 to 18
Residential	1	1	1	1
Day treatment	2	2	2	2
Parent education	3	4	4	3
Hospital	4	3	3	4
Special education	5	5	6	5
Outpatient	6	6	5	6

Concerns (top 5 in decreasing order):

1. Finances.
2. Program evaluation.
3. Quality assurance.
4. Staff salaries.
5. Training.

Sources of funds to agencies:

	Percent
Voluntary (United Way, etc.)	12.0
Fees:	
Patient, self pay	9.7
Patient, insurance	12.2
Fees: Contract for services (consulation and educational, etc.)	9.5
Loctl tax levy	9.5
State allocation	26.1
County and city	3.0
Federal Funds:	
Staffing grant	3.3
Part F, children's services	2.1
Research	.7
Title XIX	1.5
Title XX	.4
Endowment funds	1.9
CHAMPUS	1.8
Other	6.3

Allocation of State moneys:

	*Percent**
(A) Directly	35
Via local government body	75

(B) Difficulties with restrictions placed on funds:

	Percent
Yes	58
No	42

*Some get moneys both ways, hence percentage totals greater than 100.

Blue Cross/Blue Shield—Federal (1973)

High option—basic
5.9 claims per 1,000 covered population for mental disorders.
1.7 percent of total claims.
Benefits paid $1.45 per person covered (3.6 percent total benefits).

	Total (*percent*)
High option—supplemental (nonmember hospitals):	
1.2 claims per 1,000 population	18.3
$1.28 per covered persons	65.2
High option—supplemental (physicians):	
20.8 per 1,000	(18.7)
$3.75 per	[1] 53.4

[1] Total (after deductible and coinsurance).

Reference: Louis S. Reed, Ph. D. Coverage and Utilization of Care for Mental Conditions under Health Insurance Various Studies, 1973–74 American Psychiatric Association, 1975.

TABLE 12.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973: BASIC INPATIENT HOSPITAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX (IN GENERAL HOSPITALS AND MEMBER MENTAL HOSPITALS)

Age	Male	Female	Total
	Admissions—rate per 1,000		
Under 19	1.3	1.4	[1] 1.3
19 to 34	7.1	9.2	8.3
35 to 44	6.3	10.7	8.6
45 to 54	7.6	10.1	8.9
55 to 64	6.7	6.9	6.8
65 and over	3.5	4.0	3.8
All ages	4.2	5.6	4.9
	Days of care—rate per 1,000		
Under 19	34.7	34.1	[2] 34.4
19 to 34	149.4	163.9	157.2
35 to 44	86.4	169.5	130.0
45 to 54	103.4	165.7	134.7
55 to 64	100.0	125.6	112.5
65 and over	60.9	74.4	68.0
All ages	73.3	100.1	86.9
	Average length of stay (days)		
Under 19	27.3	23.8	[3] 25.5
19 to 34	21.0	17.7	19.0
35 to 44	13.6	15.8	15.1
45 to 54	13.5	16.4	15.2
55 to 64	15.0	18.1	16.5
65 and over	17.3	18.4	17.9
All ages	17.5	17.7	17.6
	Average covered charges per covered person		
Under 19	$2.39	$2.45	[4] $2.42
19 to 34	10.47	11.62	11.11
35 to 44	5.82	11.46	8.77
45 to 54	7.08	11.39	9.24
55 to 64	6.90	9.16	8.00
65 and over	2.66	2.75	2.71
All ages	4.98	6.90	5.95

[1] 27 pct of average rate.
[2] 40 pct of average rate.
[3] 145 pct of average rate.
[4] 41 pct of average rate.

TABLE 13.—BLUE CROSS AND BLUE SHEILD FEDERAL, HIGH OPTION, 1973: HOSPITAL CARE FOR MENTAL DISORDERS AS PERCENT OF CARE FOR ALL CONDITIONS

Age	All conditions	Mental	Mental as percent of all
	Admissions—rate per 1,000		
0 to 18	50.5	1.3	2.7
All	118.5	4.9	4.2
	Days of care—rate per 1,000		
0 to 18	249.4	34.4	13.8
All	926.3	86.9	9.4
	Covered charges per person		
0 to 18	$25.33	$2.42	9.6
All	89.61	5.95	6.6

TABLE 14.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973: BASIC HOSPITAL OUTPATIENT BENEFITS FOR MENTAL DISORDERS, BY SEX AND AGE

Age	Male	Female	Total
	Admissions—rate per 1,000		
Under 19	0.1	0.2	[1] 0.2
19 to 34	.8	1.1	1.0
35 to 44	.6	1.6	1.1
45 to 54	.7	1.6	1.1
55 to 64	.5	1.8	.9
65 and over	.4	1.0	.7
All ages	.4	.8	.6
	Covered charges per covered person		
Under 19	(2) $0.02	(2) $0.03	(2) $0.02
19 to 34	.02	.04	.03
35 to 44	.02	.04	.03
45 to 54	.01	.03	.02
55 to 64	.01	.01	.01
All ages	.01	.02	.01

[1] 33 pct of average rate.

[2] Less than ½ of 1 ct.

TABLE 15.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973; BASIC SURGICAL-MEDICAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX

Age	Male	Female	Total
	In-hospital medical claims per 1,000		
Under 19	1.3	1.5	[1] 1.4
19 to 34	7.7	9.7	8.8
35 to 44	[illegible]	11.8	9.3
45 to 54	[illegible]	11.4	9.4
55 to 64	6.4	7.9	7.2
65 and over	3.3	4.3	3.8
All ages	4.2	6.2	5.2
	Visit days per 1,000		
Under 19	24.5	26.2	[1] 25.4
19 to 34	103.7	123.9	115.0
35 to 44	70.4	131.4	102.4
45 to 54	76.8	125.7	101.3
55 to 64	70.4	94.4	82.2
65 and over	35.7	51.8	44.1
All ages	52.7	76.1	64.6

TABLE 15.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973; BASIC SURGICAL-MEDICAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX—Continued

Age	Male	Female	Total
	Benefits paid per covered person		
Under 19	[1] $0.45	[2] $0.50	[3] $0.47
19 to 34	2.14	2.52	2.35
35 to 44	1.39	2.72	2.09
45 to 54	1.49	2.61	2.05
55 to 64	1.36	1.85	1.60
65 and over	.50	.72	.62
All ages	1.02	1.52	1.28

[1] 27 percent of average rate.
[2] 39 percent of average rate.
[3] 37 percent of average rate.

Source: Louis S. Reed, Ph. D., "Coverage and Utilization of Care for Mental Conditions under Health Insurance Various Studies, 1973–74". American Psychiatric Association. 1975.

TABLE 16.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973: SUPPLEMENTAL BENEFITS FOR MENTAL DISORDERS, BY AGE AND SEX

Age	Males	Females	Total
	Hospital cases per 1,000 population		
Under 19	0.8	0.6	[1] 0.7
19 to 34	2.9	2.4	2.6
35 to 44	1.2	2.1	1.7
45 to 54	1.2	2.2	1.7
55 to 64	1.1	1.5	1.3
65 and over	.8	1.0	.9
All ages	1.2	1.4	1.3
	Physicians' services—cases per 1,000 population		
Under 19	7.1	4.8	6.0
19 to 34	44.9	59.1	52.8
35 to 44	32.7	44.0	38.6
45 to 54	17.3	26.3	21.8
55 to 64	8.7	13.7	11.1
65 and over	3.2	5.7	4.5
All ages	16.1	21.8	19.0
	Hospital charges per person covered		
Under 19	$0.98	$0.74	[2] $0.87
19 to 34	3.75	2.28	2.[illegible]
35 to 44	.92	1.55	1.25
45 to 54	1.02	1.92	1.47
55 to 64	1.02	1.60	1.30
65 and over	1.02	1.29	1.16
All ages	1.34	1.36	1.35
	Physicians' charges per person covered		
Under 19	$1.61	$1.10	$1.36
19 to 34	13.[illegible]	15.95	15.02
35 to 44	9.38	10.64	10.04
45 to 54	3.78	[illegible]	4.65
55 to 64	1.62	2.[illegible]	2.15
65 and over	.37	.53	.46
All ages	4.26	5.27	4.77
	Total supplemental benefits paid by program per person covered		
Under 19	$2.45	$1.71	[3] $2.08
19 to 34	15.01	15.80	15.45
35 to 44	8.78	10.77	9.82
45 to 54	4.14	6.83	5.49
55 to 64	2.33	3.91	3.10
65 and over	1.42	2.30	1.88
All ages	4.90	5.93	5.42

[1] 54 percent of average.
[2] 64 percent of average.
[3] 38 percent of average.

TABLE 17.—BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES, HIGH OPTION, 1973: ALL BENEFITS PAID FOR MENTAL DISORDERS PER PERSON COVERED, BY AGE AND SEX

Age	Male	Female	Total
Under 19	$5.29	$4.67	[1]$4.98
19 to 34	27.63	29.96	28.93
35 to 44	16.01	24.99	20.71
45 to 54	12.73	20.87	16.82
55 to 64	10.60	14.95	12.73
65 and over	4.59	5.79	5.22
All ages	10.91	14.37	[illegible]

[1] 39 percent of average.

Source: Louis S. Reed, Ph. D., "Coverage and Utilization of Care for Mental Conditions Under Health Insurance Various Studies, 1973-74," American Psychiatric Association, 1975.

TABLE 6.—NUMBER AND COST OF PSYCHIATRIC SERVICES PER 1,000 BENEFICIARIES, BY AGE AN[illegible] 1973

[Data from Quebec Health Insurance Board]

Age	Male		Female		Total	
	Number	Cost	Number	Cost	Number [1]	Cost [2]
0 to 1	4	$45	3	$45	3	$45
1 to 4	10	120	6	84	8	103
5 to 9	27	396	17	229	22	313
10 to 14	36	551	25	373	30	464
15 to 24	96	1,435	154	2,549	125	1,987
25 to 34	190	3,160	373	6,379	281	4,770
35 to 44	180	2,871	361	5,834	270	4,352
45 to 54	164	2,446	285	4,207	226	3,345
55 to 64	144	2,048	215	2,957	181	2,521
65 and over	83	1,092	127	1,633	108	1,401
Total	110	1,700	191	3,030	151	2,370

[1] Average: Ages 0 to 14=16; ages 0 to 24=38.
[2] Average: Ages 0 to 14=$231; ages 0 to 24=$582.

TABLE 7.—AVERAGE COST OF PSYCHIATRIC SERVICE (COST PER SERVICE), BY AGE AND SEX, 1973

Age	Male	Female	Total
0 to 1	$10.99	$16.57	$13.17
1 to 4	11.85	13.31	12.39
5 to 9	14.53	13.14	14.01
10 to 14	15.27	15.12	15.21
15 to 24	14.94	16.53	15.91
25 to 34	16.63	17.12	16.95
35 to 44	15.92	16.17	16.09
45 to 54	14.87	14.77	14.81
55 to 64	14.23	13.75	13.93
65 and over	13.16	12.83	12.94
Total	15.39	15.83	15.67

Note.—Average: Age 0 to 14, $13.70; age 0 to 24, $14.14.

Source: Louis S. Reed, Ph. D., Coverage and Utilization of Care for Mental-Health Conditions under Health Insurance Various Studies, 1973-74," American Psychiatric Association, 1975.

CHAMPUS

(1) Less than 2-percent utilization of mental health services for past 3 years (1.82 percent in fiscal year 1975).

(2) Per user/per year cost for mental health services in fiscal year 1975 equals $1,181 less coinsurance and deductible.

On per capital basis: mental health services/person equals $20.90.

(3) Mental health services used 17.7 percent of total health benefit fund.

Average duration of hospital stay (all conditions) equals 8.6 days.

Childhood behavior disorder: average duration equals 47.4 days.

Personality disorders: all age average duration equals 20.4 days.

Age 5 to 14 average duration equals 53 days.

Diagnosis of schizophrenia and aged 1 to 14:

4 percent of all admissions in diagnosis.

18 percent of hospital days (58 days average 1 to 14); (12.1 days average all ages).

PERSONALITY DISORDER

Age	Admissions (percent)	Hospital days (percent)	Average stay (days)
5 to 14	12	31	53.0
All ages	100	100	20.4

Source: Draft of paper by Herbert Dorken, Ph. D., Langley Porter Institute, University of California, San Francisco, Calif., Feb. 10, 1977.

TABLE I.—NUMBER AND PERCENT DISTRIBUTION OF TOTAL PATIENT CARE EPISODES, AND NUMBER, PERCENT DISTRIBUTION, AND PERCENT CHANGE IN PATIENT CARE EPISODES UNDER 18 YEARS OF AGE, BY TYPE OF PSYCHIATRIC SERVICE, UNITED STATES 1966, 1969, AND 1971

Type of psychiatric service	Number of psychiatric services 1971	1971					1969				
		Total patient care episodes—all ages		Patient care episodes—under 18 years of age			Total patient care episodes—all ages		Patient care episodes—under 18 years of age		
		Number	Percent	Total	Percent	Percent of all episodes	Number	Percent	Number	Percent	Percent of all episodes
Total—All psychiatric services [1]	4,053	3,861,343	100.0	771,874	100.0	20.0	3,385,909	100.0	647,490	100.0	19.1
Inpatient psychiatric services [1]	1,774	1,544,589	40.0	139,658	18.1	9.0	1,491,458	44.0	105,565	16.3	7.1
State and county mental hospitals	324	745,259	19.3	39,196	5.1	5.3	767,115	22.7	35,287	5.4	4.6
Private mental hospitals	158	97,963	2.5	7,668	1.0	7.8	102,510	3.0	7,275	1.1	7.1
General hospital inpatient psychiatric units	653	542,642	14.1	46,065	6.0	8.5	535,493	15.8	36,908	5.7	6.9
Residential treatment centers for emotionally disturbed children	344	28,637	.7	28,637	3.7	100.0	21,340	.6	21,340	3.3	100.0
Community mental health centers	295	130,088	3.4	[2] 18,092	2.3	13.9	65,000	1.9	[2] 4,875	.8	7.5
Outpatient psychiatric services	2,279	2,316,754	60.0	632,216	81.9	27.3	1,894,451	56.0	541,905	83.7	28.6
Community mental health centers	295	622,906	16.1	194,877	25.2	31.3	291,148	8.6	[2] 76,281	11.8	26.2
All other outpatient psychiatric services	1,984	1,693,848	43.9	437,339	56.7	25.8	1,603,303	47.4	465,624	71.9	29.0

1966[3]

	Total patient care episodes—all ages		Patient care episodes—under 18 years of age			Percent change in number of patient care episodes under 18 years of age		
	Number	Percent	Number	Percent	Percent of all episodes	1966–69	1969–71	1966–71
Total—all psychiatric services[2]	2,649,000	100.0	485,700	100.0	18[illegible]	33.3	19.2	58.9
Inpatient psychiatric services[1]	1,463,000	55.2	86,700	17.8	5.9	21.8	32.2	61.1
State and county mental hospitals	802,000	30.3	36,900	7.6	[illegible]	−4.4	11.1	6.1
Private mental hospitals	104,000	3.9	7,800	1.6	7.5	−6.7	5.4	−1.7
General hospital inpatient psychiatric units	549,000	20.7	34,000	7.0	[illegible]	8.3	25.1	35.5
Residential treatment centers for emotionally disturbed children	8,000	.3	8,000	1.0	100.0	166.8	34.2	258.0
Community mental health centers	NA	NA	NA	NA	NA	....	271.1	....
Outpatient psychiatric services	1,186,000	44.8	399,000	82.2	33.[illegible]	35.8	16.7	58.5
Community mental health centers	NA	NA	NA	NA	NA	....	155.5	....
All other outpatient psychiatric services	1,186,000	44.8	399,000	82.2	[illegible]	16.7	−6.1	9.6

[1] Excludes inpatient psychiatric services of Veterans Administration hospitals.

[2] Data are for under 20-yr age group.

[3] Figures shown for 1966 represent revisions of the 1966 data as shown in earlier NIMH publications.

NA-Not applicable—only a few of these facilities began functioning in this year and reporting was not requested.

Source: Statistical note No. [illegible], DHEW/Pub[illegible]lth Services, ADAMHA/NIMH, Division of Biometry and epidemiology Survey and Reports [illegible]ch, Rockville, Md., July 1973, DHEW publication No. (ADM) 73-158.

TABLE 2.—NUMBER, PERCENT DISTRIBUTION, RATE FOR 100,000 POPULATION, AND PERCENT CHANGE IN RATE OF PATIENT CARE EPISODES IN PSYCHIATRIC SERVICES, BY TYPE OF PSYCHIATRIC SERVICE, BY AGE, UNITED STATES, 1966 AND 1971

	Total—all ages		Under 18		18 to 24		25 to 44		45 to 64		65 and over	
	1971	²1966	1971	²1966	1971	²1966	1971	²1966	1971	²1966	1971	²1966
						Number						
Total—all psychiatric services¹	4,038,143	2,772,[illegible]	771,874	485,729	681,641	334,422	1,433,[illegible]	959,959	888,231	678,[illegible]	263,264	313,014
All inpatient services	1,721,389	1,5[illegible]	139,658	86,729	245,106	134,084	614,[illegible]	560,825	512,379	515,[illegible]	209,345	288,551
State and county mental hospitals	745,259	80[illegible]	39,196	36,902	97,285	53,748	23[illegible],337	239,060	238,710	283,[illegible]	133,731	188,521
Private mental hospitals	97,963	10[illegible]	7,668	7,794	14,095	11,154	34,253	41,361	29,525	[illegible]	12,422	13,178
Residential treatment centers/children	28,637	[illegible]	28,637	8,000								
General Hospital psychiatric services	542,642	5[illegible]	46,065	34,033	94,569	66,968	231,[illegible]	216,824	132,863	166,[illegible]	37,769	64,224
VA hospitals	176,800	12[illegible]			20,967	2,214	58,[illegible]	63,580	79,885	34,[illegible]	16,210	22,628
CMHC's	130,0[illegible]	NA	³18,092	NA	⁴18,190	NA	53,197	NA	31,396		9,213	NA
All outpatient services	2,316,754	1,1[illegible]	632,216	399,000	436,535	2[illegible]338	818,[illegible]	399,134	375,852	163,[illegible]	53,919	24,463
CMHC's	622,[illegible]	NA	³194,877	NA	⁴92,609	NA	221,796	NA	95,412	NA	18,212	NA
All other services	1,69[illegible]	1,10[illegible]	437,339	399,000	343,926	2[illegible]338	596,436	399,134	280,440	163,[illegible]	35,707	24,463
						Percent distribution						
Total—all psychiatric services¹	100.0	[illegible]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
All inpatient services	42.[illegible]	[illegible]	18.1	17.9	36.0	40.1	42.9	58.4	57.7	76.0	79.5	92.[illegible]
State and county mental hospitals	18.5	[illegible]	5.1	7.7	14.3	16.1	[illegible]	24.9	26.9	41.8	50.8	60.[illegible]
Private mental hospitals	2.4	[illegible]	1.0	1.6	2.1	3.3	2.4	4.3	3.3	4.5	4.7	4.2
Residential treatment centers/children			3.7	1.6								
General hospital psychiatric services	13.[illegible]	[illegible]	6.0	7.0	13.9	20.0	[illegible].1	22.6	15.0	24.6	14.3	20.[illegible]
VA hospitals	4.4	[illegible]			3.0	.7	4.2	6.6	9.0	5.1	6.2	7.[illegible]
CMHC's	3.2		2.3		2.7		3.7		3.5		3.5	
All outpatient services	57.4	[illegible]	81.9	82.1	64.0	59.9	57.1	41.6	42.3	24.0	20.5	7.[illegible]
CMHC's	15.4		25.2		13.6		15.5		10.7		6.9	
All other services	42.0		56.7	82.1	50.4	59.9	41.6	41.6	31.6	24.0	13.6	7.[illegible]

Rate per 100,000 population[5]

Total—all psychiatric services[1]	1,967.[illegible]	1,433.2	1,090.6	695.7	2,882.8	1,709.2	2,984.[illegible]	2,[illegible]5.6	2,105.0	1,718.8	1,310.2	1,671.8
All inpatient services	[illegible]	820.0	197.3	124.2	1,029.4	653.3	1,272.0	[illegible]24.2	214.3	1,306.[illegible]	1,041.9	1,541.2
State and county mental hospitals	[illegible]	414.8	55.4	52.9	408.6	274.7	488.9	521.9	556.7	718.[illegible]	665.6	1,006.9
Private mental hospitals	[illegible]	53.8	10.8	11.2	59.2	57.0	70.9	[illegible]0.3	70.0	77.[illegible]	61.8	70.4
Residential treatment centers/children	14[illegible]	4.1	40.5	11.5								
General hospital psychiatric service	264.4	283.8	65.1	48.7	397.2	342.3	478.2	[illegible]3.3	314.9	422.[illegible]	188.0	343.0
VA hospitals	86.2	63.6			[illegible].1	11.3	123.6	[illegible]	189.3	87.5	80.7	120.9
CMHC's	63.4		25.6		75.4		100.0		74.4		45.9	
All outpatient services	1,129.[illegible]	613.2	896.3	571.5	1,833.4	1,023.9	1,692.7	[illegible]71.3	890.7	412.[illegible]	268.3	130.7
CMHC's	303.[illegible]		375.3		389.0		458.[illegible]		226.1		90.6	
All other services	825.[illegible]	613.2	618.0	571.5	1,444.4	1,023.9	1,233.8	[illegible]3	664.6	412.8	177.7	130.7

Percent change in rates 1966–71

Total—all psychiatric services[1]	[illegible]3	56.8	67.5	5	22.5	−21.6
All inpatient services	7	58.9	57.6	[illegible]9	−7.0	−32.4
State and county mental hospitals	−[illegible]4	4.7	48.7	−6.3	−21.3	−33.9
Private mental hospitals	−[illegible]3	−3.6	3.9	−21.5	−9.3	−12.2
Residential treatment centers/children	24[illegible]5	252.2				
General hospital psychiatric service	[illegible]	33.7	16.0	1.1	−25.4	−45.2
VA hospitals	[illegible]5		679.6	−11.0	116.3	−33.3
CMHC's						
All outpatient services	[illegible]	56.3	79.1	94.3	115.8	105.3
CMHC's						
All other services	34.[illegible]	8.1	41.1	[illegible]4.7	61.0	36.0

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[1] See footnote 2 [illegible] for psychiatric services excluded from this table.

[2] The figures shown represent revisions of 1966 data [illegible] earlier NIMH publications.

[3] Under 20 yr.

[4] 20–24 yr.

[5] Sources of base populations used to compute rates were as follows: 1966—U.S. Bureau of the Census, "Current Population Reports," series P-25, No. 483; 1971—U.S. Bureau of the Census, "Current Population Reports," series P-20, No. 225 (tables 1 and 3).

NA—Not applicable—only a few centers had begun functioning in this year and reporting was not requested.

1971 (Sample of 69 CMHC's)

38.44 percent of total population in 69 catchment areas are under 20 years.

Patient additions under 20 are 26.1 percent of total additions.

0.61 percent of total population under 20 are additions.

0.90 percent of total population all ages are additions.

	0 to 19		All ages	
	Number	Percent	Number	Percent
Population	3,609,047	38.4	9,388,619	100.0
Patient additions	21,929	26.1	84,192	100.0

All centers—1971

Age group under 20 form 27.4 percent of total additions (118,748/432,640).

	0 to 19		All ages	
	Number	Percent	Number	Percent
All services	118,748	100.0	432,640	100.0
Inpatient	10,413	8.8	75,900	17.5
Outpatient	102,669	86.4	335,648	77.6
Partial	5,666	4.8	21,092	4.9

1973 (261 centers)

Population under 15 is 28.6 percent total catchment population and forms 16.7 percent of patient additions.

Population under 25 is 46.8 percent of catchment population and forms 43.7 percent of patient additions.

	Catchment population	CMHC additions	Addition as percent to total population
All ages	39,172,2[illegible]	419,107	1.07
Under 15	11,264,60[illegible]	70,004	.62
Under 25	18,343,669	182,985	1.00

NUMBER AND PERCENT DISTRIBUTION OF PATIENT CARE EPISODES UNDER 18 [illegible] OF MENTAL DISORDER, BY TYPE OF PSYCHIATRIC SERVICE, UNITED STATES, [illegible]

Type of mental disorder	Total—all psychiatric services [1]	Percent	Total inpatient services [1]	Percent	Total outpatient services	Percent
Total—all mental disorders	743,237	100.0	111,021	[illegible]	[illegible]	100.0
Mental retardation	55,264	7.4	5,835	[illegible]	[illegible]	7.8
Organic brain syndromes (excluding alcohol and drug)	19,128	2.6	3,649	[illegible]	[illegible]	2.4
Schizophrenia	42,035	5.7	21,341	[illegible]	[illegible]	3.3
Depressive disorders (psychotic and neurotic)	24,250	3.3	8,657	[illegible]	[illegible]	2.5
Other psychotic disorders	2,408	.3	1,199	[illegible]	[illegible]	[illegible]
Alcohol disorders	2,373	.3	870	[illegible]	[illegible]	[illegible]
Disorders associated with drug abuse	13,072	1.8	7,357	6.6	[illegible]	[illegible]
All other disorders	584,707	78.6	62,[illegible]	55.9	[illegible]	82.[illegible]

[1] Includes State and county MH, PMH, GHIPU, CMHC's; excludes VA hospitals and residential treatment centers for emotionally disturbed children.

NUMBER AND PERCENT DISTRIBUTION OF DISCHARGES UNDER 18 YEARS BY [illegible] OF MENTAL DISORDER, BY TYPE OF PSYCHIATRIC SERVICE, UNITED STATES [illegible]

Type of mental disorder	Inpatient psychiatric discharges	Percent	Outpatient psychiatric discharges	Percent
Total	70,085	[illegible]	[illegible]	100.0
Mental retardation	4,427	[illegible]	23,778	8.1
Organic brain syndromes (excluding alcohol and drug)	2,170	[illegible]	6,820	2.3
Schizophrenia	9,835	[illegible]	[illegible]	2.9
Depressive disorders (psychotic and neurotic)	6,553	[illegible]	[illegible]	2.0
Other psychoses	723	[illegible]	[illegible]	.1
Other neuroses	4,277	[illegible]	[illegible]	3.0
Personality disorders	6,357	[illegible]	[illegible]	8.1
Alcohol disorders	750	[illegible]	275	.1
Disorders associated with drug abuse	3,743	[illegible]	[illegible]	.7
Transient situational disturbance	16,926	[illegible]	[illegible]	30.5
All other disorders	14,324	[illegible]	[illegible]	42.2

Source: Statistical note No. 90, DHEW/Public Health Service, ADAMHA/NIMH [illegible] of Biometry Survey and Reports Branch, Rockville, Md., July 1973, DHEW publication No. (ADM) 73-158.

ADDITIONS TO 69 SELECTED COMMUNITY MENTAL HEALTH CENTERS BY AGE, COLOR AND SEX, UNITED STATES 197[illegible] NUMBER

Color and sex	Total	Percent of population	0 to 4	Percent of population	5 to 14	Percent of population	15 to 19	Percent of population	20 to 24	Percent of population	25 to 44	Percent of population	45 to 64	Percent of population	65 and over	Percent of population
Total	[illegible]192	0.90	[illegible]	[illegible]	10,441	.55	10,633	1.15	12,146	1.48	[illegible]	1.[illegible]	[illegible]	0.87	3,339	0.36
White male	34,376	.85	[illegible]	[illegible]	5,532	.67	4,105	1.00	4,582	1.28	11,781	1.23	[illegible]	.87	1,217	.34
White female	37,[illegible]	.90	287	[illegible]	3,301	[illegible]	5,053	1.29	5,919	1.62	14,391	1.46	7,[illegible]	.84	1,[illegible]	.3[illegible]
Black male	[illegible]	1.[illegible]	69	[illegible]	923	[illegible]	584	.93	630	1.35	2,174	1.[illegible]	300	1.12	221	.66
Black female	[illegible]	1.[illegible]	44	[illegible]	615	[illegible]	921	1.52	1,015	2.02	2,490	1.[illegible]	[illegible]	.83	256	.52

POPULATION OF CATCHMENT AREAS SERVED BY 69 [illegible] COMMUNITY MENTAL HEALTH CENTERS BY AGE, COLOR AND [illegible] UNITED STATES, 1970

Color and sex	Total	0 to 4	5 to 14	15 to 19	20 to 24	25 to 44	45 to 64	65 and over
Total	9,388,4[illegible]	[illegible],690	1,885,735	927,622	820,146	2,[illegible]	1,837,157	921,[illegible]
White male	4,08[illegible]	390,221	890,127	411,918	358,650	[illegible]	794,718	359,[illegible]
White female	4,20[illegible]	333,508	792,536	392,130	364,285	[illegible],843	852,966	48[illegible]
Black male	[illegible]	56,008	131,941	62,987	46,785	[illegible],355	86,772	33,[illegible]
Black female	[illegible]	56,353	131,131	60,587	50,225	[illegible],590	102,701	46,[illegible]

Source: Statistical Note Number 86, DHEW/Public Health Service, [illegible]/NIMH, Division of Biometry, Survey and Reports Branch, Rockville, Md., June [illegible]73, DHEW publication No. (ADM) 73-[illegible].

ADDITIONS [illegible] SELECTED COMMUNITY MENTAL [illegible] CENTERS BY AGE, COLOR AND SEX, UNITED STATES, 1971: PERCENT DISTRIBUTION BY AGE[1]

Color and sex	Age: Total	0 to 4	5 to 14	15 to 19	20 to 24	25 to 44	45 to 64	65 and over
Total	100.0	1.0	12.4	12.7	14.4	36.6	18.9	4.0
White male	100.0	1.3	16.0	11.9	13.3	34.1	19.9	3.5
White female	100.0	.8	8.8	13.3	15.6	38.0	19.0	4.5
Black male	100.0	1.2	16.7	10.5	11.3	39.0	17.4	4.0
Black female	100.0	.7	10.0	14.9	16.4	40.3	13.8	3.8

[1] Where percents do not add up to totals shown, discrepancies are due to rounding error.

[illegible]PARISON OF PATIENT ADDITIONS BETWEE[illegible] AND 69 SELECTED COMMUNITY MENTAL HEALTH CENTERS BY AGE, UNITED STATES, 1971

[illegible]	Number		Percent distribution by age[1]									
			[illegible]		White male		White female		Black male		Black female	
	All centers	69 Selected centers	All centers	69 Selected centers	All centers	69 Selected centers	All centers	69 Selected centers	All centers	69 Selected centers	All centers	69 Selected centers
Total	411,149	84,192	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
[illegible]4	4,239	855	1.0	1.0	1.3	1.3	.7	.8	1.5	1.2	1.0	.7
[illegible]14	54,938	10,411	13.[illegible]	12.4	17.0	16.0	8.9	8.8	21.4	16.7	11.8	10.0
[illegible]19	53,602	10,663	13.[illegible]	12.7	13.1	11.9	13.1	13.3	12.4	10.5	13.4	14.9
[illegible]	63,314	12,146	15.[illegible]	14.4	14.8	13.3	15.7	15.6	15.3	11.3	16.5	16.4
[illegible]44	151,105	30,846	36.[illegible]	36.6	33.6	34.1	38.5	38.0	34.9	39.0	39.0	40.3
[illegible] to 64	69,011	15,912	16.3	18.9	16.9	19.9	18.0	19.0	11.6	17.4	14.5	13.8
65 and over	14,880	3,359	3.6	4.0	3.3	3.5	4.1	4.5	2.7	4.0	3.7	3.8

[1] Where percents do not add up to totals shown, discrepancies are due to rounding error.

104

DISTRIBUTION OF ADMISSIONS TO FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS BY AGE AND DIAGNOSIS, UNITED STATES, 1970

Diagnosis	Number								Percent							
		Age of admission								Age of admission						
	Total	0 to 4	5 to 14	15 to 19	20 to 24	25 to 44	45 to 64	65 and over	Total	0 to 4	5 to 14	15 to 19	20 to 24	25 to 44	45 to 64	65 and over
Total	[illegible]	3,420	48,201	42,245	48,985	121,116	57,655	13,128	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mental retardation	[illegible]	506	4,035	1,671	1,085	1,824	693	222	3.0	14.8	8.4	4.0	2.2	1.5	1.2	1.7
Organic brain syndromes (excluding alcoholism and drug abuse)	[illegible]	136	974	550	665	1,783	2,154	3,477	2.9	4.0	2.0	1.3	1.4	1.5	3.7	26.5
Schizophrenia	[illegible]	92	1,040	4,173	[illegible]	24,062	11,049	1,331	15.1	2.7	2.1	9.9	18.1	19.9	19.2	10.1
Affective disorders (including psychotic depressive and depressive neurosis)	[illegible]	60	1,017	3,760	[illegible]	22,696	13,796	2,864	15.7	1.7	2.1	8.9	17.1	18.7	23.9	21.8
Other psychotic disorders	[illegible]	1	145	596	895	2,331	1,650	376	1.8	[1]	.3	1.4	1.8	1.9	2.9	2.9
Alcoholism (including alcoholism associated with organic brain syndromes)	[illegible]	[illegible]	114	[illegible]	[illegible]	9,743	7,209	661	5.9	.3	.2	1.0	3.2	8.0	12.5	5.0
Drug abuse (including drug abuse associated with organic brain syndromes)	[illegible]	9	181	[illegible]	[illegible]	3,778	636	109	3.1	.3	.4	5.7	6.9	1.1	1.1	.8
Behavior disorders of childhood and adolescence (including adj. reaction of infancy, childhood and adolescence)	[illegible]	[illegible]	17,303	11,091	1,437	1,588	486	119	9.9	29.1	35.9	26.3	2.9	1.3	.8	[illegible]
All other mental disorders	[illegible]	[illegible]	6,889	7,182	10,775	24,673	8,636	1,728	18.0	11.7	14.3	17.0	22.0	20.4	15.0	13.2
Unknown or undiagnosed mental disorder	[illegible]	153	15,362	8,932	9,335	23,357	10,200	2,048	21.0	33.1	31.9	21.1	19.1	19.3	17.7	15.6
Social maladjustments without manifest psychiatric disorder and no mental disorder	[illegible]	79	1,141	[illegible]	2,614	5,281	1,146	183	3.6	2.3	2.4	3.4	5.3	4.4	2.0	1.9

[1] Less than 0.05.

Source: Based on data from the January 1971 "[illegible] of Federally Funded Community Mental Health Centers," Biometry Branch, National Institute of Mental Health.

Reference: "Financing Mental Health Care in the United States," DHEW Publication No. (HSM) 73-9117, printed 1973.

STATE AND COUNTY MENTAL HOSPITALS—1972

Additions

6.1 percent of all additions are under 18 years old.
16.3/100,000 population under 18 are additions.
197.2/100,000 general populations are additions (under 18 rate is 8.2 percent of regular rate).

Resident population

Rate per 100,000 for resident population decreased each year from 1969 to 1973 for under 18 age group: from 18.4 in 1969 to 15.5 in 1973.

TABLE 3.—NUMBER AND PERCENT DISTRIBUTION OF ADDITIONS UNDER 18 YEARS OF AGE TO STATE AND COUNTY MENTAL HOSPITALS BY AGE, SEX, AND DIAGNOSIS, UNITED STATES, 1973

Sex and diagnosis	Total under 18		Under 5		5 to 9		10 to 14		15 to 17	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Both sexes	25,830	100.0	208	100.0	1,796	100.0	7,695	100.0	16,131	100.0
Mental retardation	2,878	11.1	122	58.6	473	26.3	955	12.4	1,328	8.2
OBS associated with drug abuse	370	1.4	0		1	.1	28	.4	341	2.1
Other OBS	1,045	4.1	7	3.4	135	7.5	353	4.6	550	3.4
Schizophrenia	3,996	15.5	25	12.0	198	11.0	906	11.8	2,867	17.8
Depressive disorders	1,045	4.1	1	.5	12	.7	202	2.6	830	5.1
Personality disorders	2,104	8.1	4	1.9	15	.8	476	6.2	1,609	10.0
Drug dependence	1,443	5.6	0		0		94	1.2	1,349	8.4
Adjustive reaction	6,723	26.0	16	7.7	348	19.4	2,258	29.3	4,101	25.4
Behavioral disorders	3,864	15.0	26	12.5	452	25.2	1,708	22.2	1,678	10.4
Other	2,362	9.1	7	3.4	162	9.0	715	9.3	1,478	9.2

TABLE 5.—NUMBER AND PERCENT DISTRIBUTION OF RESIDENT PATIENTS UNDER 18 YEARS OF AGE IN STATE AND COUNTY MENTAL HOSPITALS BY AGE, SEX, AND DIAGNOSIS, UNITED STATES 1973

Sex and diagnosis	Total under 18		Under 5		5 to 9		10 to 14		15 to 17	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Both Sexes	10,576	100.0	74	100.0	1,136	100.0	4,145	100.0	5,221	100.0
Mental retardation	2,494	23.6	48	64.9	360	31.7	861	20.8	1,225	23.5
Organic brain syndromes	822	7.8	7	9.5	123	10.8	358	8.6	334	6.4
Schizophrenia	2,386	22.5	11	14.9	203	17.9	872	21.0	1,300	24.9
Personality disorders	611	5.8	0		6	.5	203	4.9	402	7.7
Adjustive reaction	1,701	16.1	2	2.7	153	13.5	696	16.8	850	16.3
Behavioral disorders	1,775	16.8	5	6.7	246	21.6	927	22.5	597	11.4
Other	787	7.4	1	1.3	45	4.0	228	5.5	513	9.8

Source: Statistical note number 115, DHEW/Public Health Service, ADAMHA/NIHM, Division of Biometry, Epidemiology Survey, and Reports Branch, Rockville, Md., April 1975, DHEW Publication Number (ADM) 75-158.

ADMISSIONS TO STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, 1969-73

Year—both sexes	Total under 18			Under 5			5 to 9			10 to 14			15 to 17		
	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent
1969	27,973	40.1	100	410	2.4	1.5	1,999	9.9	7.1	8,503	41.2	30.4	17,061	148.3	61.0
1970	27,189	39.0	100	155	.9	.6	1,685	8.5	6.2	7,840	37.6	28.8	17,509	148.2	64.4
1971	28,029	40.3	100	268	1.6	1.0	1,776	9.2	6.3	7,643	36.3	27.3	18,342	152.4	65.4
1972	27,133	39.3	100	245	1.4	.9	1,633	8.7	6.0	7,984	38.0	29.4	17,271	140.4	63.7
1973	25,830	37.9	100	208	1.2	.8	1,796	9.9	6.9	7,695	36.9	29.8	16,131	129.1	62.5

[1] Rate per 100,000 population

RESIDENT PATIENTS IN STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, 1969-73

Year—both sexes	Total under 18			Under 5			5 to 9			10 to 14			15 to 17		
	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent	Number	Rate[1]	Percent
1969	12,841	18.4	100	84	0.5	0.7	1,600	7.9	12.5	5,067	24.5	39.4	6,090	53.1	47.4
1970	12,844	18.7	100	53	.3	.4	1,560	7.8	12.1	4,952	23.8	38.6	6,279	53.3	48.9
1971	12,519	18.0	100	133	.8	1.1	1,408	7.3	11.2	4,838	23.0	38.6	6,140	51.2	49.1
1972	11,269	16.3	100	85	.5	.8	1,284	6.9	11.4	4,398	21.0	39.0	5,502	44.9	48.8
1973	10,576	15.5	100	74	.4	.7	1,136	6.3	10.7	4,145	19.9	39.2	5,221	41.9	49.4

[1] Rate per hundred thousand population.

Source: Statistical note No. 115, DHEW/Public Health Service, ADAMHA NIMH, Division of Biometry and Epidemiology Survey and Reports Branch, Rockville, Md., April 1975, DHEW publication No. (ADM) 75-158.

RESIDENTIAL TREATMENT CENTERS FOR CHILDREN. (1973)

As of January 1974

There were *340* RTC's w/*19,023* beds.
27.9 RTC beds per 100,000 population under 18.

1973

29,726 children received care, amounting to 6,337,926 days.
Average residence/day=17,624, at end of 1973, 17,697 in residence.
12,029 discontinuations, 12,179 additions.
Average of *92.6 percent* beds occupied daily.
Expenditures: total: 242,348,00 (approx.); $38 per patient day; and $20,389 per discontinuation.

TABLE 1.—COMPARISONS OF SELECTED DATA ON RESIDENTIAL TREATMENT CENTERS AND PSYCHIATRIC HOSPITALS FOR CHILDREN: UNITED STATES, 1973

Selected measures for 1973	Residential treatment centers (N=340)	Psychiatric hospitals for children (N=26)
Predominant type of ownership	[1]	[2]
Average (mean) size (in beds)	56	90
Most frequent minimum admission age (years)	6	6
Most frequent maximum admission age (years)	18	18
Average caseload per facility:		
Annual additions	36	84
Annual discontinuations	35	85
Resident patients as of Dec. 31, 1973	52	79
Addition Indices:		
Additions per 100 beds	64	94
Additions per 100 average residential patients	69	107
Additions per 100 discontinuations	101	99
Additions per 100,000 U.S. resident population under 18 yr	18	3
Full-time equivalent staff per 100 residents:		
Total patient care staff	77	143
Professional	50	67
Other	27	76
Expenditures:		
Annual total expenditures per facility	$712,788	$2,208,724
Annual salary expenditures per facility	$425,847	$1,870,902
Percent salaries are of total	60	80
Average total expenditure per patient day	$38	$82
Average total expenditures per discontinuation	$20,389	$25,561

[1] Private nonprofit.
[2] State and county.

Source: Statistical Note number 130, DHEW/Public Health Service, ADAMHA/NIMH, Division of Biometry and Epidemiology Survey and Reports Branch, Rockville, Md., April 1976, DHEW Pub number (ADM) 76–158

TABLE 2.—COMPARISONS OF SELECTED DATA ON RESIDENTIAL TREATMENT CENTERS: UNITED STATES, 1971 AND 1973

Selected measures	1971	1973	Percent change 1973 versus 1971
Number of facilities	344	340	−1.2
Average (mean) size (in beds)	57	56	−1.8
Average caseload per facility:			
Annual additions	32	36	+12.5
Annual discontinuations	29	35	+20.7
Resident patients at end of year	51	52	+2.0
Additions Indices:			
Additions per 100 beds	56	64	+14.3
Additions per 100 resident patients	63	69	+9.5
Additions per 100 discontinuations	110	101	−8.2
Additions per 100,000 U.S. civilian population under 18 yr	16	18	+12.5
Full-time equivalent staff per 100 average daily residents:			
Total patient care staff	64	77	+20.3
Professional	38	50	+31.6
Other	26	27	+3.8

TABLE 2.—COMPARISONS OF SELECTED DATA ON RESIDENTIAL TREATMENT CENTERS: UNITED STATES, 1971 AND 1973—Continued

Selected measures	1971	1973	Percent change 1973 versus 1971
Expenditures:			
Annual total expenditures per facility	$573,000	$712,788	+24.4
Annual salary expenditures per facility	$348,000	$425,847	+22.4
Percent salaries are of total	61	60	+1.6
Average total expenditures per patient day	$31	$38	+22.6
Average total expenditures per discontinuation	$19,654	$20,389	+3.7

Source: Statistical Note No. 130, DHEW/Public Health Services, ADAMHA/NIMH, Division of Biometry and Epidemiology Survey and Reports Branch, Rockville, Md., April 1976, DHEW Pub. No. (ADM) 76-158.

TABLE 3.—NUMBER AND PERCENT DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS; AVERAGE NUMBER OF BEDS PER GROUP AND BEDS PER 100,000 RESIDENT POPULATION OF THE UNITED STATES UNDER 18 YEARS, BY SELECTED FACILITY CHARACTERISTICS: UNITED STATES, 1974

Selected facility characteristics	Residential treatment centers		Inpatient beds			Beds per 100,000 U.S. resident populatiou under 18
	Number	Percent	Number	Percent	Average number per group	
All residential treatment centers	340	100.0	19,023	100.0	56	27.9
Size (based on number of beds):						
Under 25 beds	88	25.8	1,472	7.7	17	2.2
25 to 49 beds	129	38.2	4,588	24.1	36	6.7
50 to 74 beds	69	20.4	4,033	21.2	58	5.9
75 to 99 beds	26	7.5	2,251	11.8	87	3.3
100 beds and over	28	8.1	5,679	35.2	239	9.8
Ownership:						
Private/nonprofit	330	97.1	18,543	97.5	56	27.2
State and county government	10	2.9	480	2.5	48	0.7
Geographic region:						
Region I	41	12.1	1,729	9.4	43	46.4
Region II	36	10.6	3,039	16.0	84	38.3
Region III	24	7.1	2,291	12.0	95	30.3
Region IV	15	4.4	1,022	5.4	68	9.3
Region V	104	30.5	4,447	23.3	43	29.7
Region VI	22	6.5	1,840	9.7	84	25.3
Region VII	20	5.9	759	4.0	38	20.7
Region VIII	15	4.4	534	2.8	36	27.1
Region IX	47	13.8	2,645	13.9	56	34.6
Region X	16	4.7	667	3.5	42	30.4

TABLE 6.—PATIENT MOVEMENT AND ANNUAL VOLUME OF SERVICES IN INPATIENT SERVICE OF RESIDENTIAL TREATMENT CENTERS BY SIZE (BASED ON NUMBER OF BEDS) AND GEOGRAPHIC REGION: UNITED STATES, 1973

Size (based on number of beds) and geographic region	Patient movement during year				Annual volume of service		
	Residents at beginning of year	Additions during year	Discontinuations during year	Residents at end of year	Patients under care	Average resident patients	Number of patient days
All residential treatment centers	17,547	12,179	12,029	17,697	29,726	17,624	6,337,926
Size (based on number of beds):							
Under 25 beds	1,354	1,145	1,205	1,294	2,499	1,324	457,836
25 to 49 beds	4,231	3,199	3,142	4,288	7,430	4,260	1,514,614
50 to 74 beds	3,691	3,079	2,989	3,781	6,770	3,736	1,333,683
75 to 99 beds	2,084	1,874	1,877	2,081	3,958	2,083	739,866
100 beds and over	6,187	2,882	2,816	6,253	9,069	6,220	2,291,927
Geographic region:							
Region I	1,617	958	907	1,668	2,575	1,643	580,907
Region II	2,820	1,676	1,589	2,907	4,496	2,864	1,012,828
Region III	2,331	850	866	2,315	3,181	2,323	824,187
Region IV	800	685	563	922	1,485	861	350,086
Region V	4,004	3,120	3,076	4,048	7,124	4,026	1,436,597
Region VI	1,826	1,067	1,210	1,683	2,893	1,755	642,283
Region VII	661	668	649	680	1,329	671	240,812
Region VIII	445	422	342	525	867	485	163,095
Region IX	2,439	2,203	2,295	2,347	4,642	2,393	875,120
Region X	604	530	532	602	1,134	603	212,011

TABLE 15.—NUMBER AND PERCENT DISTRIBUTION OF EXPENDITURES, RESIDENTIAL TREATMENT CENTERS BY TYPE OF EXPENDITURE AND SIZE (BASED ON NUMBER OF BEDS): UNITED STATES, 1973

Size (based on number of beds)	Total expenditures	Operating expenditures: Total operating expenditures	Operating expenditures: Salaries	Operating expenditures: Other operating expenditures	Capital expenditures
	Annual expenditures in thousands of dollars				
All sizes	242,348	222,550	144,788	77,762	19,798
Less than 25 beds	21,366	20,862	13,801	7,061	500
25 to 49 beds	57,349	52,549	35,730	16,819	4,804
50 to 74 beds	52,067	50,094	32,415	17,679	1,973
75 to 99 beds	24,812	23,707	14,726	8,981	1,105
100 beds and over	86,754	75,338	48,116	27,222	11,416
	Percent distribution of expenditures				
All sizes	100.0	91.8	59.7	32.1	8.2
Less than 25 beds	100.0	97.6	64.6	33.0	2.4
25 to 49 beds	100.0	91.6	62.3	29.3	8.4
50 to 74 beds	100.0	96.2	62.2	34.0	3.8
75 to 99 beds	100.0	95.5	59.3	36.2	4.5
100 beds and over	100.0	86.8	55.4	31.4	13.2

TABLE 16.—AVERAGE EXPENDITURES PER PATIENT DAY AND PER DISCHARGE IN RESIDENTIAL TREATMENT CENTERS, BY TYPE OF EXPENDITURE AND SIZE (BASED ON NUMBER OF BEDS): UNITED STATES, 1973

Size (based on number of beds)	Total expenditures	Operating expenditures: Total operating expenditures	Operating expenditures: Salaries	Operating expenditures: Other operating expenditures	Capital expenditures
	Average expenditures per patient day				
All sizes	$38	$35	$23	$12	$3
Less than 25 beds	46	45	30	15	1
25 to 49 beds	39	36	24	12	3
50 to 74 beds	39	37	24	13	2
75 to 99 beds	34	32	20	12	2
100 beds and over	38	33	21	12	5
	Average expenditures per discontinuation				
All sizes	$20,389	$18,795	$12,198	$6,597	$1,594
Less than 25 beds	18,341	17,932	11,834	6,098	409
25 to 49 beds	18,922	17,420	11,817	5,603	1,502
50 to 74 beds	17,088	16,476	10,634	5,842	612
75 to 99 beds	13,437	12,872	7,974	4,898	565
100 beds and over	31,133	27,239	17,351	9,888	3,894

TABLE 17.—DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS (RTC'S) BY RESPONSE TO SPECIFIC ITEMS ON THE 1973 INVENTORY OF MENTAL HEALTH FACILITIES

Date item and group	Number of RTC's surveyed	Response: Number of RTC's	Response: Percent	Nonresponse: Number of RTC's	Nonresponse: Percent
Number of beds	340	314	92.4	26	7.6
RTC's by geographic region	340	314	92.4	26	7.6
Type of ownership	340	314	92.4	26	7.6
Type of service modes:					
By bed size	340	314	92.4	26	7.6
By geographic region	340	314	92.4	26	7.6
Region I	41	37	90.2	4	9.8
Region II	36	33	91.7	3	8.3
Region III	24	24	100.0		
Region IV	14	15	100.0		
Region V	104	97	93.3	7	6.7
Region VI	22	20	90.9	2	9.1
Region VII	20	18	90.0	2	10
Region VIII	15	15	100.0		
Region IX	47	41	87.2	6	12.8
Region X	16	14	87.5	2	12.5
Patient movement and volume of service:					
By bed size	340	292	85.9	48	14.1
By geographic region	340	292	85.9	48	14.1
Region I	41	32	78.0	9	22.0
Region II	36	29	80.6	7	19.4
Region III	24	21	87.5	3	12.5
Region IV	15	15	100.0		
Region V	104	92	88.5	12	11.5
Region VI	22	20	90.9	2	9.1
Region VII	20	17	85.0	3	15.0
Region VIII	15	13	86.7	2	13.3
Region IX	47	40	85.1	7	14.9
Region X	16	13	81.3	3	18.7
Number of staff and hours worked by bed size	340	312	91.8	28	8.2
Expenditures:					
By bed size	340	285	83.8	55	16.2
By geographic region	340	297	87.4	43	12.6
Region I	41	36	87.8	5	12.2
Region II	36	31	86.1	5	13.9
Region III	24	24	100.0		
Region IV	15	14	93.3	1	6.7
Region V	104	92	88.5	12	11.5
Region VI	22	18	81.8	4	18.2
Region VII	20	18	90.0	2	10.0
Region VIII	15	14	93.3	1	6.7
Region IX	47	37	78.7	10	21.3
Region X	16	13	81.3	3	18.7
Expenditures per patient day and per discontinuation by bed size	340	285	83.8	55	16.2

TABLE 3.—EXTENT TO WHICH NEEDS FOR PSYCHIATRIC SERVICES WOULD BE MET IN RELATION TO VARIOUS ASSUMPTIONS OF NEED: ASSUMING 1971 USE RATES ONLY, BY AGE, UNITED STATES, 1975 AND 1980

Age	Estimated general population¹ (In thousands)	Estimated patient care episodes	Estimated number persons receiving Care	Estimated number of persons needing care, assuming			Number in need not receiving care, assuming			Percent unmet need, assuming		
				2 percent in need	10 percent in need	20 percent in need	2 percent in need	10 percent in need	20 percent in need	2 percent in need	10 percent in need	20 percent in need
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1975												
Total, all ages	215,324	4,237,576	3,390,061	4,306,480	21,532,400	43,064,800	1,060,510	18,142,339	39,674,739	24.6	84.3	92.1
Under 18	68,109	809,377	647,502	1,362,180	6,810,900	13,621,800	[illegible]4,678	6,163,398	12,974,298	52.5	90.5	95.2
18 to 24	27,780	716,150	572,920	555,600	2,778,000	5,556,000	0	2,205,080	4,983,080	0.0	79.4	89.7
25 to 44	53,835	1,504,340	1,203,471	1,076,700	5,383,500	10,767,000	0	4,180,029	9,563,529	0.0	77.6	88.8
45 to 64	43,430	932,267	745,814	868,600	4,343,000	8,686,000	122,786	3,597,186	[illegible]940,186	14.1	82.8	91.4
65 and over	22,170	275,442	220,354	443,400	2,217,000	4,434,000	223,046	1,996,646	4,213,646	50.3	90.1	95.0
1980												
Total, all ages	228,676	4,500,3[illegible]4	3,600,275	4,573,522	22,867,600	45,735,200	1,030,028	19,267,325	42,134,925	22.5	84.3	92.1
Under 18	69,646	839,566	687,653	1,392,920	6,964,600	13,929,200	705,267	6,276,947	13,241,547	50.6	90.1	95.1
18 to 24	29,156	760,558	608,446	583,120	2,915,600	5,831,200	0	2,307,154	5,222,754	0.0	79.1	89.6
25 to 44	62,332	1,697,622	1,278,097	1,246,640	6,233,200	12,466,200	0	4,955,103	11,188,303	0.0	79.5	89.7
45 to 64	43,489	990,076	792,061	[illegible]9,780	4,348,900	8,697,800	77,719	3,556,839	7,905,739	8.9	81.8	90.9
65 and over	24,053	292,522	324,018	481,[illegible]0	2,405,300	4,810,600	247,042	2,171,282	4,576,582	51.4	90.3	95.1

[1] U.S. Bureau of the Census, Series D projection of the U.S. population ("Current Population Reports," series P-25, No. 493).

Derivation of cols. 2 through 12:

Col. 2—Total patient care episodes obtained by applying 1971 patient care episode rate per 100,000 population (1,968 per 100,000) to the projected 1975 and 1980 total U.S. population. Age distributions of patient care episodes obtained by applying 1971 percentage distribution of patient care episodes by age to the 1975 and 1980 estimated total patient care episodes.

Col. 3—Represents a conversion of patient care episodes into number of persons accounting for these episodes bt multiplying patient care episodes by a factor of 80. This factor was derived from findings of the Maryland Psychiatric Case Register that every person in that register had an average of 1.2 episodes of care per year.

Col. 4=Col. 1×.02.
Col. 5=Col. 1×.10.
Col. 6=Col. 1×.20.
Col. 7=Col. 4−Col. 3 (Note: For this column negative values were assumed to be zero, i.e., the need for services would be met. Also the total is the sum of the parts.)
Col. 8=Col. 5−Col. 3.
Col. 9=Col. 6−Col. 3.
Col. 10=Col. 7÷Col. 4.
Col. 11=Col. 8÷Col. 5.
Col. 12=Col. 9÷Col. 6.

Fiscal year 1976: 48 percent of medicaid eligibles under 21; 18.4 percent expenditures for services to under 21's.

Mental Health Services

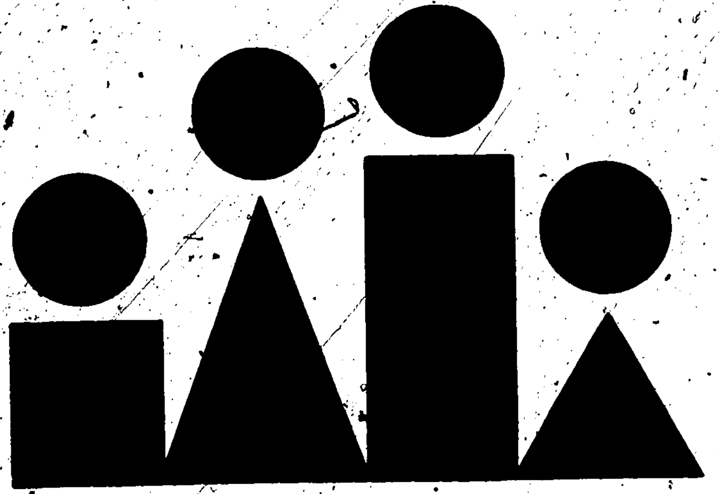
1. 28 States currently cover children under 21 for inpatient psychiatric care. 24 provide other services, e.g., clinic, outpatient, evaluations.

2. In fiscal year 1976, 11.1 million children under 21 received services under Medicaid. It is estimated that only 7,000 received covered services in mental hospitals. (.063 percent received services in mental hospitals.)

3. Children receiving inpatient psychiatric care in mental hospitals accounted for an estimated 6.4 percent of all recipients of mental hospital care under Medicaid in fiscal year 1976.

4. In fiscal year 1976, $503 million were expended for mental hospital care; it is estimated that $45.8 million (roughly 9 percent) was expended on children under 21.

APPENDIX II



DEVELOPMENTAL REVIEW IN THE EPSDT PROGRAM

Prepared by

U.S. Department of Health, Education, and Welfare
HEALTH CARE FINANCING ADMINISTRATION
in cooperation with
THE AMERICAN ASSOCIATION OF
PSYCHIATRIC SERVICES FOR CHILDREN, INC.

DEVELOPMENTAL REVIEW
in the
EARLY and PERIODIC SCREENING, DIAGNOSIS and TREATMENT PROGRAM

FINAL REPORT

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116

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Conference Participants

Robert S. Adams, M.D.
Allan G. Barclay, Ph.D.
Thomas J. Boll, Ph.D.
Harold Boverman, M.D.
Richard J. Bonnie, L.L.B.
Thomas Coleman, M.D.
Marcene Erickson, R.N.
Anne-Marie Foltz, M.P.H., M.Phil.
Martin E. Glasser, M.D.
Fernando A. Guerra, M.D.
Frances Degan Horowitz, Ph.D.
Dorothy S. Huntington, Ph.D.
Conference Chairman
Harold Ireton, Ph.D.
Sydney Koret, Ph.D.
LuVerne A. Kunze, Ph.D.
Harryetta B. Matthews, R.N.
Jane R. Mercer, Ph.D.
L. Wendell Rivers, Ph.D.
Carlos J. Sanchez, M.D.
Henry R. Shinefield, M.D.
Sheila Swaiman
Judith Humphreys Weitz

Observers

Karl Banks
Rudolf Hormuth, M.S.W.
Beatrice D. Moore, M.S.W.
Laurence J. Platt, M.D.
Linda Randolph, M.D.
Robert S. Thompson, M.D.
Elsie M. Tytla, M.D.
Charles Wilkinson, M.D.

Conference Staff

Debora D. Kramer
Ruth Ann McGrail
Monica G. Noether
Marietha J. Slade

CONTENTS

RATIONALE AND ELABORATION

EXECUTIVE SUMMARY

I. PROLOGUE

Developmental assessment is an extraordinarily complex topic, but one which holds enormous promise for all children. Attempting to make recommendations about developmental assessment perhaps approaches the level of a Herculean task.

> In view of the work ahead of this group I am reminded of a story which appeared in the **Washington Post** supplement. The story was set on an ancient Roman galley and the Hortator, the one who bangs on the drum to keep oarsmen in cadence, says—"I got some good news and some bad news! You all get steaks tonight!" "Yea!" "Yea!" from the rowing benches. "And now the bad—the Captain wants to go water skiing tomorrow!" I get the feeling that the organizers of this conference are *avid* water skiers. (Hurt, 1974)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) became a mandated service under the Medicaid Program through an amendment in 1967 to the Social Security Act, Title XIX, Section 1905 (a) (4) (B). Effective July 1, 1969, it required

> . . . such early and periodic screening and diagnosis of individuals who are eligible under the plan or are under the age of 21 to ascertain their physical and mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby as may be provided in regulations of the Secretary.

We recommend that a major shift in emphasis and conceptualization be made with reference to EPSDT and developmental issues. These recommendations flow from a consideration of a wide variety of salient points, the most basic of which is that development is not a disease which yields a judgment of present or absent. We are basically concerned with the concept of competence—how well has a child met, and how well does he now meet, the expectations implicitly and explicitly set by his society for an individual of his/her age and sex group.

The legislation authorizing EPSDT makes it national policy that the development of our children, our future citizens, be safeguarded so as to insure that each child reaches maturity functioning at a maximum level of development. This goal is more than the finding, the study, and the treatment of disease. The guardianship of the health of children is in the national interest as well as in the interest of the individuals; this is the essence of EPSDT.

Parents must be accepted as full partners with the professionals who plan and staff the services provided for children. If responsible parenthood is to be encouraged, then parental involvement must be fostered. No single department or unit of the Federal government nor of local governments, and no single profession, has "the key" alone to promoting childrens' development. Only through coordinated service delivery as proposed herein is this possible.

We must develop a system of health care that treats the person rather than the disease or dysfunction. We are urging the development of a system for the protection of child development, a system of developmental review.

No single test or instrument is recommended because none could possibly be used for the adequate accomplishment of a developmental review for all ages and functions. Each review must include multiple assessment procedures tied to the age of the child and the dimensions to be assessed.

Any system of review must be predicated upon parental and child involvement in the review.

Any review must be oriented to the discovery of developmental strengths as well as weaknesses, not to the exclusive search to rule in or rule out pathology.

Every attempt must be made to voluntarily engage and utilize parents in the entire process of continuity of care and developmental review.

We recommend this system for all our child citizens. We encourage the recognition that the current law as specifically written is inadequate, undesirable and almost impossible to implement, but if the welfare of children is the goal, this proposed system should be set in its place.

There must be an integration into the EPSDT program of payment for all services which are needed by a child or family as a result of developmental review, including special education costs.

Our basic message is that developmental review is much more complicated than it appears when it is labeled "developmental screening" but yet the system of developmental review holds out enormous promise. We are, in this program, at a point of crisis; it is instructive to note that the word crisis in Chinese calligraphy is the blending of the two symbols for danger and opportunity.

National and individual interests may or may not coincide in a screening operation; indeed they may sometimes be in conflict, but they will always coincide with regard to the guardianship of the development of our future citizens. Thus the issues are more complicated and more relevant to both national and individual interests than the critical incident style of assaying or analyzing for specific fixable defects. The issues are more in the realm of a periodic review of a process, that of development. They are relevant to all children. Further, they are more relevant to a synthesis of function, supports, and developmental needs than to analysis and fragmentation.

Once this departure from the former conceptual model is accepted, we can go on to the details. To state it most concretely, we believe with reference to developmental and psychological issues, that the national mandate for EPSDT may better be stated by a change in name to EPRDT; the "R" representing a developmental review rather than a screen. The function of the review is to assess the ways in which development is occuring, the form that it is taking.

It then follows that national and individual needs and priorities will determine the processes to be used for the review and the resources available. The process and the resources will in turn determine the level of review, the ages served, and the backup treatments to be made available. It is at this final level of conceptualization where specific methods of review may be suggested, and specific ways of delivering services involved in this review may be proposed.

It is apparent that the present legislative language, which states that there shall be screening ". . . for mental defect . . .", is clearly inappropriate. The proper emphasis, in our opinion, is upon a process of developmental review, with the object being to identify strengths and competencies as well as weaknesses and defects.

It is assumed that the legislative intent of the EPSDT Program was to establish a national policy such that the development of the child be safeguarded in order to insure that, as with any other national resource, the resource is available to the nation. To that end, it is assumed that the *raison d' etre* for the program must be the husbanding of our child resources, from both a humanitarian and an economic point of view, and that the EPSDT Program must not have a narrow focus upon defect, but must look as well toward the optimization of the development of the child.

The policy surrounding the fuller implementation and development of the Early and Periodic Screening, Diagnosis and Treatment Program should be based on three principles:

1. **a national commitment to the well-being of all children**
2. **a fostering of parental involvement**
3. **a pooling of professional and parental knowledge.**

A policy for children must give practical recognition to the fact that they are the citizens of the future. Their development determines the fabric of tomorrow's society. At a time when resources are limited, there is a case for concentrating them where they can do the most good, in the area of well-being of children and families.

II. RECOMMENDATIONS

A. Our first recommendation is that the EPSDT mandate be broadened to apply to all children in this country so that a system of developmental review and protection might be planned for comprehensive implementation. It is also urged that funds be made available for the development of health care resources, including manpower, facilities, and research and development.

B. In the interest of pooling resources, consolidating efforts, and effecting maximum impact, we recommend that the currently existing extensive overlap in functions and goals of existing Federal programs be eliminated. The Maternal and Child Health program, the Education for All Handicapped Children Act (PL 94–142), and other programs sponsored by NIMH, NICCHD, BEH and OCD/Children's Bureau have significant duplication of effort with EPSDT; a thorough review of existing programs and agencies serving children should be undertaken, with the goal of effecting such mergers as would improve our services to children and reduce duplication.

C. The establishment of an EPSDT Coordinating Office at the local level is recommended; the function of this local coordinator will be to insure that the review, referral, treatment, information dissemination and follow-up resources of the community be utilized in carrying out the goals of the "merged", coordinated EPSDT program. Also recommended is the establishment of EPSDT Community Coordinating Councils to include the schools and all service agencies, as well as representatives of parents and service providers.

D. These support systems are being recommended in order to enable and facilitate planning on the local level; identification of gaps and needs in the service resources; coordination and stimulation of services relevant to achieving goals of EPSDT, and cooperation and contribution to the external evaluation of EPSDT. We clearly are recommending multiple models of service delivery depending on the characteristics of individuals and agencies available as support systems.

E. We recommend a new approach to the discovery of "handicapping conditions" or "mental defects". Developmental review is seen as the first step in engaging children and parents in an ongoing concern with their health and well-being. We see it as a way of promoting strengths, as a way of engaging parents with their children, of strengthening these parent/child ties, and of reducing the anxiety so prevalent in our society today regarding issues in parenting and child rearing. This is a true system of health care versus specific medical care.

F. As the individual with primary responsibility for the care of the child and for the facilitation of development, it is vital that the parent or other caregiver be meaningfully involved in the process of developmental review.

G. Such developmental review should, to the maximum extent possible, avoid coercion such as mandating that the developmental review be a condition for a survival need such as a welfare payment. Vigorous efforts should be made to insure voluntary participation by the parent in the developmental review.

H. Such developmental review should, to the maximum extent possible, provide significant benefit from participation, in the form of a better understanding of the child, with the aim being to provide assistance to the parent in coping with developmental issues, and facilitating future development.

I. Such developmental review should, to the maximum extent possible, recognize, respect and incorporate ethnic, cultural, social and linguistic differences that exist in a pluralistic and culturally and ethnically diverse nation such as the United States.

In a free, pluralistic society, there are clear boundaries on the scope of legitimate inquiry into personal and familial concerns. Therefore a mass government financed screening program should be limited to:

1) those measures of organic functioning and basic, adaptive coping skills which enjoy a high degree of consensus within the health professions and effected communities, and

2) those behavioral factors especially associated with learning, language and speech development, motor skills and perceptual abilities.

Specific assessment of emotional and behavioral adjustment and parent/child interactions should be left to parental initiative and sensitive clinical observation (Stage Three as herein proposed.)

As an integral part of the initial outreach phase of a developmental review effort, parents should be provided in the language most appropriate to them, a written description of the nature and purpose of the proposed procedures, including adequate assurances of its quality, confidentiality and benefits to the child and family. At the time the parent personally appears, he or she should be verbally informed of the nature and purpose of all developmental review procedures, and should be notified that selective participation is possible. A refusal to authorize any given procedure must not jeopardize the child's access to any other aspects of the program. Parental consent should then be obtained for each procedure and for any proposed transfer of records or information upon completion of the developmental review. Each child being served should be informed of the nature and purposes of the procedures and their results to the maximum extent possible consistent with his or her level of intellectual and emotional maturity.

Any transfer of developmental information between and among systems is recommended *only* when the information would be helpful in identifying those conditions under which a child functions best, so as to enable, for example, optimal school placement. It is our recommendations that only diagnostic (Stage Three) information that is pertinent to educational prescription for the child be communicated to the schools, subject always to informed parental consent.

J. It is strongly recommended that no single instrument for development assessment be mandated nationally. There is no one single instrument, inventory or assessment tool that is totally satisfactory.

Any instruments, materials and methods for developmental review within the EPSDT program must be normed for the minority group with whom they are to be used. They must also be interpreted by persons who are familiar with the economic and cultural background of the populations being assessed.

K. The system for developmental review must be clearly recognized as a system, not a piecemeal approach.

We recommend research and development or demonstration projects to develop measurement and evaluation standards appropriate to the assessment of children and their environments. There should also be research into the methodology of developmental review with emphasis on a variety of assumptions and theories related to age and ethnicity.

There must be the development of strategies for the simultaneous selection of measurement variables and the identification of program needs, for the establishment of research, development and evaluation priorities. There must be an emphasis on the overlap between research and consumer priorities. In addition, there must be provision for taking into account family needs and values in the conceptualization of measurement related problems, and in the development, selection and application of any measurement or other instruments. Parents and those directly responsible for the welfare of the children must be involved in all decision making processes in this area.

The focus in interpretations of assessment must always be on individual differences that will lead to appropriate intervention for each specific child, as opposed to a focus on group difference and comparisons.

There should be a collection of multi-measure, multi-domain, multi-function measures from which instruments may be selected at a local level, by local option for Stage Two and Stage Three reviews.

L. Adequate developmental review would include factors from these areas:

1) biological dimensions
2) psychological dimensions
3) family dimensions
4) environmental/social/cultural elements

M. The review should be carried out in three stages:

1) Stage One

a. The biological dimensions would be reviewed within the framework of the pediatric physical examination, which would be expanded to include an opportunity for the child and family to discuss, if they so wish, any stresses or problems with which they would like help, or to identify strengths and support systems that could be engaged to provide for furthering development.

b. An assessment of the child's functioning would be done based upon the parents' report in the areas of development of skills and emotional and behavioral status.

2) **Stage Two**

Direct observation of the child's functioning, utilizing a variety of broader developmental screening inventories or instruments.

3) Stage Three

This stage of developmental review would include detailed aspects of the four domains: biological, psychological, family, and environmental/social cultural. The psychological domain would include a wide variety of functions—cognitive development, coping strategies, social development, emotional development, language and speech development, auditory perception, visual perception and physical functions.

This extensive review of a child's development at Stage Three, this clinical assessment, must be done with great clinical sensitivity by people highly skilled both in child development and in working with parents.

N. It is clearly necessary that we develop appropriate instruments in order that all stages of developmental review be carried out most adequately. There is not at the present time a single, universally acceptable tool for developmental review although there is a multiplicity of such instruments appropriate in differing situations and for differing developmental problems.

It is strongly recommended that the Medical Services Administration take a leadership role in establishing task forces and demonstration projects to develop further review procedures relative to acceptability, standardization norms, instrument reliability, instrument validity, concurrent validity, use by paraprofessionals, cost effectiveness and availability. In developing parent questionnaires, concerning their child's development, it is obvious that the questionnaires must not be trivial, must have developmental implications, and must have cross-cultural validity.

O. It is also recommended that a separate task force be appointed to supply a list of tests currently available, with information on how well they meet these criteria (section N above) of appropriateness, and in what areas of psychological, family and environmental review.

In connection with this, it is strongly recommended that there be constructive use made of data already available from past projects such as the collaborative studies, in order that we may become much more sophisticated about issues of longitudinal prediction.

After two years, no standardized procedure should be utilized in the program until it has been approved pursuant to regulations adopted by the Secretary. In the interim period, this Task Force shall review standardized procedures currently in use to determine their compliance with these above mentioned criteria, and shall recommend appropriate regulations to the Secretary.

P. It is recommended that a separate task force be developed that would collate and make available to local communities the varying models of parent based "treatment" programs that have been developed, and also make available the wealth of parent education materials that currently exist in many scattered places. This particular use of parent education materials holds within it a truly exciting and innovative approach to health care in this country.

Q. Any developmental review system initiated under EPSDT should clearly reflect the important distinction between the disease recognition and prevention model, and the cultural diversity model. Screening may legitimately utilize the "disease model" during the years of infancy and early childhood development when the child's primary social group is the family; in doing so, however, developmental review must focus primarily on the child's "physiological" development. Conversely, as children enter the mandated school system, when their behavior is evaluated with reference to the expectations of the social group, developmental assessment necessarily encompasses behavioral measures, and policies must therefore be formulated within the normative framework of the "cultural diversity" model.

R. It is recommended that specific guidelines concerning program evaluation be developed by a task force of experts who have specific competency in this area. We caution that this must be done quite soon, so that elements considered essential to proper program evaluation be included in those programs now in the process of implementation. Evaluation of EPSDT should be done in relation to specific, predetermined process and outcome measurements.

One of the most important issues in evaluation must be the inclusion of a search for possible positive and negative side effects of any system of developmental review on children and their families. This would include an investigation of any problems associated with potential "labelling" as a consequence of the administration and implementation of any of the aspects of developmental review herein recommended.

Research must be set up to provide answers to cost issues, and to develop appropriate systems for collection of data to estimate costs and benefits of publicly financed child health programs.

S. The proper implementation of EPSDT across the country will require the development of training programs in order to increase the sophistication of professionals in the area of normal development, developmental review, and opportunities for the developmental protection of children. Therefore, we recommend that there be an expansion of existing sources of funding so that training programs necessary for existing professionals who will contribute to the achievement of the goals of EPSDT be made available. We include in the group of eligible professionals: physicians, nurses, teachers, psychologists, social workers, school counselors, and speech pathologists and audiologists. Training programs should be carried out by existing accredited training resources and institutions (for example, universities, state colleges, community colleges). Training could be offered in the form of workshops, courses, seminars, and inservice training programs. We also recommend that training funds for paraprofessional personnel be made available on the assumption that Stage One and perhaps Stage Two of the developmental review process will be carried out by such personnel, and on the assumption that a great deal of the parent support work will also be carried out ultimately by paraprofessionals.

We urge increased effort to sensitize health professionals to the problems of parents, to the issues of ethnic diversity within this pluralistic socety, and we urge that health professionals be trained to offer increased support and counseling to all families.

In order to achieve the goals of EPSDT, special resources for developmental review need to be created to supplement the kinds of assessments typically done by physicians. The nature of these special resources are largely specially trained personnel. Such personnel should have extensive skills in using developmental evaluation techniques, should know something about the arena in which physicians operate and similarly should have some familiarity with the nature and requirements of effective educational settings. They must also know about parents, about families, their ethnic and economic diversity and the realities in which they live in our society.

RATIONALE AND ELABORATION

1. What is Developmental Review?

It is evident that the development of a child is a process, requiring periodic review to insure that development is proceeding adequately. Thus the term "screening", with its connotation of searching for a defect, is less appropriate than is the term "developmental review" which implies a process orientation rather than a simple cross-sectional view. While it may be difficult to change the present legislative language, it is urged that the process of developmental review be strongly encouraged, and that the concept of developmental screening, which is more appropriate to medical or disease oriented conceptual models, be avoided.

Developmental review in the context of a health program has three goals:

1. The promotion of strengths of a child and family to cope with the various tasks of living;
2. The prevention of specific developmental disabilities;
3. Early case finding;

At this time we are recommending an entire reconceptualization of developmental assessment within the EPSDT program. The elements of "Operation Rethink" involve a reassessment of what "mental defects" are; what mental health and development are; the role of the family in child development; the orientation of a screening, diagnosis and treatment program around the integration of the family within the system; and finally, how one produces developmental gains via various support systems.

Under the proposed system of conceptualization there is no way in this field to identify precise tests to distinguish between "normal" and "abnormal" children; there are dozens of crucial functions subsumed under the concept of development, since development is not one *thing*. Developmental review would thus consist of an assessment of these functions rather than the specific diagnosis of a condition. A functional assessment, a profile of strengths and weaknesses, or assets and liabilities, describes the transactions between the child and the world around him in terms of the tasks asked of him and the people significant to this life, in the context of the particular setting in which the child is found and at the particular time of every developmental review. The outline of assets and liabilities, strengths and weaknesses, is clearly not related solely to the functioning of the child but is defined specifically in relation to the expectations of the important people and institutions in a child's life: family, school, friends, whatever is uniquely and individually important to any one particular child.

The effects of early life experiences as well as the effects of recent experiences such as a divorce in the family, the loss of a parent or other significant person via death, situational issues such as a fear of the procedures, all have a powerful effect on the ability of a child to demonstrate the quality of his functioning during any specific review. Developmental review would thus assume that the child and his environment (including significant caregivers) are a unit and are not divisible. One does not exist without the other. One cannot be reviewed adequately without consideration of the other. Developmental review concerns itself with what goes on between the child and this environment on the biological, psychological, social and cultural levels.

It is just as foolish to search for a single method of observing a child's development as it is to tell a physician that he must use only one method (using a stethoscope versus using a thermometer versus visual inspection, for example) to complete an entire physical examination. However, it is obvious that a combination of methods will allow the observation of a set of significant functions. It must be stressed repeatedly that development is not a disease which yields a judgment of present or absent. We are basically concerned with the concept of competence—how well has this child met, and how well does he now meet, the expectations implicitly and explicitly set by his society for an individual of his/her age and sex group?

This approach raises a host of questions and issues. To be addressed are such considerations as the difference between medical and psychological screening, diagnosis and treatment; the difference between an individual problem of a child and the matrix of social problems that might be reflected in a child. Also to be addressed are issues such as primary prevention as the detection of disease in non-symptomatic persons versus the newer concept of promoting strengths and promoting health. One must also consider health care in general versus medical care; this is a particularly prominent issue since EPSDT is essentially a medical care system.

With all the foregoing in mind, we recommend a new approach to the discovery of "handicapping conditions" or "mental defects". We do not see developmental screening only as a quick, simple procedure to identify those in need of further study but rather we see it as the first step in a way of engaging children and parents in an ongoing concern with their health and well being. We see it as a way of promoting strengths, as a way of engaging parents with their children, of strengthening these parent/child ties and of reducing the anxiety so prevalent in our society today regarding issues of parenting and child rearing. This is a true system of health care versus specific medical care.

We run the danger within developmental review of the fallacy of misplaced concreteness. There has been in the past an almost obsessive concern with the number of false positives and false negatives that each specific test yields. This is not truly the issue; the issue is what a parent thinks of his child, how he perceives the child, and how the child thinks of himself/herself. In addition it must be noted that this obsessive concern makes it sound as if there were a magical treatment available once the case is "diagnosed" according to this single all powerful instrument. That this is not the case will be reviewed in the following section. Again, we see the screening process and the diagnostic process themselves as the first order "treatment", through the engagement process by helping a parent think about the child's emotional and developmental status in a new way, in the context of a relationship with a helping person, a health professional in the broadest sense who is interested, who cares, is supportive and listens.

Engaging the Parents

In order to accomplish the goal of assessing a child's growth, strengths and weaknesses, one must as a prerequisite engage the cooperation of his parent or caregiver. Although logical, this process is at times ignored. This leaves the parent non-engaged, virtually sabotaging any cooperative effort on the part of an "outsider" to assess the function of a child. In actual practice this also leads to a very low number of return visits for diagnosis and treatment, when referral is made without parental engagement.

The parent is the only observer of a child's rate of growth from birth until school age. Health professionals are not predictably involved in any consistent manner. When the child enters school, a new observer is identified, the teacher. Therefore, the parent must be engaged early in the infant's life in order to utilize his observational skills in developmental review. The teacher likewise can be a valuable adjunct with parental approval to give information about the rate of growth of the child. The exclusion, however, of the parent when the teacher's observations are sought, can lead once again into a sabotage of future attempts to assess the child.

All parents, whether single or "coupled", have some fears about outsiders observing their child, and indirectly their "parenting". These fears can be stated as a "fear of labeling: good parent—bad parent" with a further extension of such, "good child—bad, defective child". Since parenting is frequently filled with ambivalent feelings of whether or not the "effort is enough", the fear of intrusion from an outsider is constant. On the other hand, the assistance and clarification of areas of concern are greatly welcomed and invited.

A further fear is that if any defect is discovered, there will be in fact no assistance or treatment for the correction of such. With these considerations in mind, the following suggestions for engagement are made:

1. Every attempt should be made to voluntarily engage the parents and the child. Coercion by mandating an exam or by attaching the exam to a survival need (money from welfare), immediately raises resistance and anger.

2. In order to have the parents cooperate, they must understand the benefits of participation. A model allowing for parents to evaluate the child first (parental inventory) with the opportunity to discuss areas of concerns as well as strengths, allows parents to look forward to assistance, rather than to fear "criticism".
3. The process of engagement should follow the stages of the parents' assessment of their child's development, and the parents' participation with a health worker to talk about areas of concern. (This also offers the opportunity for direct observation.) It would, in addition, be important at this stage to have a health worker who is bicultural and bilingual.
4. Although there may be a period of time from the initial contact to the definitive "diagnosis", the process of engagement with parents will enable the review to proceed. The failure to follow this engagement process could negate the opportunity to proceed to the desirable goals of treatment, remediation and facilitation of growth and development.
5. The definitive diagnosis, even though confirmed by criteria and norms, must be shared with the parents by a health professional with high sensitivity, expertise and knowledge of the parents.
6. The earlier the engagement process takes place, the easier it will be to have an accurate assessment of the child. Once rapport has been established at an early age, ideally birth, the review can take place with ease.

2. Some Considerations in Developmental Screening, Diagnosis and Treatment: Strengths versus Weaknesses

We must think very clearly about the implications of the difference in concept between screening oriented to promotion of strengths and prevention of disorders, and screening oriented to defects, damage, dysfunction, illnesses and weaknesses. We select tests partially on the basis of what use is going to be made of the results. The emphasis on defects and weaknesses leads to many ethical, social and psychological problems. In order to be concerned with success rather than failure, we need to establish a non-pathological model. As Brazelton (1976) has said,

> A new model is needed in pediatrics—a non-pathological model. With such a model that identifies the strengths of parents and children, the pediatrician would present himself as an advocate rather than a labeler. The Hawthorn effect would be great—expectations that they would succeed might reinforce their sense of dignity, of their own coping capacities, instead of the kind of expectancy to fail which, too often, they find now.

This viewpoint is especially important if we are to screen for mental retardation where, without ignoring pathology, we must be concerned with positive adaptive, coping capacities and not just with "defective" scores or failures on formal I.Q. testing.

The Nature of Intelligence and the Concept of Development

The traditional assumption is that mental retardation is a chronic handicap that exists in a person as an individual characteristic, unrelated to the circumstances of that individual's life. There are two models, then, of retardation: the pathological and the statistical. The pathological model is based on a disease model that views mental retardation as a biological dysfunction typified by particular biological symptoms. The statistical models states that a person is abnormal if he falls into the tails of the statistical distribution of the population on whatever measure is being used for diagnosis. Both models imply a relatively simple conception of a developmentally constant and pervasive factor of general intelligence, yet this conception is no longer tenable as a model for "mental" development.

Intelligence is clearly a matter of basic endowment, health status, environmental expectations and experience, learning and definition. The pathological model fails when one refers to psychological functions: development is not a disease that yields a judgment of present or absent. There is an enormously wide range of what is "normal" or "average" in developmental processes, and an equally wide range in the variant rates at which different functions develop in different children. One frequently wishes that this were not so, but it must be stressed that "development is not a single unfolding of more complicated behavior from infancy to maturity, but a process of learning and interaction." (Boelsche, 1969)

The Model of Medical Screening versus Developmental Assessment

The nature of developmental phenomena discussed above leads to very different models of screening and assessment.

Medical screening is a sophisticated concept; such screening is usually simple, quick, capable of "pass or fail" interpretation; it is applied once to each subject to minimize non-cooperation, and lends itself to evaluation in terms of sensitivity, specificity and repeatability.

Developmental assessment of psychological functions on the other hand, is a clinical procedure to which "pass or fail" interpretation should not be applied, repeated examinations are essential and it is not amenable to detailed quantitative evaluation. (Rogers, 1971). The essentially clinical nature of developmental assessment must never be overlooked; screening cannot be a "one-shot" attempt on a parameter that is developmental.

Developmental assessment involves a description of the child's adaptive functioning in the major areas of development of skills (motor, language, self-help, etc.) and adjustment, including behavioral and emotional characteristics. Such description of development and adjustment may be based on parental report, clinical observation and possibly direct testing of the child.

Preliminary interpretation of functioning in relation to the expectable range for children of the same age, sex and cultural group then defines a developmental profile of the child's strengths and weaknesses. This developmental profile may be used to define needs for further evaluation or other intervention.

There are marked differences in the personnel required, also, for medical and developmental screening: for medical screening tests, suitable training in procedure is necessary but no previous clinical experience is necessary or even desirable. Developmental assessment, on the other hand, should only be performed by personnel having broad experience in the children of the age being assessed, and having specific training and experience in the field.

If one uses the analogy of screening oranges for size as an appropriate one for medical screening, then it is easy to see that the appropriate method for screening is the use of some sort of size sorting equipment—screens with progressively finer mesh.

> Of course there may be numerous other standard characteristics against which any given orange must be assessed, such as juiciness, sweetness, resistance to bruising, color, thickness of skin, peeling ease, general esthetic appearance, etc. Some of these characteristics are more difficult to mechanically screen and assess than others, thus requiring the informed, relatively subjective assessment of trained interpreters to differentiate and classify them. (Meier, 1973)

This seems an appropriate analogy to developmental screening and assessment. Because we use the same word—"screening"—we seem to have confused the concepts of medical screening for the presence or absence of disease with developmental screening, which might more appropriately be called review of developmental status.

The distinctions between the two models complicate the generation of a comprehensive, nation-wide screening system. The dangers of over-generalizing a model which may be relatively satisfactory in one realm to other, inappropriate realms cannot be overstressed.

State Behavior

The physiological and psychological state of the infant and child at the time of testing, that is, the degree of wakefulness, alertness, anxiety and attention is an important confounding factor in all screening and assessment efforts and frequently has been overlooked. Thus it is possible that a low score on some screening or assessment procedures may not be a function of some deficiency, but rather a function of the child being in a state inappropriate for that assessment at the time. The issue of the strange surroundings must also be carefully considered in relation to the child's degree of comfort, and therefore test-taking ability.

Developmental Issues

Screening cannot be a one-shot testing session on a parameter that is developmental. There is a great deal of misunderstanding about developmental issues in children, and about the constant change in their developmental capacities. In addition, infants and very young children are difficult to screen and assess definitively because of the wide range of normal inter-and intra-individual variations as they rapidly grow and develop.

Lack of Predictive Validity

Developmental screening in the traditional sense cannot be used to predict future potential, because of the nature of "intelligence", because of the limited number of items on such screening devices, and because of the difficulty of standardization using different ethnic, socio-economic and educational backgrounds of children and families. Such procedures should be used only as observational descriptions, by thoroughly trained examiners, which would then lead to plans for educational and remedial intervention for each child. Stability of intellectual functions is very probably in large part a function of environmental stability, and in no way may one predict how an individual might do when the environment is radically modified toward greater enrichment or deprivation. The predictive validity of developmental screening devices is thus very poor, based on issues of environmental stimulation or interference.

Problems of Personnel

Since children of pre-school age are frequently shy with strangers, in a new setting and with strange tasks, the skill of the examiners is an especially important issue. In many cases, bilingual competence will be crucial, as will be a thorough knowledge of the expectations of each ethnic group for their children. Programs to develop personnel with such skills, and to train, re-train, do periodic proficiency checks and constant supervision are extremely costly.

The "Treatment"/intervention System

The basic question of having a detection system when no "treatment" is available must be faced. If screening and then full scale assessment do not guide some form of "teaching" process or intervention system, why do it? Improvement in the health status of poor children requires meeting ~~a large~~ volume of unmet need for health care as well as changes in environmental, social and other factors that affect health status, but are outside the scope of a reimbursement and support system related solely to health services delivery. This is a crucial point, particularly in the area of "mental defects". Many developmental "defects" are social, educational or nutritional. Unfortunately the required services are not eligible for reimbursement under the current Medicaid system. The Federal appropriation for Medicaid does not include, and State Medicaid agencies do not have, funds that can be directed toward development of health care resources, whether manpower, facilities, or equipment, or toward research and demonstration efforts, specifically for the purposes of EPSDT.

When a satisfactory comprehensive developmental screening system has been field tested and thoroughly debugged, it is only useful if it plugs into practical intervention programs. The implementation of early childhood intervention through EPSDT has enormous potential for impact on the health, mental health and welfare of the entire country.

3. An Approach to Developmental Review

Given that the process of developmental review is more appropriate than that of screening, it becomes apparent that such developmental reviewers must, of necessity, engage the parent or other caregiver as a significant aspect of the review process. Thus, in order to accomplish the goal of reviewing the development of the child and the concomitant strengths and weaknesses, the assistance of the parent, or other caregiver must be engaged. Any such review process must make vigorous efforts not only to engage the caregiver in the review process, but must also be alert to the psychological dynamics of the review process, such as the natural ambivalence to intrusion into the family and consequent concern about adequacy as a parent or caregiver. Any such developmental review process should, to the maximum extent possible:

1. Avoid coercion, such as mandating that the developmental review be a condition for a survival need such as a welfare payment.
2. Provide for significant benefit participation in the form of a better understanding of the child, with the aim being to provide assistance to the parent in coping with developmental problems, rather than the anticipation of criticism for inadequate parenting.
3. Recognize the ethnic, cultural, social, and linquistic differences that exist in a pluralistic and culturally and ethnically diverse nation such as the United States. The developmental review process especially the interpretation of the findings of such a review, must make a vigorous effort to insure that such differences are recognized, respected and incorporated appropriately.
4. Insure that there is adequate provision for an interpretation and review of the findings with the parent, taking into account the strength as well as the weaknesses of the child, and insuring that the interpretation is, to the maximum extent possible, of practical benefit to the child and parent in the facilitation of future development.

Thus, the process of parent "engagement" is viewed as a primary prerequisite for any adequate developmental review, and as a *sine qua non* of the adequate implementation of such a program.

Developmental Review

Given an extensive review of currently available materials, it is strongly recommended that no single instrument for developmental assessment be mandated nationally. There is no one single instrument, inventory, or assessment tool that is totally satisfactory. Any instruments used must meet the criteria discussed below. At the current time there is no one instrument that meets such criteria. There are a number of assessment tools that might serve as prototypes of approaches to the adequate conduct of a developmental review, and the criteria for such exemplars are discussed in the following section. It is also strongly recommended that the system of developmental review herein discussed be clearly recognized as a system for developmental review, not simply a piecemeal approach. We strongly urge that this system of review be adopted and implemented, and that appropriate guidelines and regulations be developed for its implementation.

In essence, the system of developmental review proposes that an adequate review would include factors for these areas:

1. biological dimensions
2. psychological dimensions
3. family dimensions
4. environmental social cultural elements.

The review should be carried out in three stages:

Stage One

The biological dimensions would be reviewed within the framework of the pediatric physical examination. The basic sampling from the biological domain would be conducted as set forth in the guidelines for the pediatric examination of the American Academy of Pediatrics. It is further proposed, however, that the pediatric examination be slightly expanded to include an opportunity for the child and family to discuss, if they so wish, any characteristics of the family situation that they identify as causing stress and problems, as well as to identify strengths and support systems that assist the family in its coping behaviors. Some sample questions that might be added in the course of the pediatric examination and health history are:

Who is in the family unit?

- How are the key relationships functioning (parent/child, couple, child/child)?
- Are there health and/or social or emotional problems that are of concern to the family?

This opening of an opportunity to review problems and assess strengths and support systems with the health personnel allows for further engagement and child/family development.

The second area to be covered in Stage One review is an assessment of the child's functioning based upon the parent's report. This would provide an opportunity for the parent, alone or in interaction with the health personnel, to comment on the child's developmental progress and on issues relating to behavioral adjustment, temperament, coping capacities and the like. This would involve two sub-sections:

1. A parent report (interview or inventory) of the child's developmental skills (motor, language, etc.) that would provide a developmental profile of the child's functioning.
2. A parental report (interview or inventory) of the child's adjustment and emotional and behavioral status.

Both of these reports may, according to local option, be developed as structured inventories which would permit review of changes over time as the child is followed in the health care system. The use of structured inventories would also allow paraprofessionals a key role in gathering this information.

Stage Two

On the basis of the informal observations of the person doing the health examination, and on the material from the parent questions, the parent inventory covering developmental areas and the parent inventory covering behavior, it would be decided if there were a need to refer a specific child to Stage Two. In Stage Two there would be direct structured observation of the child's functioning. This might be accomplished using a variety of broader developmental screening inventories or instruments that are currently available. Paraprofessionals might then be trained to administer these screening inventories, if interpretation of results and constant monitoring of reliability were the responsibility of more highly trained professionals.

Stage Three

Based on the findings from Stage Two a child might be referred to a Stage Three assessment of functioning. This stage of the developmental review would include aspects of the four domains listed above: biological, psychological, family and environmental/social/cultural.

In the *biological domain,* one might envision a child being referred for careful neurologic assessment, or for an extensive physical examination and review of health history. The health history, as specified in the guidelines of the American Academy of Pediatrics will also yield a great deal of pertinent information on development.

In the *psychological domain,* the recommendation is that an adequate developmental review cover behavior representative of a wide variety of functions:

Cognitive Development

Cognitive Skills
Judgment and reasoning processes (as opposed to outcome)
Memory
Interest and skill at gaining information
Information about the world
Integration and organization
Attention, persistence

Coping Strategies

Characteristic patterns of dealing with tasks
Motivation

Social Development

- Relation to adults
- Relation to children
- Self-help and adaptive skills
- Concepts of responsibility and moral dictates

Emotional Development

- Affect expression and control
- Self-concept, self esteem
- Body image
- Individuation
- Concept of competence

Language and Speech Development

- Receptive language; language comprehension
- Expressive language
- Articulation
- Fluency

Auditory Perception

- Discrimination
- Auditory memory

Visual Perception

- Visual
- Visual motor
- Visual memory
- Visual integration
- Visual sequenceing and reasoning

Physical Functions

Movement, mobility
Gross motor
Fine motor

In the *family domain,* one might use any number of currently available family stress inventory outlines. One would, in addition, be investigating the issue of what familial factors are available to support the healthy development of the child. One would like to know about parenting issues such as: do the parents feel they understand the child, do they accept the child as he is, do the parents feel in control of the child or is he "beyond" their control, and do they essentially trust the child. A variety of economic, historic, and human relationship issues might be reviewed for their strength-giving aspects in child development.

It must be emphasized that the identification of emotional and behavioral difficulties, and problems with social development or parent/child interaction, should be left to parental or child-initiative and sensitive clinical observation. Clinical inquiry as it is normally carried out with parents and children by a skilled professional must be employed at this stage. *The use of a systematized standardized procedure inquiring into these issues is ethically unacceptable.*

In the *environmental/social/cultural* area, one is essentially again looking for the factors to support the healthy development of a child and family. Particularly pertinent here would be the support of community institutions such as schools, hospitals, churches, recreational facilities, and the entire child-care/day care system.

It should be emphasized that at every point in the developmental review, the orientation is toward the child's competencies and forces which are facilitating or could facilitate the child's development.

Is Intervention Necessary?

The final question, of course, is "is intervention necessary?" The entire developmental review is a process of attempting to understand in successively finer terms the situation of the child and family that would lead to positive action. Numerical results of test items are only one very small part of the picture. The process by which a child arrives at a result is crucial.

One must observe with all clinical skill issues such as working method, attitude, motility, interest span, curiosity, how a child understands his environment, those around him and his own relationships to them. The ethical dilemma of reviewing a child's development, without reviewing the parent/child totality when this is intrusive, but crucial to adequate investigation, must always be raised. It is in this area that some of the basic disagreements of the group were raised. What is clear is that this clinical assessment must be allocated to people highly skilled both in child development and in working with parents, having a very high sensitivity to what to appropriate and what is inappropriate with any specific person. It is for this reason that any extensive review of a child's development must be done by someone with great clinical sensitivity. A true comprehension of what the clinical process is must be conveyed to all people involved in developmental review so that a very clear understanding of the difference between Stage One and Stage Two material as contrasted with Stage Three, the usual diagnostic state, is available. "Screening" is not just faster and simpler; it involves an entirely different process of understanding.

As will be noted, no specific list of tests, instrument or observation schema have been included. It was the feeling of the group that no such list should be made available since it would automatically signify to people seeing the report that these instruments were "acceptable". Two points need to be made: first, that one of the basic areas of disagreement covered the use of instruments acknowledged to be inadequate, simply to have an instrument, and second, that *it is clearly necessary that we do develop instruments in order that the developmental review may be carried out most adequately*. The recurrent theme in reports and discussions is that while it is earnestly desired that there be a uniformly acceptable set of review procedures, relative to psychometric validity, norms, cultural ethnic validity, etc., there simply is no such set of procedures currently available. It is the hope that such a set of procedures might be developed, and it is strongly urged that the Medical Services Administration take a leadership role in establishing task forces and demonstration projects to do just that.

It has been noted earlier that while there is not, at the present time, one single fully acceptable tool for developmental review of the psychological domains of cognition, emotion, perceptual-motor functions, or language, there are procedures that have reasonable utility to selected aspects of the developmental review process and are acceptable in certain situations. Any tool must meet acceptable criteria for use. The following criteria are proposed for instruments to be used in the different stages of the developmental review process, whether the review is direct, with the child, or indirect, through the parent or caregiver:

1. Acceptability of the instrument, and its content, to parent, child and professionals;
2. Standardization norms appropriate to the population to be reviewed; to include at least the following: age, sex, race, socio-economic status, and geographic area;
3. Demonstrated instrument reliability;
4. Demonstrated instrument validity, through standard correlation techniques;
5. Demonstrated concurrent validity;
6. Amenability of the instrument to administration and scoring by trained paraprofessionals, if it is to be used in Stage One or Two;
7. Cost effectiveness;
8. Instrument must be published, and widely available.

Given that the instruments to be used are in conformity with these criteria, and with appropriate consideration for cultural, ethnic, racial, and socio-economic factors that may influence interpretation of the findings from the developmental review process, this proposed system of developmental review has the following desirable characteristics:

1. It does not attach a label, or categorize, a child prior to a much more extended review, referred to as a Stage Three developmental review;
2. It makes a dedicated effort to engage the primary

caregiver, the parent, as a collaborator in the developmental review process, and attempts to insure that the interpretation of the findings of the developmental review are culturally relevant, as well as psychologically sound;

3. It establishes definitive criteria for any developmental review instrument to be used, recognizing that the present state of the art does not admit of a single universally acceptable instrument that is applicable to all of the culturally diverse and pluralistic populations involved in the EPSDT program, some twelve million American children;
4. It attempts to establish a brief, workable system of developmental review, that is functionally effective, both in terms of cost and benefits, with, hopefully, a reasonable guarantee of acceptability to both parents and professionals; and
5. It recognizes that there is not, at the present time, a single, universally acceptable tool for developmental review, while at the same time pointing out that there are a multiplicity of such instruments that have practical utility in differing situations, oriented toward review of individual and specific developmental functions.

It should be constantly emphasized that everyone is strongly opposed to any effort to attach "labels", or to make a diagnosis of the child during the first two stages of developmental review. The purposes of the initial review are to engage the parents in a collaborative effort to assess the process of the child, and to identify areas in which process has been perhaps problematic or, alternatively, to identify areas of special gifts that might be enhanced through facilitative efforts. The first two stages of review would not attempt to categorize or "label" children; rather, the system of developmental review would be devoted primarily to determining whether, in fact, there is cause for concern and if so, what further efforts must be made to determine whether the concern is valid or merely reflects transient and not continuing problems. Given this orientation, the question of false positives false negatives is moot.

The relevant question might be posed as follows: "Is there sufficient consensus between the developmental reviewer, the parent, and the child (in the case of older children) that there is need for further review?" If the answer is affirmative, then the recommendation would be that of referral for Stage Three review. It is to be noted that the assumption is that Stage One review (other than the health examination in some locations) will be done by paraprofessionals, while Stage Two would be most likely a combination of professional/paraprofessional efforts, i.e. the administration but not the interpretation of the developmental review instruments will be conducted by paraprofessional personnel at this stage. Stage Three must be carried out by experienced and skilled professional clinicians. On a concrete level, it is recommended that whenever the performance of a given child at Stage Two deviates by more than 20% either above or below what would be expected for chronological age norms for that particular developmental review instrument then the findings from the developmental review for that child should be assessed to determine whether a Stage Three referral should be made, or in the case of a child who has special gifts, to make special efforts to assist parents in seeking out means to facilitate the special talents. It is to be stressed that this proposed method of identification of children who may be at risk for developmental difficulties is both empirical and objective, and does not "label" or diagnose a child. Rather, it simply indicates that optimum developmental progress is either not occuring or is occuring at an accelerated rate. Thus, the system of developmental review as proposed recognizes that there may be strengths as well as weaknesses, and moderates the search for pathology that is the hallmark of other systems of developmental assessment.

It should be pointed out that the areas of basic disagreement were four:

1. Any review of the adequacy of parenting skills was an anxiety provoking area for many. This is discussed in fuller detail in the section on legal and ethical considerations.
2. Using instruments that are acknowledged to be inadequate, simply to have an instrument, was a further area of disagreement.
3. The absolute need not to make up lists of "approved" tests was felt strongly by many. It is suggested, however, that it would be possible to supply a list of tests

currently available with information on how they meet the criteria of appropriateness reviewed above. A separate task force could do this in a brief time, making the point always that the situation is much more complicated than many people believe.

4. In terms of the content of screening instruments, the question of whether we are ready to move from small scale to country-wide on any available instruments was an issue. The vast social implications of what we do were constantly before us.

4. The Role of the Parent

Clearly underlying the approach to developmental review suggested herein is the premise that a child's cognitive and emotional functions do not develop in vacuo. Although this appears to be a truism, it is unfortunately also true that this "truism" rarely informs the development of programs.

Health care is often delivered without the involvement of the parent. Our belief in the importance of the "engagement" of the parent in the system, in the use of information from the parent in the developmental review, and in the involvement of the parent in the full-scale treatment programs should be stressed.

> Relationships between parent characteristics and child health and child development and the greater long-term effectiveness of parent centered as contrasted to child-centered early education programs suggests that child health programs should have a major goal of supporting family care of the child. A comparison of major characteristics of parental as contrasted to professional interaction with the child—priority, duration, continuity, amount, extensity, intensity, pervasiveness, consistency, responsibility, and interfamily variability—suggests the need for a major focus on the role of the parent in the EPSDT program. Traditionally parents have had primary responsibility for the integration of screening, diagnosis, and treatment services for their children. Parental cooperation with health workers is essential in order to make EPSDT services available to their children. There-

> fore, a major component in planning State and local EPSDT programs will be to develop communication and collaboration with parents and with parent groups.
>
> To achieve the needed collaboration between health and welfare professionals and parents will require training of both parents and professionals. Health and welfare professionals should understand the role of the family in child health and should have skills in strengthening and supporting as well as supplementing family care of the child. Workshops and inservice training programs for health and welfare workers on the conceptualization of family care, on variables that influence family care, on the relationships of parental care to child health and child development, and on new methods by which professionals and paraprofessionals can strengthen and support parental care of the child are needed. The programs should motivate increased collaboration with parents in providing for the needs of children. Programs that train and motivate parents to become involved with review of developmental progress and with diagnosis and treatment through outreach programs, followup programs and continuing home visitors programs are essential to insure early and continuing care of the child. (Schaefer, 1974)

In developing a parent questionnaire, it is obvious that the questionnaire must not be trivial, must have developmental implications, but most importantly, must have crosscultural validity. There are in the United States a number of such parent questionnaires currently being used.

A second area of important contribution of parents to developmental review is the review of the family environment. The purpose of this is to describe the characteristics of the family and the social and economic circumstances in which it finds itself, in order to identify the stresses and the strengths and support systems available to the child. Some questions which might be added to the physical examination have been discussed in Stage One screening. In addition to this there is the possibility that, with parental approval, a local group might choose to add considerations of a more extensive sort in understanding the family support system. Under these circumstances, an approach such as that suggested by Mercer in discussing measures of sociocultural modality might be accepted:

1. family structure
2. Anglization
3. occupation of head-of-household
4. family size
5. parent/child relationship
6. sense of efficacy
7. source of income
8. urbanization
9. community participation.

Some local areas may choose to focus on a "problem list" such as economic stress, marital discord, parent depression, and the like. There are several family stress questionnaires currently available.

It is clearly essential that parents understand their children's abilities and assets as well as their disabilities and deficiencies. What a child can do is far more important than what a child cannot do. The dialogue which brings parents and children into a true health care system is vital. We must also think seriously about developing parent-based treatment models right at the beginning of the programs. This crucial aspect of health care is frequently ignored. Treatment in this area of development frequently involves educational programs for parents on how to work with their children, and educational materials about life styles and health impact on family organization. "Treatment" may be education of the parent to support the child's strengths.

A recently published review of intervention strategies for high risk infants and young children (Tjossem, 1976) reviews an entire series of parent projects. In assessing the availability of treatment resources in local communities, most frequently the most obvious resource is omitted—the parents. It is possible to help parents learn to work with their own children in a way that has been highly productive not only for the children but also for the parents themselves. It is recommended that a separate task force be developed that would collate and then make available to local communities the varying models of parent based "treatment" programs that have been developed, and also make available to these local communities the wealth of parent education material that currently exists in many scattered places. This particular use of parent education materials holds within it a truly exciting and innovative approach to health care in this country.

5. The Delivery System

Our first recommendation is that the EPSDT mandate be broadened to apply to all children in this country so that a system of developmental review and of developmental protection might be planned for comprehensive implementation.

This will undoubtedly require the establishment of guidelines for eligibility of families who will qualify to receive these services paid for by Federal funds and for sliding fee scales for other families, but we believe that the service delivery systems contributing to the goals of EPSDT ought to serve the needs of all children in our society. Primary prevention and early intervention programs should be available to all children and youth. The identification of EPSDT as being available only to poor children is detrimental to the poor and nonpoor alike, as well as to the long-term viability of the program. It also detracts from the potential of our efforts to conserve our most valuable resources for the future—our children.

There is extensive overlap in functions and goals of several existing Federal programs. In the interest of pooling resources, consolidating efforts, and effecting maximum impact, we recommend that such overlap be eliminated, possibly through mandated merger.

It is premature to say whether actually merging programs is possible or desirable, or whether EPSDT should have the key coordinating role, described below. We need to know a great deal more about how each of these programs operates, how they are administered, what services they can provide, to whom, and in what kind of setting, which are most acceptable to families and can best reach them, etc., before any decision can be made regarding the most reasonable and effective relationship of each to the other. Nonetheless, intensive efforts at coordination, collaboration and linkages must be continued and strengthened immediately.

Specifically, the Maternal and Child Health program and the Education for All Handicapped Children Act (PL 94–142) are programs having significant duplication of effort with EPSDT. A thorough review of existing programs and agencies serving children should be undertaken, with a goal of effecting such mergers as would improve our services to children and reduce duplication. Added to such a review should be programs sponsored by NIMH, NICCHD, BEH and OCD/Children's Bureau. Care must be taken, however, that existing services provided by current Federal programs must not be lost if and when a consolidation of effort should occur. For example, it would be unfortunate if the services now funded by Crippled Children's Services were lost in the "merger".

Interface of Medical and Educational Settings for Achieving the Goals of EPSDT (hereafter EPSDT refers to a merged program)

In order to facilitate the interface of medical and educational settings and, as well, social service delivery systems for the purpose of achieving the goals of EPSDT, we are recommending the establishment of an EPSDT Coordinating Office at the local level to be staffed by an EPSDT local Coordinator and supporting personnel. It will be the function of the Coordinator to insure that the screening, diagnosis, referral, treatment, information dissemination, and follow-up resources of the community be brought to bear upon carrying out the goals of EPSDT. It will be the function of the Coordinator to relate to the medical, educational, and service agency settings so that each contributes its competence in providing developmental review and protection for all children in the community and for individual children who need special services.

Developmental review and protection of the child begins during the prenatal period. Pregnant teenagers and pregnant non-teenagers need to be provided with a health delivery system that offers both medical and educational services. Through information dissemination and by relating to the schools, physicians, clinics, county health offices, welfare agencies, and individual families, the EPSDT local coordinator should work to insure that every pregnant woman is entered into the health delivery system as soon after the onset of pregnancy as possible.

Initial developmental review becomes possible in the first few days of life in the hospital setting on the basis of presenting conditions, some infants will be classified as high risk for normal development, some will be classified as suspected risk, and some as normal. Later developmental delay and disorder may be expected from all of these groups, in differing percentages. The normal pediatric exam needs to be supplemented by an additional screening instrument. None presently exists that can be conveniently implemented. However, we are recommending that, subject to parental consent, each newborn infant in a community or designated EPSDT district be entered in a birth registry and slated for periodic home visits by an EPSDT home visitor. The home visitor would be expected to make contact with the parents prior to the infant's dismissal from the hospital, to conduct or arrange for subsequent metabolic and/or blood screens that can be done in the home at 10-14 days and to offer the parents pertinent information concerning early child development and resources available in the community including clarification of the full range of services available from the EPSDT Program. If developmental problems are observed by the home visitor (as the result of general observations, parental concerns, or the application of a Stage Two developmental screening test) referral to appropriate medical or developmental services for Stage Three evaluation would be made if the parents are agreeable. With parental consent the home visitor would facilitate communication with the child's physician if the child is being served by a physician or would refer the child and his/her family to appropriate services. Home visitor's work should be under the supervision of the EPSDT Coordinator and be assigned in accordance with neighborhood or community EPSDT districts. However, flexibility in program requirements should be maintained; if lodging the home visitors with an existing community service rather than in the office of the Coordinator makes more sense for a particular community or neighborhood, such arrangements should be permitted.

The frequency of visits would be determined by a needs assessment by the home visitor. Visits to the home will continue until the child has been engaged in a system that provides health care overtime. The home visitor's role would serve educational goals, permitting developmental review to take place and would facilitate referral and follow-up. At any time, upon parental request, the home visits would be discontinued.

Public health nurses, pediatric nurse assistants, developmental psychologists, and other professionals with special training might serve as home visitors for the purpose of providing special services to the family (e.g., home based developmental programs for young infants).

At the end of the preschool period and just prior to entrance into the public school, the question of the interface with the public schools for purposes of information transfer will need to be faced. Children identified by the EPSDT program as having been recipients of services may or may not be served by having information communicated to the public schools. It will be the responsibility of the EPSDT Coordinator to arrange for service agency personnel providing services to the child to meet with the parents of the child for the purpose of making a decision concerning information transfer. Such developmental information transfer is recommended only when the information would be helpful in identifying the conditions under which a child functions best, so as to enable optimal school placement. It is our recommendation that only diagnostic information that is pertinent to educational prescription for the child be communicated to the schools, subject, always, to informed parental consent. We are assuming that normal medical information typically required by school systems at the time of public school entrance for all children would continue. As the child moves across systems or within systems, information transfer should only occur when the parent and service provider agree that it is the best interests of the child. With due consideration of age and maturity the child's consent should be included as a condition for information transfer.

During the years in which the child is enrolled in the public school, the teacher and parent are always the first line of information for developmental review. Special training programs will be recommended which will enhance the developmental surveillance and protection role of the teacher. It is in relation to the entrance into public school that the recommendation for the close collaboration or merger of PL 94-142 and EPSDT is most relevant. This "merger" of the mandates of PL 94-142, Maternal and Child Health and EPSDT will maximize the resources available for developmental protection of children during the school years. We recommend leaving to each State the implementation of goals of these "merged" mandates via interagency agreements and local coordination of services and agencies. Identification of individual educational needs should be part of an ongoing program, to be followed up by the provision of relevant services. During the adolescent years, educational or direct experiences which contribute to developmental readiness for parenthood and adulthood should be made available.

In an attempt to insure that services are made available, states should be required to outline a phasing plan for EPSDT implementation beginning with outreach and covering start up and activation of the full range of EPSDT services and providing for multiple entry points. Local EPSDT Coordinating Councils should be established with representation from the schools, health services and other appropriate agencies; parental representatives must also be included.

Recommendations Concerning Support Systems for EPSDT

Two major support systems were mentioned in the preceding section. Recommended is the creation of an EPSDT Coordinator, and EPSDT office and support personnel for EPSDT districts. Where feasible, these districts should be formed to be coincident with local school districts, or to be larger or smaller than existing school districts depending upon population density. Also recommended is the establishment of EPSDT Community Coordinating Councils (as noted above) to include the schools and all service agencies as well as including representatives of parents and service providers.

These support systems are being recommended in order to enable and facilitate 1) planning on the local level; 2) identification of gaps and needs in the service resources; 3) coordination and stimulation of services relevant to achieving goals of EPSDT; and 4) cooperation and contribution to the external evaluation of EPSDT.

As is obvious from the foregoing recommendations, there is an absolute necessity to examine any local situation prior to initiating a program. Questions involved in a health needs assessment of a community would give answers to "who is there to do it", "what are the supportive institutions", and "what facilities are available to work with parents in developing the fullest treatment programs."

The manpower issues involved in training, consultation and technical assistance are primary. To be carefully reviewed, again in each local situation, are issues of qualifications of personnel involved in each stage of developmental review, cultural appropriateness of these personnel, and their training and education. Each natural system on a local level would include not only the professional system but the highly valuable, and indeed critical, sources of information and support, the parents. The characteristics of each natural system need to be defined for each locality. *We clearly are recommending multiple models of service delivery depending on the characteristics of individuals and agencies available as support systems.* The local coordinating councils may decide on resource centers with transportation to these centers, on the use of mobile units, on the use of community college personnel, on a multitude of other mechanisms for obtaining services. Again, improvement in the health status of children requires meeting a large volume of unmet needs for health care as well as for changes in environmental, social and other factors that clearly affect health status but are outside the scope of a reimbursement and support system related only to health services delivery. For this reason our emphasis on coordination of program and payment mechanism must be taken seriously.

Existing programs which hold enormous potential are not adequately meeting the needs of America's children and families. Federal programs are scattered among dozens of departments and agencies.

> This fragmentation creates problems of coordination at best and conflict among programs at worst. At the state and local level the situation is even more confused. A wide range of services to families and children is currently being provided in an essentally haphazard fashion from many different government agencies and private organizations. Despite the sporadic attempts at community and regional planning and coordination, the result has been inadequate coverage in many localities and duplication of effort in others.
>
> Categorical, single strategy programs, while effective in meeting some of the specific needs of many families have failed to provide the support required by many families with multiple needs. In addition to programs specifically

> directed toward families and children, public policies in many areas have effects, both positive and negative, on the welfare of families. Despite this fact, little explicit attention is given to the impact on families and children of welfare, health, housing, transportation, environmental regulation, criminal justice, recreation, consumer protection, and other programs, both old and new. (Toward a National Policy for Children and Families, 1976)

The Parent and Support Systems

To be emphasized repeatedly in this approach toward coordination of services at a Federal and local level is the role of the parent.

> Support not intervention for parents of young risk children has emerged as the most promising available approach for producing developmental gains. Findings show that parents are effective teachers of risk children if given appropriate support. Their success in enhancing their child's development rests largely upon their motivation, involvement and acceptance of responsibility. The early relationship established between mother and infant is given as a fundamental determinant of the child's later course. With acceptance of these principles and the family as the object for support, communities can organize supportive services that enable families to enhance their risked child's development.
>
> Ideally, the approach begins in the newborn nursery. Here, both physicians and nurses are alert to sounds of early risk and show concern for the child's developmental well-being as well as health. In their appraisal, signs of risk in the early mother-infant relationship are not ignored. With evidence of risk and need for support, mother and child are discharged with an accompanying referral to be community health services for nurse support and observations in the home.
>
> In her home visit, the nurse first gives expression of the community's interest and support for the future well-being of the risk infant and family. While observant of total family needs as well as the health of both mother and child, the nurse is supportive of the mother's ben-

eficial child care behaviors. She continues her periodic visits until, after exchanges with the child's physician, determination is made that no risk or continued risk is present. With this determination, she maintains her visits and relationship with the risk child and family and terminates services [illegible]e child and family that are doing well.

In the continuing supportive relationship, the nurse extends her knowledge of child care and training to the child through the mother. For family and child requirements beyond her command, she draws upon her knowledge of community or area resources to bring them into family service. In this manner, referral of the family is made to the community's educational resource upon evidence of the risk child's needs for educational assistance in mastering the developmental tasks of childhood.

The transition from nurse and physician to education services brings with it a comprehensive understanding of the child's health and developmental status and the family's needs and strengths. Upon educational evaluation and acceptance for service, the child and family enter into the home-based training program offered by the educational resource. The individualized training program is implemented by the parents with the guidance and support of the educator. Continuing, as needed, into the preschool years, the educator monitors the family's and child's needs for adjunctive community services and assists in bringing their support to the family.

The parent approach outlined in the foregoing is but one of the many models a community might develop to provide services to risk children. To the extent that other models capture the basic principles involved, they should be effective programs. These principles restated are:

1. supportive services are initiated early
2. are offered on the basis of perceived risk and need, not diagnosis
3. are family oriented
4. support and enhance the mother-child interaction system, and
5. are sustained.

> The requirements of the basic program are modest and can be met. They exist as medical, nursing, and early educational services provided in most communities, or, in their absence, can be developed through existing agency organizations. The resources and technology are, or can be, available. The task, now, is to make them work. (Tjossem, 1976, pp. 24-25)

6. Payments and Eligibility

The coordination of services and programs discussed in the preceding section obviously dictates coordination of payment and eligibility issues. It is a strong recommendation of this group that the "merged" EPSDT Program be available to all children and families in the United States. It is also urged that funds be made available for development of health care resources, including considerations of manpower, facilities, and research and development.

In the current situation, EPSDT turnover in eligibility negates the periodic aspect of EPSDT and may deny treatment found necessary as a result of developmental review. There are lapses in eligibility and these lapses are a clearly demonstrated problem. Patients may not be eligible for services long enough to receive treatment for identified developmental problems, or their treatment may be interrupted on the basis of eligibility issues. Currently, eligibility for EPSDT depends in most states on eligibility for welfare services, and health care needs do not necessarily correspond to welfare status. EPSDT reconfirms the limitation of "means-tested medicine", and the need for a more continuous and comprehensive method of assuring the right to treatment for people whose incomes often vary widely from month to month.

7. Ethical and Legal Considerations

General Ethical/Legal Premises

In developmental review, ethical evaluations must be viewed against the backdrop of two different normative models: 1) the disease recognition and prevention model and 2) the cultural diversity model. The former emphasizes identifiable organic pathologies which imply some type of medical treatment. Within this model, the basic assumption is that false positives carry no risk aside from those associated with further diagostic procedures, while failing to detect pathology could lead to serious and possible irreversible consequences.

On the other hand, the "cultural diversity" normative model focuses on behaviors which deviate from the expectations of the social group. In this case, the basic assumption is that false positives are more serious than false negatives in screening because labeling a child as deviant tends to trigger social responses such as labeling, tracking into special programs, institutionalization, changed perceptions and expectations, etc., which in themselves may have irreversible consequences. For this reason, emerging law in the area of mental retardation and juvenile justice clearly rests on this assumption.

Thus, any developmental review system initiated under EPSDT should clearly reflect this important distinction. In our view, screening may legitimately utilize the "disease model" during the years of infancy and early childhood development when the child's primary social group is the family. In doing so, however, developmental review must focus primarily on the child's "physiological" development. Conversely, as children enter the mandated school system, when their behavior is evaluated with reference to the expectations of the social group, developmental assessment necessarily encompasses behavioral measures. and policies must therefore be formulated within the normative framework of the "cultural diversity" model.

The Scope of Developmental Review

In a free, pluralistic society, there are clear boundaries on the scope of legitimate inquiry into personal and familial concerns. Therefore a mass, government financed screening program should be limited to 1) those measures of organic functioning and basic, adaptive coping skills which enjoy a high degree of consensus within the health professions and affected communities, and 2) those behavioral factors especially associated with learning, language and speech development, motor skills and perceptual abilities. Specific assessment of emotonal and behavioral adjustment and parent/child interactions should be left to parental initiative and sensitive clinical observations (Stage Three as herein proposed).

Relationship Between Developmental Review and the Remainder of the Health Care Delivery System

1. Programs should not be instituted without careful attention to their place in the full service delivery system: coordination of services as recommended in Section E is vital.
2. A top priority is the identification of gaps in diagnostic and treatment services in each community as an integral part of health services needs assessment.
3. There must be some mechanism for assuring the quality and equivalency of all developmental review and treatment services in the community.

Relationship Between Developmental Review and Unavailability of Follow-up Services

It is not ethically mandatory to limit the scope of review by precluding a specific review procedure because treatment is unavailable for the identified condition. This is true whether or not there be known treatment at all, or treatment is not available in the community, or if available, is too costly. Reasons offered for this position include:

1. without such data, the need for the development of treatment capabilities may never become apparent;
2. the information may be useful to the provider in counseling the parent about managing the problem, and in developing parent oriented treatment programs;
3. treatment may later become available.

However, in many individual cases, it is likely that the cost of Stage Three review would be unjustified by its likely benefits to the child.

Informing Parents of Results of Screening

If the developmental review program suggests that the child is in developmental difficulty, the health professional should inform the parent of the general area of concern, being careful to avoid arousing undue parental anxiety, before recommending referral for diagnostic (Stage Three) evaluation. If the diagnosis is positive, the clinician should inform the parents fully of the child's developmental status and discuss the treatment alternatives. If treatment (or perhaps even diagnostic) services are not available in the community, then the diagnosing clinician should counsel the parent, utilizing his/her own clinical judgment in determining what information to disclose. It is, of course, also important to inform parents when no indications of difficulty are found during any of the stages of developmental review.

Criteria Governing Use of Standardized Procedures

1. We accept the view that American society is heterogeneous. Therefore, standardization of all procedures used in screening or diagnosis which are correlated with sociocultural factors must be done with appropriate sociocultural norms, and all testing must be administered in language appropriate to the language spoken by the child. Further criteria for appropriateness of instruments are spelled out in Section 3.

   After two years, no standardized procedure should be utilized in the program until it has been approved pursuant to regulations adopted by the Secretary. In the interim period, a task force appointed by the Medical Services Administration shall review standardized procedures currently in use, with the advice of appropriate professional and consumer groups, to determine whether they are correlated with sociocultural factors,

2. Each standardized procedure should have predictive validity for the behavior or conditions which they purport to measure. They must have predictive validity for children of each of the sociocultural groups with whom the procedure is to be used. After two years, no standardized procedure should be utilized in the program until it has been approved pursuant to regulations adopted by the Secretary. In the interim, the task force appointed by the Medical Services Administration shall review the predictive validity of standardized procedures currently in use for compliance with this standard.

The Ethical Relevance of Cost

Cost becomes an ethical issue when government, with limited resources, must finance services for large numbers of children and must choose to what extent which children can and will be served.

Although reliable cost estimates are presently not available for screening, diagnosis and treatment for EPSDT children, it is clear that such procedures should be as low cost as possible with the highest return.

Considering these premises, we suggest the following guidelines for priorities for the EPSDT Program:

1. Priority for care should be targeted to the prenatal, infancy and clearly childhood periods until the child reaches the mandated school entry age.
2. Stage One and Stage Two review procedures should be as quick, brief and simple as possible without sacrificing quality so that as high a proportion of funds as possible can be put toward treatment.

Informed Consent

1. Parents
   a. As an integral part of the initial outreach phase of a developmental review effort, parents should be

provided with a written description of the nature and purpose of the proposed procedures, including adequate assurances of quality, confidentiality and benefits to the child and family. Any written notification should include information in a language appropriate for that particular family.

b. At the time the parent personally appears, he or she should be verbally informed of the nature and purpose of all developmental review procedures, and should be notified that selective participation is possible. A refusal to authorize any given procedure must not jeopardize the child's access to any other aspects of the program. Parental consent should then be obtained for each procedure and for any proposed transfer of records or information upon completion of the developmental review.

2. Informing the Child

Each child being served should be informed of the nature and purposes of the procedures and their results to the maximum extent possible consistent with his or her level of intellectual and emotional maturity.

Records and Confidentiality

All patient records should be created and maintained in accordance with the customary practices of the health professions. Confidentiality should be carefully preserved and no information should be released without parental consent.

At the time of the mandated school entry screening, all records of earlier developmental review at time of birth, during infancy, or at time of pre-school entry would be consolidated by the EPSDT Coordinator. It will be the responsibility of this Coordinator to arrange for service agency personnel providing services to the child to meet with the parents of the child for the purpose of making a decision concerning information transfer. Such developmental information transfer is recommended *only* when the information would be helpful in identifying the conditions under which a child functions best so as to enable optimal school placement. It is our recommendation that only diagnostic information that is pertinent to educational prescription for the child be communicated to the schools, subject always to informed parental consent.

1. Under no circumstances should Stage One and Stage Two information be transferred to the school system.
2. "Medical" information from these records may be disclosed to authorized persons in the educational system with parental consent in accord with usual procedures.
3. "Screening information" per se should not be disclosed at all.
4. Additional information from the records may be disclosed to authorized persons with parental consent only after the EPSDT Coordinator has consulted with the parent and they have made an independent determination that the disclosure is in the child's best interest. With due consideration of age and maturity, the child's consent should be included as a condition of information transfer.

Ethical Aspects of Developmental Review and Assessment After Mandated School Entry

Many of these ethical and legal concerns about the purpose and scope of developmental assessment, informed consent, parental and child roles and confidentiality of records are especially acute after the child has entered the school system. This committee recognizes the school as a major point of impact on the child's development at this stage of his life. We also recognize our mutual concern with the critical aspects of a child's development at this point, since much of this development affects school adjustment and learning ability. There are some safeguards built into the education system to address our concerns for safeguarding the child's rights (such as the Buckley amendment) and more will doubtless come with implementation of PL 94-142. Nonetheless, the EPSDT Program should not abdicate nor delegate its responsibility for the children because they have entered the educational system. It requires instead that the criteria outlined interface with the safeguards in the education system, and buttress it when there are gaps. In fact, the "merged" EPSDT with its concern for the over-all health and well-being of the child, should feel that its responsibilities may supersede the requirements of the education system whenever safeguards for the child's rights in these processes are concerned.

The Dangers of Labeling

> "It would be unconscionably myopic to entirely overlook some of the larger societal issues inherent in any national massive screening system. The legal ethical and ethnic ramifications of labeling humans are to be carefully considered and respected, especially in light of the recommendations forthcoming from the 1971 President's Commission on Mental Retardation in Monte Corona, California which severely criticized current labeling practices and their subsequent dehumanizing efforts. For example, the determination of cutoff points separating normal development from abnormal development is extremely controversial and the Boston conference focused much discussion and debate on this crucial issue (PCMR, 1973.)". (Meier, 1973)

In a working paper prepared for the National Advisory Committee on Classification of Exceptional Children, Mer[illegible]er addresses this normality issue:

> "The classification of exceptional children has become a critical social problem because those ethnic and cultural groups disadvantaged by present classification systems are protecting the taken-for-granted value frame within which psychologists, educators, and test makers have been operating. The classification of exceptional children did *not* become an issue because psychologists, educators and medical practitioners were dissatisfied with the present system. This fact has great importance to the deliberations of this committee. It signifies that the central issues are conceptual and ethical rather than technical and empirical. It means that basic assumptions are

> being challenged. The committee must be willing to examine basic assumptions and to address the fundamental value of questions being raised by those who take issue with present policies and procedures. If, instead, the committee treats its task as merely setting guidelines for establishing the reliability and validity of measurement techniques in their traditional sense, its work will have little relevance to the current controversy because it will have misunderstood the nature of the controversy. The value issues must first be clarified and the implications of adopting a particular value frame explored." (Mercer, 1972b)

We would call attention to the crucial nature of this statement for implementing the provisions of EPSDT, for beyond the ethical issues lie the dangers of legal action. Test results are used for making far-reaching decisions about children. In recent years, a growing controversy regarding the use of tests has blossomed. It has become increasingly apparent that the large scale use of tests for placing persons in social, educational and economic niches has serious social consequences, particularly in light of the growing realization that standardized tests are unfair not only to the culturally different and the socio-economically disadvantaged, but also to the bright unorthodox person and the naive individual who lacks experience in taking them. There are potentially biasing effects of ethnicity, language, socio-economic level, and conditions of test administration on test performance. "Increasng social demands seek to modify existing uses of tests that are inappropriate and unfair, particularly with minority group children. Social pressure in this regard takes various forms, and principally includes litigation, action by professional and other types of organizations, and legislation." (Laosa and Oakland, 1974)

The messages that a child receives about himself from his environment determine to a great extent his feelings about who he is, what he can do, and how he should behave. Thus, if parents or teachers perceive children as different in some way, they will treat the child differently and may thereby encourage him to become as he is perceived. Teachers give the least acceptance and support to children they perceive as having the least promise and the least backing from parents. Teacher contacts with "low assessment" children tend to be significantly more directive and discouraging of initiative and spontaneity. When adults believe a child to be incompetent, they may protect him from exposure to experiences from which he may learn greater competence. Learning is heavily involved with the expectation that one is able to learn.

Specific Minority Issues

There is a prevailing attitude, based on economic considerations in many minority groups, that one ignores all conditions which do not cause pain. One of the major issues in any comprehensive system of developmental review is: what form of outreach must be designed and employed which will impact upon the pattern of health facility non-utilization which is so firmly established within poor minority families, and which interferes with the early detection of factors which may potentially lead to poor intellectual and emotional functioning.

Why Our Fears Will Not Be Stilled

The perhaps repetitious insistence on the appropriateness of instruments and the inappropriatness of labels comes from the experience throughout the country of harm that has been done to children under the guise of "doing good." Children have been tracked and labeled, excluded from school, on the basis of the use of psychological instruments. In addition to this, the issue of parental and teacher expectation is a daily consideration. Children taunt each other, and guilt and anxiety are easily aroused in both children and families. The basic rights of children must be considered in any program of developmental review. The *motto must always be "first do no harm"*. In the EPSDT system, there is the potential for enormous good.

8. Evaluation

Program evaluation is a highly specialized field; it is recommended that specific guidelines concerning program evaluation be developed by a task force of experts who have specific competency in this area. We caution that this must be done quite soon, so that elements considered essential to proper program evaluation be included in those programs now in the process of implementation.

Evaluation of EPSDT should be done in relation to specific, predetermined process and outcome measurements. An effort should be made, however, to insure that the evaluation of the developmental review segments of EPSDT does not itself become the controlling factor in the operation of the EPSDT program where such control would deflect the program from achieving its goals. Any evaluation program to be implemented must be done so with a minimum of paperwork and with the least distortion or interference in the operation of the program.

Process evaluation would be relatively easy to implement since it involves such matters as utilization, cost issues, volume of service and so forth. Outcome evaluation is much more difficult and more demanding, but must be done since the issue of long-term predictability of any aspect of developmental review is one that is crucial for the future of the children.

9. Cost Effectiveness *

Any publicly financed health program begins with the assumption that it provides benefits which are an adequate return on the investment of public funds. Otherwise, the government need not institute a program at all. It could let the market place regulate health care without interference. During the past forty years in the United States the government has gradually increased its share of payment for personal health services. In child health, the government paid out 3.5 billion dollars in 1973 for welfare recipients and the medically needy, which has thereby become the major governmental child health program in both numbers of recipients and dollars expended.

The history of the federally and state financed Early and Periodic Screening, Diagnosis, and Treatment Program indi-

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* This section has been adapted directly from the working paper written for the conference by Anne-Marie Foltz, "The policy dilemma: screening and cost effectiveness".

cates that it was established on the overall assumption that early detection and treatment of disease will save lives, save suffering and save the costs of life-long crippling conditions. Further, it was assumed that screening and early detection of disease can alter the natural history and course of a disease and that the benefits of this alteration can be quantified in dollar amounts. These cost-benefits assumptions were never fully documented so it is difficult to know precisely what were Congress's expectations when it passed the law in 1967 (P.L. 90–248). Thus, an evaluation of the program based on congressional goals is not possible simply because these goals were never clear.

In actual fact, despite the grandiose title of the program, it was planned and implemented in such a way that prevention and screening have been the focus, while diagnosis and treatment have been secondary if not neglected. Continuity of care has remained a distantly hoped for goal.

It was hoped that the burden of handicapping conditions would be removed by providing preventive care services for children. The Department of Health, Education and Welfare thereby thrust itself in the midst of a major debate in the field of medicine and public health which has been described as medicine's great schism: prevention versus cure.

Not only has there been no discussion of exactly what was to be prevented through the new program, there was no commentary on how effective a preventive program might be. Given this imprecision of purpose, it is no wonder that costs of these programs were even less clearly stated.

One way of controlling costs in implementation is to limit the extent of services that states are required to provide. In monitoring the programs in the states, HEW decided to focus its attentions on EPSDT and not to look at the overall care rendered under Medicaid to welfare and medically needy children.

The efficacy of disease management through screening rests on three necessary conditions: a knowledge of the natural history of the disease; the efficacy or efficiency of the treatment; and agreement on a large number of social and individual benefits which may accrue from the screening procedures. For screening to be efficacious, there must be a consensus on the social and individual benefits of the treatment procedures, and it is here that the developmental screening aspects are most vulnerable.

Few cost estimates have been made of the developmental screening components of the EPSDT program, particularly in relation to benefits. In the past, the issue of quality of care as measured by appropriate utilization has been constantly confused with the issue of costs. Sometimes costs are evaluated; sometimes costs are noted only in terms of the substitution of expensive services for less expensive services into contrasting organizations of health care. Costing out the EPSDT program and assessing cost effectiveness has received far less attention than studies for the Medicaid population as a whole. As in the case of developmental screening, the state of the art of cost effectiveness is not far advanced. Almost no work has been done on cost effectiveness for any system of developmental review; cost effectiveness itself may not be highly relevant if the goal is to provide children with relevant and promotive access to health care. A "merged" EPSDT, seen as a comprehensive care program, provides a basic package of health services which should be available to any child in the United States regardless of his economic status.

One does not need cost benefit analyses to prove that poor children should have access to the same health benefits as rich ones. Nor does or should one need cost benefit analyses to decide that children with crippling conditions deserve care. The analyses become useful, however, when, given limited resources, policy makers must decide how much of what sort of care can be given to how many people.

EPSDT's significant contribution to the field of child health has been to uncover the present health system's inability to provide comprehensive and continuous health services for poor children, even given a financing mechanism. The reasons for this failure are diverse:

1. The state of the art of preventive health services, particularly with reference to developmental review: disagreement among health professionals as to what is required and what is needed.
2. The inability of organized systems (state health or welfare departments) to monitor and follow all children under their care: the lack of case management systems.

175

3. The unwillingness of private health professionals to participate in a public health system unless adequate financial incentives are provided and bureaucratic dis-incentives are removed.
4. Confusion among federal and state agencies as to which group is responsible for child health (for example, Maternal and Child Health, Medical Services Administration, the Office of Child Development, etc.).

Research must be continued to provide answers to cost issues, and to develop appropriate systems for collection of data to estimate costs and benefits of publicly financed child health programs. The goal is, obviously, to determine the most economically feasible methods to deliver services without sacrificing quality.

The field of policy is extraordinarily important. If Congress meant what was stated in the EPSDT legislation, to make comprehensive care available for every poor child, then it must follow through on its promises and abandon cost effective approaches which subvert the intent of the policy.

10. Training, Research and Demonstration Projects

The proper implementation of EPSDT across the country will require the development of training programs in order to increase the sophistication of professionals in the area of normal development, developmental review, and opportunities for the developmental protection of children. Therefore, we recommend that there be an expansion of existing sources of funding so that training programs necessary for existing professionals who will contribute to the achievement of the goals of EPSDT may be made available. We include in the group of eligible professionals: physicians, nurses, teachers, psychologists, social workers, school counselors, and speech pathologists and audiologists. Training programs should be carried out by existing accredited training resources and institutions (for example, universities, state colleges, community colleges). Training could be offered in the form of workshops, courses, seminars, and inservice training programs. We also recommend that training funds for paraprofessional personnel be made available on the assumption that Stage One and perhaps Stage Two of the developmental review process will be carried out by such personnel, and on the assumption that a great deal of the parent support work will also be carried out ultimately by paraprofessionals.

We urge increased effort to sensitize physicians and other health professionals to the problems of parents and to the problems of ethnic diversity within this pluralistic society. We also urge that health professionals be trained to offer increased support and counseling to *all* families.

It is crucial that members of different professional groups be sensitized to the ways that their colleagues in other professions view the world. The training of any "bridge" person must include knowledge not only of the procedures used in the various professions that are being bridged, but also the institutions in which they are embedded and the professional culture that surrounds them. Some of this can be acquired by exposure to other professionals but the understanding of it that is essential to effective collaboration probably depends on a more explicit examination of it during training.

We will gain little if we establish new bureaucratic structures without careful consideration of the qualities of the people who will make up that structure.

In order to achieve the goals of EPSDT, special resources for developmental review need to be created to supplement the kinds of assessments typically done by physicians. The nature of these special resources primarily are trained personnel. Such personnel should have a very firm grounding in normal child development, should have extensive skills in using developmental evaluation techniques, should know something about the arena in which physicians operate and similarly should have some familiarity with the nature and requirements of effective educational settings. They must also know about parents, about families, their ethnic and economic diversity, and the realities in which they live currently in our society.

Data Available

It is strongly recommended that there be constructive use made of data already available from past projects such as the collaborative studies, in order that we may become much more sophisticated about issues of longitudinal prediction.

As has been noted repeatedly in this report, we recommend research and development or demonstration projects to develop measurement standards appropriate to the assessment of young children. There should also be research into methodology of developmental review of young children with emphasis on the variety of assumptions and theories related to age and ethnicity.

There must be the development of strategies for the simultaneous selection of measurement variables and the identification of program needs, for the establishment of research, development and evaluation priorities. There must be an emphasis on the overlap between research and consumer priorities. In addition, there must be provision for taking into account family needs and values in the conceptualization of measurement related problems, and in the development, selection and application of any measurement or other instruments. Parents and those directly responsible for the welfare of the children must be involved in all decision making processes in this area.

The focus in interpretations of assessment must always be on individual differences that will lead to appropriate intervention for each specific child, as opposed to a focus on group differences and comparisons.

Any instruments that are developed must describe capabilities and limitations for which some form of intervention, including parent education, may be prescribed, as opposed to tests or instruments that are interpreted only in normative terms.

There should be developed a multi-measure, multi-domain, multi-function collection of measures from which instruments may be selected at a local level, by local option.

One of the most important issues in evaluation must be the inclusion of a search for possible positive and negative side effects of any system of developmental review on children and their families. This would include an investigation of any problems associated with potential "labeling" as a consequence of the administration of any of the aspects of developmental review herein recommended.

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EXAMPLES OF DEVELOPMENTAL REVIEW IN EPSDI SETTINGS

As one component of the total EPSDI assessment, the developmental review will take place in the variety of settings in which EPSDI services are conducted. These can be basically described as: (1) free-standing EPSDT screening sites, (2) private physicians' offices, and (3) comprehensive health care centers such as community health centers. The procedures recommended in "Developmental Review inthe EPSDT program" lend themselves to each of these program designs. The brief sketches which follow are examples of how the process would flow in each setting.

MODEL 1. FREE-STANDING EPSDT SCREENING SITE

In this setting, Stage I may typically be accomplished when the child and the accompanying responsible adult (hopefully a parent) are seen by a first line staff person, perhaps a nurse or a paraprofessional, who takes a health and developmental history. In this interview, the worker also uses the opportunity to reemphasize the goals of the program in terms of preventive health care and strives to allay any anxiety on the part of child or parent as to what is to follow and to create a supportive atmosphere in which there is a clear opportunity to fully share impressions about the child's growth and development. In the conrse of this interview, the worker should utilize a brief check list (parental inventory) to gain the parent's assessment of the child's development, both strengths and weaknesses. For some parents this may also serve as an opportunity to raise questions about their perceptions of this child and of their own responses to him.

In the case of an older child, obviously for an adolescent, a brief interview with the child is a part of the history taking. (The child should also be encouraged to discuss his interests, as he sees the need, during the physical examination which follows.)

The material then accompanies the parent and child into the physical examination where more highly trained personnel, such as a physician or a nurse practitioner can use the results of the parent inventory, the history, and the findings of the physical assessment to compile a total overview of the child. This full assessment of the child's development should be discussed with the parent in whatever terms the outcomes suggest as follow-up for continued good health or the need for further assessment. If further assessment is indicated (Stage II) it may be done by professionals (or paraprofessionals under professional supervision) in this setting.

MODEL 2. THE PRIVATE PHYSICIAN'S OFFICE

In a private practice where there is appropriate support staff, a procedure similar to the screening site model can be followed. Where the physician works alone, the history taking should include a discussion with the parent (and the child, as appropriate) about the child's general growth and development. This discussion, the history, the assessment of the biological dimensions during the pediatric examination, and the physician's overall impressions become determinants for further assessment (Stage II) in the office or through referral.

MODEL 3. A COMPREHENSIVE HEALTH CARE SETTING

In the comprehensive health care center there would be a wider complement of available staff on hand, including paraprofessionals, nurses, physicians, and perhaps in more fortunate locales, mental health specialists. In such a setting, multiple services can be offered, and Stage II (and possibly Stage III) evaluations may be available within the same setting. The flow of the process remains the same, however, and the same combination of information becomes the basis for a decision on the need for a referral from Stage I.

It should also be stated that case management is an important feature of services delivery in all three models. Case management assures follow-through, either to a determination that the child is no longer considered at risk or to the completion of proper diagnostic and treatment services.

Private practitioners (Model 2) may feel confident that they can complete the first two stages of the review themselves, but they should be prepared to enlist outside resources for more thorough evaluations when suspected problem areas are not within their immediate area of expertise. Such areas might include speech and language development, cognitive development, and learning disorders.

Comprehensive Health Care Centers (Model 3) should, by definition, serve as a central resource for guaranteeing a complete and broad spectrum of evaluation services, whether within their immediate confines or through referral.

The foregoing examples are intended to illustrate that the developmental review may be adapted to the normal format of EPSDT examinations with no increase in staff. In fact, in those settings now using a structures assessment, time will be freed by the developmental review, since each child will not require a full assessment.

Senator **Ribicoff**. We will take a 5-minute recess.

[A brief recess was taken.]

Senator **Ribicoff**. The committee will be in order.

Mr. Secretary, you may proceed.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION AND WELFARE

Secretary **Califano**. Mr. Chairman, I would like to read much of my statement, but not all of it, and I would ask——

Senator **Ribicoff**. Without objection, your entire statement will go into the record as if read.

Secretary **Califano**. Mr. Chairman, it is a pleasure to be here this morning to testify before this subcommittee, and before you.

For years, you have been strongly committed to the goals of this legislation in providing health care for poor children, in finding ways to deliver that health care, and in making sure that poor children receive needed health services.

Your sponsorship of the administration's bill reflects a long and deeply-held concern for the health and well-being of America's poor children. That concern dates back many years to your days as Secretary as well as to your early Senate career.

There are, indeed, in the Medicaid program a group of children called the Ribicoff children who are covered only because of your insistence on including this provision in earlier legislation.

Mr. Chairman, we believe that the CHAP legislation represents a single opportunity for productive cooperation between the Executive and the Congress. There is widespread agreement on most of this legislation. I think it can be, without question, the most significant piece of domestic social legislation and health legislation to be enacted by the Congress and signed by the President this year.

With it, every poor child in this Nation, as defined by State income standards, would be eligible to receive basic health services for the first time in the history of this country.

The Child Health Assessment Program will increase health services for those who presently have inadequate coverage, reaching 1.7 million children in families with incomes below the poverty line who either have no health insurance or are inadequately protected. It will help eliminate aspects of the current system that often cause the poor to receive substandard care, and it will put renewed emphasis on our efforts to prevent, not to just treat, disease.

The CHAP program, together with our proposed amendments, would extend medical benefits to all low-income children under the age of 21 meeting State income standards, and would provide Medicaid coverage for all low-income pregnant women meeting State income standards.

I might note that the number of women involved is 94,000, these women are in eligible because they are categorically ineligible. 80,000 of these women are married, living in two-parent families and ineligible simply because of that fact.

An important goal of this legislation is that every child should be able to develop his or her talents to the greatest extent possible. Every child should receive continuous comprehensive health services, including the preventive care that is necesary if children are to grow into healthy productive adults. No pregnant woman should be denied the prenatal care her baby needs for a healthy start in life.

These goals are too often, far too often, not fulfilled under current health programs and practices. Millions of poor children and pregnant women in this country lack even basic health care coverage.

Today, I would like briefly to summarize our knowledge of children's health problems, especially the problems of poor children. Then I will review the achievements of the EPSDT program and the shortcomings we believe that the CHAP program will help to correct.

In recent years, as you well know, we have made great strides in improving the health of children in this country. Death rates due to early childhood diseases have dropped dramatically.

For example, the death rate for children from influenza and pneumonia declined from 150 per 100,000 in 1925 to 6 per 100,000 in 1973.

Despite such gains, millions of children still fail to receive adequate health care. The rate at which infants die in the first year of life in this Nation is higher than that of 11 other nations.

When children enter school, 17 percent have defective vision and 27 percent have defective vision by age 11.

Many children receive treatment only in times of emergency accident or injury. Nearly 6 million children over the age of 17 have no regular source of health care.

Even those able to obtain care may not receive the full range of services appropriate for proper development. It is estimated that nearly 24 million children under the age of 17 have not had a routine physical examination in the last 2 years. Ten percent of children 6 through 16 have never been to a dentist.

The burden of these problems falls disproportionately on the children of the poor. Twice as many children in families earning under $5,000 have a history of chronic kidney disease as in families earning $10,000 or more. Poor children are bedridden 25 percent more than nonpoor children.

We know that prenatal care plays an important role in influencing the health of both the mother and the unborn child. Inadequate prenatal care increases the likelihood that an infant will be born premature, suffer disability, or even death.

As in the case of health problems among children, the lack of timely and adequate prenatal care falls most heavily upon the poor and upon minorities. Babies in black families are twice as likely as babies in white families to die before their first birthday. Death rates during the first 5 months of life are four times higher among infants in low-income families than those in high-income families. More than 1 out of every 3 black mothers aged 20 to 34 do not receive prenatal care during the first trimester of pregnancy.

The Department of HEW currently administers a variety of programs aimed at improving health care for children. In fact, more than $2 billion a year under medicaid alone is spent directly on the health problems of America's children.

We are committed to upgrading the quality and availability of health care in all existing programs.

Last year, for example, the President launched an unprecedented initiative to immunize an additional 20 million children under the age of 15 against childhood diseases, such as polio, measles, rubella, diphtheria, tetanus, and whooping cough.

Senator RIBICOFF. What have the results been of that?.

Secretary CALIFANO. Mr. Chairman, the results are quite good, although they are still somewhat erratic. Our objective is to immunize more than 90 percent of the children by October 1, 1979, in many States, we have increased the number of children immunized substantially; 30 of the 50 States now report levels of protection against measles and polio above the 90-percent or greater in children entering school. Several States have begun to enforce laws that were not enforced before. There has been a sharp drop in the incidence of childhood diseases, such as measles, during the first 6 months of this year.

Senator RIBICOFF. Where there are failures in reaching your objectives, what are the causes?

Secretary CALIFANO. I think that most young parents today have never seen these diseases and do not appreciate the importance of immunizing their children against them. They have never seen polio, and what it can do, for example.

Second, I think that some doctors and perhaps nurses, have not been as attentive as they might have been to the immunization records of children.

Third, while many States have laws, many of these laws have not been enforced in the past, and some are just beginning to be enforced. In Connecticut, for instance, the Governor has undertaken a vigorous enforcement drive in which the State law has recently been changed.

Maine, for example, never had immunization requirements for all the basic childhood diseases until this year. We would expect a big change there. I think that those are the main reasons.

Mr. Chairman, the current EPSDT program works as a health outreach and health status monitoring program. Under it, the States are required to make a positive effort to inform parents that their children are eligible for this service, to offer the service to them at appropriate intervals, to regularly assess the health status of eligible children, diagnose their health problems, and assure that needed and requested followup treatment is provided.

But there have been a number of serious problems. All poor children are not eligible for EPSDT. Many children whose family income is below the Federal poverty level do not qualify because the program is linked to State income standards, and many children, who meet their own State's poverty standards are not eligible because they live in two-parent families. Of over 12 million children actually enrolled in Medicaid, only 3 million children receive up-to-date assessments.

Even among children reached by the program, many do not receive needed followup care, 28 percent of all conditions found go untreated. State assistance to improve this aspect of the progr[illegible] have not been adequately developed.

Penalties against States failing to reach eligible children have been too rigid and unenforceable.

Finally, many poor, pregnant women are not eligible for medicaid because they are not yet mothers, or because their husbands live with them. Thus, their children are denied the healthy start in life that good preventive care provides.

The CHAP proposal, as amended by our submission to you earlier this year, seeks to assist States to rectify these deficiencies in a number of ways. We would require States to cover all children under the age of 2[illegible]hose family income meets AFDC eligibility standards for both screening and treatment, regardless of whether they are categorically eligible under AFDC for medicaid.

In other words, CHAP would serve poor children in two-parent families. Our legislation would cover an additional 1.7 million children under Medicaid.

More children would be assessed. We would provide assistance and incentives to States to reach and assess more eligible children. We will pay the States a higher Federal match, a minimum of 75 percent, instead of the current average of 57 percent for all screening done under the program.

We will also pay a higher match for all ambulatory followup medical care to assess children including care in physicians' offices, clinics, and outpatient care in hospitals. We would not pay the higher match for dental services as the CHAP legislation coming out of the House would.

We would pay a higher Federal match for general administrative costs, 75 percent rather than 50 percent based on measures of performance by the State. We would expect, under our legislation, that by 1983, 9 million, instead of 3 million children, will be receiving regular preventive exams.

CHAP will require States to be responsible for managing all medical care of each assessed child. Together with a higher match for ambulatory care, we believe this will assure followup and continuous care for a much greater proportion of all those assessed. We would also guarantee, even if the child became ineligible after assessment, that the child be treated for up to 6 months thereafter.

We would change the penalty structure. Currently, any failure whatsoever by a State, no matter how minor or temporary, can make a State liable for a penalty of 1 percent of all Federal AFDC funds. The penalty is so severe, Mr. Chairman, it is unenforceable, as you are aware. We have been required by the General Accounting Office to impose it, and Congress has effectively delayed, as I think they should.

Under CHAP, we would provide much more flexibility in establishing and enforcing criteria. States would be given an opportunity and encouragement to correct deficiencies. The measure of deficiency would provide the Secretary with flexibility to impose a penalty of up to 20 percent of the administrative cost of the medicaid program.

CHAP will extend medicaid coverage to all low-income pregnant women in families that meet State income and resource standards. This would make financing for prenatal care delivery and postnatal care available to an additional 94,000 women annually, 80,000 of whom are married and living with their husbands.

Mr. Chairman, we would urge that the Senate act quickly on the administration's proposal. We believe that if the Senate acts quickly we can enact this legislation this year.

We believe that preventive care pays off. There is phenomenal cost-benefit ratio.

For example, we know that weekly mouth rinses with fluoride can result in 35-percent reduction in tooth decay. A recent study indicates that our measles vaccination program in the period from 1963 to 1972 has saved about $1.3 billion at a cost of about $100 million.

Mr. Chairman, I think I will submit the rest of the statement for the record.

Senator Ribicoff. A few questions, Mr. Secretary.

What are the implications for the future health of the country of failing to take care of the health needs of children?

Secretary Califano. Mr. Chairman, I think they are a shameful commentary on a nation as affluent as this Nation is in terms of social justice and social need. In financial terms, these are unquestionably the most cost-effective programs we can provide. We know, for example, that one of the things the CHAP program would do is provide for an effective immunization of every child in the program. The cost-benefit ratio in immunization is tremendous. In the measles program, an investment of almost $100 million over a 10-year period has saved $[illegible] billion in medical costs.

Senator Ribicoff. Everybody talks about cost, but the cost of health care for the individuals, for the State, for the Federal Government, in this Nation are magnified greatly by failing to take care of the health needs of children when you could really improve it. That has an impact for their entire lives.

Is that not correct?

Secretary Califano. That is correct, Mr. Chairman.

Senator Ribicoff. Let me ask you, do you think that the State medicaid offices are capable of handling the administrative changes proposed in this bill? Do you have any evidence one way or the other?

Secretary Califano. Mr. Chairman, we can submit some detailed analyses for the record, if we have not already given them to the staff, that we made in response to questions of the House.[1]

I think the record of the State medicaid agencies is mixed. The issue is, why is it mixed? We believe that in large part, we have not provided the kinds of financial incentives for these agencies to go out and find these children financially.

I do believe that they provide the best statewide organization that can be provided. It is an interesting question; I think partly as a result of the concern implicit in the question you have just asked, the House Committee bill changes some of the provisions in the administration bill. It expands the number of providers eligible for the maximum match of CHAP funds so that, in States where medicaid agencies are

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[1] See p. 265.

not perhaps as aggressive, as they might be, we attract a range of providers.

Senator RIBICOFF. In other words, you would be willing to have agencies other than the medicaid agencies handle these programs, especially with maternal health and child health programs?

Secretary CALIFANO. The maternal health and child health agencies are, I think, on the whole not likely to do a better job than the medicaid program agencies. They are grant-in-aid programs. They are not focused on poor children, and their whole tradition and method of operation is somewhat different.

However, I think that the medicaid agencies should be free to select providers to use grantees under those programs [illegible] well and that, in part, is what the House did in its changes to our proposed legislation. It would provide the maximum match for all kinds of providers that we did not include in our original proposal.

Senator RIBICOFF. Do you approve of the House provisons?

Secretary CALIFANO. We have no objections.

Senator RIBICOFF. We heard testimony today that S. 1392 represents a step backward in terms of health and psychiatric services. This is not my intent, and I am sure it is not yours.

Is this problem adequately addressed by the amendments that Senator Cranston introduced at your suggestion? Is the administration committed to assuring that each State maintains coverage of at least those services which children can currently receive through EPSDT and medicaid?

Secretary CALIFANO. Yes, Mr. Chairman. I think our legislation was unintentionally ambiguous when we first sent it forward. And that is why we did send forward amendments in this particular area. These amendments clarify coverage of mental health services as we originally intended.

There is no intention to reduce the mental health services covered. Indeed, I was informed coming in from the airport this morning, that Mrs. Carter called my office to make sure that appropriate mental health services would be covered in this legislation, and I indicated our desire to do that.

We are very much in support of covering mental health services, as indicated in Senator Cranston's bill. The House legislation went even beyond that, and it was only budgetary considerations that prevented us from going as far as the House legislation.

Senator RIBICOFF. In dental services, how do you think having poor children from the ghetto areas get this preventive dental care in a dentist's office, many of them downtown or scattered in the suburbs, compares with having this care in clinics established in the schools or State health offices or city health offices, in clinics around where the people are?

Secretary CALIFANO. Mr. Chairman, I think that the reality is that at least at this point in time, through the latter way, we will provide dental health services for poor children. Anyone who tries to make an appointment with a dentist knows how long it takes.

I think that dentists have been far ahead of physicians in terms of using para-dental personnel, nurses to clean teeth and perform other functions a dentist once performed. I think that we should look at new methods of delivering dental services to poor children particularly under this program.

You suggest clinics; I think that is right on the mark from my experience.

Senator RIBICOFF. Where we are reaching out to try to give new health services, does your Department or your representative sit down with the representatives of the organized dental and medical agencies and organizations to try to work out an understanding with them?

Secretary CALIFANO. We do, Mr. Chairman. Sometimes we are able to work out an understanding. For example, in our immunization program, we have complete cooperation in working with the AMA; in our antismoking program, complete cooperation. In other areas, particularly as we move into the areas that affect perceived financial and economic interests, it becomes more difficult, when we view those interests somewhat differently than those in the professions.

But they have all been helpful in terms of telling us whether they think something will work or not, even when they do not agree with it.

Senator RIBICOFF. Let me ask you, you are aware of the history of EPSDT. Great hopes for results, broken promises. This is not your fault, but it took the Department 4 years to issue regulations for the program.

What kind of implementation schedule do you have in mind to prevent CHAP from going the same way?

Secretary CALIFANO. Mr. Chairman, I think the delay in putting the regulations in this program was inexcusable. I would expect to have all regulations out within 4 months and at the outside, no longer than 6 months, but I believe we can do it in 4 months.

I think that our record in the past year with respect to regulations is much improved. We have written most of the Medicare and Medicaid Fraud regulations. We issued the rural clinic regulations, I believe, within 60 days of enactment. We are moving much better in the regulatory process. I think that we can deliver.

Senator RIBICOFF. Do you think that you can institutionalize this without your taking your personal attention and your personal commitment and your personal time?

Secretary CALIFANO. Well, Mr. Chairman, you have been Secretary of HEW. I think that we have institutionalized the regulation writing process and it is much better than it was. But I think undoubtedly it will take time, some of my personal time, to move things out on that kind of a schedule, but it is time well invested.

Senator RIBICOFF. In all of these programs, it will take your personal interest to make sure that it works.

Secretary CALIFANO. In some of them, Mr. Chairman.

Senator RIBICOFF. We recently enacted a rural clinics bill mandating medicaid coverage in those clinics. To what extent would CHAP, or the present EPSDT program, use those clinics for screening and followup in the rural areas?

Secretary CALIFANO. We would use those clinics energetically. We would want the States to use those clinics energetically.

I just saw a rural clinic when I was up in Maine with Senator Hathaway on Friday. It was wonderful to see one of these clinics developed in a distant area called Abbey, Maine, northwest of Bangor. What it meant to the people in that community—they, themselves put $47,000 into putting this clinic together.

Senator Ribicoff. If these clinics work in the rural areas, why could they not work in the ghettos of America?

Secretary Califano. Mr. Chairman, we did have—I believe we originally recommended that we be permitted to reimburse nurse practitioners through these clinics in inner-city areas as well as in rural areas. The Congress decided to let us just demonstrate in the urban areas but we went forward full blast in the rural areas.

I cite that as an example of our general belief that clinics like this can work in the inner-city area.

Senator Ribicoff. How expensive was the demonstration?

Secretary Califano. We have just begun. We just got the authority at the end of last year. We are just beginning to develop demonstrations now.

Senator Ribicoff. I am curious—where are they?

Secretary Califano. I do not know the extent of progress but I can provide that for the record.[1]

Senator Ribicoff. I think this is a very important demonstration program to be monitored and I would hope that you would expend one of your key people [illegible] monitor these, because I think that is very, very important.

It is very difficult to get people from the inner cities and the ghettos to go downtown to the prestigious private medical buildings. They just will not do it. And as you say, the dentist is busy, the doctor is busy and it takes a long time to be able to get an appointment with them—weeks, months sometimes.

And yet there must be millions of people who do not get this care because of nonaccessibility. I can understand that. The doctors go where it is more convenient, they like the atmosphere, but there is a need elsewhere. I think the dental societies and the medical societies could work together, in having the various doctors volunteer a certain amount of their time every month to staff these clinics. They can do it.

And I think there is a willingness, they are willing to organize it on their own.

Secretary Califano. Mr. Chairman, I think they can do it and I think also, as was the case in this Maine situation, we can also get a national health services corps of doctors to staff these clinics. This particular clinic is staffed by two national health service corps doctors.

Senator Ribicoff. I understand that your Department is giving serious study to revisions in other child health programs in the Department, especially the title V, the maternal and child health program under the Social Security Act.

What effect do you believe that this study should have on our consideration of this bill?

Secretary Califano. Mr. Chairman, I think this committee can go forward in considering this bill regardless of that study. We are looking at title V. I do not know what changes, if any, we will propose. If we propose them, we will propose them sometime next spring. It would take at least a couple of years before they would become law, and we would like to have this legislation effective by April 1, 1979. That is what we have been shooting for—April 1, of next year.

I do not think that should effect broad consideration at all. I also think it is possible that, especially in a situation in which budget restraints are so tight, that we would have no recommendations.

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[1] See p. 265.

Senator RIBICOFF. I would say we are all pleased to have your commitment—more important, Mrs. Carter's commitment. I have always found that a President's wife can act as a greater goad than the President or the Secretary in many of these programs.

I would hope that you and your staff would study all of these various programs that you are working on now with the viewpoint of presenting at the beginning of next year a series of suggested pilot or demonstration projects and I would consider it a privilege to introduce such a measure. We can look at some of these thoughts and ideas and your deep concern. Where there is either a budget problem or a question, we can try to see would they work, how they work, can it be done. We can try these ideas out in selected places around the country. And I think you would find sympathy in the committee and sympathy in the Congress to try these ideas out. There must be many of them that concern all of you that you are discussing constantly.

You have another 4, 5, or 6 months into next year. You are not going to get it this year; Congress is going home some time in October. However, it is something that I think we ought to have, a broad-scale series of demonstrations to try to solve some of these problems.

Secretary CALIFANO. I would be delighted to do that, Mr. Chairman.

Senator RIBICOFF. I would commend to you consultation with members of the committee staff, Mr. Constantine, and Susan Irving of my own staff to try to work these out with you, so we would have a cooperative effort.

Secretary CALIFANO. Good.

Senator RIBICOFF. There may be some other questions, Mr. Secretary. Again, my commendation to you for going very well on a very, very tough job.

I think the country is fortunate to have you heading HEW.

Secretary CALIFANO. Mr. Chairman, thank you very much. I think the country is fortunate to have you serving on this subcommittee.

Senator RIBICOFF. Thank you very much.

[The prepared statement of Secretary Califano follows:]

STATEMENT OF SECRETARY JOSEPH A. CALIFANO, JR., DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee, it is with great pleasure that I appear before you to testify in favor of S. 1392, the Administration's Child Health Assessment Program (CHAP).

I know that you are strongly committed to the goals of this vital legislation, which addresses on[illegible]ur nation's most important problems—providing adequate health care [illegible] to children and pregnant women. There can be no more important t[illegible] compassionate society than ensuring that those most in need of care—pr[illegible] mothers and young children, especially poor mothers and poor children—receive those services which can mean the difference between a full, productive life and a life impeded or retarded by unnecessary illness.

Senator Ribicoff, your sponsorship of this bill reflects a long and deeply held concern for the health and well being of America's poor children. That concern dates back many years—to your days as HEW Secretary, as well as to the early days of your Senate career. Your early and enthusiastic efforts to enhance the health care of poor children is reflected in your proposal to permit States, at their option, to cover otherwise ineligible categories of poor children under Medicaid. This proposal became law, and the mandatory State coverage of these "Ribicoff children" is one cornerstone upon which we constructed the CHAP proposal that is before you today.

Mr. Chairman, the CHAP legislation represents a signal opportunity for productive cooperation between the Executive and the Congress. There is widespread agreement both in the House and the Senate that the bill is necessary. And together we can attain a humane and noteworthy objective: With the passage of CHAP, every poor child in this nation—as defined by State income standards—will be eligible to receive basic health services.

Your consideration of this legislation is especially significant in light of the President's recent announcement of his principles for national health insurance. Although CHAP is not, of course, a formal part of the President's forthcoming proposal, it represents a critical step—a separate legislative step that is not part of, but leads to, comprehensive reform—that can be taken now to remedy some of the problems that the program he sends to the Congress next year will address.

Like the National Health Plan, CHAP will increase health services for those who presently have inadequate coverage, reaching 1.7 million children [illegible]milies with incomes below the poverty line. It will help eliminate aspects of the current system that often cause the poor to receive substandard care. And it will put renewed emphasis on our efforts to present, not just to cure, disease.

Mr. Chairman, the CHAP program—together with our proposed amendments that would extend its benefits to all low-income children under [illegible] of 21 meeting State income standards and would provide Medicaid coverage for all low-income pregnant women meeting State income standards—is also founded on several essential goals of sound maternal and child health care:

Every child in this Nation should be able to develop his or her talents to the greatest extent possible.

Every child should receive continuous, comprehensive health services, including the preventive care that is necessary if children are to grow into healthy, productive adults.

No pregnant women should be denied the prenatal care her body needs for a healthy start in life.

Yet, these goals too often—far too often—are not fulfilled under current health programs and practices. Millions of poor children and millions of poor pregnant women in this country lack even basic health care coverage, under Medicaid or any other program, and suffer serious health consequences as a result.

This shameful national failure must be remedied.

Today, I would like briefly to summarize our knowledge of children's health problems—especially problems of poor children. Then I would like to review the achievements, and the shortcomings, of Federal child health programs. Finally, I wish to explain why CHAP will correct some serious weaknesses in the way we discover and care for the health problems of poor children under Medicaid.

HEALTH STATUS OF CHILDREN

In recent years, we have made great strides in improving the health of children in this country. Death rates due to early childhood disease have dropped dramatically. For example, the death rate for children from influenza and pneumonia declined from 150 per 100,000 in 1925 [illegible]6 per 100,000 in 1973.

Yet, despite such gains, millions of children still fail to receive adequate health care.

The rate at which infants die within the first year of life in this country is higher than that of 11 other nations.

When children enter school, 17 percent have defective vision, often not corrected. By age eleven, 27 percent have defective vision.

Many children receive treatment only in times of emergency, accident or injury. Nearly 6 million children under the age of 17 have no regular source of health care.

Even those able to obtain care may not receive the full range of services appropriate for proper development. It is estimated that nearly 24 million children under the age of 17 have not had a routine physical examination in the past 2 years, 10 percent of children 6 through 16 have never been to a dentist.

The burden of these problems falls disproportionately on the children of the poor.

Twice as many children in families earning under $5,000 have a history of chronic kidney disease as in families earning $10,000 or more.

Children in families earning less than $3,000 are four times more likely to be reported in poor or fair health than children in families with incomes of $15,000 or more.

Poor children are bedridden 25 percent more than nonpoor children—an average of 5.4 days per year, while the nonpoor child spends 4.2 days in bed annually.

We know that prenatal care plays an important role in influencing the health of both the mother and the unborn child. Inadequate prenatal care increases the likelihood that an infant will be born premature, suffer disability, or even death. As in the case of health problems among children, the lack of timely and adequate prenatal care falls most heavily upon the poor and upon minorities.

Babies in black families are twice as likely as babies in white families to die before their first birthday.

Death rates during the first 5 months of life are 4 times higher among infants in low-income families than those in high income families.

More than one out of every 3 black mothers aged 20 to 34 do not receive prenatal care during the first trimester of pregnancy.

CURRENT FEDERAL EFFORTS

The Department of Health, Education, and Welfare currently administers a variety of programs aimed at improving health care for children: through research, education and prevention—and through the provision and financing of health care services in community health centers, maternal and child health programs and medicaid. In fact, more than $2 billion a year under medicaid alone is spent directly on the health problems of America's children.

We are committed to upgrading the quality and availability of health care in all existing programs. Last year, for example, the President launched an unprecedented initiative to immunize an additional 20 million children under the age of 15 against childhood diseases such as polio, measles, rubella, diphtheria, tetanus and whooping cough. Recently reported data shows that we have made considerable progress toward achieving our goal: 30 of the 50 States report levels of protection against measles and polio of 90 percent or greater for children entering school. We are also encouraged about the decline in the incidence of measles, mumps and rubella during the first 26 weeks of this year; cases of measles were down by 50 percent, mumps by 16 percent and rubella by 19 percent over the same period last year.

PROBLEMS OF MEDICAID AND EPSDT

But despite existing child health programs and services, we are here today because we perceive serious shortcomings in our health care system for children. And the most basic shortcoming is the lack of adequate health care services for poor children and pregnant women under Medicaid.

The medicaid program is primarily a payment program—it assures eligible persons that when they need health care, the bill will be paid. A different focus, however, underlies a part of the Medicaid program which is designed to meet the health needs of children. The Early and Periodic Screening, Diagnosis and Treatment program—the EPSDT program—operates as a health outreach and health status monitoring system.

Under EPSDT, the States are required to make a positive effort to inform parents that their children are eligible for this service; to offer the service to them at appropriate intervals; to regularly assess the health status of eligible children and diagnose their particular health problems; and to assure that needed and requested followup treatment is provided.

But there have been a number of serious problems with EPSDT:

All poor children are not eligible for Medicaid and EPSDT.

Of over 12 million children actually enrolled in Medicaid, only 3 million children receive up to date assessments.

Even among children reached by the program, many do not receive needed followup care: 28 percent of all conditions found go untreated. State systems to improve this aspect of the program have not been adequately developed.

Penalties against States failing to reach eligible children have been too rigid and unenforceable.

Finally, many poor pregnant women are not eligible for Medicaid because they are not yet mothers or because their husbands live with them. Thus, their children are denied the healthy starts in life that good preventive care provides.

The Administration's CHAP proposal, as amended by our submission to you earlier this year, seeks to assist States to rectify these deficiencies in a number of ways:

Expanded Eligibility.—CHAP will require States to cover all children under the age of 21 whose family income meets AFDC eligibility standards, for both screening and treatment, regardless of whether they are categorically eligible under AFDC for Medicaid. In other words, CHAP would also serve poor children in two parent families. Thus, an additional 1.7 million poor children would be eligible for health services under Medicaid.

More Children Assessed.—CHAP will provide assistance and incentives for States to reach and assess more eligible children. We will pay States a higher Federal match—a minimum of 75 percent instead of the current average of 57 percent—for all screening under the program. We will also pay the higher match for all ambulatory, followup medical care to assessed children, including care in physicians' offices, clinics, and outpatient care in hospitals. And we will also pay a State a higher Federal match for general administrative costs—75 percent rather than 50 percent—if the State meets certain standards of good performance. Thus, we expect that by 1983, 9 million, instead of 3 million, children will be receiving regular preventive exams.

Better Followup.—CHAP will require States to be responsible for managing all medical care of each assessed child. Together with the higher match for ambulatory care, we believe this will assure followup and continuous care for a much greater proportion of those assessed. The program will also guarantee 6 months of continued eligibility for followup care for children who have been assessed, even if their eligibility for assistance otherwise terminates.

Sensible, Enforceable Penalties.—Currently, any failure whatsoever by a State, no matter how minor or temporary, can make the State liable for a penalty of one percent of all Federal AFDC funds. Under CHAP, there will be considerably more flexibility in establishing and enforcing performance criteria. States will be given ample opportunity and encouragement to correct their deficiencies before a penalty is assessed. I have also asked Congress to repeal the current penalty clause retroactively when the changes proposed in CHAP are enacted, so that penalties assessed under current law need not be collected.

Prenatal Care.—Finally, CHAP will extend Medicaid coverage to all low income, pregnant women in families that meet State income and resource standards. This will make financing for prenatal care, delivery and postnatal care available to an additional 94,000 women annually.

Mr. Chairman, I strongly hope the Senate can act quickly in the Administration's CHAP proposal. We must move to assure that poor children have access to the same preventive and treatment services enjoyed by more affluent children. Preventive early and continuing care can produce significant improvement in the health of our children.

By emphasizing regular, preventive care, we can detect problems at an early stage which can be corrected and treated before they reach crisis proportions. Investing preventive, ongoing care also reduces the need for more sophisticated and costly services which are needed to treat more advanced conditions.

Weekly mouth rinses with fluoride can result in an average 35 percent reduction in tooth decay.

A recent study estimates that $1.3 billion was saved in medical costs over a 10-year period (1963–72) through measles immunizations.

Where comprehensive care became available to women who had formerly lacked access to such care, infant mortality rates can be cut in half.

In some child care centers, hospital days decreased up to 40 percent as comprehensive preventive and followup care was delivered to children.

We estimate that the first full year Federal cost of CHAP, in fiscal year 1980, will be $592 million. Because of the financial incentives contained in the bill, a number of States will experience cost savings during the first full operational year. By fiscal 1983, we estimate States will save a total of $27 million.

As you know, Mr. Chairman, the House Commerce Committee has added a number of amendments to the bill which greatly increase the total first year costs of the Administration's proposal. And we estimate that the Federal costs of these amendments will add another $347 million to the Administration's CHAP bill. In the current fiscal and economic climate, Mr. Chairman, we oppose these add-ons to the 1979 budget.

The Administration's CHAP proposal is a sound and realistic reform of the current EPSDT program. CHAP will enable us to render ongoing health services to children more effectively. It will expand available benefits and provide incentives under the higher Federal matching rate and performance bonus. We are confident that the improvements we are proposing will give the Federal government, the States, the consumers and providers of health care a significant opportunity to reach out to more needy children and pregnant women.

I hope the Senate will pass the Administration's CHAP proposal as quickly as possible. The current EPSDT program is badly in need of overhaul, and we are shortchanging one of the weakest, most vulnerable groups in our society until we make these improvements. I hope that the President can sign this much-needed reform into law this year as proposed by the Administration.

We will all be able to take great pride in a bill that makes many poor children eligible for ba[illegible]ealth services.

Thank you.

[Thereupon, at 11:05 a.m., the subcommittee recessed, to reconvene at the call of the Chair.]

[By direction of the chairman the following communications were made a part of the record:]

STATEMENT OF HON. RON DE LUGO

Mr. Chairman and honorable members of the Senate Finance Subcommittee on Health. I am grateful for this opportunity to testify in support of H.R. 9434, legislation I have co-sponsored to eliminate discriminatory treatment of the Virgin Islands under the Medicaid provisions of the Social Security Act. The purpose of this legislation, which was reported by an overwhelming margin by the House Committee on Interstate and Foreign Commerce and passed by the full House, is to guarantee equal protection under the law by extending to residents of the United States Virgin Islands the same rights and benefits already enjoyed by residents of the several states and the District of Columbia.

Section 1108 of the Social Security Act sets absolute ceilings on Federal funding for the Medicaid programs in the Virgin Islands, Guam and Puerto Rico. Federal financial participation with respect to the Virgin Islands is subject to a 50/50 matching rate, whereas the Territory would qualify for 75 percent Federal matching if it were entitled to a full state-like treatment. The net effect of these provisions is to reduce the level of health care services available to low income persons in the Virgin Islands, as well as to place an ever increasing financial burden on the fiscally strapped local government that is disproportionately higher than that of individual states.

I should like to point out that the health care responsibilities of the Virgin Islands Government are expected to increase significantly over the next few years. The aggregate case load for government-sponsored health services has increased from 25,000 in 1972 to 34,000 in 1976, and additional growth is expected to continue as large numbers of non-resident aliens in the Territory are adjusted every year to permanent resident status under Federal law. Moreover, operational costs are expected to increase as the local Government moves ahead with its $52 million health care modernization and construction program. While eliminating the Federal ceiling altogether and allowing the matching rate to rise under the variable state formula would enable the Virgin Islands to help finance needed improvements in its health care system, the Congressional Budget Office has estimated that full state-like treatment would barely cost an additional $730,000 in fiscal year 1979, rising to an additional $2.2 million in fiscal year 1982.

The principle justification for discriminatory treatment of the Virgin Islands under the Social Security Act has been its special tax status. However, in October of 1976, the HEW Under Secretary's Advisory Group on Puerto Rico, Guam, and the Virgin Islands issued a report which concluded that "the current fiscal treatment of Puerto Rico and the territories under the Social Security Act is unduly discriminatory and undesirably restricts the ability of these jurisdictions to meet their public assistance needs." The report went on to recommend full state-like treatment for the off-shore areas, arguing that "while the legitimate obligations of Puerto Rico and the territories to contribute to general Federal tax revenues should be considered within the context of their overall political relationship with the Federal Government, there is little justification for addressing this issue within the context of the Social Security Act."

This conclusion is in accordance with statements of general policy the present Administration has made with respect to the off-shore territories. As President Carter recently stated: "The Constitution of the United States does not distinguish between first and second class citizens.

Rather, the Constitution specifically guarantees equal protection under the law to all United States citizens, regardless of where they may live. The logic of the constitutional argument, moreover, is strengthened by the fact that while the people of the Virgin Islands do not contribute to the Federal Treasury, neither do millions of Americans who are unable to pay taxes because of economic circumstances. In the final analysis, neither of these circumstances relieves the Federal Government of its responsibilities to these citizens.

While the Under Secretary's Report mentioned above also recommended full state-like treatment, it did suggest a number of ways in which to do it, including phasing in reforms over a three year period. The House Ways and Means Committee took a major step in this direction last May when it voted unanimous to extend the Supplemental Security Income Program, eliminate the Federal ceilings on cash assistance programs and revise administrative procedures for the Title XX Social Services Program for the benefit of United States citizens in the Virgin Islands, Guam and Puerto Rico. In its Report on H.R. 7200, the Ways and Means Committee sta[illegible] that its action was a "necessary and important step" in the direction of [illegible]plete equity between the States and the Territories."

More significantly, President Carter has included the Virgin Islands and the other United States Territories in his comprehensive welfare reform proposal on a full and equal basis with the several States and the District of Columbia.

To accept continued discrimination in the Medicaid program, then, would run counter to the trend toward equal treatment under the law for United States citizens in our offshore areas. I would respectfully urge, therefore, that the members of the Senate Finance Committee support H.R. 9434 as passed by the House.

[illegible]NGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 15, 1978.

HON. HERMAN E. TALMADGE,
Chairman, Senate Subcommittee on Health,
Dirksen Senate Office Building,
Washington, D.C.

DEAR [illegible] CHAIRMAN: On behalf of the American citizens of Guam, I respectfully request [illegible] your subcommittee [illegible] H.R. 9434, legislation which proposes increased federal support for medicaid programs in Guam, the Virgin Islands, and Puerto Rico.

The success of this measure [illegible] correct a long-standing inequity which provides the people of these [illegible] with substantially less federal assistance for Medicare programs [illegible]ded to residents of the 50 States. As a direct consequence, [illegible] Guam are unable to en[illegible] the full protection of this program.

Under present law, Guam [illegible] a ceiling of only $900,000. Under the provisions of the measure pending before your subcommittee, the ceiling would be raised for Guam to $1.8 [illegible] exactly double the present amount.

Equally important, H.R. 9434 [illegible] raise the federal matching level, which now [illegible] at 50 percent [illegible] funds expended in the territories, to [illegible] 1.87 percent [illegible] increase, which is predicated on the same matching rate [illegible] states, would again benefit local residents. [illegible] the House Committee on Interstate and Foreign Commerce noted in its report on the measure, "Guam, for example, is unable to take advantage of the federal assistance that [illegible] because they cannot raise the local matching rates."

Finally, I would urge adoption of the provision included by the House which permits increases in the annual Medicaid ceiling for all territories based on the cost of living indexes. While I recognize that this formula is [illegible] in the Medicaid program, I stress that the cost of living in Guam is far higher than here in the mainland. According to federal figures, the cost of living on Guam is at least 10 percent higher than in the District of Columbia. Thus, the automatic indexing of rates would provide a much needed economic buffer to keep federal [illegible] at a level consistent with the true cost of living.

My office stands ready to assist you in answering any questions you may have. Please contact Mr. Roger Stillwell of this office for further information.

Sincerely yours,

ANTONIO B. WON PAT,
Member of Congress.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association, which represents over 6,400 member hospitals and health care institutions, as well as more than 27,000 personal members, appreciates this opportunity to present its views on S. 1392, the Child Health Assessment Act.

This proposed legislation seeks to improve the health status of over 12 million children whose families or guardians have low incomes by providing for a program of regular health assessments and follow-up treatment. The AHA wholeheartedly supports such efforts to encourage preventive care and early medical intervention on behalf of children who suffer from disease. Our membership has a history of significant efforts to provide primary care in appropriate settings through the expansion of outpatient and ambulatory clinic programs. Therefore, efforts to improve access to comprehensive diagnostic and treatment services are consonant with our policies and goals.

We believe that any program attempting to address the subject of child health should consider the full range of issues which will confront the patients and the providers involved. In this regard, we would commend to the Committee's attention the recent study funded under a grant from HEW by Anne Marie Foltz, "Uncertainties of Federal Child Health Policies: Impact in Two States" (National Center for Health Services Research, April, 1978).

The findings of this study indicate that previous federal efforts to improve child health often have suffered from problems in implementation which have frustrated the original intent of legislators. Among these problems are: Failure to target specific populations, Fragmentation of and conflict between different agency jurisdictions, Failure to provide sufficient financial incentives to encourage provider participation in federal programs, Lack of adequate reporting systems to generate appropriate assessment data for programs.

In the context of our concerns for addressing the full spectrum of considerations related to child health legislation, we would like to offer the following specific comments and recommendations.

PROGRAM CONCERNS

1. *Comprehensive Services.*—The AHA strongly supports the provisions of the proposed legislation to encourage the screening of eligible children in settings which provide the range of comprehensive health services necessary to ensure adequate and appropriate treatment of diagnosed conditions. Screening programs are of little value unless [illegible] intervention is also [illegible]. Early treatment greatly reduces the need [illegible] expensive modes of medical [illegible] which become necessary when diseases reach [illegible] urgent or acute states. W[illegible] this to be [illegible] effective means of controlling medical care costs over the long run.

Not all settings allow [illegible] of a full range of diagnostic and treatment services in a comprehensive health center, especially in sparsely populated rural areas. We therefore support an amendment to the proposed act, such as that introduced by Senator [illegible] (amendment No. 1029), which would allow a state to consider local conditions and, when appropriate, certify individual providers for participation if they have agreed by contract to operate in a network for the provision of child health assessment services.

Specifically in this regard, we are concerned that the specific language of the proposed act would limit the ability of providers to render the intended range of referral and follow-up services. Proposed section 1912(3) would permit the treatment only of those conditions diagnosed in an initial screening. A literal interpretation of this section would preclude conditions uncovered during the course of referral or follow-up services. We believe that this section should be amended as follows to include the treatment of conditions uncovered at any point in the assessment process: "1912(3) refer such individuals to appropriate providers for any corrective treatment the need for which is disclosed in the assessment process (including conditions discovered during follow-up treatment), but which is not available directly from the provider maintaining an agreement with the State, and for follow-up to assure the provision of such treatment;"

This expansion would be consistent with the intent of the bill to provide timely intervention at the earliest possible stage for children involved in a periodic health assessment program.

2. *Prenatal and Postnatal Care.* The success of any program to improve child health will be greatly dependent on the adequacy of efforts to ensure proper

prenatal and postnatal care for expectant mothers with low incomes. For too long, this country has been concerned about a high infant mortality rate. By including screening and appropriate follow-up care for expectant mothers in this program, Congress will be taking necessary steps toward the goal of improving the health status of children in the target population groups.

Studies have shown that many environmental and social factors, such as poor housing and the lack of proper nutrition, prevalent among low income groups, are directly linked to a high incidence of physical and mental disabilities in children. In addition, the frequency of alcoholism and drug abuse in low-income groups makes it imperative that expectant mothers in these groups be screened so that high risk pregnancies can be identified promptly. Thus, AHA recommends that eligible expectant mothers be covered under the program authorized by this legislation, and that eligibility for such women be sustained for up to two months following delivery. Further, it is our understanding that this bill would provide coverage for infants at birth, in contrast to some current state Medicaid programs that begin coverage at six months of age.

3. Dental Care.—The AHA believes that adequate dental care is an important component of child health. The problem of dental neglect among low-income groups cannot be overestimated. If the Committee determines that sufficient financial resources would be available, we would support an amendment to the bill, such as that proposed by Senator Chiles (amendment No. 1031), to include dental care in a manner comparable to other medical services.

4. Health Education.—We believe that public awareness is an essential element in the success of the CHAP effort and suggest that the bill be expanded to provide funds for both national and local promotion of public health education. In addition to traditional health education functions, this activity also could reduce the burden on provider resources by instructing parents in the appropriate use of services, (e.g., telephone consultations, appointment procedures, and use of slack periods of elective demands).

ADMINISTRATIVE CONCERNS

1. Financing and Payment System.—Experience with the financing and payment system utilized by the Medicaid program has pointed up a number of serious concerns from the point of view of hospitals. While the entitlement to health benefits for the indigent and for persons with low-incomes has resulted in improvement in their access to needed health care services, the unevenness of eligibility requirements and variations in payment methodologies among the states often have led to a failure of the program to meet the full costs of providing high quality health care.

As a consequence of Medicaid rate freezes, benefit limitations, and partial payments under some state plans, other hospital patients and third-party payers are, in effect, subsidizing the costs of services rendered to Medicaid beneficiaries. Such inequitable circumstances could make it difficult for providers to participate in the proposed child health assessment program. Moreover, in some states the problems will be exacerbated by the program's potential for increasing the volume of services, which would be an inevitable result of this broad screening effort. Senator Ribicoff pointed out in his remarks accompanying the introduction of this legislation that only about one-sixth of the over 12 million children eligible for screening services under the current EPSDT program actually have been screened. This proposed new and expanded program must, therefore, address the financial and payment issues arising from the increased demand generated by a significant increase in the pediatric case load of health care providers.

The increased case load would come from three sources: (1) patients not previously eligible for, or taking part in, the existing screening program; (2) patients referred to qualified providers with the necessary diagnostic and treatment services to meet their needs; and (3) the provision of additional services within existing case loads as a result of more thorough and comprehensive screening and follow-up systems.

We are pleased to note that the bill in several areas recognizes the need to provide adequate financial resources for the program. Specifically, the bill would authorize an increase in the federal matching rate for required ambulatory care services. It also would standardize eligibility requirements among the states so that children of intact families as well as single parent households would be covered under the program.

Nevertheless, the bill does not provide for any modification of the present Medicaid payment system to institutional providers, including free-standing clinics, which has permitted some states to pay less than the [illegible] costs incurred in rendering services. The AHA urges the Committee to include specific language in the legislation, under the proposed section 1903(a)(6 [illegible] to require that payment for services delivered pursuant to the screening process be based on the reasonable direct and indirect costs of such providers.

2. *Allied Health Professionals.*—In order to encourage [illegible] and economical provision of services under the program, the AHA [illegible] the bill should specifically recognize the role that nurse practitioners [illegible] physician extenders can play in some screening and follow-up activities. [illegible] that proposed section 1902(a)(37) be amended to require a state [illegible] (37) provide that the State will encourage participation by physicians and health care centers and, to the extent permissable under State law allied health personnel, including nurse practitioners and physician extenders in the [illegible] described in section 1912 of this Act.

3. *Coordination with Other Programs.*—A number of [illegible] programs receiving federal support provide related services for children among them various health, nutrition, and social services. The AHA believes that the bill should provide for the administrative and clinical coordination of the Child Health Assessment Program and other federal programs for the [illegible] provision of health and related social services to children. Such coordination would [illegible] increase the combined impact of the services on the target population and decrease administrative costs.

Moreover, we support the concept of a "lead agency" [illegible] proposed by Senator Chiles in his amendment (amendment [illegible]) to coordinate for each county or health service area all programs [illegible] the health status of mothers and children whether provided through [illegible] clinics, public health agencies, school health agencies, migrant health centers or maternal and child health centers.

We appreciate the opportunity to present our views [illegible] the Child Health Assessment Act. AHA supports the intent of this legislation [illegible] we will be pleased to provide any additional information or assistance [illegible] may request.

STATEMENT OF THE ASSOCIATION OF STATE AND TERRITORIAL MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S DIRECTORS

(Presented By Judson Force, M.D., Director, [illegible] Services, Department of Health and Mental Hygiene)

ACKNOWLEDGEMENTS

This statement has been prepared by a Task Force of the Association which represents some ninety-seven (97) physician [illegible] and [illegible] estimated 1,600 other professionals working in all State and Territorial Maternal and Child Health and Crippled Children's Services programs. [illegible] staff located in local and regional areas of states and involved [illegible] health services represents an additional and substantial corps of trained [illegible] experienced personnel.

State and local staff include public health [illegible] practitioners, physicians, dentists, medical social workers, nutritionists, [illegible] educators, audiologists, speech pathologists, physical therapists, [illegible] occupational therapists. Responsibilities are such that most staff members [illegible] administrative and direct patient care services.

Therefore, it is appropriate to acknowledge th[illegible] is presented in this statement reflects the concern of persons [illegible] close to those for whom this Act is intended.

The Association of Maternal and Child Health [illegible] Children's Directors of Title V Programs support the purpose [illegible] to strengthen and modify EPSDT and broaden program eligibi[illegible] in the past has recognized that a special public responsibility e[illegible] most dependent and vulnerable citizens who require more care and [illegible] support than can be reasonably expected of most low income famili[illegible] will can provide a needed opportunity to reinforce previous congressional [illegible] and commitments under Public Law 90–248 and the 1967 EPSDT amen[illegible] to title V and title XIX of the social security laws. Both title V and title [illegible] child health mandates need careful consideration as the language of H.R. [illegible] undergoes further development.

The Child Health Assessment Act is an initiative that should promote healthy children and prevent unnecessary disease, disability, and hospitalization by improving the opportunities for more needy children to be identified and provided with a continuing source of quality medical care. A major goal of this Act must be to emphasize the need and ensure the availability of necessary primary, secondary and tertiary preventive care services through a comprehensive and coordinated network of providers. The Association vigorously supports the intent to have every needy child introduced and assured a medical program where health needs would be periodically assessed, a prevention oriented care plan developed and necessary diagnostic, treatment and aftercare services provided in accordance with the plan.

The following statements and recommendations are made, then, in keeping with what we believe to be [illegible] basic health care provisions that Congress intends for all children served through EPSDT services under title V and title XIX, and to be further amended through H.R. 6706.

A. TREATMENT COVERAGE

In this country the prevalence of severe handicapping conditions is greatest among those children served by title [illegible] title XIX programs. Section 1905 now requires title XIX payment [illegible] for EPSDT services of all eligible persons under twenty-one years of [illegible]rdless of diagnostic category. It is of great concern, therefore, that [illegible] would amend this section whereby State title XIX programs would no longer be required to provide appropriate care and services to handicapped children with mental illness, mental retardation, or developmental disabilities.

This exclusion is contrary to the [illegible] intent of sec. 1901 which states that title XIX appropriations are for the [illegible] of enabling states to furnish (1) medical assistance on behalf of [illegible] with dependent children and disabled individuals and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence of self care.

Some of the most urgent medical diagnostic and treatment needs and opportunities for secondary and tertiary [illegible] in those conditions or categories which are not to be mandated [illegible] appropriate care and services. To exclude these conditions or to limit treatment when there is a reasonable expectation of eventually attaining or retaining capability for at least independence of self care may not be in a state's best financial interest. Many states are presently investing substantial amounts of limited program funds in developing health care resources and services to reduce the need for costly institutional care.

Also to be excluded under CHAP is dental treatment unless the need is discovered during an assessment. Since a large percentage of dental defects can only be detected after a thorough diagnostic examination, it is imperative that children receive diagnostic dental care on an ongoing regular preventive and curative basis. Furthermore the vast majority of needy children are already known to have dental conditions requiring diagnosis and treatment. Assessment for disease in this circumstance is believed to be cost effective.

We also recommend that dental treatment services not be excluded from the increased Federal medical assistance reimbursement as described in sec. Ambulatory dental care for poor and handicapped children is limited and inadequate financial incentives will only make it more difficult for states to make these needed services available.

B. PROVIDER PARTICIPATION

It is believed that satisfaction with program direction and equitable reimbursement provisions have the greatest influence on EPSDT provider participation and practice patterns. Also of importance to the patient and provider is the organizational structure, setting and atmosphere in which health care services are to be delivered. Therefore a diversity of choices in delivery systems and funding arrangements should be mandated by statute to allow for differences in personal preferences which exist among patients and providers.

We fully support the CHAP intent as expressed in sec. 1912 to require the responsible state administrative unit to provide greater access to programs and providers which can assume not only periodic assessments but also the necessary treatment and continuing followup care needs. However, the Association is greatly concerned that the requirements under Section 1912 could interfere with a State's ability to deliver EPSDT services through title V programs. Under title V local community providers, including health departments, provide services to several million children annually. In particular, children and families served by health department programs could be adversely affected by this section.

Local health departments continue to be a major resource of a broad spectrum of health care specialties and disciplines in under-served areas throughout the country. Their outreach capability in the community is considerable. Depending on local needs, care available through these community programs may vary from assessment clinics to comprehensive services offered in primary care community hospital, and university medical center settings. Most local programs have, however, traditionally focused on well child and primary preventive care; diagnostic consultation, treatment and ongoing management services have been provided to a lesser extent and mainly developed for handicapped children followed through State title V crippled children's services. Arrangements have been worked out over the years to coordinate assessment services with necessary diagnostic, treatment and follow-up care to assure comprehensiveness and continuity.

It is imperative that local programs which have been developed and are continuing to meet community expectations and needs not be disrupted but hopefully reaffirmed and strengthened under this section. If this section is not changed, health departments could only continue assessment services in those geographic areas where it has been determined that the State has made reasonable efforts to assure provider participation but the number of enlisted providers is insufficient to serve the number of eligible children. There is great reservation about the efficacy of this provision as presently developed.

There is the potential for incalculable disruptive and damaging effects on local health departments. (That is, possible elimination of many local health programs and a decrease in available assessment health services particularly at a time when there is expected to be an increased demand for such services as a result of Public Law 94–142, the Education for the Handicapped Act, which is to be implemented soon by local education agencies.)

At best it is felt that the provider requirement under Sec. 1912 would have very little beneficial effect on the further development and strengthening of present delivery systems for the health needs of poor children. Most States would need total Federal funding to enable existing health department assessment programs to add the required level of diagnostic and treatment services. It is conceivable that some health departments might be inappropriately forced to expand into primary care delivery programs; there isn't any provision that would prohibit a local program from taking this course of action even if located in an area where there were already a sufficient number of diagnostic and treatment providers. Lastly, the selection of appropriate criteria to be used for such a determination would appear formidable when considering the many geographic, provider and consumer variations that exist on a nationwide basis.

Accordingly, the Association recommends that section 1912(b) (2) (A), (B) and (C) be deleted except for the statement that in lieu thereof "a State may enter into an agreement with any health care provider who has written arrangements for the referral of such individuals to appropriate providers for such diagnostic and treatment services." This change should not have any significant adverse effect on the overall intent of the section, to reach increasingly more title XIX children with a full range of appropriate and ongoing preventive health services. The change would eliminate, much earlier than otherwise, those asessment providers who cannot assure a minimum coverage of diagnostic and treatment services, or who have not been successful in affiliating with an appropriate health care provider. In addition, it is believed that the logistics involved in administering the compliance aspects of section 1912 over a 3 year phase-in period would be monumental.

C. PROGRAM AUTHORITY

Enabling legislation for title V programs is for the express purpose of extending and improving health care services to children throughout States, especially in under-served and economically depressed areas. Title V agencies have been directed by Federal and State statutes to administer or supervise the administration of the State plan for identifying health needs of children and developing strategies for meeting those needs including the provision of direct services by the agency when necessary. Under Public Law 90–248 Congress further specified and attempted to strengthen title V authority to provide for ongoing continuous programs of preventive care, by amending title V State plan requirements to provide specifically for EPSDT services: Section 505(a)(7) was added which provides 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 provision of such periodic screening and diagnostic services, and such treatment, care and other measures to correct or ameliorate defects or chronic conditions.

Also, under Public Law 90-248, conforming amendments were added to title XIX. These additions were seemingly intended to provide the necessary funding mechanisms for EPSDT services which were to be developed and made available under section 505(a)(7) of title V. Section 1905(a)(4)(B) defines EPSDT for the purposes of payment and section 1902(a)(11)(B) requires the title XIX agency to enter into reimbursement agreements with providers receiving payments for part or all of the cost of plans or projects under title V.

The Association submits that most of the shortcomings of EPSDT can be attributed to the very low priority this program has received at the State level subsequent to these 1967 EPSDT amendments. Part of the failure of title V and title XIX agencies to establish EPSDT as a priority program is believed related to the difficulties and delays which surrounded the development of regulations and guidelines. In addition, when regulations and guidance material finally became available in 1972 many States were beginning major efforts to contain title XIX costs and were not particularly interested in providing funds for EPSDT program development. In fact, as of December 1973, 6 months after the date for full implementation, only about half of the States had some services available on a statewide basis.

Much of the initial and most of the technical expertise for developing EPSDT standards and assessment schedules has been provided by title V agencies. However, the administrative responsibility for overall EPSDT program direction continues to reside with title XIX agencies. Since title XIX is a Federal-State-grant-in-aide program, a serious constraint to fulfilling the EPSDT mandate has existed whereby states have opted to limit eligibility, the scope of services, and in some instances have even declined the opportunity to participate.

Interagency agreements between title V and title XIX agencies have been tried as a means to improve EPSDT performance but have generally proved inadequate for the needs. It is believed that this administrative mechanism will fall short of well intentioned hopes and promises because of inherent differences in agency mandates and goals. Title XIX, being administered by Welfare, is primarily aimed at income maintenance for families, the aged and disabled. Children's health needs are of only secondary importance as a factor in supporting the overall stability and functioning of the family unit. Title V orientation, as previously cited, is for the express purpose of improving health services for children and in particular those children from low income families. Cost containment under title XIX is viewed primarily as less income maintenance for needy families, not as possibly denying a child the opportunity for a fair start in life.

The Association respectfully concludes that if the desire and intent of Congress is to meet the critical health needs of medicaid children, then the responsibility for CHAP program authority must reside in Federal and State agencies that have as their primary objectives the protection and promotion of children's health. These agencies must have the necessary professional capabilities and incentives to develop and ensure the availability of a comprehensive, integrated and continuing system of child health services. It is with regard to the issue of program authority that provisions of the existing title V child health and EPSDT statutes must be specifically addressed and references made in H.R. 6706. It is essential that CHAP intent and language reflect an understanding of both title V and title XIX child health mandates and activities.

STATEMENT OF THE EPILEPSY FOUNDATION OF AMERICA, THE NATIONAL ASSOCIATION FOR RETARDED CITIZENS, THE NATIONAL SOCIETY FOR AUTISTIC CHILDREN AND UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

SUMMARY STATEMENT

The four voluntary agencies serving mentally retarded and develomentally disabled persons are profoundly shocked at the de facto exclusion of children with these disabilities from treatment and referral services under the Child Health Assessment Program (CHAP). Permitting such children to receive services at the option of the state is tantamount to insuring their being barred from any but the most skeletal screening services required by law.

OUR OPPOSITION IS PREDICATED ON THE FOLLOWING REALITIES

1. Treatment and referral services under CHAP are routinely available to all other qualifying low-income children, services to which many mentally retarded and developmentally disabled children would otherwise be entitled on the basis of their family's financial status.

2. Mentally retarded and developmentally disabled children are particularly in need of early intervention if lifelong disabling conditions are to be ameliorated to the greatest extent possible or prevented altogether.

3. Excluding mentally retarded and developmentally disabled children from care will only exacerbate chronic problems already experienced by low-income ~~individuals in attempting to access health services.~~

4. CHAP was designed to expand, not restrict, the scope and availability of health care for poor children. By excluding mentally retarded and developmentally disabled children from all but screening services, the program is clearly not meeting its intent.

THE RATIONALE FOR SUCH AN EXCLUSION IS BASED UPON ASSUMPTIONS WHICH ARE FUNDAMENTALLY UNSOUND

1. Contrary to prevailing opinion, the majority of mentally retarded and developmentally disabled children do not require costly long-term institutional care; and their inclusion in the CHAP program would not represent a substantial additional commitment of resources.

2. As mentally retarded and developmentally disabled children will automatically become recipients of Medicaid benefits once they attain their majority, it would be both practical and cost-effective to reduce their later cost to the system by providing early intervention in order to significantly lessen or even eliminate the long-term effects of such disabilities.

3. While many individuals erroneously assume that mentally retarded and developmentally disabled children can receive treatment services under the Developmental Disabilities Act (Public Law 94-103), in fact that legislation facilitates planning and coordination of services only, and is not equipped either financially or administratively to deliver direct care.

THE CONSEQUENCES OF EXCLUDING MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED CHILDREN FROM CHAP ARE POTENTIALLY VERY GRAVE

1. By providing an incentive to states to classify more children as mentally retarded or developmentally disabled in order to forego the full extent of their financial liability under CHAP, the act is virtually assuring that many children who most need the benefits of early intervention will receive delayed treatment, or will be denied treatment altogether.

2. A categorical exclusion—indeed, a categorical approach of any kind—runs counter to the recent trend toward providing functional assessment and individualized treatment for all children in health, education, and other social service programming.

3. The exclusion of mentally retarded and developmentally disabled children contravenes Medicaid's historical refusal to deny services on the basis of diagnosis.

STATEMENT ON THE CHILD HEALTH ASSESSMENT CENTER

INTRODUCTION

The four national voluntary agencies representing persons with developmental disabilities have been historically supportive of comprehensive health care programs for children as a primary mechanism for preventing and reducing the incidence of these handicapping conditions. Programs such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) initiative provided under Medicaid have been welcomed by our organizations as major Federal commitments to assuring and increasing the continuity, quality, and availability of such efforts.

The Child Health Assessment Program (CHAP) is another such potentially valuable tool for implementing a national strategy of health promotion and prevention for low-income children, a population statistically at high risk for long-term, permanently disabling conditions. For this reason our organizations are particularly distressed by the flagrantly discriminatory categorical exception made in providing treatment services to mentally retarded and developmentally disabled children under section 3(G) of the proposed legislation. By rendering the provision of care and treatment services to mentally retarded and developmentally disabled children optional under each state's Medicaid program, section 3(G) effectively excludes such children from receiving those same health services available on a routine basis to their nondisabled peers, services which they unquestionably require and to which they would otherwise be entitled by virtue of their financial status.

NEED FOR EARLY INTERVENTION

Of all child population groups, low-income children are at greatest risk of experiencing developmental disability or delay as the result of inadequate prenatal care, poor nutrition, environmental hazards such as lead-based paint poisoning and mercury toxicity, and, above all, lack of early diagnosis and treatment of various disorders due to insufficient utilization or availability of health services.

In his address to the White House Conference on the Handicapped on May 23 of this year President Carter enunciated his administration's commitment to insuring the health of financially disadvantaged children:

> As I look across this tremendous auditorium, with many different kinds of handicaps represented here, I know that many of them could have been prevented in your early life . . . within just a few years we will multiply five times the number of poor, young children who have a chance to see a doctor early in their lives so their potential handicap or affliction might be prevented or corrected.[1]

This preventive emphasis has already been endorsed by this committee and by the Congress as a whole in such legislation as the Health Promotion and Disease Prevention Act of 1976 (Public Law 94-317) and the Health Professionals Educational Assistance Act (Public Law 94-484), which seek to insure the adequacy and availability of preventive services and primary care professionals to deliver them. We are thus particularly dismayed at the exclusion from such services of precisely that population which has a demonstrable need for them: mentally retarded and developmentally disabled low-income children.

It has been abundantly documented that disabling conditions occur with greater frequency among the low-income population which Medicaid is designed to serve.[2] Those disabling physical and mental conditions which are not the result of prenatal problems often first manifest themselves during infancy or the preschool years. Without immediate and ongoing therapeutic intervention these conditions can become permanently disabling. With many low-income children in need of treatment for medical conditions related specifically to problems of growth and development,[3] it becomes particularly essential that individuals so identified be eligible to receive the full range of referral, treatment and follow-up services available under Medicaid auspices, so as to insure the amelioration of their condition before damage or degeneration becomes irreversible.

Current regulations under EPSDT require States to arrange for treatment of conditions discovered during routine screening either by providing such services themselves or by referring children appropriately. There is little doubt that the de facto exclusion under CHAP of mentally retarded and developmentally disabled children from even this basic referral function will create even more severe impediments to attaining appropriate services than these children already face as the result of inadequate parental information or preventive education, and the inherent difficulties which lay consumers—and particularly the poor—continually experience in attempting to access health services.

Moreover, the few Federal programs providing some medical or health-related services to children with mental retardation and developmental disabilities are so fragmented, condition/region specific, and hedged with varying eligibility requirements and application procedures that tracking appropriate services within such a "non-system" becomes a confusing and frustrating process; and it goes almost without saying that under these conditions continuity of services is impossible to guarantee.

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[1] "President Carter Gives Hope to Handicapped Individuals," Congressional Record, Vol. 123, No 99, June 9, 1977, pp H5690-H5691.

[2] For example, National Center for Health Statistics, HRA/PHS/DHEW, Selected Vital and Health Statistics in Poverty and Nonpoverty Areas of 19 Large Cities, United States, 1969-71, (DHEW Pub. No. (HRA) 76 1904); The Children's Defense Fund, EPSDT: Does It Spell Health Care for Poor Children? (Washington, D.C.: The Washington Research Project, Inc., June, 1977).

[3] Children's Defense Fund, op. cit., p. 109.

In short, it had been our understanding that the Child Health Assessment Program was designed to expand, not restrict, the scope of the EPSDT mandate. Clearly the new program as drafted contravenes that goal as articulated in section 2 of the proposed legislation (Appendix).

EXCLUSIONARY RATIONALE: FACT AND FALLACY

Cost.—The Administration's failure to require follow-up treatment services for mentally retarded and developmentally disabled children appears to be motivated primarily by a concern that the cost of providing such services will be prohibitive to states. An unstated but implicit assumption appears to be that mentally retarded and developmentally disabled children are at high risk for long-term institutional care.

Such an assumption is not warranted. The overwhelming number of mentally retarded and developmentally disabled children do not require institutional care. Even among the more severely involved institutional care is only rarely called for and need not be long-term. Equally important is the recognition that early intervention and followup can prevent the development of some forms of developmentally disability (such as mental retardation caused by inborn errors of metabolism); can dramatically reduce the severity of the disability (as in many seizure disorders which, if untreated, can significantly increase in frequency and intensity of occurrence); can compensate for disability-produced impairments (as in the case of children with cerebral palsy who, with appropriate therapy, can be helped to reduce or compensate for communication and motor difficulties); and can reverse symptoms (as in the case of those autistic children whose cognitive and behavioral functioning has improved significantly as a result of neurological intervention). Early intervention, in other words, is a significant factor in reducing the need for long-term institutional care among the mentally retarded and developmentally disabled child population; and any legislation inhibiting the provision of such care as early as possible not only fails to save money, but virtually assures additional public expense throughout the life of the child, expense which might otherwise have been avoided.

In assessing cost it must also be remembered that severely mentally retarded or developmentally disabled children eligible for Medicaid as SSI recipients or as AFDC children will in most cases become eligible for Medicaid as adults on the basis of their disability. Nondisabled AFDC children, in contrast, will generally lose eligibility for Medicaid when they reach their majority. Thus the disabled Medicaid child will also be Medicaid's responsibility as an adult. If these children are not reached in childhood—when the possibility of reversing or reducing disability is greatest—the long-term cost to Medicaid will be dramatically increased.

The Developmental Disabilities Act.—A second and equally specious rationale for excluding mentally retarded and developmentally disabled children from the program is the putative availability of treatment services for them under the Developmental Disabilities Act (Public Law 94–103). The legislative mandate of Public Law 94–103 is that of planning and coordination of services, and not service delivery. Public Law 94–103 is equipped to provide neither the funding nor the administrative apparatus necessary to deliver services, except as the provider of last resort in certain limited instances. Even then, current appropriations ($30 million) could not possibly absorb the burden of providing in full those referral and treatment services currently available to mentally retarded and developmentally disabled children under the EPSDT mandate. Clearly it is unrealistic to expect that, given its current structure and funding levels, Public Law 94–103 could provide the scope and volume of services which the Medicaid apparatus is already organized to deliver.

CONSEQUENCES OF EXCLUSION

Perhaps the gravest danger inherent in the exclusion of mentally retarded and developmentally disabled children from services under CHAP is the very real likelihood of its acting as an incentive to states to reclassify many otherwise eligible children as mentally retarded or developmentally disabled in order to lessen state financial involvement in the provision of screening, referral and treatment. Such a response on the part of the states will delay or deny treatment to many children for whom immediate therapeutic attention is critical if permanent damage is to be avoided. Yet it is evident from the preliminary response by many states to programs such as Public Law 94–142, the "Education for All

Handicapped Children Act," that additional state administrative and/or fiscal commitments to comprehensive new programs, even with the incentive of a matching provision, tend often to be viewed in terms of the most expedient rather than the most equitable implementation route.

In the case of the CHAP program categorical exclusion is regressive as well as obstructive. During the past few years Congress has been moving away from defining basic social needs such as health in categorical terms, preferring to emphasize functional capabilities and the specific types of services an individual might require in order to optimize his/her physical and mental competencies. At the same time there has been a trend toward the individualization of services provided under many federal programs, and a concentration upon developing programs whose balance of components reflects each person's unique needs. In this context it becomes readily apparent that a policy of blanket categorical exclusion is at best outdated, at worst insensitive, and in any event contradictory to the health needs of low-income mentally retarded and developmentally disabled children.

Finally, such a policy is clearly incompatible with Medicaid's long-standing reluctance to authorize a more circumscribed set of services to one group of eligible recipients than to another on the basis of diagnosis. (Section 1902(a) (10).)

The EPSDT system was originally conceived as a mechanism for coordinating referral and treatment services for all eligible children under a centralized administrative rubric. By providing clients with a central locus through which they could be assured of receiving treatment, the program was to minimize the haphazard and discontinuous service delivery which generally characterizes an individual's attempts to receive health care from more than one agency or program. The EPSDT model is, of course, only a model: and many flaws exist in the way the system currently operates. But despite its many failures of implementation, we blieve that the philosophical underpinnings of the program—the provision of centralized, comprehensive health care to all low-income children, including those mentally retarded and developmentally disabled—remain sound and ought to be perpetuated.

We therefore urge you to remove from the CHAP proposal as drafted that language which denies to mentally retarded and developmentally disabled children their right to receive the health care necessary to insure their maximum participation as adults in American society. To this end we respectfully suggest the following revision of section 3(G);

> "effective October 1, 1977, in the case of any individual under the age of twenty-one who has received his periodic assessment pursuant to section 1912(b) (1), for the inclusion of all care and services appropriate for individuals under age twenty-one for which payment is available under this title, whether or not under the State plan for the State such care and services are provided to individuals who have not been periodically assessed pursuant to section 1912(b) (1);"

The House Committee on Interstate and Foreign Commerce has recently reported favorably H.R. 13611, a clean proposal embodying our recommendations. In doing so they have palably acknowledged the wisdom, in both humane and cost-beneficial terms, of encouraging preventive and ameliorative care for Medicaid-eligible mentally retarded and developmentally disabled children. We urge you to respond likewise.

Thank you for permitting us this opportunity to express our concerns. We look forward to the day when we unreservedly express our support for a revised and expanded program of comprehensive health care for all low-income children. To that end we will be happy to cooperate with your staff in providing any further information or assistance the Subcommittee may require.

APPENDIX.

S. 1392—DECLARATION OF PURPOSE

Sec. 2. The purpose of this act is to modify the early and periodic screening, diagnosis, and treatment program and broaden medicaid eligibility—

(1) to continue and expand the availability of health care to children whose families do not have adequate resources to cover the cost of such care and to strengthen efforts to assure adequate child health assessments, diagnosis, treatment, and periodic reassessment of all eligible children;

(2) to increase the number of children eligible for such care;

(3) to assure the continuity of care for a period after a child would on account of income become ineligible for medical care under title XIX of the Social Security Act;

(4) to increase immunization levels of children; and

(5) to provide further incentives to States to arrange for and encourage quality health care for children.

AMERICAN PUBLIC HEALTH ASSOCIATION,
Washington, D.C., August 21, 1978.

Hon. RUSSELL B. LONG,
Chairperson, Senate Finance Committee,
Dirksen Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The American Public Health Association wishes to submit a statement for the hearing record on S. 1392, Child Health Assessment Program.

Although EPSDT has been a much criticized program, we believe nevertheless that it is a most useful and important program. We believe that the CHAP legislation with modifications can strengthen the EPSDT program and correct its failings.

Attached is a copy of our previous comments on this legislation presented by Dr. C. Arden Miller before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. We wish to reaffirm our commitment to the proposals contained in this testimony and to urge their consideration as you review the CHAP legislation.

Additionally, we are in support of several changes to the CHAP proposal which have been made by the House of Representatives and encourage you to include similar language in your markup of S. 1392. These are:

1. Language which allows qualified health care providers, including public health departments to perform health assessments.
2. An increase of up to a maximum of 90 percent in the Federal matching rate for health assessments.
3. The inclusion of basic dental care as a required service under the program.
4. Provision of Medicaid eligibility for individuals under 18 years of age who are financially eligible under the State welfare or Medicaid standard, or who have income of less than $4,200 a year for a family of four.
5. Eligibility of pregnant women and children if they meet the State welfare or Medicaid standard or have incomes of less than $3,000 a year.

In light of the current controversy surrounding national health insurance, and the disappointment we feel with the President's National Health Insurance initiatives, there is an even greater cause for prompt action on this legislation to address the health needs of children. Poor children are the most vulnerable and perhaps the most neglected people in our society. Their rights to health care continue to be largely unfulfilled. CHAP, with suggested modifications, represents the best initiative now on the public agenda to meet these unfulfilled health needs.

We urge you to carefully consider the legislation before you and to work towards strengthening its provisions to assure that the children of our Nation may participate, under public auspices to the extent necessary, in a program of health care that emphasizes primary and preventive services and access to accurate diagnosis and treatment as individually required.

Very truly yours,

E. FRANK ELLIS, M.D., M.P.H.,
President.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION BY C. ARDEN MILLER, PROFESSOR, MATERNAL AND CHILD HEALTH, UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH

This testimony is presented on behalf of the American Public Health Association. I am Dr. C. Arden Miller, a pediatrician and Professor of Maternal and Child Health at the School of Public Health, University of North Carolina; I speak for the association as a past president. The Association, with affiliates in all 50 States, comprises a total membership through the National Association and its affiliates of about 50,000 people. Most of them are health professionals;

nurses, physicians, social workers, environmentalists, administrators, nutritionists, health educators, podiatrists, technicians, and a number of new professionals such as health aides and community outreach workers. Consumers are welcome members of the Association.

Although I take responsibility for the contents of this testimony, I wish to acknowledge important assistance from statements that were prepared by the Children's Defense Fund, the Coalition for Children and Youth, the American Academy of Pediatrics, and colleagues in the American Public Health Association.

Since November of 1976 a strong theme for our Nation has emerged in defense of human rights. The American Public Health Association applauds that emphasis and invokes it today in consideration of the Child Health Assessment Act of 1977 (H.R. 6706/S. 1392).

Programs that address the needs of poor people are predominantly addressing the needs of children. The majority of poor people in the United States are children, and there are more of them raised in poverty today than in 1970. [1] About forty percent of all minority children and about fifteen percent of all white children are raised in poverty. Their rights to health services have been well defined for nearly a decade under the entitlements of the Early Periodic Screening Diagnosis and Treatment Program of the Medicaid amendments. Medicaid eligible children are entitled to services that screen for health problems, and are further entitled to accurate diagnoses and treatment of any problems that are identified. These entitlements—these human rights—have been upheld repeatedly in litigation that has attended implementation of EPSDT.

The need for such a program is great. More than half of the children who have been screened have been found to suffer one or more health problems. Only about forty percent of those problems have been treated even though the most conspicuous of them—dental disease, nutritional anemia, hearing disorder and visual defect—are readily correctible. This circumstance is especially tragic because without treatment all of these conditions can be expected to lead to lifelong disabilities. But, most tragic of all, about three out of every four children who are entitled to the services of EPSDT have not been reached by it.

Poor children are the most vulnerable and perhaps the most neglected people in our society. Their rights to health care continue to be largely unfulfilled. The full scope of children's health problems is superbly documented in the first twenty pages of, "A Proposal for New Federal Leadership in Maternal and Child Health in the United States", Office of Child Health Affairs, Office of Assistant Secretary for Health, DHEW, November 1, 1976.

The probable advent of national health insurance in the years immediately ahead requires that prior attention be given to strengthening health services for children. Unless special provision is made for children, they will get pushed to the end of the queue when they are incorporated into service or financing systems along with their elders.

But more than delay is involved: the nature and scope of health services that children require are different from what their elders expect and require.[2]

The experience of other nations is relevant. When universal health insurance was introduced in Quebec, the number of physician visits per person each year remained constant but were shifted from those in high to those in lower income groups. But disturbingly enough there was a decline of about seven per cent in physician visits for ages under 17 years. Enterline concludes that the decline "may reflect inability of the age group to compete for services".[3] Children in another province of Canada (Newfoundland and Labrador) were protected from such crowding out. A children's health service was established there in 1958. Later when a health insurance program was established for all ages, special benefits for children were retained.[4]

Recent experience in Britain is even more compelling. When the National Health Service was enacted in 1948 preventive services, consisting most conspicuously of primary health care to mothers and children, were separately maintained under the Local Health Authority. A much admired feature of this service was the work of specially trained nurses, known as Health Visitors. In 1974 all health services were merged under a unified authority for the sake of integrating preventive and curative medicine and providing a single door of access through the offices of general practitioners. A report published in December, 1976 by a government committee on Child Health Services states that since unification ". . . families with young children have had less than their previous share of the health visitor time, and this is a development we should like to see reversed".[5] Special provision must be for health services to children; the report urges that those provisions be made once again in Britain.

In this country we are obliged to develop systems of care that legitimately derive out of American institutions; but we are not obliged to repeat the mistakes of others nor of our own past. Special provision must be made for health services to children.

The CHAP program as currently proposed is not an adequate response to the health problems of children. The APHA supports the concept underlying CHAP; the most timely avenue for improving health services to children rests with extending and improving EPSDT. It represents a powerful entitlement for children. Its failures of implementation are correctable under stronger federal support, technical assistance, standard setting and enforcement.

CHAP should state explicitly that its purpose is stronger than health assessment; it should seek to introduce every child into a community based health care system—public or private—that will provide continuing primary and preventive health care, and access to a full range of diagnostic, curative and rehabilitative health services as may be required.

CHAP eases some eligibility requirements now existing under EPSDT for children under six years of age, but discriminates against the school age population and fails to cover medically needy children. We urge that eligibility be modified to include all children and youth up to 21 years of age who meet the financial requirements for cash assistance. Children should not be excluded if family income falls within the levels of welfare eligibility even if they fail to meet other state welfare requirements. Eligibility once achieved should be continued for at least twelve months after a health assessment. Even with these revisions eligibility is seriously limited; plans should be laid to expand eligibility to the 23 million children living in families that are supported at less than 150 percent of poverty levels. And even this step should be regarded as an interim measure towards the eligibility of all children and youth. The healths needs of all people over 65 years of age, regardless of their economic resources, were addressed under Medicare; children are the next population group whose health needs should be met under public responsibility.

The benefits provided under CHAP, as it is now proposed, exclude certain kinds of treatment, and exclude care for children suffering from certain diagnoses, namely mental illness, mental retardation, and developmental disabilities. Treatment for these disorders, as well as all appropriate preventive health services including prevention of dental caries, should be restored. Dental care should be provided. Efforts to disqualify certain conditions or diseases will foster circumventions in some instances, and discriminatory practices in others, and will impose expensive and unnecessarily complicated administrative conditions. Many children will suffer needless neglect. Unsatisfactory early experience with administration of Crippled Children's services in some states that required eligible children to be "of sound mind" is relevant. When eligibility requirements were liberalized, the "adjustments" of I.Q. scores became less urgent.

There should be no limit on the number of medically indicated visits; data do not support an expectation that children will visit health service providers unnecessarily.

Uniform federal standards of care should be adopted, similar to those which have been recommended by the American Academy of Pediatrics. Performance standards should be adopted to assure that a reasonable proportion of eligible children in each state are reached by services that conform to defined standards. A state's failure to meet standards of performance with minimally acceptable outcomes should be penalized not as now proposed. By withholding funds that are specifically identified with services to poor people, but by withholding a portion of the state's revenue sharing funds. Rationale can be developed for this action on the basis that a number of federally financed programs, many of them targeted as health services for poor people, were curtailed in favor of revenue sharing in expectation that states would assume and extend services that had previously been sponsored by federal government. Where health services are demonstrably deficient the states may rightfully be considered to have failed an obligation that was implicit in the principle of revenue sharing.

CHAP should provide 90 percent Federal reimbursement of state expenditures for services. Precedent for this level of matching derives from some other aspects if Medicaid. Additional federal funds should be made available to develop resources that are required to implement CHAP.

The American Public Health Association's greatest emphasis with regard to CHAP concerns resource development, especially in the agencies of government at the local level that carry greatest responsibility for implementing the program.

Nearly 60 percent of all health assessments that were performed under EPSDT were rendered by local health departments. Those states, 25 of them in 1975, which relied exclusively on health departments for screening reached a higher proportion of eligible children than those states that relied on multiple providers. [6] Many children who were found to have health problems by EPSDT screenings were not subsequently enrolled in programs of adequate diagnosis and treatment. Evidence has not been presented to suggest that these failings occurred any more commonly after screening in health departments than in private physicians' offices or in hospital clinics.

Certainly any child who receives health care from a qualified provider—be it neighborhood health center, physician, or special project of Title V—should not have the care interrupted in order to participate in the services of a health department clinic where there has been no previous contact. But large numbers of poor children receive no services, and their care ultimately fall as a responsibility of the local health department. Regulatory models simply do not exist to assure that private and voluntary providers can be made equitably to honor the entitlements of all children to health services. The fulfillment of those entitlements—the guarantees that human rights will be honored—falls ultimately as an obligation of government. In matters of health service that obligation is best fulfilled by the public health service agency that functions closest to most people—local health departments.

At least three times within recent years federal government has attempted to implement massive programs of personal health service without developing the resources of implementation. Family planning, immunization against influenza, and health screening for children all made appropriate and extensive use of private and voluntary providers. But ultimately the guarantor for those services—the assurance that everyone would be reached—rested with local health departments. In all of these programs health departments carried the greatest burden of service. Insofar as the programs failed the failures should be attributed to a false expectation that local health departments can expand performance without expanding facilities and staff. In aggregate health departments represent the potential for an effective health service infrastructure that can assure that every person is reached with essential primary care.

In an excellent recently published book on primary health care (Lewis, Mechanic and Fein) the statement is made that adequate first contact care requires at a minimum: insuring necessary immunization, providing prenatal and child care and monitoring overall health needs. These requirements are well within the capability of at least one-fourth of this nation's 1,700 local health departments. [7] CHAP should be used as a device for resource development that would enable other health departments to develop such a capability wherever there are children who are not adequately served by existing health care providers.

Some data on health services for children is timely.

In 1975 one out of every four Americans received some personal health service from local health departments. By far the largest population served was children. [8]

In some census tracts as many as 80 percent of all children receive their personal health care from well child stations or school health clinics that function as programs of local health departments. [9] In at least one state 50 percent of all children receive whatever health care they get, except at times of hospitalization which is rare among children, at the clinics of local health departments. [10]

Although the availability of Medicaid reduced the economic barriers between poor people and health care—and increased the number of their visits to health care providers—it did not substantially alter the sources of health care for children. [11]

Only about 30 percent of practicing physicians will see Medicaid patients [6]: in at least one state for which a recent report is available 60 percent of pediatricians refuse to see Medicaid enrolled children. [12]

The most effective public initiatives during the past two decades for improving health services to children were included in the Neighborhood Comprehensive Health Centers and in the Children and Youth and Maternal and Infant Care projects of title V. The Department of HEW has curtailed the growth of the neighborhood health centers and has reassigned the Child and Youth and Maternal and Infant Care projects to the states for inclusion in their Programs of Special Projects. By all available measures these programs have affirmed their effectiveness in maintaining health and in reducing unnecessary hospitalization.

surgery, laboratory tests and x-rays. The per capita cost of such programs of comprehensive care, including all administrative costs, is substantially less than more traditional fragmented forms of health service. These projects remain little more than token demonstrations of what might be done to improve health services to children. In 1974 an estimated 550,000 children were served by the Children and Youth projects, and an estimated 7.000,000 additional children would have qualified for such comprehensive care. [1] Similarly in 1975 only an estimated 145,000 out of total need of 500,000 were served in the Maternal and Infant Care projects. [1] The constraints were fixed by policy and funding at the federal level of government.

For most of this century the prevailing public policy for improvement of health services has been to develop at public expense the resources that are incorporated in private and voluntary health service systems. These resources include hospitals, technological development, training of manpower including physicians, and direct reimbursement for services. The benefits of this emphasis have been enormous; it represents a commitment that needs to be continued. But at the same time our nation needs to strengthen and expand those agencies of health service that perform in the public sector and which are obligated to fill the gaps in our piece-meal laissez-faire system of health care.

Providers of personal health services under public authority are important for children and are important for the whole spectrum of maternal and child health services. The importance is most critical for children and families who are in greatest need: minority groups and poverty level families. The populations for whom public providers render extensive services present a disproportionate burden of diseases, disability and neglect.

Assumption that all health care now provided under public authority can be transferred to private providers is not justified. Models for regulating private and voluntary providers are not available to reassure that maldistribution will be corrected or that entitlements will be equitably honored. Many advantages of health care under public authority are not transferable to private systems. For example, the valuable work of new professionals is most conspicuously developed in public agencies. Support systems such as outreach, counseling, education and transportation more readily characterize public systems of care than private ones. Efforts to force all poor people into private and voluntary health care systems, while retaining public responsibility for transportation and outreach, will result in even greater fragmentation of programs and will place unfair burdens on children and all health care agencies and providers.

Critics of public provision of health services sometimes raise the specter of a monolithic public program. We run a contrary kind of risk—sacrificing the well-being of children to a monolithic health service system that assures private professional prerogatives. So long as a substantial portion of our population lives in poverty, I submit that we must provide the special support systems that impoverished people require. Arguments in favor of a single system of health care—a subsidized private one which minimizes public health provider systems—monopolizes resources, favors a special privilege, and fosters a narrow concept of health care.

The credentials of private and voluntary health service delivery systems are strong in the interest of children's health. They deserve to be further strengthened, but if concurrent efforts are not made to strengthen health services which are rendered by official agenvies of government, then another generation of children will suffer blighted health.

It is urgent that CHAP be strengthened as a device to provide federal funds, facilities, technical assistance, and standards to assist organized providers of limited services in order that they may do a more adequate job of assessment, diagnosis and treatment of all children. Local health departments represent the greatest need and greatest potential for expansion of health provider systems on behalf of children. CHAP should incorporate provision for pass through funding of federal money for local health departments to develop the services necessary to implement CHAP according to uniform national standards. Federal funds that pass through state and local government for support of local health departments should not substitute for present funding from local sources. Under these provisions local health departments would not be placed under federal authority; they would be strengthened in order equitably to achieve specified national health goals and objectives.

These recommendations should not invite criticism that local health departments, or a public system of care, will supplant private providers, or compete unfairly with them. Where children are adequately served by qualified providers—or where that potential exists—contracts should be written as now recommended by CHAP to continue and extend that care. But greatest concern attaches to the many children where there are no providers, or where there are few who will see poor children. For those children our public system of primary health care needs to be improved and expanded; CHAP should provide the facilities, staff support, and technical assistance for that important purpose.

In locales where population groupings and other circumstances are conducive, provision should be made to expand a state's Program of Special Projects according to well known models of comprehensive health service (comprehensive neighborhood health centers and special projects of title V of the Social Security Act).

We urge that administration of CHAP be established in State Health Departments. Although eligibility for the program is tied to eligibility for welfare support the program is in fact a health service, predominantly implemented even now through health departments.

Title V of the Social Security Act provided authorization for government to respond to the unmet health needs of children. In the intervening forty years many children benefited from this authority, but many were missed, due largely to the wide discretion allowed states in implementation of Title V. EPSDT in part corrected this circumstance by uniformly providing poor children with a strong entitlement to health services. CHAP should now fulfill that entitlement by providing the mandate and the resources to assure that every child in this country participates, under public auspices to the extent that may be necessary, in a program of health care that emphasizes primary and preventive services and access to accurate diagnosis and treatment as individually required.

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NATIONAL HEALTH LAW PROGRAM,
Washington, D.C., August 21, 1978.

Re S. 1392, the Child Health Assessment Act.

MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The National Health Law Program is a support center funded by the Legal Services Corporation to provide technical assistance to local Legal

Services Program representing low income clients in health law matters. In that capacity, the National Health Law Program has been extensively involved in litigation, legislative advocacy, and administrative advocacy regarding the inadequacies of the present EPSDT Program. While NHeLP supports the views expressed by the Children's Defense Fund in their testimony, we believe that three points need to be further highlighted.

I.

Problem.—The proposed legislation would still exclude many children whose families do not have adequate resources to cover the costs of health care.

Recommendation.—Establish federal resources and income levels to assure that all financially needy children will have access to needed health care.

Discussion.—By eliminating the requirement of categorical linking, many additional children are now eligible for health assessments and necessary services. However, use of state AFDC income and resources standards will necessarily exclude many needy children from coverage.

The House of Representatives has taken an important step in establishing a federal income floor of $4,200 for a family of four. This federal income floor would supplant AFDC income levels in those states which provide less than $4,200 for a family of four. In this way, a minimum nationwide federal program would be established. States would still be able to utilize higher income levels, similar to the Supplemental Security Income Program.

Unfortunately, a federal income floor addresses only half the problem. Utilizing state AFDC resources standards will insure that thousands of financially needy children will be excluded from CHAP eligibility in contravention of the stated goals of the legislation. The children in a working family in Arkansas owning a home worth $10,000 would be ineligible for the CHAP program. Similarly, a child living in California would be ineligible if her parents owned a $350 refrigerator. In other states, the ownership of a car worth $1,000 would deprive needy children of CHAP eligibility. While controls could be established to bar eligibility for applicants owning mansions, luxury cars, or home entertainment systems, such basic resources as a moderately price home, car, or a major appliance, should not deprive an otherwise needy child from eligibility.

This problem could be easily reconciled with the need to protect state fiscal integrity by establishing a federal resources floor using SSI standards. These standards have proven workable in the SSI program, and were supported in Congress as the appropriate guidelines for eligibility under the Administration's welfare reform program. This approach would realize the goals of a minimum nationwide program based on rational guidelines.

II.

Problem.—The proposed legislation does not provide CHAP eligibility for families with substantial work expenses or high medical expenses.

Recommendation.—Require the use of applicable AFDC income disregards and require states to implement a spend-down program for CHAP eligibility.

Discussion.—The purpose of the CHAP legislation is to provide health care services to children in families whose income is insufficient to meet medical expenses. The proposed legislation, however, does not consider the actual income available in the family to meet medical expenses.

Working families may have substantial work-related expenses which reduce the amount of money actually available to meet the costs of health care. Income disregards for such work-related expenses as child care and transportation should be applied, since these expenses reduce the income available to meet present needs.

Similarly, a family may be medically indigent, despite a seemingly substantial income, if the family has medical expenses which significantly deplete this income. Such families should be allowed to spend-down their income when incurring medical expenses. This spend-down program is already a feature of many state's Medicaid programs.

III.

Problem.—The proposed legislation does not specifically provide for the full range of Medicaid reimbursable services.

Recommendation.—States should be required to provide the full range of Medicaid services for which reimbursement is available under section 1905(a) of the Social Security Act.

Discussion.—Many states have cut back their Medicaid programs by imposing limitations on the amount, scope, and duration of services available under state plans. Often these limitations conflict with medical necessity, and frustrate or even prevent the delivery of necessary therapeutic care.

By overriding state limitations in the CHAP legislation, services can be provided in the most cost-effective manner. Often, states eliminate or limit services which may reduce the need for more costly services later. A prohibition on such limitations in the CHAP legislation would help realize the goal of improving the health of the nation's children in the most cost-effective way possible.

The EPSDT Program has long been in need of major overhaul. We look forward with anticipation to the rapid pas[illegible]ge and implementation of the CHAP legislation. We appreciate the opportun[illegible]rticipate in this process. Please do not hesitate to contact me if I can be [illegible]e.

Yours truly,

DAVID CHAVKIN,
Senior Staff Attorney.

THE AMERICAN COLLE[illegible]STETRICIANS AND GYNECOLOGISTS,
Washington, D.C., August 21, 1978.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR CHAIRMAN TALMADGE: The American College of Obstetricians and Gynecologists is pleased to comment on the content and interest of S. 1392, the "Child Health Assessment Act," now before your Subcommittee on Health of the Committee on Finance.

The members of the College—totaling nearly 20,000 obstetricians and gynecologists in the United States and North America—applaud your efforts to continue and expand the health benefits under the early and periodic screening, diagnosis, and treatment program (EPSDT). We feel that the EPSDT program has made a positive contribution to the health and well-being of the children served by acknowledging the importance of preventive and comprehensive health care. By broadening the definition of eligibility, thereby including additional children for participation in the Child Health Assessment Program authorized by the provisions of S. 1392, the Subcommittee has moved toward achievement of these goals.

We further support provisions similar to those included in the amendments to S. 1392 submitted on August 15, 1978, by Senator Cranston on behalf of the administration. These amendments would open eligibility for participation in CHAP to individuals below the age of 21 who are financially eligible under the State welfare or Medicaid standard. The present bill only extends eligibility based on income apart from categorical definitions for those under the age of six. Adolesence is a time of great importance, not only to the health of the young person, but to the health of babies born to adolescents.

In addition, the College strongly supports provision of Medicaid eligibility to all pregnant women who otherwise would qualify for Medicaid assistance if they had a dependent child. By including these women who are pregnant for the first time, we will be able to serve a critically needy population who otherwise would have no assured prenatal care and thus jeopardize their health and the healthy delivery of their children. These women would, in any case, become eligible within six to eight months; but it is a critical six to eight months for the health of mother and child. In light of the serious rise in our country of the incidence of adolescent pregnancy and the need for assuring these young mothers of good health care, it is essential for the Committee to incorporate these amendments into the Senate legislation. We look forward to the expanded provision of these needed services and implementation of the programs with the enactment of legislation currently under your consideration.

Our members practicing obstetrics and gynecology recognize the importance of, and contribute to the good health care of participating families by serving as providers according to agreement with the appropriate State agency. We do have concern, however, with the language of the bill with respect to this agreement. Specifically, our concern lies with the providers responsibility to "follow-up to assure the provision of such treatment" and "to assure . . . that reassessments are performed as required" (section 1912(b) (3) and (4)). As physicians, we question the feasibility of mandating this responsibility to the provider. In essence, continuation of proper health care can be assured only if the individual being served shares responsibility for his own health. The provider certainly can facilitate this action by making his services easily accessible and providing mechanisms to encourage continued participation in the program. In this regard, we urge further consideration of this provision within the bill and suggest that any new language incorporated into S. 1392 should reflect our concern for this followup activity.

Again, we commend you for your efforts with respect to maternal and child health care and would be pleased to provide any assistance to the Committee as this legislation moves forward in the Senate.

With best wishes,

Sincerely,

ERVIN E. NICHOLS, M.D. FACOG,
Director, Practice Activities.

AMERICAN ACADEMY OF CHILD PSYCHIATRY,
Washington, D.C., August 17, 1978.

Hon. ABRAHAM RIBICOFF.
Committee on Finance, U.S. Senate,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR RIBICOFF: The American Academy of Child Psychiatry, the American Association of Psychiatric Services for Children, the American Psychiatric Association, the Association for the Advancement of Psychology, the Mental Health Association, and the National Association of Private Psychiatric Hospitals appreciated the opportunity to testify before the Senate Finance Health Subcommittee on August 14 on S. 1392.

We wish to expand and clarify the responses made to you by Dr. Joseph Noshpitz regarding an acceptable alternative which our organizations would consider in order to reduce the costs incurred if all treatment for mental illness, mental retardation, and developmental disability were made mandatory in the Child Health Assessment Program (CHAP).

Our organizations strongly believe that it is cost effective to include coverage for mental illness in the same manner as physical illness—without exclusion by diagnosis. Studies, such as those indicated in the enclosed summary, show lower costs for the treatment of physical illness when adequate mental health services are available.

The House Committee on Interstate and Foreign Commerce has taken a first major step in its legislation: it has mandated treatment for children screened and diagnosed with mental illness, mental retardation, or developmental disability for all but inpatient treatment in psychiatric hospitals. We hope that the Senate Finance Committee will go beyond this to insure that all treatment modalities are available on a mandatory basis, and that exclusion by diagnosis or type of treatment will be eliminated from S. 1392.

However, as you recommended in the course of the hearing, representatives from our organizations would be pleased to meet with your staff and the staff of HEW to further discuss mental health provisions in the CHAP legislation.

Sincerely,

VIRGINIA Q. BAUSCH,
Executive Director,
American Academy of Child Psychiatry.

COVERAGE OF MENTAL HEALTH IN NATIONAL HEALTH INSURANCE CAN BE COST EFFECTIVE

Early studies, such as Goldberg, Krantz and Locke's, conducted in 1965, have located a significant factor in the cost of comprehensive health coverage.

The results of their pilot study clearly indicate that, "the short-term outpatient psychiatric benefit at G.H.A. (Group Health Association) was associated with a decrease in the utilization of physician and ancillary services under the plan. Not only was there a decreased utilization following psychiatric referral for the study group as a whole, both with respect to the number of persons seen and the number of visits made, but this decreased utilization held—to a greater or lesser degree—for all subsegments of the population studied. . . . There was no attempt to do any cost-benefit analysis in this study, the primary purpose of which was directed at utilization without regard to costs. However, an inference could be made that the cost savings due to reduced utilization would be reflected in the entire benefit structure without setting forth dollar amounts." [1]

Other studies at Kaiser-Permanente [2], and at the Department of Research and Statistics, Health Insurance Plan of Greater New York [3], strengthen the hypothesis that reduced utilization of medical services is a result of short-term outpatient mental health benefits, in prepaid health plan settings.

Mary Ellen Olbrisch in "American Psychologist" [4] has prepared an overview of the literature on the effects of psychotherapeutic treatment on physical health. She says, "A question of central importance in policy decisions regarding national health insurance is whether it will be economically feasible to cover the cost of psychotherapy." In reporting the effects of psychotherapeutic programs on alcohol abuse, she notes that, "Persons with alcohol problems constitute a group whose medical costs are very high. In addition to their high utilization of medical services, these individuals cost their employers a great deal in absenteeism and lost production. Some interesting research has been conducted which suggests that active intervention programs not only reduce medical care utilization by troubled persons, but actually result in a profit to the employer funding the intervention program."

The Kennecott Copper Corporation has estimated a return of "$5.83 per $1.00 cost per year for its psychotherapy program. Impact is noted in reduced absenteeism, reduced hospital, medical and surgical costs, and reduced costs of non-occupational accident and illness." [4] [5]

More recently, December 1976, a study sponsored by Blue Cross of Western Pennsylvania reports that "overall medical/surgical utilization is reduced for that subgroup of subscribers who use the outpatient psychotherapy benefit. Further, this phenomenon of reduced medical/surgical utilization with exposure to outpatient psychotherapy was found to be independent of age, sex, or employment level (salary versus hourly employee groups). The study findings are consistent with the results of two previous studies. . . ." [6]

The Western Pennsylvania study estimates the resultant cost savings relative to the cost of providing the benefit. "Since 1958, this population has had access to outpatient psychotherapy services through a community mental health clinic. However, Blue Cross coverage for these services did not become available until January, 1968.

The outpatient coverage provided for this population includes only those services obtained through the local mental hygiene clinic or a similar 'approved comprehensive community mental health center.' The outpatient services covered included:

1. Group therapy up to 50 sessions during any 12-month period;
2. Collateral visits with members of the patient's family;
3. Professional services up to 50 visits during any 12-month period;
4. Psychoactive drugs.

Inpatient coverage, which was not limited to the clinic, provided for up to 90 days of inpatient care per year.

Emphasis was on early referral and short-term intensive therapy. Services of all mental health disciplines were covered, including those of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. The first 15 visits for any of these services were covered in full. Thereafter the subscriber was required to make a co-payment of one-third of the cost of covered services. The coverage was designed to discourage long-term psychotherapy by stipulating that any treatment given more than 15 days following the date of the first covered service would be covered only if a psychiatrist certified that continuing treatment was required. Thereafter, this certification had to be renewed every 30 days."

These benefits closely resemble those advocated by the Mental Health Association for inclusion in National Health Insurance.

Findings of the study report that "The average adult total monthly costs after initiating outpatient psychotherapy are $8.52 less than they were before first outpatient psychiatric contact (even with the cost of that therapy included), . . ."

Figure I compares the pre-contact and post-contact experience of adult males with that a adult females. "Of particular interest is the indication that adult males have the highest pre-contact use of medical services of any sub-group in the sample (costs of $21.00 per month), the greatest post-contact reduction in use of these services ($15.72), and the greatest reduction ($11.23) in total costs per month after initiating outpatient psychotherapy."

The California Psychological Health Plan, a statewide, prepaid mental health plan offered by a public carrier, entitles eligible subscribers and their dependents (for a cost of $4.00 per family, per month), to obtain benefits from any member of a panel of 200 contracted providers located throughout the state.

The plan is based on the concept that the consumer has the responsibility for his/her own mental health and its maintenance through utilization of insured mental health benefits. The California Psychological Health Plan emphasizes education of the consumer about mental health needs, and early intervention. It offers incentives through a system of total confidentiality, no deductible, no co-payment for the first five visits, quality control and the elimination of claim forms.

The C.P.H.P. was first placed in a small health and welfare trust of 1,000 employees and their families. The trust had been insured for 5 years prior to the integration of C.P.H.P. in the benefit program. In the year prior to the institution of the C.P.H.P. (11–74 to 8–75), 95 percent of the total paid premium was paid out by the company for medical claims. In the year following (12–75 to 9–76), 73.5 percent of the premium was paid out for medical claims. Within one and one-half years, the "loss ratio" had decreased to 67 percent. These figures represent an approximate decrease of 27 percent in medical care utilization costs.

FIGURE 1

COMPARISON OF ADULT MALES AND ADULT FEMALES—MONTHLY AVERAGES OF UTILIZATION BEFORE AND AFTER FIRST OUTPATIENT PSYCHIATRIC CONTACT

			Medical-surgical			Psychiatric			
	Number	Average expsoure (months)	In-patient days/month	Out-patient visits/month	Cost/patient/month	In-patient days/month	Out-patient visits/month	Cost/patient/month	Total cost/patient/month
Adult males:									
Precontact	24	21.74	.198	.139	$21.00	.157		$6.72	$27.72
Postcontact	27	24.15	.077	.015	5.28	.154	.715	11.21	16.49
Adult females:									
Precontact	43	2[illegible]95	.189	.044	13.22	.205		7.72	20.94
Postcontact	50	2[illegible]23	.096	.025	8.83	.043	.491	5.95	14.78
Increase or (decrease):									
Adult males			(.121)	(.125)	(15.72)	.003	.715	4.49	(11.23)
Adult females			(.094)	(.019)	(4.39)	(.162)	.491	(1.77)	(6.16)
Ratio—post/pre:									
Adult males			.389	.107	.251	.980		1.669	.595
Adult females			.505	.675	.668	.210		.771	.706

The only component in the trust which changed, over this period, was the mental health benefit. [7]

Research findings continue to show the relationship between appropriate mental health coverage and reduction of cost of physical health coverage. Nicholas Cummings, reflecting on his studies now in press, says, "We have found not only that psychotherapy can be economically included as a prepaid insurance benefit, but also that failure to provide such a benefit jeopardizes the effective functioning of the basic medical services, since 60 percent or more of the physician visits are made by patients who demonstrate on emotional, rather than an organic, etiology for their physical symptoms." [8]

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YALE UNIVERSITY,
SCHOOL OF MEDICINE,
New Haven, Conn., August 14, 1978.

Mr. MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: I would like to submit for the record of the hearings on the Child Health Assessment Act (S. 1392), the enclosed recently published report of the Yale Health Policy Project on "Uncertainties in Federal Child Health Policies."

The findings of this study relate directly to the CHAP legislation, particularly the recommendations on pages 20–21. To improve federal child health programs, we recommend the consolidation of existing agencies or creation of new ones to avoid present fragmentation. We also recommend the development of appropriate reporting systems, case management systems, and the increase in matching rates to provide states with greater incentives to carry out programs.

Thank you for the opportunity to submit this statement.

Sincerely yours,

ANNE-MARIE FOLTZ, M.P.H., M. Phil.,
Research Associate.

NCHSR

RESEARCH DIGEST SERIES

Uncertainties of Federal Child Health Policies: Impact in Two States

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Center for Health Services Research

National Center for Health Services Research Research Digest Series

The *Research Digest Series* is published by the National Center for Health Services Research (NCHSR) to provide overviews of significant research supported by NCHSR. The series describes either ongoing or completed projects directed toward high priority health services problems. Issues are prepared by the principal investigators performing the research, in collaboration with NCHSR staff. Digests are intended for an interdisciplinary audience of health services planners, administrators, legislators, and others who make decisions on research applications.

Abstract

This report assesses the impact of federal child health policy under Titles V and XIX of the Social Security Act upon the states of Connecticut and Vermont for the years 1935 to 1975, and analyzes the reasons for the discrepancy between policy intent and state execution. Research methods comprised a review of Congressional intent, HEW regulations, state legislation, administrative performance, services with special reference to urban/rural variations, and EPSDT. This study offers a basis for a methodology for policy evaluation studies in other states or the country as a whole. *Findings:* federal agencies diversely interpreted federal laws; states faced with uncertain policy, short funds, and external pressures failed to comply even with the federal EPSDT mandate. Since HEW failed to monitor its programs, states faced no loss of funds or penalties. *Recommendations:* that Congress provide sufficient funding to assure state cooperation, and monitor state performance with continuous reporting systems; that Congress be specific as to populations to be served and services to be provided; that administrative agencies be consolidated to avoid interbureaucratic confusion; and that child health advocacy groups become more involved in legislation and in monitoring programs.

NCHSR

RESEARCH DIGEST SERIES

Uncertainties of Federal Child Health Policies: Impact in Two States

by Anne-Marie Foltz

April 1978

DHEW Publication No. (PHS) 78-3190

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Center for Health Services Research

This issue of the NCHSR Research Digest Series by Anne-Marie Foltz draws on her work and that of Yale Health Policy Project colleagues, Christa Altenstetter, James Warner Bjorkman, and Milton Chen under the leadership of Dr. George A. Silver, principal investigator. The research was performed for NCHSR under Grant HS 00900.

Mrs. Foltz is Research Associate and Lecturer at Yale. Dr. Silver is Professor of Public Health at Yale.

The final report of the grant, *Impact of Federal Health Policies in the States of Connecticut and Vermont*, 397 pages, is for sale to the public from the National Technical Information Service, Springfield, VA 22161 (tel.: 703/557-4650), and may be ordered as PB 262 959 in either paper or microfiche.

The research staff thanks the Commissioner of Health of Connecticut, Dr. Douglas Lloyd, and the former Commissioner of Health of Vermont, Dr. Anthony Robbins, for their assistance; Dr. Estelle Siker, Director of Community Services, Connecticut, and Mr. Paul Philbrook, Director of Social Welfare, Vermont, for providing records and financial information; and the Yale Health Policy Project Advisory Board, Drs. Thomas Dolan, Jack Elinson, James Fesler, Herbert Kaufman, Kenneth Keniston, Howard Newman, Donald Patrick, and David Warner.

NCHSR publications are avail[illegible]on request from NCHSR, Office of Scientific and Technical Information, room 7-44, 3700 East-West Highway, Hyattsville, MD 20782 (tel.: 301/436-8970). Current NCHSR publications are listed inside the back cover.

Foreword

This report reviews two federally supported child health care programs from the original statement of Congressional intent to its questionable delivery at the local level in two states. While other stud[illegible] have documented the variance between Congressional intent and local performance, this provides the in-depth analysis necessary to identify and weigh its causes. The particular value of this study is that its findings and recommendations can be used to assess the prior effects of national health care policy as well as to guide the formulation of health care legislation and interest group participation in the future.

Gerald Rosenthal, Ph.D.
Director

April 1978

Preface

The extraordinary interest in health policy during the past decade reflects both public and professional concern. Political scientists, long preoccupied with purely theoretical formulations, increasingly have seized opportunities to test theories in the marketplace. The public, disappointed in political solutions that did not solve social problems, increasingly turned to the academic community for answers. Health care, particularly in recent years, has been a source of public discontent and academic inquiry. However, evidence of public dissatisfaction and demand for action can be traced back as far as the Republican Party platform of 1912, when national health insurance was one of the Bull Moose planks. Academic concern goes back as far as the 1916 report of Edgar Sydenstricker and Rollo Britten to the Public Health Service designing a National Health Insurance program. But the attack on the process of public and private medical care financing and delivery is more recent, and the investigation of the policy process, from program inception through implementation, is also relatively new.

Many studies have been directed at the policy formation process whereby public concerns are turned into laws. Fewer studies have been directed at the obstacles, flaws and miscarriages between the passage of a law and its implementation. Yet it is the visible effects of the law, success and failure in the light of the Congressional intent, that cry out for study.

In the case of child care, we wanted to find out why there were few services, and lagging examinations and immunizations, despite heavy federal investment.

The path of study led through many interesting ramifications. Addressing ourselves to the federal/state interface, the Yale Health Policy Project reviewed the relevant papers and reports affecting Connecticut state child health activity and, later, Vermont activities over the past 40 years, and interviewed present and former officials, interest group leaders and public figures along the way. It was a monumental task, fascinating in the history it revealed and a bit disheartening in the pattern of social policy it displayed.

In this report interested readers can find some explanation of the puzzling contradictions in our public posture and program shortfall, evidenced in the federal/state programs affecting child health. Neither the conclusions nor recommendations can be generalized because the information is drawn from only two states. In any case, the project findings indicate that more federal concern, more federal supervision, and better reporting, would seem to be needed. Until the Congress and the American people reach some consensus as to what they want in the way of a child health program, what the goals are and how they might be reached, conclusions drawn from policy studies can only be tentative, at best. It seems that for the foreseeable future, federal health (and child health) actions will be crisis generated and not derived from reasoned construction and judicious long-term planning. The lessons of these programs therefore ought to be taken to heart.

George A. Silver, M.D.

Contents

Introduction

In 1972, the Yale Health Policy Project undertook a study of the impact of federal health policy on the states. Child health policy was chosen as the focus of the study; and two New England states, Connecticut and Vermont, were chosen as the sites. The purpose was to analyze the implementation of federal policy to explain the gap, often noted in the literature, between federal intent and state performance. The research questions were: What was the intent of federal child health policy; did federal programs stimulate states to carry out federal policies; if not, what were the major causes of this failure; and finally, which of these causes was amenable to change?

The rationale for this ambitious undertaking was that few studies of this kind had previously been undertaken and none existed in the field of health even though federal involvement and commitment in health through grant-in-aid programs had increased notably since the 1960's. Such a study could thereby provide valuable information about the operation of federal health programs.

This NCHSR Research Digest reviews the methodology and findings of the project. The findings have been presented in published papers, project working papers, and in the final report (3) submitted to the National Center for Health Services Research, which supported the four-year study. Since a report of this size cannot do justice to so diverse a project, publications and reports are cited to assist the reader in finding original sources.

Methodology

Model and framework

For this study, we adopted a model based on a definition of policy as "a projected program of goal values and practices." Policy in our model is a dynamic process and hence subject to changing or diverse conceptions both within one level of government and also through the various levels of government from inception and regulation to implementation. It is recognized that policy may be formed as much from informal administrative practices as from laws, regulations and rules. The flow of policy is not necessarily one way; decisions taken at lower levels of government can affect those at higher levels. Nor can the various levels of government be considered autonomous or closed, as the model presupposes permeability of governmental institutions. We proposed, then, a project which would follow more closely the format of implementation studies than program evaluations.

To analyze the flow of the policy process requires a detailed knowledge of shifting events and actors. To make this task manageable, the scope of the project was limited to cases which would be studied comprehensively. These cases were limited by: (1) geographic area, (2) target population, (3) policy content, and (4) the way in which impact was assessed.

Connecticut, an urban state, was chosen as the original site for the implementation study. As the project progressed, we chose Vermont, a rural state, as a second site to test hypotheses generated by the Connecticut study and to verify that we were not dealing with unique relevant characteristics. Any state, in some sense, is unique, and in case studies, generalizations, from a sample of two, must be made with a certain caution. The case studies provided the opportunity for the careful analysis of interrelationships which would not be available in cross-sectional and survey analyses alone.

Children were chosen as the target population because the effects would be easier to assess when the federal program was aimed at a particular population than when it was more diffuse in intent. The study of child health was particularly compelling. We suspected that despite the mythical primacy of the child in the American "child-oriented" society, there was sufficient evidence in terms of the prevailing higher health risks for poor children, that children, and particularly poor children, were not getting their fair share in American society.(1, *27–32*) Moreover, health policy toward children constitutes major social policy since children comprise 40 percent of the United States population. Public interest, or at least public rhetorical interest, in children is high, exemplified by the White House Conferences on Children held every decade since 1909. Other studies on child health programs had focused on surveys, cross-sectional analyses, and inventories, but none had examined the processes of child health policy itself.

Many different child health programs were considered, but it was clear we could not study all federal programs and policies affecting child health. The criteria for inclusion in the study were that the program had to be directed mainly toward the health of children, and had to be broad in scope, affecting as many children as possible. From these criteria, two programs, both legislated under the Social Security Act, emerged as the logical choices:

Title V : Maternal and Child Health (1935)
Crippled Children's Services (1935)
Maternity and Infant Care Projects (1963)
Children and Youth Projects (1965)
Title XIX: Also known as Medical Assistance, or Medicaid (1965).
Early and Periodic Screening Diagnosis and Treatment (EPSDT 1968).

These were the major child health programs of DHEW and accounted for the greatest proportion of federal funds expended for child health and for children served. By 1970, the latecomer, Title XIX, had outstripped even Title V in both dollars and services. (Table 1) Both Titles V and XIX involved grants-in-aid to the states, but they provided also a series of contrasts. Title V was a system of formula grants to the states, and project grants to localities: Title XIX was open-ended reimbursement to the states for medical vendor payments. The formulae used to allocate grants among the states were different. Title V allotments were determined by a ratio to favor poor and rural states with each state required to match federal funds with equal state funds; Title XIX reimbursements were made on the basis of a matching formula intended to favor poorer states. The categorical formula grants of Maternal and Child Health (MCH) and Crippled Children's Services (CCS) could be considered the forerunners of health revenue sharing since their mandates were broad and they provided wide latitude for the states. The Title V projects were so specialized and localized that we chose to consider their impact only in the context of the larger Title V formula grants and the Title XIX programs. Title XIX was a system of vendor payments for health services which reimbursed the states for certain types of health services for three categories of persons: (1) those eligible for public assistance; (2) those categorically eligible whose incomes made them medically needy; and (3) all financially eligible children. (2)

In both Titles V and XIX, states could choose whether or not to participate. In the case of title V, within a few years of its passage, all states elected to participate. For Title XIX, only two states, Arizona and Alaska, were not participating by 1972.

During the first year of our study, we spent considerable time defining quantifiable indicators of impact and obtaining data on them. As we learned more about federal-state administration and the service arena, it became clear that the sketchy nature of the data available would not in most cases provide reliable quantifiable indicators to demonstrate federal impact. Moreover, any causal connection between federal policy and service, or health outcome, could not be presumed from any change that appeared subsequent to federal legislation. Many other factors, perhaps not quantifiable, might intervene. Impact, was not to be demonstrated on the health outcome of children, but to be described through an analysis of the state level and service level changes which took place during a period of increasing federal investment in child health programs.

Four major areas of research became the focus for the qualitative assessment of impact: (1) administration and relations among and within different levels of government; (2) health services delivered by the federally sponsored programs; (3) expenditure patterns for child health, both federal and state; and (4) private interest group activity in the states in relation to federal policy. We also expanded our time frame to provide for historical analyses of the Title V programs which date back to the 1930s. Their implementation provided the administrative framework within which the developments of more recent years must be viewed.

Procedures

Given the broad framework of the policy process model, data gathering was of necessity eclectic, using techniques mainly from the fields of public health and political science. Two approaches were used simultaneously: the first was a cross-sectional perspective using data collected from one time segment across different areas; and the second was an historical approach for analysis of the development of policy and administrative change. Federal intent for titles V and XIX was analyzed first through legislative intent by the study of Congressional reports, hearings, and debates, the *Congressional Quarterly*, and interviews with relevant actors. Federal executive intent was then examined through regulations, guidelines, informal Department of Health, Education, and Welfare (HEW) memos and letters, and also through interviews with those in the executive agencies charged with promulgation of regulations (which have the force of law), and implementation. The distribution of Titles V and XIX funds among the states was also collected as well as whatever data were available on services provided by the programs under study. The HEW Region I

5

office provided data in the form of memos and interviews as to its role in the policy process.

State activities were analyzed from legislation, debates, reports, hearings and newspaper files; from health and welfare department reports on services and administration; and from financial statistical data from the fiscal office. In addition, demographic data were calculated for the states, including density of population; proxies for need, such as infant and neo-natal mortality rates; poverty levels; and distributions of health resources. As for the federal level, relevant actors were interviewed.

During two summers, surveys were held in Connecticut and Vermont to assess the impact of the Medicaid-EPSDT program on health providers and children's services, and to assess its relation to the earlier established Title V MCH and CCS services and projects. These surveys included inventories of child health resources in the states and interviews with providers.

The role of private interest groups was examined through studies of voluntary health and advocacy organizations, as well as the professional associations, with particular attention to the medical societies. These groups were studied through their publications and interviews.

Out of the materials and interviews the staff prepared a chronology of events describing state activities prior to and following federal legislation. From the descriptive material, a series of analytic working papers was prepared to serve as mutual information sources and for testing hypotheses. These papers and additional materials then became the basis for publications and the project reports.

Findings

The states of Connecticut and Vermont

Connecticut and Vermont were chosen as contrasts for this study: they are respectively high and low income, urban and rural, industrial and agricultural. (Table 2) Politically, Connecticut has seen continuous changes and competition between the political parties, while Vermont remained long a Republican stronghold. In administrative structures the states differ too: Vermont has fewer autonomous agencies, and has an integrated human resources agency, while Connecticut has maintained separate government agencies for different functions and even for different populations cutting across functional lines.

However, the two states were markedly similar in several surprising respects. Both states have more physicians per capita than the national average and rank in the top ten states for per capita Medicaid expenditures. Infant mortality is lower in Connecticut and Vermont than in the nation as a whole, but Connecticut has a higher non-white population (6 percent) and sharply divergent mortality rates for this latter group.

In social policy, at least policy directed toward child health, we found the states differed markedly. Vermont has tended to apply universalist solutions to its problems, while Connecticut focused on assistance only to certain selected needy groups. Thus, the Vermont legislature produced more progressive legislation than its Connecticut counterpart although Connecticut's financial resources were greater. (3, 2[illegible]) When dental services for children were required under the EPSDT program, the Vermont legislature initiated a dental insurance program for all low to middle income children while Connecticut served only those required under Medicaid and, in fact, decreased the services available to children. (4, *17*) Administratively, means tests for CCS services were never adopted in Vermont, but were established in Connecticut.

It is not clearly evident what accounts for these divergent social policies. What accounts for Vermont, a poor state, spending as much per capita as Connecticut? The usual quantifiable indicators, such as health needs, health resources, or fiscal resources, do not explain the differences. More likely it stems from a self-selected population which is more committed to social goals, despite its relative poverty, and which on ideological grounds, performs differently from its equally poor counterpart states.

Intent of federal policy

"Ambiguous" was the word we used most frequently to describe federal intent for child health policy. Some of the confusion as to intent can be attributed to excesses of rhetoric raising hopes and expectations which cannot be met in the practical implementation of a program. Congress, in its legislation, was the main creator of ambiguity, but the problems were compounded as policy moved from the legislative arena to the executive branch and then to the states and localities for interpretation and reinterpretation.

The stated Title V—MCH goal of "promoting the health of mothers and children" was broad and clear in intent. However, since 1935, the funds allocated for this purpose by Congress have been so low per capita that no observer realistically can expect the states to initiate major child health programs on the basis of the additional federal funding. Moreover, another goal also underlay the original Title V legislation. The prevailing philosophy among health professionals of the day was to build up health resources which were lacking in the country as a whole by building up public health agencies. (3, *33–38;* 1, *36–38*) Title V required the establishment of a single-state agency (health department) to administer the federal grant programs. The public health interest groups felt that only fully formed public health departments could carry out a federal mandate to promote the health of mothers and children. Thus, the administrative base would have to precede any federal attempts to provide direct services to children. This philosophy prevailed until the 1960's when Title V instituted projects in selected localities which would provide direct services, but these were not of a scope to have national impact. Yet, the service orientation of Title V did exist from the beginning in the Crippled Children's Program, the other major part of the Title V legislation. This program required states to identify and treat children suffering from handicapping conditions.

The potential for conflict and uncertainty as to goals was built into the original Title V legislation. In addition, the Children's Bureau, which administered the program, over the years elaborated policy which was not always consonant with the original Congressional goals, imprecise as they may have been. (3, *147*)

Title XIX (Medicaid) intent was hedged with restrictions. "As far as practicable under the conditions" in each state, the states were to furnish medical care to welfare recipients and the medically needy. As with Title V, a single state agency had to be designated to receive funds. Each state could determine what was practicable for itself. There were no obligations in the law if the states chose not to accept Title XIX. Even if a state chose the program, the procedures spelled out in the Handbook of Public Assistance (no regulations were published until late in the 1960s) were not limiting. Moreover, the states quickly learned, as they had with Public Assistance, that the federal government would not enforce its own rules. In Medicaid's ten-year history, no state had been found out of compliance. The law and regulations were therefore unclear since states that did not conform, even when the subject of Medicaid scandals, were not penalized.

A major confusion of intent in the Title XIX program arose in 1968 after Congress had added a requirement that each state was to provide its eligible children under 21 with early and periodic screening, diagnosis, and treatment (EPSDT). This amendment could be read as a mandate for comprehensive care for every Medicaid-eligible child. However, the scope of the screening and care, and the definition of the children eligible to receive services were hardly mentioned by Congress in its hearings or debates. Estimates of cost were applied separately for Title XIX and CCS programs, which were also part of the amendments, with no mention of how the two implementing agencies would carry out these programs or reimburse one another, if at all. Another amendment requiring agreements between different agencies did not clarify matters much. It was not clear whether health or welfare would be responsible for the program. Moreover, HEW's long delay in issuing regulations confused matters more because the states began to recognize that HEW itself was not much interested in enforcing Congressional intent. HEW, in regulations which finally emerged in late 1971, defined the narrow scope of treatment services following screening. However, the regulations did not clarify the ambiguity in administrative direction. To compound matters, in 1972 Congress reaffirmed its intent by requiring states to inform all eligible persons of the program and thereby engage in outreach services at the risk of incurring a one-percent penalty against state AFDC funds. (5, *40–64*) Again, HEW delayed several years before issuing penalty regulations. Thus, in the case of EPSDT, HEW and Congress each were providing different interpretations of federal intent to the states.

Further confusion in intent was created by frequent HEW reorganizations. The Children's Bureau, the original administrator of the Title V programs, was eventually dismembered, while the major expenditures and services for child health were administered under Title XIX by the Medical Services Administration, whose major concerns were not children but services for the adult poor which took up more than 80 percent of its expenditures.

Despite these ambiguities, federal policy intent can be seen as both stimulative and redistributive. The purpose was to stimulate states to spend their own funds on federal goals and to redistribute funds from wealthier to needier areas both within states and among states. The Title V program was to stimulate the states to increase their expenditures for child health through the required matching mechanism, to build health agencies, and to provide services, particularly for handicapped children. The Title XIX program was to stimulate the states to pay for medical assistance to all persons eligible for welfare and for the medically needy as well as for financially eligible children if the states chose the option of including these two latter categories. (2, *3–5*) In addition, the EPSDT program was to stimulate states to provide for preventive health and treatment services for all children eligible under Title XIX and to search out these children and bring them in to care. As with Title V, states would be expected to increase their expenditures in order to match federal grants.

Federal policy was also directed toward the redistribution of funds among the states. The Title V legislation targeted rural and poor areas and the administrators carried out this policy by adopting an allocation formula which would favor states with these characteristics. Title XIX matching grants also favored poor states by adopting a matching formula which matched federal to state funds on a sliding scale from 50 to 83 percent, depending on the state's wealth.

Within the states as well, the policy was also redistributive. Title V was targeted to rural and poor areas while Title XIX, through its tie to the welfare programs, directed its services to the poor and near poor.

Were federal policies stimulative?

Federal policy intent to stimulate the states could result in four possible outcomes: (1) states could increase their funds allocated for federal purposes; (2) states could provide services required by the federal policy; (3) states could build up their administrative capacity to handle the federal programs; (4) private interest groups could be stimulated to participate more in the state-federal policy-making process.

Fiscal stimulation. The fiscal stimulation was expected to take place mainly through the federal matching ratio, although the fact that the Title XIX funds were open-ended gave the states potential for limitless funding as long as they were willing to spend some of their own funds as well. In the case of Title V, neither Connecticut nor Vermont appreciably increased its state funds for child health when it began its programs. Since both states were already supporting child health and crippled children's services before 1935, these programs were used as the matching funds to obtain the additional federal funds. (3, *315–316*) Federal administrators never examined closely how the states arrived at their matching fund figures.(6) Today, this practice is so ingrained that state matching in Title V formula funds is only an accounting procedure. Any personnel and activities in state and local health departments which are in the field of child care all qualify as matching funds. The minimal stimulation effect of the matching requirement may be attributed partially to the fact that the overall state child health programs represent only a small fraction of the state budget. (3, *315–317*)

In the case of Title XIX, earlier researchers had found that no stimulation effect had taken place. Our study (7, *13*) indicated that Medicaid expenditures from state and local sources could be explained mostly by factors such as fiscal capacity and urbanization. The federal matching ratio of between 50 and 83 percent did not provide strong incentives for generating state fiscal effort. Yet, both Connecticut and Vermont, despite this lack of incentive, increased their spending for Title XIX. Between 1968 and 1973, Connecticut's Title XIX expenditures rose from $58 million to $119 million while Vermont's rose three-fold from $8.6 million to $24 million. Thus, although the matching ratio did not of itself stimulate spending, the availability of federal funds did stimulate Connecticut and Vermont to increase their expenditures for health services to the poor.

Impact on services. Table 3 shows that both Connecticut and Vermont experienced a decline from 1940 in the proportion of the population served through well child clinics, and an overall decline in MCH direct services. (Data were not available for the years prior to the implementation of Title V in 1935.) In the CCS program, Vermont consistently provided services for at least that proportion of the population that might be considered poor and near poor while in Connecticut the proportion of children served declined to far lower than the proportion below the poverty level. (3, *220–225*)

Over the years, both states had been providing fewer direct MCH services and Connecticut alone decreased crippled children's services. If the original intent of Title V was mainly to build up an infrastructure to assist in child health services, then the services should not have declined, as they did, long after the structure was in place. We concluded that the goal of services, although not explicit in the Federal intent, was one that was accepted by the states, at least in their early implementation. The later move from direct services must be explained by shifts in state views of the role of public agencies toward the private sector and particularly their reluctance to compete with physicians whose numbers greatly increased during the forty-year period under study.

In Medicaid and EPSDT programs, the numbers of children served in both states increased over the years. Unfortunately, data were reported separately for the two services so that there may well be duplications. Table 4 shows the growth of these services and the increasing proportion of the population covered. Prior to EPSDT, almost all these services were for acute episodic care. EPSDT was intended to bring the children into regular and periodic care. However, we found in both states, that many of these EPSDT children had been served earlier through free clinics. (4, 8) Moreover, screening services were likely to be highest in those two or three areas where states had established Title V projects.

The EPSDT services reported only screenings. Neither state could document whether children who were screened and needed treatment were followed and received the required care. Moreover, the states reported each screening as a separate child, so that an infant who received several screenings in a year would be counted several times, inflating the number of children who received care during the year. In the case of Medicaid-EPSDT, the program, rather than competing with the private sector, provided reimbursement for it without interfering with prevailing private patterns of health care. Nevertheless, for ESPDT, both states exhibited reluctance to proceed with implementation of the program as evidenced by the low proportion of eligible children who received services during the first two full years of implementation, fiscal 1974 and 1975. The particular format of the Title XIX grant system was a weak instrument to stimulate the states to increase services (4, *20–21*)

Impact on administration. The federal requirement to designate a single state agency for both Title V and XIX programs strongly stimulated the development of state administration. This administrative device required changes in state laws after 1935 to allow health and welfare departments to accept and administer federal funds under Title V and the welfare titles of the Social Security Act.

Under Title V, Connecticut already had its Bureau of Child Hygiene which qualified for MCH funding, but it had to create a separate crippled children's division. Vermont reconstituted an MCH unit and brought in a privately-funded infantile paralysis division as the basis for a state crippled children's division (3, *239–241*) The funds were then used to build up personnel in the two divisions.

The single state agency requirement had affected welfare agencies in the 1930s and had permitted them gradually to take over the welfare functions of localities.(9) By 1965, the welfare agencies in both Connecticut and Vermont had grown considerably. In Connecticut and Vermont, as in most states, the welfare department was designated as the single state agency for Title XIX. (A few other states designated health departments.) The states took on little administrative staff to carry out Medicaid. By 1973, Vermont had one staff person and Connecticut had three staff persons administering a program of $24 million and $119 million, respectively. Thus, even though federal matching funds were available for administration as well as for vendor payments, in contrast to the Title V programs, state Title XIX programs were, if anything, underadministered. This problem became particularly evident when the states were required to carry out the EPSDT program. The paperwork of the officials at times seemed to overwhelm them (10, *3–19*) Even though federal funds were available with the usual matching by the state, states did not take advantage of these funds to build up their managerial capability for these large programs. In this case, the federal stimulative policy did not work.

The single-state agency requirement turned into its own kind of administrative headache for the states as it developed state agencies with overlapping functions. States were not allowed to consolidate their MCH and CCS divisions until as late as 1974 even though the divisions' functions overlapped. (3, *239*) More confusing was the overlap of functions where the welfare departments had to provide for services under Medicaid, and then for preventive health services for children through EPSDT. The health and welfare agencies were asked to "enter into agreements" but the agency with the service capacity (health) was not the agency with responsibility (welfare). Federal policy stimulated both health and welfare agencies to develop overlapping functions within the state.(8)

Impact on interest groups. The existence of federal policy, particularly in crippled children's services and EPSDT, stimulated interest groups which used the federal policy as a focus for their activities. In Connecticut, associations were formed on behalf of children with cystic fibrosis, cerebral palsy and cardiac disease. Within a few years the state legislature required that these diseases be included in the state's coverage of its crippled children's program (3, *253*). In Vermont, a public interest group lobbied successfully for a dental insurance program for children at the time that the state became required to provide dental care to Medicaid-eligible children. (4, *16–17*)

Poverty lawyers working on behalf of Medicaid-eligible clients filed suits to oblige states to implement federal law and provide preventive health services to children under EPSDT. Such suits were filed in Connecticut and Vermont as well as nine other states by the end of 1974. These suits indicated that the existence of the federal law was a stimulus to the interest group which provided a secondary stimulus to the state to comply. The resolution of the suits also showed that courts were willing to intervene in issues of positive government programs if the state's deviation from the standards set by the statute was sufficiently great. Moreover, state agencies submitted willingly to judicial orders requiring specific administrative actions. (11, *44–45*; 8, *635*)

The state medical societies reacted strongly to the implementation of Title XIX but were less of a secondary stimulus to the state than a hindrance. Their concerns centered very closely on the question of fees and reimbursement. In Vermont, they succeeded in having the issue settled privately and getting their chosen type of reimbursement. (3, *381–387*) In Connecticut they were obliged to enter the public arena to achieve a usual and customary fee system, only to have it rescinded by the legislature within a year because of its high costs. (3, *391–394*) Through their societies physicians were a secondary stimulus to the program by instigating fees which physicians would accept. The physicians would thereby be more likely to care for Medicaid patients, facilitating implementation of federal policy. However, when

13

physicians did not receive the fee rates they wanted, many, particularly in Connecticut, refused Medicaid patients.

The stimulative effects of federal policy were very different for Title V and Title XIX. Title V did not stimulate the states to increase their funds for child health services, nor to increase substantially those services themselves. The federal policy did stimulate the states to build administrative capacity in maternal and child health. Title XIX, on the other hand, stimulated state funds for medical vendor payments and services, but did not stimulate states to build administrative capacity to deal with these large programs. Both Title V and Title XIX stimulated interest groups acting as secondary stimuli, particularly to enforce the implementation of federal intent.

Was federal policy redistributive?

Federal allocation formulae were intended to redistribute federal funds among the states to favor poor and rural states in the case of Title V, and the poor in the case of Title XIX. We analyzed this redistribution, first in terms of the net inflow or deficit of federal Title V and XIX grants received by each state, in relation to its tax burden. (Table 5) The redistributional patterns differed substantially among the different child health grants. Title V formula grants tended to equalize interstate distribution; Title V project grants favored wealthy and urban states with localities which had the capacity to apply for project grants; Title XIX open-ended funding favored wealthy and urban states with liberal programs. (3, *310–314*) Vermont, although poor and rural, developed a liberal program because of its ideology and therefore deviated from the prevailing pattern of grant distribution.

Title V funds could be targeted to rural and poor states, but they did not necessarily distribute equitably for poor persons. However, as Table 6 shows, the variation in Title XIX expenditures, ranging from $7.54 (Mississippi) to $280.82 (Massachusetts), indicated that the poor in wealthy states with liberal policies were favored to the detriment of the poor in other wealthy states and in poor or rural states. (3, *320–321*) The pattern of redistribution among states was thus inequitable and discriminatory.

Within the states as well, distribution of health resources did not follow the expected pattern of federal intent. In the case of Connecticut, we examined the distribution of health resources among towns in relation to socioeconomic factors and health needs. (12) Private health resources, such as physicians, were concentrated in wealthier towns. Federal policy attempts to equalize access through Title V grants and EPSDT funds did not have the intended effect. In neither case were public resources such as Title V services or EPSDT providers allocated by state administrators to towns where health needs were greatest as measured by poverty levels, Aid for Dependent Children rates and five-year infant mortality rates. Health planners were not distributing resources to needy areas, even assuming imperfect information. Thus, there was little evidence that a rational planning model was operating in Connecticut in the early 1970s. Rather, a "bureaucratic politics" model may be more appropriate for explaining the variations in the distribution of health resources. Planning programs may have improved information available to decision-makers but they did not necessarily change the patterns of decision-making which resulted not from agreed-upon strategies or goals such as equalizing health resources, but from different understandings of what the goals were and from differing organizational and personal interests. (12)

However, we should note that at least for CCS the redistributive intent for rural services under Title V formula grants was met. Both the states of Connecticut and Vermont placed CCS clinics in predominantly rural areas. (3, *208–209*)

Reciprocal Impact

Since the policy model we employed assumed permeability of institutions, we found that while policy was moving downward through federal-regional-state levels, other policy was moving upwards. Many such instances of reciprocal impact took place during the period under study.

Under title V-CCS programs in the early years, states determined that all children under 21 were eligible for services, but federal policies did not formally incorporate this practice until 1949, and Congress not until 1968. Although most states by 1939 appointed physicians as their MCH and CCS program directors, this did not become a federally required practice until 1951. (13, *33*)

States influenced federal programs which they did not want to implement. The proposed regulations for EPSDT published in 1970 required states to provide EPSDT regardless of the limitations of the state plans. Thus, states which did not previously pay for certain types of services would have to pay for them under the new rules. The states objected vigorously and effectively. When HEW published final regulations nearly a year later, the scope of requirements had been considerably decreased to meet state demands. (5, *54*)

States also influenced the Regional Offices of HEW. We had selected two states within the same HEW Region to mitigate the effects of differential directives from different regional offices. Instead, we found that the regional office itself reflected more often the opinions of the state rather than the federal policy it was supposed to administer. (14, *40–41*)

The gap between intent and performance: policy fragmentation

The Federal Title V and XIX programs did not necessarily stimulate the states to spend more for child health programs but merely to take on the federal programs as part of what they had been doing earlier. The federal programs, as administered by the states, failed to redistribute services to poor and rural persons. In addition, at least in the case of Title XIX, the funds failed to be redistributed equitably among the states. What accounts then for these failures?

Ambiguity of intent. Our first finding about the hypothesized gap between intent and performance is that it was not always as great as purported to be. Close analysis of federal intent revealed ambiguous language and internal conflicts even before the law had left Congress. Congressmen with particularistic interests geared toward election-day success did not give child health policy, which was of low political salience, the care which a well-thought out policy required. Thus, the original ambiguity of goals created some of the gap between intent and performance.

Federal ambiguity of intent may appear as flexibility, but it also left the policy vulnerable to fragmentation by bureaucracies and private interest groups among different levels of, and between different agencies within, government. Thus arose the possibility for different interpretations by bureaucrats and private interests depending upon their own particular interests and narrower goals.

Intergovernmental problems. A first source of fragmentation in federal child health policies came from the multiplicity of interdependent governmental levels. In 1935, the states we studied had maternal and child health programs similar to those mandated by federal law. Rather than expand their own programs, they substituted. This behavior was made possible by the weakness of the federal position and by the flexibility that had been built into the provisions for federal-state relations. The state legislature of Connecticut, particularly, had never devoted much attention to child health, so it was not surprising that the state did not seize the opportunity to increase its expenditures for children.

States had extraordinary discretion in how they interpreted Title V formula grants: these funds should therefore best be viewed as prototypes of revenue sharing. (15, *217–237*) Title XIX, as a reimbursement grant, prevented states from collecting federal funds, unless they paid out first to health providers. Thus, the Title XIX mechanism theoretically provided greater control by the federal government. However, since states still had discretion in eligibility, scope of services, and payment fees, the program developed more according to what the states wanted than the federal intent. States could refuse to participate; if they participated, they could refuse to conform even to their own state plan. (3, *197*) The states were particularly reluctant to initiate the EPSDT program because of the increased costs it would engender. The federal government had to proceed by negotiation with the states rather than to order them directly to implement. Even threats of penalties did not move state officials who believed the penalties would never be applied, just as in the case of Title XIX. Moreover, the states were right. Although the first penalty recommendations for EPSDT were handed down in 1975, no penalties had been applied by 1977.

Intragovernmental problems. Another major cause of fragmentation of policy was confused bureaucratic assignment. No one agency was in a position to build bureaucratic solidarity behind that policy. This issue was mainly a problem in the case of Title XIX and EPSDT. Since this program provided the greater part of health services to poor children, this problem was of major consequence. Title XIX was a policy that grew out of welfare legislation, but in fact it was health policy. Health and welfare agencies, however, have differing ideologies, professional personnel, clientele, types of services, control over functional areas and hierarchical relations relative to higher and lower levels of government. (3, *194–199*) Ideologies of welfare agencies prevailed so that discussions of Title XIX more often revolved around issues of fiscal probity than whether services should be provided. Welfare is a field in which the government has a virtual monopoly over its functions and the state welfare agencies have increased their functional control over localities during the years. However, only a small proportion of the health sector is controlled by the public sector and only a small proportion of these functions are controlled by health departments. Table 7 shows the proportions of state health and welfare functions of Vermont and Connecticut which were actually administered by their respective departments. One should also note that during recent years, at least in Connecticut, both the health department and health functions have received a declining share of the state general fund. (3, *187–190*)

The federal requirement of bureaucratic assignment to a single-state agency without control over its functional area negatively affected policy implementation. (3, *196*) Although close cooperation between agencies had been mandated under Title XIX in 1965, health and welfare agencies were unable to agree as to who would pay whom for what. Connecticut, for example, resolved the issue by having neither agency pay for the other and in fact, no contacts or cooperation developed between welfare and the crippled children's program. (2, *16–19*)

Inadequate information systems. Symptomatic of this fragmentation of policy were the information systems established by federal and state governments to manage the Title V and Title XIX programs. Federal surveillance of state performance can at best be termed inept, (3, *244*) and information feedback was poor. (1, *81–83*) There were two problems: the types of information requested by the federal government; and the time lag allowed to states to report.

States reported children who received physician's services from Title V-CCS but not those who received CCS care from other persons; they reported well-child services if the state-federal MCH funds paid any part of the services regardless of what other sources provided the services. Matching funds did not have to appear as a specific line-item in the state budgets and states never had to document in detail their matching accounting for formula grant funds. Under Title XIX, states reported financing and services, but no accurate figures were available on how many children were actually eligible for these services. (10) For Title XIX-EPSDT, the federal government did not require states to report follow-up care of children screened although that should have been the main purpose of screening. Moreover, the state of Vermont claimed that children were receiving preventive care from private physicians through regular Medicaid reimbursement. However, state officials were unable to document this claim because their reporting system was not equipped to deliver the information.

The federal government tolerated long delays by the states in reporting: nearly two years in the case of mandatory Title V reports (3, *242*), and similar delays in Title XIX, as in Connecticut's failure to submit Title XIX reports for fiscal 1975, even as late as mid-1977.

The information system which should have provided the federal agencies with information about state implementation, in fact, tended to obscure activities rather than reveal them. It may be that HEW did not want to know; in that case, the information system was most successful in preventing federal surveillance of the states.

Salience of child health. The final source of fragmentation was the low salience of child health in public policy. For the most part; child health was outside the glare of public attention which left both federal and state health and welfare bureaucrats a relatively free hand in the shaping of the policy. Title V had been only a very small section of the major social policy of the day, the Social Security Act, and had consequently received very little attention; Title XIX had never been intended as a child health program; the EPSDT provisions of 1967 passed through Congress as a miniscule part of massive revisions in the Social Security Act, receiving very little attention in hearings and debates. (5, *49–50, 59–60*) One could characterize Title V and Title XIX as programs without strong constituencies. (8) Children did not vote and since they were poor, were unlikely to have voting parents either.

Child health was also not of great salience at state levels, as noted by the low legislative input in the bills related to child health. The interest groups concerned with child health were themselves fragmented into different aspects of a disease or of the policy itself. Thus, interest groups formed to lobby for children with cystic fibrosis or cerebral palsy, rather than for preventive health services for all children. The only exceptions were the cases of the poverty lawyers, but even their efforts were limited to those children eligible for Medicaid services in the state in which they were suing. Their categorical concern did not allow them to apply their interests to other poor or needy children. Thus, the lobbies which might have counteracted the effects of policy fragmentation were themselves fragmented or non-existent.

In summary, the ambiguity of the original federal intent set the scene for the further fragmentation of policy. Different federal and state bureaucracies interpreted the policy according to their own needs; health and welfare agencies vied with one another as to who had the responsibility for child health. Quarrels at the state level were sent to higher levels for adjudication with no better results. Thus, those at lower levels made *ad hoc* decisions to carry out policy, or as in the case of Title XIX and EPSDT, when the policy was expensive, and time-consuming to administer, they made policy by avoiding implementation. This became easier because the federal government did not require the management information that would enable it to evaluate the implementation of its own policy.

The one force which could counter the effect of this fragmentary process was the interest groups which, operating from outside the governmental process, could intervene at whatever level necessary to enforce their own interpretations of child health policy. This process could have been particularly effective if the interest group had been involved in the policy formation. However, in the case of federal child health policy under Title V and Title XIX, the interest groups themselves fragmented. Thus, the one potential cohesive force in federal policy-making was not operating and the policy decisions were controlled by those who held power closest to the delivery points and who were responsive not to issues of child health but to particularistic bureaucratic and private interests.

Recommendations

These findings on the gaps, failures, and fragmentation of federal child health policy suggest several recommendations for policy-makers.

First, on the issue of ambiguous policy: given that Congressmen are rewarded not for their attention to detail but for their espousal of popular programs, it is unrealistic, without changing our electoral system, to expect Congressmen to change considerably. However, Congress can demonstrate more concern for child health policies by assuring, at least, that in hearings and debates, the issues are debated and the intent, even if conflicting, is voiced. Moreover, even though the temptation is always to let the Secretary of HEW work out the details, Congress should consider that some of these details will be so important that they may change entirely the original intent. Thus, Congress should be more specific in targeting the populations to be served by a particular piece of legislation, the types of services expected, the costs, and the administrative framework.

In intra-governmental relations, particularly in the question of health-welfare agencies, we recommend that Congress examine the issues of bureaucratic assignment. If Title XIX is to remain predominantly a welfare program, tied to welfare by eligibility restrictions, the welfare agencies will have to develop capabilities in case management in health. In so doing, they may, in the many states where the Title XIX agency is not the health agency, be in conflict with the health agency as to who has jurisdiction over what areas. The bureaucratic assignment of a policy to a single-state agency does not make much sense if that agency has little functional or hierarchical control. (3, *199*) Nor is a health department necessarily a solution since these agencies also have little control even over the public funds expended for health. Thus, the assignment of policies by Congress may be crucial in determining whether that policy can be implemented. Moreover, interbureaucratic confusion at the federal level spills over into confusion at lower levels of government. We recommend that Congress consider carefully either creating new agencies for its child health policies or requiring consolidations of existing ones to assure stronger agencies with capabilities in their own fields. This recommendation applies both to federal and state agencies.

In inter-governmental relations, we recommend first that Congress maintain a closer watch on the executive branch for enforcing its own policies, and secondly, that the states be given greater incentives to cooperate with federal policies by increasing the funds available to them. States, particularly in recent years, have increasingly faced budget cutbacks; to induce states to take on new programs or even to carry out their present programs will require positive incentives, such as considerably higher matching funds with a concomitant requirement of maintenance of effort of present services and expenditures.

Fourth, DHEW must develop reporting systems which will provide data consonant with intent so that federal officials can know whether a particular program is in fact reaching its goals. Reporting data should be monitored and checked on a random basis. In addition, inducements for improved management should be added for Title XIX's child health programs; otherwise, the present situation will continue in which even HEW does not know how many children were actually served by EPSDT and Medicaid combined.

The final and most important recommendation consists of raising the salience of children and child health as a political issue. As noted earlier, the legislation we studied had received scant attention from advocacy groups. When Title V was passed, children at least had the remnants of a lobby from the earlier heady days when the Children's Bureau was formed. However, this influence quickly waned. During the period under study, there was no well organized general child health advocacy group. The existence of such a lobby is the one force that can prevent the fragmentation of policy as it moves through the layers of government and among different agencies. The children's advocates, to be effective, however, would have to mobilize for child health in general rather than themselves being fragmented as they were by concerns for specific diseases or particular needy children. Such a lobby would have to oversee policy not only as it were being formed, but also as it were being implemented.

The experience of Titles V and XIX indicate that even such major health policy for children cannot provide care for the intended children unless the groups which should be looking out for their interests are mobilized to supervise that policy every step of the way. Policies do not happen just because Congress passes a law. Policies are shaped by the entire implementation process. Those who would be concerned that children receive the best health care through federal assistance, must then supervise that process.

21

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* "Working Papers" and "Reports."

Table 1: Federal expenditures for children under 21, Title V and Title XIX Programs, and numbers served as a percentage of U.S. population under 21

	1940	1955	1970
Federal Expenditures			
Title V	$8,058,000	$22,532,351	$223,504,648*
Title XIX	—	—	481,063,000
Children Served			
Title V	1,698,529 (3.5%)**	3,905,657 (6.2%)**	6,074,675 (7.5%)**
Title XIX	—	—	7,614,000 (9.4%)

* May include child welfare funds of approximately $20 million as well as the maternal and child health, crippled children's, special projects, and research funds.

** Excludes immunizations and school health examinations as data are not comparable. May include duplicate counts.

Source: (5) *38* and (8) *631*

Table 2: Population and health characteristics of Connecticut and Vermont

	Connecticut	Vermont
Population, 1973	3,080,000	466,000
Rural population, 1970	22.3%	65.2%
Per capita personal income, 1972	$5,931	$4,185
Percent of persons below poverty level, 1969	7.2%	12.1%
Expenditures for education per capita, 1973	$278	$297
Infant mortality per 1,000 live births, 1973		
White	13.3	16.2
Other	24.9	—
M.D. Population/Active physician per 100,000, 1970	191	187
Hospital beds per 100, 1970	3.34	4.51
Medicaid (Title XIX) expenditures per capita, 1972	$34.67	$37.93

Source: (3) *121* and *212*

Table 3: Children served by Connecticut and Vermont Maternal and child health and crippled children's services

	Children served by state-sponsored well-child conferences as a percentage of all children aged 0–5		*Children served by state crippled children's services as a percentage of handicapped children* aged 0–21*	
	Connecticut	Vermont	Connecticut	Vermont
1940	8.5	**	7.1	**
1950	2.5	**	8.0	15.8
1960	1.3	11.0	5.5	22.9
1970	1.0	7.0	3.9	21.8

* Handicapped children estimated as seven percent of the population.

** Data not available.

Source: (3) *220–224*

Table 4: Children served by Title XIX and its EPSDT Screening Programs: Connecticut, Vermont and United States

	CY 1968	CY 1970	FY 1974	FY 1975
Title XIX children served				
Connecticut	83,594	95,617	112,299	**
Vermont	7,611	17,675	20,226	24,949
United States	5,910,000	7,614,000	10,110,317	10,329,000
Title XIX children served as a percentage of population under 21				
Connecticut	7.3%	8.2%	10.1%	**
Vermont	4.3	9.6	11.1	13.8%
United States	7.3	9.5	12.7	13.1
EPSDT: percentage of Title XIX eligible children screened *				
Connecticut	—	—	3.9%	21.3%
Vermont	—	—	5.5	8.1
United States	—	—	7.7	14.1

* The federal government and the states count separately children receiving regular Title XIX services and those receiving screenings. At present, there is no way of knowing whether the same children are included in each count.

** Data not available.

Source: (4) 32

Table 5: Interstate redistribution effect of federal health grants to states, FY 1972 (in thousand dollars)

State	(1) Maternal and child health, formula	(2) Maternal and child health, project	(3) Maternal and child health, total	(4) Total health excluding Medicaid	(5) Medicaid	(6) Total health including Medicaid
Alab	+1,481	+3,206	+ 4,687	+ 5,415	+ 19,329	+ 24,744
Alaska	+ 216	− 122	+ 94	+ 281	− 6,374	− 6,093
Ariz	+ 165	− 424	− 259	+ 2,223	− 30,276	− 28,053
Ark	+ 933	+ 497	+ 1,430	+ 2,350	+ 548	+ 2,896
Calif	−4,974	5,317	−10,291	−47,790	+161,464	+113,665
Colo	+ 14	+2,748	+2,762	+11,583	− 1,548	+ 10,035
Conn	−1,156	−1,158	− 2,314	−12,337	− 37,673	− 50,010
Del	+ 71	− 376	+ 305	− 865	− 10,318	+ 11,183
D.C.	− 6	5,601	+ 5,595	+23,450	+ 3,524	+ 26,974
Fla	− 55	+1,617	+ 1,562	− 6,866	− 78,903	− 85,769
Ga	+1,504	+ 880	+ 2,163	+ 2,133	+26,902	+29,035
Hawaii	+ 83	+ 251	+ 334	+ 383	− 4,478	− 4,095
Idaho	+ 280	− 5	+ 275	+ 1,865	− 243	+ 1,622
Ill	−3,170	−1,095	− 4,265	−45,572	− 72,692	−118,264
Ind	+ 384	−2,351	+ 1,967	− 5,364	− 44,004	− 38,640
Iowa	+ 411	−1,224	− 813	+ 555	− 30,722	− 30,167
Kans	+ 134	− 139	− 5	+ 3,252	− 5,416	− 2,164
Ky	+1,328	− 250	+ 1,078	+ 5,301	+ 8,600	+ 13,901
La	+1,363	−1,411	− 48	+11,725	+ 611	+ 12,336
Main	+ 334	− 369	− 35	+ 899	+ 4,001	+ 4,900
Md	− 307	+5,876	+ 5,589	+ 6,705	− 25,530	− 18,825
Mass	−1,444	+2,122	+ 678	+13,194	+ 60,971	+ 74,165
Mich	− 649	+ 178	− 473	−12,014	− 14,416	− 26,430
Minn	+ 340	+ 313	+ 653	+20,485	+ 14,638	+ 35,123
Miss	+1,601	+ 136	+ 1,737	+ 4,930	+ 21,445	+ 26,375
Mo	+ 150	− 29	+ 121	+ 5,985	− 48,029	− 42,044
Mont	+ 214	+ 15	+ 229	− 758	− 1,968	− 2,726
Nebr	+ 158	+ 621	+ 779	+ 4,195	− 5,033	− 838
Nev	+ 80	− 276	− 196	− 4,095	− 8,739	− 12,834
N.H.	+ 134	− 272	− 138	− 1,180	− 8,200	− 9,380
N.J.	−2,082	−4,536	− 6,618	−30,884	− 65,428	− 96,312
N. Mex	+ 337	+ 139	+ 476	− 1,510	− 756	− 2,266
N.Y.	−6,065	+2,493	− 3,572	−10,986	+417,448	+406,462
N.C.	+2,195	+ 133	+ 2,328	+12,172	+ 3,157	+ 15,329
N. Dak	+ 283	− 240	+ 43	+ 472	+ 3,234	+ 3,706
Ohio	− 850	+ 164	− 386	− 3,293	−117,940	−121,233
Okla	+ 367	−1,112	− 745	+ 4,142	+ 32,112	+ 36,254
Oreg	+ 191	− 51	+ 140	+ 2,158	− 18,742	− 16,584
Penn	− 521	− 905	−1,426	+15,776	− 72,177	− 56,401
R.I.	+ 65	− 325	− 260	+ 347	+ 6,060	+ 6,407
S.C.	+1,490	− 203	+ 1,287	+ 4,610	− 4,956	− 346
S. Dak	+ 278	− 264	+ 14	+ 547	− 410	− 957
Tenn	+1,230	+ 670	+ 1,900	+ 7,343	− 15,899	− 8,556
Texas	+ 621	1,433	− 812	− 91	− 20,529	− 20,620
Utah	+ 382	− 203	+ 179	+ 6,588	+ 1,364	+ 7,932
Vt	+ 214	− 228	− 14	+ 4,423	+ 6,085	+ 10,808
Va	+ 772	− 929	− 157	− 3,039	− 27,991	− 31,030
Wash	− 49	− 207	− 256	− 1,971	− 17,078	− 19,049
W. Va.	+ 737	− 132	+ 605	+ 2,027	− 6,079	− 4,082
Wisc	+ 286	−1,735	− 1,449	− 7,401	+ 14,795	+ 7,394
Wyo	+ 233	− 103	+ 130	− 1,082	− 3,752	− 4,834

Note: Items may not add to the total because of rounding
Source: (2) 330

26

Table 6: Federal Grants-in-Aid ($) per poor person, FY 1970

	Title V total	Total health excluding Medicaid	Title XIX (Medicaid)	Total health including Medicaid
U.S.	6.62	36.12	93.20	129.32
Alab	7.17	30.23	32.04	62.27
Alaska	10.20	63.00	0	63.00
Ariz	4.43	54.73	0	54.73
Ark	4.47	20.01	5.89	25.90
Calif	5.39	32.64	240.94	273.58
Colo	15,47	66.60	85,82	152.42
Conn	9.47	87.71	193.88	261.54
Del	7.76	37.76	40.57	78.33
D.C.	37.41	109.75	103.45	213.20
Fl	7.31	26.53	16.01	42.54
Ga	5.74	28.80	56.93	85.73
Hawaii	16.67	112.45	109.62	222.07
Idaho	7.97	39.18	63.10	102.28
Ill	8.15	33.47	90.44	123.91
Ind	4.97	38.15	23.73	61.88
Iowa	4.83	41.20	44.68	85.88
Kans	5.50	42.76	89.35	132.11
Ky	4.04	28.27	55.46	83.73
La	2.91	21.82	39.77	61.59
Maine	5.24	35.30	55.78	91.08
Md	15.58	50.59	101.95	152.54
Mass	13.86	65.32	280.82	346.14
Mich	10.28	56.37	133.47	189.84
Minn	7.92	38.61	160.79	199.40
Miss	3.31	17.89	7.54	25.43
Mo	6.33	41.15	48.82	89.97
Mont	7.73	46.16	64.13	110.29
Nebr	11.16	43.10	53.42	96.52
Nev	11.91	39.14	87.91	127.05
N.H.	7.95	46.03	60.48	106.51
N.J.	4.06	36.28	45.93	82.21
N.M.	5.55	43.70	41.61	85.[illegible]1
N.Y.	8.71	40.67	273.69	314.36
N.C.	5.71	35.45	19.89	55.34
N.D.	4.86	40.59	87.84	128.43
Ohio	9.32	43.78	51.17	94.95
Okla	2.63	26.20	133.64	159.84
Oreg	7.51	41.56	41.89	83.45
Penn	6.20	50.86	99.38	150.24
R.I.	6.54	41.35	170.80	212.15
S.C.	4.49	24.39	38.98	63.37
S.D.	3.81	28.94	42.04	70.98
Tenn	5.09	30.46	15.60	46.06
Texas	4.23	22.52	43.54	66.06
Utah	6.65	61.92	88.88	150.80
Vt	7.27	75.60	163.19	238.79
Va	5.88	28.23	26.14	54.37
Wash	8.61	34.87	115.71	150.58
W. Va	4.27	26.23	32.91	59.14
Wisc	5.30	39.43	194.71	234.14
Wyo	9.32	57.42	24.32	81.74

Source: (3) 333

Table 7: Health and welfare functional and department expenditures as a percentage of the state's general fund, Connecticut and Vermont

	State expenditures on health functions	Expenditures by health department	State expenditures on welfare functions	Expenditures by welfare department
A. *Connecticut*				
1935	6.3%	0.4%	4.3%	0.3%
1940	5.7	0.8	10.0	4.1
1950	15.7	4.7	18.8	18.7
1960	13.3	3.3	15.8	15.8
1970	9.4	2.0	19.6	19.6
B. *Vermont*				
1935	*	*	*	*
1940	1.4%	1.0%	15.2%	6.4%
1950	7.8	1.7	13.2	11.2
1960	1.9	1.3	13.0	7.0
1970	4.9	1.6	13.2	13.0

Source: (3) 189

*Data not available

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Anne-Marie Foltz

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9. Performing Organization Name and Address
Yale University School of Medicine
Department of Epidemiology and Public Health
60 College Street
New Haven, CT 06510 (Tel.: 203/432-4566)

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DHEW, PHS, OASH, National Center for Health Services Research
3700 East-West Highway, Room 7-44 (STIB)
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See PB 262 959 for final report entitled: "Impact of Federal Health Policies in the States of Connecticut and Vermont (Final Report)."

16. Abstracts
This report assesses the impact of federal child health policy under Titles V and XIX of the Social Security Act upon the states of Connecticut and Vermont for the years 1935 to 1975, and analyzes the reasons for the discrepancy between policy intent and state execution. Research methods comprised a review of Congressional intent, HEW regulations, state legislation, administrative performance, services with special reference to urban/rural variations, and EPSDT. This study offers a basis for a methodology for policy evaluation studies in other states or the country as a whole. <u>Findings</u>: federal agencies diversely interpreted federal laws; states faced with uncertain policy, short funds, and external pressures failed to comply even with the federal EPSDT mandate. Since HEW failed to monitor its programs, states faced no loss of funds or penalties. <u>Recommendations</u>: that Congress provide sufficient funding to assure state cooperation, and monitor state performance with continuous reporting systems; that Congress be specific as to populations to be served and services to be

17. Key Words and Document Analysis. 17a. Descriptors

<u>16. Abstracts (continued)</u>:

provided; that administrative agencies be consolidated to avoid interbureaucratic confusion; and that child health advocacy groups become more involved in legislation and in monitoring programs.

<u>15. Supplementary Notes (continued)</u>

NCHSR publication of research findings does not necessarily represent approval or official endorsement by the National Center for Health Services Research or the Department of Health, Education, and Welfare.

17b. Identifiers/Open-Ended Terms

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH SERVICES,
Sacramento, Calif., August 28, 1978.

MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: California has received a copy of the amendments to S. 1392 dealing with the Child Health Assessment Program (CHAP), which were introduced by Senator Cranston. We feel that these are good amendments and California is in full agreement with them. There are some areas of clarification we will need on the technical aspects of some of these amendments. We are working directly with Senator Cranston's office in seeking this clarification.

We are requesting that the Committee include these comments as an addendum to our August 21, 1978 letter to the Committee, which contained California's written testimony on S. 1392 and H.R. 13611. We ask that this addendum be included in the Record along with our August 21, 1978 letter.

The three areas we address below have been discussed with Senator Cranston in the past, and we would like to bring these to the Committee's attention at this time:

1. *Development Assessment.*—California concurs with Senator Cranston that the developmental assessment issue should be fully examined. It has been California's experience that requiring developmental assessments as a separate, specific component should be deleted from any child health program, as there is no clear, acceptable definition of what a "developmental assessment" should encompass. In California's view, there is no existing developmental assessment instrument which is acceptable as a screening tool. The national and local publicity that has been focused on the deficiencies of developmental assessment and the damaging consequences of the inaccurate labeling of persons that frequently occurs has already had a negative impact on California's EPSDT program. Numerous studies indicate that development assessments do not take into consideration different cultural and child-rearing practices and backgrounds. Upon the recommendation of a broadly representative developmental screening task force, California eliminated the use of a specific developmental screening tool from its EPSDT health assessment in 1976. Therefore, California recommends that developmental assessments be done in the general context of the health history.

2. *Count of Screens.*—California's experience under EPSDT leads us to believe that it would be advisable for the CHAP legislation to speak to the manner in which health assessments will be reported to HEW. Currently the federal Department of Health, Education and Welfare (HEW) allows only completed screens to be reported according to guidelines in HEW's "Program Instruction IS–NCSS–PI–74–13". When compiled according to these HEW guidelines, California's reported statistics always appear deceptively low. For this reason it would seem appropriate to specify reporting requirements in the statute, rather than to leave this process to interpretation through HEW regulations.

According to the HEW guidelines, California has many "partial screens", primarily due to four factors: (a) Physician providers many times do not perform vision and hearing testing because these tests are routinely done by the schools under a state legislative mandate; (b) Many health assessments are rendered incrementally over a period of time, sometimes by more than one provider. California's current manual claims processing system does not have the capability to link these component parts into "completed screens"; (c) Many physician providers bill preventive child health services, including EPSDT screening, directly to the Medi-Cal billing system. Because the billing codes used in the Medi-Cal billing system are not always as precise as those used in the Child Health and Disability Prevention (CHDP) Program system (CHDP administers the EPSDT program in California), HEW does not allow such screens to be called "completed screens". (d) Some providers do not, in fact, provide all the mandated EPSDT service. Further work with these providers is necessary.

The result is that these "incomplete screens" (health assessments) are never included in California's quarterly tally, and the figures do not reflect the true picture. It is California's position that there is a good deal more preventive health care rendered than the figures would indicate. We would suggest that the new health screening program being created under CHAP: (a) Make allowances for vision and hearing testing which is done in schools; (b) Allow states time to develop automated capabilities that could link screening components done over time or by different providers into complete screens, and allow the counting of partial screens when at least the health history and physical examinations are done; (c) Count EPSDT screens billed to the Medi-Cal billing system as "complete screens"; (d) Allow states time for orientation, education and monitoring of providers as to what constitutes a "complete screen". In the meantime, accept "partial screens" as "complete screens" if the health history, physical examination and selected additional components are completed.

3. *Penalties.*—California again recommends that penalties be eliminated, that any penalties assessed to date be repealed, and that there be no penalties assessed in the future. California believes that the assessment of penalties has deliterious effects on child [illegible] programs. We strongly support the recognition of positive efforts through the use of financial incentives. (This issue is also addressed on page 8, of our August 21, 1978 letter to the committee.)

California brings to the committee's attention that the provision of child health services, and the creation of a program (CHAP) to assure delivery of these services has been the subject of correspondence between California and Senator Abraham Ribicoff (on S. 1392) and Congressman Paul Rogers (on H.R. 6706) in September, 1977.

The current set of amendments to this very important legislation, introduced recently by Senator Cranston, have received the full support of the California Department of Health Services, which administers the child health programs in this state.

We appreciate the opportunity of providing these comments to the Committee as it considers S. 1392, and its potential impact on child health in California.

If you wish further information on these issues, please telephone either, Ramona Thompson, (916) 322-8041, of the Child Health and Disability Prevention Branch, or Joan Spieler of California's Medical Assistance Program at (916) 445-1995.

Sincerely,

BEVERLEE A. MYERS, *Director*.

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,
August 30, 1978.

Hon. HERMAN E. TALMADGE,
Chairman, Finance Subcommittee on Health, U.S. Senate, Russell Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The American Occupational Therapy Association is pleased to submit this statement on S. 1392, the "Child Health Assessment Act", which strengthens and improves the early and periodic screening diagnosis and treatment program (EPSDT).

For over sixty years this Association has represented independent health professionals who specialize in alleviating the suffering and increasing the independence and productivity of the aged, the physically or mentally disabled, and the economically or culturally disadvantaged. Occupational therapy practitioners are trained in curricula involving developmental psychology, anatomy, neurophysiology, and the social sciences. This training is followed by field work experience in areas such as psychiatry, rehabilitation, developmental disabilities, and gerontology.

Occupational therapists are among the few non-physician mental health professionals who are trained in the medical and biological sciences. They provide services in general and psychiatric hospitals, nursing homes, community mental health and mental retardation centers, rehabilitation agencies and home health settings, and public and private school systems.

Of the occupational therapists engaged in direct service to clients, 25 percent work exclusively with persons under the age of twenty. Many of these therapists perform developmental screenings, such as the Denver Developmental Screening Test, on children up to age six to discover any developmental deficits which could hinder their performance in school or at work. The Association and the 25,000 members which it represents, therefore, have a direct interest in legislation which improves the provisions of screening, diagnosis, and treatment services to Medicaid eligible children.

The Association is pleased that S. 1392 expands the eligibility of children for Medicaid services and provides incentives to the states to encourage the provision of quality health care services to eligible children within those states.

However, we believe that there remain several problem areas in the Child Health Assessment Program (CHAP) which need to be addressed before this legislation is enacted.

The Association is concerned that S. 1392 gives states the option of including **or excluding care and services, for individuals** under age 21, for the "treatment **of mental illness, mental retardation**, or developmental disabilities . . ." We believe that if the coverage for these services remains optional and not mandatory, many states will not provide treatment services for these individuals.

The Association strongly believes that the growth and development of Medicaid-eligible children will suffer if problems discovered by the screening of the developmentally disabled, mentally retarded, and emotionally disturbed are not treated or at least referred for treatment. Therefore, we recommend the deletion of the following discriminatory language in S. 1392, Section 3(G): "but not necessarily including (i) those for the treatment of mental illness, mental retardation, or developmental disabilities."

The above language was eliminated in the House Subcommittee on Health and the Environment, and we strongly urge your committee to follow this lead.

The Association appreciates this opportunity to submit our comments on the Child Health Assessment Program and stands ready to offer our assistance in the implementation of this much needed legislation.

Sincerely,

JAMES J. GARIBALDI,
Executive Director.

AMERICAN ACADEMY OF PEDIATRICS,
Evanston, Ill., August 22, 1978.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health,
Committee on Finance, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: In the near future the Committee on Finance will be asked to consider the House-passed version of S. 1392, the "Child Health Assessment Act." As per your letter of March 20, 1978, to Dr. Martin Smith, member of the Academy's Executive Board, we are pleased to note that you plan to include in the scope of those hearings a review of the administration of Maternal and Child Health programs (S. 3188 and S. 3401). While the Academy elected to submit written testimony in response to the August 14 hearings, we will request to testify at these expanded hearings. In the interim, the Academy wishes to draw the attention of you and your colleagues on the Committee to the implementation of current and any amended legislation on EPSDT aspects of the Medicaid Law.

As you appreciate and understand, the passage in 1967 of the EPSDT component of the Medicaid Act heralded a very deliberate change in the concept from the remainder of the Act. It represented an expressed intention to seek poor children to periodically assess their health and health needs and to secure the distinct services required to meet their needs on an ongoing basis throughout the child and youth age periods. This purpose was a most distinct difference from financing personal medical care. The judgment of the Academy is that the Administration is just beginning to appreciate this difference, and, thus, the purpose has never been fully realized. Our judgment is based essentially on the reluctance of the Administration to develop an appropriate staff, in federal central or regional offices which is knowledgeable and technically competent to administer a health care program for children, as opposed to a staff to administer a financing mechanism per se.

The changes proposed by the Administration in S. 1392 and those modifications present in the bill reported by the House Committee do address useful improvements in such issues as eligibility and financing. However, it is our judgment that unless very definitive changes are made in the administration of the EPSDT component, the legislative improvements alone are insufficient. You and your colleagues rightfully and persistently ask why there is so much difficulty having private medical practitioners participate in Medicaid, including EPSDT. The Academy expresses its firm belief that without a significant voice in the formulation of policy, regulations, guidelines and ongoing advice to the respective state offices from those knowledgeable about child health and the delivery of ambulatory child health care, the Administration of EPSDT and the whole of Medicaid itself has a strictly financial orientation. As important as financial fraud and abuse issues are, they have never been issues in preventive care for children in this country. Our task is to seek poor children and have them become part of a sensible, high-quality, on-going health care program. The fraud and abuse in this respect is the failure of the Administration to understand the purpose of the 1967 amendments and to staff the agency appropriately.

We respectfully suggest you examine the number and roles of physicians, nurses and allied health personnel employed in the central and regional offices of the EPSDT and whole Medicaid Programs. Without such talent in significant numbers and appropriate positions to direct the Program, it is impossible to expect that the Program offers to the states the direction and advice intended by Congress.

We suggest you consider the following structural changes in order to realize the intent of Congress:

1. Centralize and elevate within DHEW the authority and responsibility for health programs serving mothers and children. At present there are two principal offices carrying this responsibility, one under the Public Health Service administering title V SSA and one in the Health Care Financing Administration administering title XIX SSA.

2. Authorize the organization of a national advisory body on maternal and child health within DHEW. This group would review all health programs serving mothers and children and advise Congress and the Administration on the content and implementation of such programs.

3. Authorize each State to develop a similar advisory body to assist in the state level administration and implementation of maternal and child health programs.

4. Direct the Secretary of DHEW to develop a staff in the central and regional offices competent in the content and delivery of child health services.

The Academy appreciates and supports the wisdom in the separation of legislative and executive powers in our government. The steps we suggest do not infringe on that principle. We believe these changes will greatly assist the realization of the intent of the 1967 amendments, and those currently before Congress.

In closing, I would add that, despite the above-cited criticism of the EPSDT Program, the Academy continues to consult and cooperate with the Administration in the general area of provider participation in Medicaid programs. We are interested in seeing practical, working relationships developed at all levels and in all aspects of that program. Nevertheless, the shortcomings in EPSDT and the effect of those shortcomings on our nation's children force us to speak out in favor of reform.

Sincerely yours,

DONALD A. CORNELY, M.D.,
Chairman, Task Force on EPSDT and Title V.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association takes this opportunity to submit its views on S. 1392, legislation that would modify the current Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program under the Social Security Act.

BACKGROUND ON PROPOSED LEGISLATION

This proposed legislation would amend title XIX (Medicaid) of the Social Security Act to provide for a Child Health Assessment Program. The stated purposes of enacting this new Child Health Assessment Program are to modify the current EPSDT program and to extend Medicaid EPSDT eligibility to those children whose families are of low income but who do not otherwise qualify for Medicaid because of family structure.

S. 1392 would require states to offer through their Medicaid programs the provison of child health assessments and primary care to all children under six years of age whose family meets the state's income test for Aid to Families with Dependent Children (AFDC), but whose family structure makes them ineligible for AFDC. In addition, the state would be required to provide child health assessments and primary care to children under the age of twenty-one whose families are receiving aid or assistance under certain state welfare programs.

An individual under the age of twenty-one who has received a health assessment under the Child Health Assessment Program would continue to be eligible for medical care for six months after eligibility for medical assistance would otherwise terminate because his family exceeded the eligibility limits to continue in the Medicaid program.

Child health assessment could be provided only by a health care provider who entered into an agreement with the state agency responsible for administering the state Medicaid program to provide to eligible children services including: periodic health assessments, a minimum range of diagnostic and treatment services, and when indicated, referral to appropriate providers for needed treatment.

To be eligible to participate in the program a health care provider would have to assume responsibility for the management of the medical care of each individual assessed to assure that all medical services which are offered under the state plan and which are found to be necessary pursuant to an assessment are made available in a timely manner and that reassessments are performed as required in regulations to be promulgated by the Secretary.

As an incentive to states to enroll eligible children with health care providers participating in the program, the federal matching contribution would be increased. For any state, this incentive rate would be half of the sum of the state's current Medicaid matching rate and 90 percent (but not less than 75 percent) for sums expended during each quarter which are attributable to child health assessments, diagnosis, treatment, follow-up and medical care management of individuals who have been assessed under an approved child health assessment program.

Federal reimbursement under the Medicaid program would be contingent upon a state meeting such standards as the Secretary may determine for the purpose of (a) informing families of children eligible under the program of the availability of child health assessment services; (b) assuring the provision of child health assessments in a timely manner; (c) assuring the provision of any medical care or service, the need for which is disclosed by assessments; and (b) assuring compliance with terms of agreements it has with providers of services under a state's child health assessment program. Failure to comply with these stated requirements would subject the state to a 20 percent reduction in the federal matching rate under the Medicaid program.

In addition, where the Secretary determines that a state has met the criteria (pursuant to regulations) for good performance under the Child Health Assessment Program, a 25 percent federal matching rate "bonus" for administration of the program would be made to the state.

COMMENTS

The American Medical Association expresses its strong support for the goal of expanding the availability of quality health care to children, particularly those children from medically indigent families who should benefit most from health care services such as those currently provided under the EPSDT program. Physicians, perhaps more than anyone else, appreciate the importance of adaquate health assessment and care for our young people. It is in the formative years of growth and development of the individual, both physically and intellectually, that such services are the most crucial. The importance of adequate health assessment and care cannot be emphasized too strongly, and the medical profession is most pleased to support the formulation of legislation to expand access to America's health care delivery system to meet more adequately the needs of our nation's children and young people.

The early and periodic screening, diagnosis, and treatment (EPSDT) program has come under increasing scrutiny recently. There is little question that improvement in the EPSDT program is needed. President Carter, in his health initiatives message to the Congress last year, observed that the EPSDT prgoram reaches only 30 percent of the 12 million children currently eligible for Medicaid; that approximately 22 percent of the children screened under EPSDT and found to need treatment do not receive the services required; and that the present program does not reach an estimated 700,000 children under six years of age who are in families whose income meets state financial requirements for Medicaid but whose family structure makes them ineligible for Medicaid.

While we recognize the weaknesses of the present program, we believe that the EPSDT program under the Medicaid law is fulfilling a needed service and deserves continued support but only with appropriate modification. However, we are concerned that the modifications proposed by this legislation would detract from assuring full access to quality care.

First, the Federal Government is already deeply involved in a large number of health care programs, each addressed to various segments of the population. Accordingly, the approach to meeting the health care needs of our citizens has often been fragmentary. For example, in attempting to assure maternal and child health, two special programs exist, the Maternal and Child Health Care provisions under title V of the Social Security Act and the current EPSDT program under title XIX of the Social Security Act. While these two programs are in many instances complementary, they are also duplicative in other instances. We believe that each of these programs has a function and should be retained, and in many respects expanded, to assure quality health care to eligible children and their mothers. Yet, we would urge that these programs must be viewed together. Neither program was intended nor can reach all deserving potential beneficiaries.

Another reason why we believe that the legislation as it is proposed is not an adequate approach to assuring full access to the health needs of our nation's children is that the Child Health Assessment Program would continue to be administered under the present Medicaid program. Under present law, a state having a Medicaid program is required to provide EPSDT services to all children eligible for Medicaid, yet the program has failed to do so. We recognize that the proposed legislation does provide increased incentives to a state to provide child health assessment services. Nevertheless, we fail to understand how increased incentives alone will provide assurance that the health services will, in fact, be provided under the respective state Medicaid programs. The Medicaid program has left gaps in the provison of "mandated" services by the respective states, and the bill would not eliminate this potential for leaving gaps.

Furthermore, the Child Health Assessment Program does not address the health needs of pregnant women and mothers of young children who are themselves not eligible for Medicaid. Certainly the health of the unborn and the newborn cannot be separated from the health of the mother. It is for this reason that we emphasize the continuing need for a program to provide not only for the health of young children, but as well for pregnant women and mothers of very young children.

As to specific provisions of the Child Health Assessment Program, we have several strong concerns. First, we note the requirement under the bill that child health assessments under the program may be provided only by a health care provider who enters into an agreement with the state agency responsible for administering or supervising the administration of the state Medicaid plan. This provision is undesirable, and could result in the receipt of levels of health care for those individuals receiving care under the CHAP program different from those individuals receiving care through other health care providers. To require a health care provider to enter into a health care agreement is not only onerous for the provider, but could tend to concentrate CHAP beneficiaries around a limited range of providers, such as in special CHAP clinics. This provision in itself could lead to curtailment of the individual family's right to select a physician or other health care provider and may in fact effectively deny a beneficiary desired medical attention by restricting the medical resources available to such CHAP beneficiary.

By requiring only health care providers that have contracted with the state Medicaid agency to be permitted to provide CHAP services could result in the evolvement of special "clinics" for the provision of CHAP services and thus preclude any participation by health care providers or physicians who might otherwise desire to provide such services. This could result not only in severely restricting the availability of medical services but in failing to take advantage of the broad range of medical services now readily available through the private health care sector. The establishment of a "mini-health delivery system" analagous to a government health service under an expanded EPSDT program will limit access to many of the available medical resources in our present system and may well limit the scope and quality of services to CHAP beneficiaries.

In addition, under the bill a health care provider participating in the Child Health Assessment Program would be required to take responsibility for the management of the medical care of each individual assessed to assure that all medical services which are offered under the state's Medicaid program are made available in a timely manner and the reassessments are performed as required in regulations to be issued by the Secretary.

The provider would be required to refer individuals to other appropriate providers for any corrective treatment which is not available directly from the paticipating provider. The health care provider would be required to follow-up this referral to assure the provision of such treatment.

While it is desirable for a patient to have a primary physician on whom that patient may rely for the coordination of his medical care, we must take strong exception to any specification in the law that requires the health care provider to assume responsibility for assuring that a patient received specific follow-up treatment. We need only point out that the physician-patient relationship is a voluntary one and as such a physician maintains no control over whether a patient will return for follow-up treatment and/or consultation. The physician cannot command the patient to return for follow-up treatment, even though he realizes that such follow-up is necessary to insure the effectiveness of earlier treatment. To mandate by law that a health care provider is responsible for a patient over whom the provider has no control once that patient leaves the office or institution is at best a gratuitous requirement incapable of fulfillment, but at its worst, is a condition which may well deter participation by physicians in the program because of ostensible legal implications.

We believe that the requirement in the bill that the health care provider follow up such referrals to assure the provision of the indicated treatment is inappropriate for another reason. When a patient is referred to a specialist for treatment, the medical specialist is responsible for the patient's specialized care. Accordingly, the provisions as stated in the bill should be modified to reflect the applicable law.

The bill would require a participating health care provider in the Child Health Assessment Program to provide to individuals receiving benefits under the program "a minimum range" of diagnostic and treatment services. However, no further definition is provided for what specific services will be deemed "minimum." Because the success of the Child Health Assessment Program will depend in large part on the scope of services made available to beneficiaries, we believe that it is crucial that any legislation not limit access to physicians.

We believe that the use of the phrase "a minimum range" could be construed in such a manner as to preclude physicians and other health care providers who may not have specific equipment and facilities in their offices from providing certain services (e.g., laboratory services, certain diagnostic equipment, or certain treatment facilities). A lack of such facilities does not, however, in any manner necessarily affect an individual's physician's ability to provide the appropriate assessment and care needed for beneficiaries under the Child Health Assessment Program. A strict definition could thus remove ready access to such assessment and care and should not be encouraged nor permitted under the bill.

Our concerns over the use of the phrase "a minimum range" are even stronger when we consider other language of the bill in relation to "health care centers." The bill would require that a State plan for medical assistance must provide that a State will encourage participation by physicians and health care centers in the Child Health Assessment Program. Success of the program will of necessity require wide participation by physicians. As the principal health care provider, the physician provides, and will continue to provide, the basic structure around which any Child Health Assessment Program must be fashioned.

To require that a state encourage participation by "health care centers" in the Child Health Assessment Program raises several questions with respect to assuring full access to quality health care. The principal purpose of the CHAP program is to increase access to care. However, requiring "health care centers" unduly emphasizes a particular location for receiving health care and overlooks the health care available to most children at other than centers. No definition is provided of what will constitute a "health care center." The undesirable reference to "health care centers" should be removed.

We see the desirability for Congress to express its concern over the scope of benefits. If done through an expression in Committee reports, greater flexibility would result without freezing into statutory language the specific scope of benefits desired. At the same time, unless some specification is provided, a mere legislative shell may be created without substance.

Another concern we have with the legislation is that there is no provision to assure fullest participation by physicians in the CHAP program. Presently the EPSDT program is under the Medicaid program and reimbursement is determined under that program. However, reimbursement is restricted in many states to insufficient levels. While under the statute no reimbursement can exceed what Medicare would pay (itself set at an arbitrary level), Medicaid is generally lower. Retention of such levels will accentuate current problems facing the Medicaid program, and with an artificially restricted payment mechanism physicians will be discouraged from participating in such programs. Any such impediments to physician participation in the program will prevent full access by individuals to intended benefits of the program. To encourage full participation and access, reimbursement should be at usual and customary levels.

The bill also requires that a health care provider rendering services under the Child Health Assessment Program must make such reports as the state or the Secretary of HEW may require to assure compliance with the requirements of the program. However, no specific guidance is provided with respect to the content of these reports nor the extent of data which might be required in such reports. Again, while we do believe that the law should not spell out all details as are normally undertaken in regulations we do believe that the law should provide reasonable guidance to the agency responsible for drawing up specific guidelines or regulations for the administration of the program. Therefore, we would urge that greater information be provided with respect to material that would be required to be included to be made. At the same time, the Subcommittee should weigh carefully the creation of burdensome paperwork and administrative impediments deterring program participation.

As we have expressed earlier, we fully support the provision of health care services as are envisioned under the present early and periodic screening, diagnosis, and treatment program. Our major concern is not that the program should not be improved, but rather than any changes be made so as not to discourage full opportunity of patients to have access to care and that any changes be made in conjunction with an evaluation of other related programs. We are concerned, as is the Subcommittee, with health care costs, with efficiency in health care delivery, and with the quality of health care services provided. It is with these concerns in mind that we raise these issues with respect to the expansion of the EPSDT program as proposed in S. 1392.

We believe that in your consideration of modifications of the current EPSDT program, consideration should also be given to the availability of maternal and child health care under title V of the Social Security Act. Title V, in its support of local and regional programs, has long been a prominent and effective source of health care for underserved children and youth. Established in 1935, this program currently affords health services to mothers and children who, for economic reasons, have difficulty in obtaining the services they need. The title V program would be expanded under legislation recently adopted in a joint effort of the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, so as to address more fully the spirit and intent of this program in meeting the national needs of maternal and child care and giving added emphasis to special health service needs of prospective mothers and the developing fetus, the needs of the infant in its first year of life, and the need for treatment and counseling for conditions associated with pregnancy, venereal disease, drug addiction, and mental health. This legislation has been introduced as S. 3401, the "1978 Amendments to the Maternal and Child Health and Crippled Services Act." We commend it to the attention of this subcommittee.

CONCLUSION

In conclusion we would like to point out that in addition to needed changes in title V of the Social Security Act and to changes in the Child Health Assessment Act, some of the issues of access, free choice, and quality care would with greater efficiency and cost effectiveness be handled through a comprehensive health insurance proposal such as is set forth in S. 218—a health insurance program that the AMA supports. One of the advantages to be gained by such legislation is that the health care of all members of families of all economic levels is taken into account, not just the health care of a particular member of a certain family. As you might well agree, oftentimes the health of one family member has a significant bearing on the health of other family members. Accordingly, consideration must not be lost of a holistic approach as the most appropriate manner of assuring quality health care to all needy individuals.

We wish to reiterate our support for the current EPSDT program. We believe that this program is fulfilling a vital need and providing certain health services to children of low income families. Yet, while we support the present EPSDT program, we believe that this program should not be viewed as addressing the total health care problems of our nation's children. As we pointed out earlier, EPSDT services are required to be provided under existing state Medicaid plans. Yet, EPSDT services have not been provided to all eligible Medicaid beneficiaries. We suspect that many of the basic problems with the EPSDT program may not be in the scope of benefits but rather in the administration of the program. Therefore, we do not believe that the reforms suggested in this proposed legislation would effectively achieve the desired goals in providing increased quality health care services to children.

We urge that the subcommittee consider our specific concerns with the proposed legislation to modify the current EPSDT programs. While we support the general concept embodied in the Child Health Assessment Program legislation, we urge that the subcommittee not adopt this proposed legislation without modifications reflecting our concerns.

STATEMENT OF THE DENTAL HYGIENISTS' ASSOCIATION

INTRODUCTION

The American Dental Hygienists' Association is pleased to submit a record statement to the Subcommittee on Health of the Senate Finance Committee and to present its views and recommendations on S. 1392, the Child Health Assessment Plan and related bills. The Association testified last year on H.R. 6706, the House counterpart bill introduced by the Administration, and supported amendments presented by Congressman Andrew Maguire and the American Dental Association, both of which advocated the inclusion of a dental care component for Title XIX eligible children and matching funds to states at parity with levels specified for other health care services. In the Senate, the Association is pleased to support the amendments proposed by Senator Chiles, to accomplish the same basic purpose.

In view of the extensive review and consideration of the CHAP legislation by the House Commerce Health Subcommittee in 1977 and this year and the approval of H.R. 13611 (an amended H.R. 6706) by the House Commerce Committee, the Association urges that the Subcommittee on Health amend S. 1392 in a similar vein.

GOALS OF TITLE V OF THE SOCIAL SECURITY ACT

The Association recognizes that the Child Health Assessment Plan (S. 1392) introduced by the administration is intended to be a successor program for the title XIX, Medicaid, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program authorized by Congress in 1969, with implementation beginning in the early 1970's. The 1969 Social Security Act amendments provided clear evidence of the intent of Congress that the states were required to include dental care for children in their EPSDT programs in order to be eligible for federal matching funds. The accepted definition intended by Congress was that states should provide dental care which is necessary for "relief of pain and infection and restoration of teeth and maintenance of dental health". In 1972, Congress gave further indication of its intent that vision, hearing, and dental care be included in state programs, by authorizing the Department of Health, Education and Welfare to impose penalties on states which did not fully implement the EPSDT program for the Medicaid-eligible children's population.

Although the 1969 and 1972 Social Security amendments established the intent of Congress with respect to dental care for title XIX eligible children, the implementation of state dental programs nevertheless has been sporadic and, in general, disappointing. Even the publication of HEW regulations for state dental EPSDT programs in 1975 did not provide the impetus needed to fulfill the major goal of title V of the Social Security Act which calls upon all states "to provide quality health services for prospective mothers, infants and children, particularly in urban and/or low income areas where access to quality care is otherwise limited". This high expectation and low fulfillment with regard to care programs for needy children—particularly dental care—appears to be the foremost reason which encouraged the Administration to introduce legislation last year to improve, refine and strengthen the faltering EPSDT programs.

Since the Administration intends to replace the Maternal and Child Health EPSDT programs with the new CHAP legislation, the Association believes that an ideal opportunity is now at hand for Congress to develop new legislation which will allow it to carry out the original intent of the Title V, Social Security Act legislation. Longstanding Association policies support the passage of federal programs which provide comprehensive dental health care programs for all children. In addition, we support with the highest priority, programs which concentrate on providing health care to children of families eligible to receive Medicaid assistance through state and local governments. The Association believes that dental care should be an integral part of the total approach to the prevention of disease and disability and that the maintenance of good oral health of children and youth is an essential ingredient of their total health and well being. ADHA members also believe that it is extremely important that federal programs, such as the CHAP, include adequate provision and financial support for oral health care and services.

EPSDT PROGRAM WEAKNESSES

Over a 10-year period, 1967–1977 inclusive, Medicaid expenditures for dental services increased from $72 million to $400 million annually. However, as a percent of all Medicaid expenditures for health care, the high point was 5.5 percent in 1968 and the low point 2.5 percent in 1977. In 1968 federal expenditures for all Medicaid health care services were $3,451,000,000, while in 1977 they reached an all-time high of $16,257,000,000. It is obvious that EPSDT dental health programs for disadvantaged and needy children—an estimated 11,000,000–15,000,000 eligible beneficiaries—have been comparatively ineffectual, despite the efforts of 34 states to develop such programs. Even with its flaws, however, the Medicaid program has made health care available to millions who, before 1965, were not able to obtain it. On the other hand, it is an accepted fact that from 90 to 95 percent of all children, from early childhood to the late teens, need dental care. A highly placed official of the Medicaid Bureau of DHEW, as recently as April 1978, told a dental audience that "as far as the Medicaid legislative structure is concerned, you have, if you will, a second-class program . . . only 34 states have chosen to provide (dental care) and of those states, 12 of them to provide it only to the 'categorical needy'; i.e., those who receive a cash welfare grant".

Under the circumstances described, the Association agrees that from a dental health care standpoint the Medicaid state EPSDT programs should be replaced and that a CHAP program, amended to include dental benefits for children up to age 21, should be passed by Congress. In our view, H.R. 13611, developed by the House Commerce Health Subcommittee, voted up by the Interstate and Foreign Commerce Committee and sent to the floor of the House of Representatives, would remedy the many flaws of the current Medicaid program, especially those which have discouraged state welfare departments and state dental organizations from developing children's dental health programs.

Although EPSDT Medicaid regulations required that states provide "at least such dental care as is necessary for the relief of pain and infection and for the restoration of teeth and maintenance of dental health", states applied this definition in a variety of ways. A majority of states provided services only if a health assessment had generated a dental referral. With assessments performed by physicians and nurses, rather than dental personnel (i.e., dentists or dental hygienists), only about 25 percent of the screening resulted in dental referrals. Only a few states paid for dental services whether or not an assessment had occurred.

There is a consensus among professionals in dentistry, medicine, and public health that virtually all children age 3 and above need dental care. The health screening requirement of the current EPSDT program and the Administration's CHAP (S. 1392), predicates eligibility for Medicaid dental benefits on a general health assessment which is clearly inadequate for the dental needs of children. If the approach to dental care contained in H.R. 13611 were taken by the Senate, all children eligible for a health assessment would automatically be referred to a dental office, in which thorough and effective dental screenings, performed by licensed dentists or dental hygienists, could be accomplished.

The Association urges that the provisions of the House Commerce Committee's bill mandating dental care for children eligible for CHAP program benefits be approved by the Senate. We also urge that all children who undergo a CHAP clinic health assessment, simultaneously be referred to dentists or dental hygienists who are professionally qualified to assess oral health care needs and provide preventive care that is indigenous to general health care and well-being of children and youth.

A second major flaw of EPSDT state dental programs has been the low federal/state match, averaging 55 percent and ranging between 50 to 78 percent. The administration's CHAP proposal increases the federal match up to a maximum of 90 percent but it leaves dental services at the former low and inadequate level. As a mandated CHAP service in H.R. 13611, dental services would be at parity with all other health care services. The Association urges that this level of federal funding for children's dental health care be endorsed by the Senate. Under the new matching level proposed for all health care services provided under state CHAP programs, there is no logical reason from the standpoint of children's health and welfare to maintain dental care in its current second-class status.

Despite its awareness of flaws and criticisms of state EPSDT programs, the Association believes that the efforts of some 34 to 40 state welfare, dental health departments and dental organizations to develop programs under Title XIX Medicaid should not only be maintained but vastly improved. The higher federal matching formula included in H.R. 13611 should provide the necessary stimulus required to attend to the dental needs of children of poor and disadvantaged families. We are concerned that the downgrading of dental care in the administration's bill, omitting dental care from the increase of funding levels for medical services, would adversely affect the state EPSDT programs now operating. An even greater concern is that many existing children's dental care programs, for the lack of financial incentives to the states, may be permitted to deteriorate or be phased out entirely. As inadequate nationally as Medicaid EPSDT dental programs have been, it is unthinkable that existing levels of oral health care services will not be maintained.

COST EFFECTIVE CHAP DENTAL PLANS

The Association is well aware of the concerns of the Subcommittee on Health which relate to the add-on costs of including dental benefits in a new CHAP bill. We share the concerns of committee members of Congress, and the general public that new programs in the health and welfare areas should be considered sparingly, if at all. In the present mood and temper of Congress and the general public, the add-on cost of a CHAP dental program will not be insignificant. However, the inclusion of dental benefits under the Medicaid program can hardly be considered as a new benefits package. Nor because a dental component is included at federal matching levels adequate to encourage states to develop them, should their probable cost-effectiveness, in the long run, to the nation's health be ignored. In our opinion, the public health policy view encompassed in the House Commerce Committee's bill, which holds that dental care and preventive oral health services are an integral part of the total health care of the nation's children and youth, is a sound policy. It is also a policy which we believe will be endorsed by the Senate. We believe that the investment of public funds in a preventive dental health program for disadvantaged and needy children will be a sound investment in the future good health of the next generation of adults.

Although records and data from state dental health Medicaid programs are not available in great abundance, one state, the state of California, has been successful in developing a sophisticated and effective Medicaid program which might well be a model for many other states to emulate. This plan includes both the children and adult Medicaid populations of the state. The California Denti-Cal program, as it is called, is efficient. Ninety-four and one half (94.5 percent) of the public funds expended pay for dental care and services. Only 5.5 percent are required for administrative services. Through regional dental offices, Denti-Cal scheduled nearly 45,000 clinical screenings in 1976. In the children's program, Denti-Cal enrolled 1,196,897 patients in the years 1974–1976. It provided a three-year total of 750,000 preventive prophylaxis and topical fluoride treatments and completed 3,406,749 dental restoration in the same three-year period. The number of dentists participating in Denti-Cal increased from 8,000 in 1973 to more than 12,500 in 1976.

The most impressive accomplishments of the Denti-Cal program, however, are best summed up by the Executive Vice-President of the California Dental Service, Dr. Eric D. Olsen. In his remarks delivered at an April 1978 Conference on Dentistry in the Medicaid Program, Dr. Olsen observed that:

> The amount of dental care deliveries has almost doubled between 1973 and 1977. Total program costs have increased due to three factors. First, more equitable reimbursement levels have resulted from annual fee increases which have approximated the increase in the cost of living. Second, there has been the aforementioned increase in the utilization of beneficiaries. Third, the largest increase in total program costs has been due to the dramatic increase in the number of people eligible for Medicaid. Yet, the actual cost for each eligible has not changed very much over the four years of the project even though program utilization has gone up dramatically. During 1974, Denti-Cal's first year, CDS paid $85.75 for each patient receiving care. Through effective administration, dental review and accumulation of patient treatment histories, the cost per patient has since decreased to $74.90. These figures indicate that more beneficiaries are receiving services while CDS' professionally oriented administration is reducing the cost of care.

The California experience with state dental Medicaid programs—probably the largest dental program administered by any state government—should be reassuring to Congress, government officials and the public that the long benign neglect of dental conditions known to exist among the nation's children whose families live near or at poverty levels, can be ended. The example of California, and several other states which have been developing dental plans for state Medicaid programs, are proof enough that public and private sector programs are needed, widely utilized, and can be cost-effective when essential administrative controls are imposed. Because dental care is intrinsically a preventive health service, the long-range cost benefits for the adult population of a future generation are probably incalculable. However, as an investment in health, long-range dental care programs for needy and poor children can no longer be shunted aside "because they are too expensive" for governments to consider.

The Association urges the Subcommittee to judge the addition of mandated dental services in CHAP Medicaid programs on the merits of the services which can obviously be provided by the dental profession; on the need in relation to the importance of dental care for children; on the foreseeable improvement of the general health and well-being of the next generation of adults; and finally, on the basis of recognition by health professionals and consumers alike, that dental care is indeed a basic medical service, rather than an optional service which is too expensive to add to current health care services provided under the Medicaid program.

Last year when Senator Chiles introduced the "Children's Medicaid Amendments" for the Administration's "Child Health Assessment Plan" (S. 1392), he pointed out that dental care was a "glaring omission" in many state Medicaid programs, despite the fact that dental care "has the highest rate of incidence and the lowest rate of treatment for poor children". The Association concurs with this observation and the provision in his amendments "that states provide routine dental care for eligible children through the age of 17". While we believe that the upper age limit should be revised to 21, as H.R. 13611 has done, we share the Senator's views that dental care for children is clearly a medical service and that untreated dental problems can produce not only pain but also permanent physical impairment. We believe, as does Senator Chiles, that the exclusion of dental care from Medicaid coverage at levels recommended for other health care services included in S. 1392, is essentially "an arbitrary attempt to save money that undermines the central intent of Medicaid". We urge that the Senator's colleagues on the subcommittee share these views by approving a bill which embodies the major features of House bill H.R. 13611.

DENTAL MANPOWER RESOURCES

The association wishes to assure the subcommittee that the dental profession has ample manpower resources currently to assume responsibility to administer an expanded and improved CHAP Medicaid program. At the close of 1977 calendar year, there were 112,700 dentists engaged in private practice, 32,000 dental hygienists, and 144,700 dental assistants. In 1976 and 1977, dental and dental auxiliary schools reported the number of graduates as follows:

Dental 5,177 (1977); Dental hygienists 4,616 (1976); and Dental assisting 6,208 (1976).

The current dental work force and the annual output of dental and dental auxiliary graduates is more than adequate to be responsive to an improved and expanded CHAP dental Medicaid program. In addition, between 1972 and 1977, the profession has graduated more than 6,000 Expanded Function Dental Auxiliaries (EFDA) who under the direction of a dentist, can perform new and expanded functions in the dental care delivery system. EFDA graduates are dental hygienists or dental assistants who have either graduated from accredited dental auxiliary schools, or who have left practice temporarily to complete special studies in continuing education programs to become qualified to perform expanded functions as state dental laws permit.

The association wishes to inform the subcommittee that dental hygienists, who are already licensed to provide preventive care and direct patient services, are a unique standby manpower resources of the dental profession. Dental hygienists are ready and willing to assist the profession in meeting further increases in consumer demands for dental care. In order to obtain a license to practice, dental hygienists must be graduates of accredited dental hygiene schools. The dental hygiene educational program includes instruction in the biomedical, dental, and behavioral sciences and substantial amounts of preclinical and clinical dental hygiene instruction. In addition, in order to obtain a license as a Registered Dental Hygienist, most dental boards examine graduates for proficiencies in dental and periodontal charting, X-ray theory and technique, and competency in rendering prophylactic treatment and other therapeutic treatment procedures. In developing new or expanded CHAP programs in all of the nation's 50 states, dental hygienists are qualified by education and license to assist dentists to provide the highest level of preventive dental care to the currently undeserved Medicaid-eligible children's population.

In our view there should be no reason to set aside a Medicaid children's dental program because of any claim, however spurious, that there is insufficient professional manpower. The facts speak otherwise and, in fact, reinforce the view that given adequate financial incentives to develop quality dental care programs, state dental plans under CHAP can be [illegible]ly improved and expanded in all states.

SUMMARY

The Association concludes this statement with the following summary of its views and recommendations:

1. The Association believes that dental services are medical services, as defined in the federal EPSDT Medicaid program for children, and that dental assessment, diagnosis, and treatment should be mandated in CHAP legislation for Medicaid-eligible children;
2. The Association strongly recommends that federal matching funds for state Medicaid dental CHAP programs be provided at the same level as specified for all health care services; i.e., the federal matching share should be increased over existing EPSDT funding levels by 25 percent and up to a maximum of 90 percent;
3. The Association urges the Senate Finance Subcommittee to require that state dental CHAP programs provide oral health assessments, diagnosis, treatment, referral, and dental care management for all eligible children and youth under age 21; in addition, the Subcommittee is urged to require that oral health assessments, diagnosis, treatment, and referrals be automatic, or simultaneous, with other health assessments when individuals are registered in the health assessment program;
4. The Association believes that preventive dental care programs for Medicaid-eligible children will be cost-effective and produce long-range cost benefits which will be in the public interest; and
5. The Association is confident that the dental profession, by utilizing its dental auxiliary work force at maximum, has sufficient available dental manpower currently to administer CHAP dental programs at substantially improved levels of services; in particular the dental hygiene work force is uniquely prepared by education, license, and experience in dental offices, to assist the profession to maintain the highest quality of service in the delivery of dental care to the nation's poor and needy children.

APPENDIX

CHAP ADMINISTRATIVE COMPLEXITIES

(HEW RESPONSE FROM PAGE 181)

The attached paper identifies 11 potential problems for States in administering CHAP. The solutions proposed are dependent upon the development of comprehensive data processing systems. A separate paper on current systems capabilities of States presents the projected time schedule for developing State systems to a sufficient level to handle CHAP. The attached solutions represent the kinds of capabilities State systems would be expected to have when they have reached the CHAP level of sufficiency. These "solutions" are intended to serve as examples of the way systems could handle the CHAP administrative complexities, but it is expected that States will retain the flexibility to select alternative systems solutions to these problems.

Attachment.

CHAP ADMINISTRATIVE COMPLEXITIES

Problem Area: Varying Match

Services for CHAP children receive different match from those rendered to other medicaid eligibles.	(a) When a child receives an assessment, the bill for the screen triggers the posting of an assessment on the eligibility file. (b) At end of quarter, the State selects all claims by recipient identifier and totals expenditures for CHAP children separately.
CHAP services vary in Federal match among family planning, inpatient services and other services.	(a) The computer files would contain a cross-reference file associating type of service to matching rate. (b) Referring to the selection described in 1(b) above, claims would be classified by service type within all claims for each recipient.
Higher match ends when child is due for next assessment.	(a) The eligibility file would contain a field denoting the date the next assessment is due for each child. (b) When the computer is totalling expenditures for CHAP children (item 1(b)), it will ignore claims for any services rendered after the next assessment due date if the next assessment has not been conducted.
Higher match for outreach.	(a) State could manually record the salaries, fringe benefits, overhead, and transportation costs for personnel engaged in outreach. This would be similar to the methods States currently use to keep track of administrative costs associated with medical personnel and their staffs. (b) For personnel engaged in outreach plus some other activity, the State would have to document an allocation method for distributing costs between the two activities.

Problem Area: Eligibility

PROBLEM	SOLUTION
CHAP splits a family's eligibility or medical assistance three ways: The family can be eligible for AFDC or on 4-month continued AFDC coverage, thereby receiving Medicaid, as is currently the case. A child can be individually eligible for medicaid since, for example, a family income of $4,100 might leave the parent(s) ineligible, while the child is eligible. The child also becomes eligible for additional services after having been assessed, so there is a need to recognize a child as CHAP-eligible.	(a) It is likely that States will have to issue a separate medicaid card for children in the family. This should only be difficult for States which have not assigned separate medicaid identifying numbers to individual members of the family heretofore. A child's eligibility for medicaid would probably be determined by the caseworker who is examining the family's eligibility for public assistance. It is also likely that States will have to issue a separate CHAP card for a child who has been assessed. The CHAP caseworker could issue a temporary CHAP card upon learning that the assessment has been completed. When the provider's bill for the screen is submitted to the State, it could then trigger the issuance of a CHAP card which would be valid until the next assessment is due. (c) The public assistance eligibility unit will have to alert the medicaid unit responsible for updating the medicaid eligibility reference file when changes in family income have made the family ineligible, have placed the family on 4-month continued coverage, or have placed the child on 6-month continued coverage.
Assessed children with lapses in eligibility would have to be reidentified for CHAP benefits to continue without a requirement for another assessment upon becoming eligible again.	(a) States would retain computerized eligibility records on each child for 12 months following ending date of medicaid coverage. Keeping inactive files for more than 12 months would become too burdensome in relation to the lower likelihood of reentries after that time.
Twenty-five States will have a new eligibility determination process for children in families under $4,200. It will take more staff and space to handle the workload.	(a) The greater the extent to which the eligibility criteria are similar to ones with which the eligibility workers are already familiar, the easier it will be to establish this additional process. For example, any disregards for CHAP eligibility should not introduce new disregards not already present in AFDC. (b) The additional staff and space problems can only be handled by advanced State (or County) planning to have the necessary resources available.

Problem Area: Provider Agreements

States may have to enroll new provider types, such as CMHC's, chiropractors and podiatrists, and set reimbursement schedules for them.	(a) Use Institute for Medicaid Management to provide examples of provider agreements and reimbursement schedules from States which already offer services from these provider types.

PROBLEM	SOLUTION
States will have to waive limits on amounts, duration, and scope for CHAP children only.	**(a) States amend provider manuals to make providers aware of removal of limitations for CHAP children.** **(b) Computer processing routine will match claim against eligibility file, identify that recipient as a CHAP child, and then ignore service limitations applicable to non-CHAP recipients.** **(c) States will need to concentrate their utilization review activities upon services which have had amount, duration, and scope limitations removed.**
Copayments may be required for adults in a family, while they are prohibited for CHAP children.	**(a) Modification of the provider manuals should alert providers to a copayment policy which differs between children and adults. A CHAP card would help protect the child from being asked for a copayment. The computer could adjust cost-sharing and reimbursement between child and adult services. This conflict in copayment requirements is already present under the current EPSDT program.**

Problem Area: Tracking Children Into Treatment

Many States do not have the capability to track children into treatment or, as a corollary, to associate a treatment bill with conditions found in screening.	**(a) EPSDT penalty regulations will require tracking of each child with problem conditions, and will help motivate States to install improved systems.** **(b) A general systems design of a model EPSDT Management Information System is being developed by HEW and will be delivered to the States when the final penalty regulations are promulgated.** **(c) The Medicaid Bureau will award contracts in fiscal year 1978 for technical assistance to States in improving their case management systems.** **(d) The Medicaid Bureau is investigating the possibility for advanced systems funding (90/75 percent) for States which develop computer systems which fulfill the principle functional requirements of EPSDT.**

(HEW RESPONSE FROM PAGE 184)

The Department has developed a draft request for proposal (RFP) which will be used to elicit proposals for demonstration sites. We expect to have the final RFP ready shortly. The release of the RFP will depend on the availability of funds, since these demonstrations and their independent evaluations would cost in excess of $4 million over a three-year period. The funds are not available to do the projects because of general limitations and higher priority work. We would hope that in 1981 sufficient funds could be found with which to do these projects. In addition, HCFA and the Robert Wood Johnson Foundation have been collaborating on a series of demonstrations and evaluations to test new methods of delivering and reimbursing services by expanding the delivery of primary care and preventive services in ambulatory clinic settings in underserved urban areas.