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ABSTRACT

This report of Senate hearings on health assistance for low income children presents the testimony of administration and public witnesses concerning Senate Bill S. 1204. The purpose of the bill is to broaden medical eligibility for children and pregnant women and to improve the delivery of preventive and other health care services to children under Medicaid. An attempt is made to legislate expansions of the Medicaid Early, Periodic Screening, Diagnosis and Treatment program to insure that the neediest children have an adequate level of basic health care. Communications from associations and organizations and additional information are included. (Author/RH)

HEALTH ASSISTANCE FOR LOW-INCOME CHILDREN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 1204

A BILL TO STRENGTHEN AND IMPROVE MEDICAL SERVICES
TO LOW-INCOME CHILDREN AND PREGNANT WOMEN, AND
FOR OTHER PURPOSES

JUNE 25, 1979

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Printed for the use of the Committee on Finance

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CONTENTS

ADMINISTRATION WITNESSES

PUBLIC WITNESSES

COMMUNICATIONS

ADDITIONAL INFORMATION

HEALTH ASSISTANCE FOR LOW-INCOME CHILDREN

MONDAY, JUNE 25, 1979

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

The subcommittee met, at 2 p.m., pursuant to notice, in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Bradley, Ribicoff, Durenberger, and Heinz.

[The press release announcing this hearing and the bill S. 1204 follow:]

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON CHILD HEALTH

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 Monday afternoon, June 25, 1979 on a proposal to expand health assistance for low-income children.

The hearing will begin at 2:00 P.M., Monday, June 25, 1979 in Room 2221 Dirksen Senate Office Building.

Senator Talmadge said, "There are a variety of Federal programs which currently provide some type of health care services to mothers and children. However, population groups targeted for assistance by these programs often overlap, resulting in confusion and duplication. Moreover, many eligible persons are left without services.

"One of the major Federal programs providing child health services is Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Although this program is intended to serve all children under age 21 who are eligible for Medicaid, only about 2 million of the 11 million eligible children are being reached."

Pending before the Committee is S. 1204, the Administration's Child Health Care Assessment Program (CHAP). CHAP would replace the current EPSDT program with an expanded program of medical services to a greater proportion of low-income children and pregnant women.

In addition to testimony on S. 1204, the Chairman stated that the Subcommittee would be pleased to receive suggestions on improvements in and coordination of existing programs.

Requests to testify.—Senator Talmadge stated that witnesses desiring to testify during this hearing must make their requests to testify to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510 not later than Monday, June 18, 1979.

Senator Talmadge said that because a large number of requests to testify are anticipated, the Committee will not be able to schedule all those who request to testify. Those persons who are not scheduled to appear in person to present oral testimony are invited to submit written statements. He emphasized that the views presented in such written statements will be as carefully considered by the Committee as if they were presented orally.

All parties who are scheduled to testify orally are urged to comply with the guidelines below:

Notification of witnesses.—Parties who have submitted written requests to testify will be notified as soon as possible as to the time they are scheduled to appear. Once a witness has been advised of the time of his appearance, rescheduling will not be permitted. If a witness is unable to testify at the time he is scheduled to appear, he may file a written statement for the record of the hearing.

Consolidated testimony.—The Chairman also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views on the total bill than it might otherwise obtain.

Panel groups.—Groups with similar viewpoints but who cannot designate a single spokesman will be encouraged to form panels. Each panelist will be required to restrict his or her comments to no longer than a six-minute summation of the principal points of the written statements. The panelists are urged to avoid repetition whenever possible in their presentations.

Legislative Reorganization Act.—The Chairman observed that the Legislative Reorganization Act of 1946, as amended, 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.

Senator Talmadge stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses must comply with the following rules:

(1) All statements must be filed with the Committee at least one day in advance of the day on which the witness is scheduled to appear. If a witness is scheduled to testify on a Monday or Tuesday, he must file his written statement with the Committee by the Friday preceding his appearance.

(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 lettersize paper (not legal size) and *at least 100 copies* must be submitted to the Committee.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their six-minute oral presentations to a summary of the points included in the statement.

(5) Not more than six minutes will be allowed for the oral summary.

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

Written statements.—Witnesses who are not scheduled for oral presentation, and others who desire to present a statement to the Committee, are urged to prepare a written position of their views for submission and inclusion in the record of the hearings. Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with five (5) copies by July 9, 1979 to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510.

96TH CONGRESS
1ST SESSION

S. 1204

To strengthen and improve medicaid services to low-income children and pregnant women, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 22 (legislative day, MAY 21), 1979

Mr. RIBICOFF (for himself, Mr. DANFORTH, Mr. BRADLEY, Mr. BAUCUS, Mr. HEINZ, Mr. JAVITS, and Mr. MOYNIHAN) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To strengthen and improve medicaid services to low-income children and pregnant women, and for other purposes.

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

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Child Health Assurance Act of 1979".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

PURPOSE

SEC. 2. The purpose of this Act is to broaden medicaid eligibility for children and pregnant women, and to improve the delivery of preventive and other health care services to children under medicaid—

(1) to increase the number of needy children and pregnant women eligible for medicaid coverage;

(2) to replace the early and periodic screening, diagnosis, and treatment program with a strengthened child health assurance program;

(3) to encourage participation in the medicaid program of providers willing to assume responsibility for comprehensive, continuing primary and preventive health care of individual children;

(4) to require more comprehensive medicaid coverage of needed health services for eligible children; and

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

TITLE I—CHILD HEALTH ASSURANCE PROGRAM; MEDICAID ELIGIBILITY OF POOR CHILDREN

MEDICAID ELIGIBILITY OF POOR CHILDREN

SEC. 101. (a)(1) Section 1902(a)(10)(A) is amended—

(A) by inserting the clause designation "(i)" after the clause designation "(A)", and

(B) by adding at the end the following:

"(ii) for making medical assistance available to any individual under the age of 18 (or, at the option of the State, to any individual under the age of 19, 20, or 21) whose resources (including the resources of his family) meet the resources test of eligibility for medical assistance under the State plan approved under this title applicable to a family with dependent children, and whose income either (I) meets the income test of eligibility for medical assistance under such plan applicable to a family with dependent children or (II) does not exceed 55 per centum of the amount established for an individual or for a family of that size, as appropriate, by the income poverty guidelines for the nonfarm population of the United States as prescribed by the Office of Management and Budget (and adjusted annually) pursuant to section 625 of the Economic Opportunity Act of 1964;".

(2) Sections 1903(a)(1), 1903(f)(4)(C), and 1905(a) are amended by striking out "section 1902(a)(10)(A)" and inserting instead "section 1902(a)(10)(A)(i)" each place it appears.

(b)(1) Section 1902(b) is amended by striking out clause (2) and redesignating clauses (3) and (4) as clauses (2) and (3), respectively.

(2) Section 1905(a) is amended in clause (ii) by striking out ", except for section 406(a)(2),".

(c) Section 1902(a)(17) is amended in clause (B) by inserting immediately after "except for income and resources" the following: "or family composition".

CHILD HEALTH ASSURANCE PROGRAM (CHAP)

SEC. 102. (a) Section 1902(a) is amended—

(1) by striking out "and" after paragraph (39),

(2) by striking out the period after paragraph (40) and inserting instead "; and" and

(3) by adding after paragraph (40) the following new paragraph:

"(41) provide for a child health assurance program in accordance with section 1913.".

(b) Title XIX is amended by adding at the end thereof the following new section:

"CHILD HEALTH ASSURANCE PROGRAM (CHAP)

"SEC. 1913. A child health assurance program under this section shall meet the following requirements:

"(a)(1) The program must assure the availability, to each child eligible under section 1902(a)(13)(iii) to receive such services, of child health assessments in accordance with this subsection, at such periods and including such services and procedures appropriate for an individual of his age as the Secretary shall specify in regulations, in order to determine the child's health status and to identify health problems.

"(2) Child health assessments may be provided under this subsection only by an eligible provider (as determined under subsection (e)) who enters into a written agreement with the single State agency (in accordance with standards established by the Secretary) to do the following:

"(A) To provide timely and appropriate child health assessments to individuals eligible under the State plan to receive such assessments (hereinafter in this section referred to as 'eligible individuals').

"(B)(i) To provide directly to eligible individuals whom it has assessed such basic diagnostic and treatment services (including immunization against childhood diseases) as the Secretary shall specify in regulations, or

"(ii)(I) To refer eligible individuals whom it has assessed promptly to other health care providers for the provision of the basic diagnostic and treatment services specified in clause (i), and (II) to provide to such individuals followup services to insure the timely and appropriate provision of the services for which such a referral has been made, or to furnish to the single State agency such information as that agency determines to be necessary to allow followup on the provision of needed services.

"(C) To make such reports as the single State agency and the Secretary may require to assure compliance with the written agreement and with the requirements of this section.

"(3) The program must assure that the State agency assumes responsibility for the management of the medical care of each assessed child, including followup on the provision of needed care and services, and scheduling for and provision of subsequent periodic child health assessments, unless the child health assessment provider or the continuing care provider has assumed such responsibility.

"(b)(1) The program must provide for participation in the program under this title by providers of continuing care for children in accordance with this subsection.

"(2) Continuing care under this subsection may be provided by a qualified provider (as determined under subsection (e)) who enters into a written agreement with the single State agency to do the following with respect to a specific eligible individual:

"(A) To provide child health assessments in accordance with subsection (a)(2)(A), "(B) To provide continuing diagnosis and treatment services in accordance with subsection (a)(2)(B)(i), and to make all reports required pursuant to subsection (a)(2)(C).

"(C) To manage the medical care of such individual to assure that all necessary medical services which are provided under the State plan are made available in a timely manner, and to assure that reassessments are performed on a timely and periodic basis, as required by the Secretary in regulations.

"(D) To provide continuing primary and preventive care (including such care and services as the Secretary may specify in regulations), and to be reasonably available on a continuing basis for delivery of services.

"(3) States shall make payments to continuing care providers for services provided pursuant to paragraph (2) in accordance with methods and standards meeting such requirements as the Secretary may by regulation provide. The Secretary may establish minimum reimbursement levels (which may be uniform nationally or may vary by State or region), may permit or require payment based on a prospectively determined capitation rate, and payment on a periodic basis, and may permit or require other payment incentives.

"(c) The program must assure that the State agency (1) assumes responsibility for assuring that all children of whom it has knowledge eligible for services under the plan are informed of the need for and availability of dental services, and are referred to providers of such care and services on a timely and periodic basis, and (2) will prepare a list of dentists providing services under the plan, which it shall update regularly and provide at least annually to all such children.

"(d) The program must provide for outreach to individuals eligible for assessments under this subsection. Outreach under this subsection includes such activities as the Secretary may permit or require, but must include identifying and locating families of eligible children and informing them of the availability of assessments, continuing care, and other child health services.

"(e)(1) Providers of child health assessment services under subsection (a) and continuing care services under subsection (b) shall include primary health care centers funded under the Public Health Service Act (including community health centers and migrant health centers); maternal and infant care projects and children and youth projects fun[illegible] under title V of the Social Security Act; facilities delivering ambulatory health services operated by the Indian Health Service; State health departments and other State and local governmental entities; schools; rural health clinics; health maintenance organizations; physicians; and such other providers as may be specified by the Secretary in regulations.

"(2) The State agency shall enter into a written agreement under subsection (a) or (b) with any provider specified in paragraph (1) unless it reasonably determines with respect to a specific provider, in accordance with such standards and procedures as the Secretary may prescribe, that such provider will not satisfactorily provide the care and services required under such subsection.

"(f) The Secretary may by regulation require that all providers of child health assessments and other ambulatory child health care services under this title (or all providers within reasonable classifications of such providers) submit uniform reports and use uniform claim forms.".

REQUIRED COVERAGE FOR CHILDREN

SEC. 103. (a) Section 1902(a)(13) is amended by inserting at the end of clause (A) the following new clause:

"(iii) in the case of any individual under the age of 18, (I) for inclusion of the care and services listed in clauses (1), (2), (3), (4)(B)(i), and (5) of section 1905(a) without limitation on the amount, duration, or scope of medical assistance, (II) for inclusion of the care and services listed in clause (4)(B)(ii) which may not be less in amount, duration and scope than minimum limits which the Secretary may prescribe, and (III) for inclusion of the care and services listed in clause (4)(B)(iii) of section 1905(a), and".

(b) Clause (I) of section 1902(a)(10) is amended by inserting "and the making available of the services described in clause (iii) of paragraph (13)(A) to individuals meeting the requirements prescribed therein" after "section 1905(a)".

(c) Section 1905(a)(4)(B) is amended to read as follows: "; (B) the following services for individuals under the age of 18 (and, where the State exercises the option under section 1902(a)(10)(B)(ii), to individuals under the age of 19, 20, or 21): (i) child health assessment services and continuing care services provided in accordance with section 1913, immunizations, prescribed drugs and insulin, diagnosis and treatment of vision and hearing problems, including hearing aids and eyeglasses, (ii) ambulatory mental health services delivered in centers funded under the Community Mental Health Centers Act or meeting standards established by the Secretary in regulations, and (iii) routine dental care and services (which shall include only diagnostic, preventive, restoration, and emergency dental services);".

TREATMENT OF COPAYMENTS FOR CHILDREN

SEC. 104. (a) Section 1902(a)(14)(A) is amended by inserting immediately after "paragraph (10)(A)" the following:

", or who are eligible for medical assistance under the State plan pursuant to paragraph (10)(A)(ii)".

(b) By adding after subparagraph (B) the following new subparagraph:

"(C) in the case of individuals under the age of 18 and individuals eligible for medical assistance under the State plan pursuant to paragraph (10)(A)(ii), no enrollment fee, premium, deductible, cost sharing, or similar charge with respect to any of the care and services listed in section 1905(a)(4)(B) may be imposed under the plan;".

CONTINUATION OF ELIGIBILITY

SEC. 105. Section 1902(e) is amended—

(1) by inserting "(1)" after "(e)";

(2) in subsection (e)(1), as redesignated, by deleting ", while a member of such family is employed,"; and

(3) by adding at the end thereof the following new paragraph:

"(2) Notwithstanding any other provision of this title, each State plan approved under this title must provide that any individual under the age of 18 (or, at State option, any individual under the age of 19, 20, or 21) who becomes ineligible, because of increased income from employment of himself or his family, for medical assistance under the State plan shall, nonetheless, remain eligible for all medical-assistance provided under the State plan to such individuals until the end of the 4-calendar-month period beginning with the month following the month in which the individual became ineligible."

FEDERAL REIMBURSEMENT

SEC. 106. (a) Notwithstanding any provision of section 1903 of the Social Security Act, for the first calendar quarter beginning at least six months after enactment of this Act, and for each of the five succeeding quarters, the Federal medical assistance percentage for ambulatory care and services for children shall be the Federal medical assistance percentage as defined in section 1905(b) of that Act plus 4 percentage points.

(b) Section 1903(a) is amended by redesignating clause (7) as clause (8), and by adding after clause (6) the following new clause:

> "(7) an amount equal to 75 per centum of the sums expended during such quarter for the costs to public agencies (or to private agencies pursuant to a contract with the State agency) of outreach in accordance with section 1913(a)(4).".

(c) Section 1903(a)(1) is amended by deleting "subject to subsections (g) and (h)" and inserting instead "subject to subsections (g), (h), and (n)".

(d) Section 1903 is amended by adding at the end thereof the following new subsection:

"(n)(1) For the first calendar quarter beginning at least 24 months after enactment of the Child Health Assurance Act of 1979, and for each succeeding quarter, the Federal medical assistance percentage for ambulatory care and services for children shall be adjusted as provided in paragraphs (2) through (5) of this subsection.

"(2) The Secretary shall promulgate, and may at appropriate intervals revise, regulations establishing a formula for measuring the effectiveness of a State's child health assurance program, which formula shall take in account with respect to children under the age of eighteen enrolled in the State's program under this title (other than children whose eligibility is based on the cost of medical care to themselves or their families)—

"(A) the percentage of such children who were covered under an agreement with a continuing care provider pursuant to section 1913(b)(2) and who received, during the period under review, all necessary care and services covered under such agreement; and

"(B) the percentage of such children not covered by a continuing care agreement who

"(i) received, during the period under review, a timely child health assessment, and received in a timely manner after an assessment (as specified by the Secretary in regulations) any necessary medical care or treatment for conditions found during an assessment, or

"(ii) were not due for assessment and did not need treatment for conditions found during an assessment.

The formula under this paragraph shall give greater weight to the State's performance as measured under clause (A) than to its performance as measured under clause (B).

"(3) The Secretary shall publish, and may revise and republish as appropriate, a formula for graduated adjustment of States' Federal medical assistance percentages (as defined in section 1905(b)) with respect to the services specified in paragraph (1), based on States' performance with respect to the standards established under paragraph (2). No State's Federal medical assistance percentage, as adjusted pursuant to this subsection, shall be lower than 5 percentage points below, or higher than 20 percentage points above (up to a maximum of 90 per centum), its Federal medical assistance percentage as defined in section 1905(b).

"(4) The Secretary shall evaluate at least biannually, on a sample or other basis, each State's performance with respect to the standards established under paragraph (2), and shall report his determination evaluating the State's performance to the State not later than six months after the end of the period reviewed.

"(5) The Secretary shall by regulation provide for a procedure whereby a State agency may demonstrate to the satisfaction of the Secretary, with respect to any period, that it has achieved a performance level which entitles it to a higher Federal medical assistance percentage, pursuant to paragraph (3), than the percentage determined by the Secretary pursuant to paragraph (4).".

EFFECTIVE DATE OF AID TO FAMILIES WITH DEPENDENT CHILDREN PENALTY; REPEAL OF PENALTY; ADDITION OF STATE PLAN REQUIREMENT

SEC. 107. (a) No reduction in the amount payable to States pursuant to section 403(g) of the Act shall be made with respect to any quarter beginning before the effective date of final regulations pursuant to section 403(g) published after January 1, 1979.

(b) Effective the first day of the first calendar quarter beginning at least six months after enactment of this Act, section 403(g) of the Social Security Act is repealed.

(c) Section 402(a) is amended by adding after paragraph (16) the following new paragraph:

"(17) provide that the State agency shall inform all families in the State receiving aid to families with dependent children of the availability of child health assurance services under the plan of such State approved under title XIX;".

TITLE II—MEDICAID ELIGIBILITY OF PREGNANT WOMEN

MEDICAID ELIGIBILITY OF PREGNANT WOMEN

SEC. 201. (a) Section 1902(a)(10)(A), as amended by section 101 of this Act, is further amended by adding at the end the following:

> "(iii) for making medical assistance available for care and services provided during pregnancy and for 60 days following the termination of pregnancy to any woman whose resources (including the resources of her family) meet the resources test of eligibility for medical assistance under the State plan approved under this title applicable to a family with dependent children, and whose income either (I) meets the income test of eligibility for medical assistance under such plan applicable to a family with dependent children or (II) does not exceed 55 per centum of the amount established for an individual or for a family of that size, as appropriate, by the income poverty guidelines for the nonfarm population of the United States

as prescribed by the Office of Management and Budget (and adjusted annually) pursuant to section 625 of the Economic Opportunity Act of 1964;".

(b) Section 1905(a) is amended—

(A) by striking out "or" at the end of clause (vi);

(B) by inserting "or" at the end of clause (vii);

(C) by inserting after and below clause (vii) the following new clause:

"(viii) women during pregnancy and during the 60 days following the termination of pregnancy,".

REQUIRED COVERAGE FOR PREGNANT WOMEN

SEC. 202. Section 1902(a)(13)(B) is amended to read as follows:

"(B) in the case of any individual described in paragraph (10)(A), for inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and".

CONTINUATION OF ELIGIBILITY

SEC. 203. Section 1902(e)(1), as amended by section 105 of this Act, is further amended by adding at the end thereof the following new paragraph:

"(3) Notwithstanding any other provision of this title, each State plan approved under this title must provide that any pregnant woman who is eligible for, has applied for, and has received medical assistance under this title and who becomes ineligible for such assistance because of increased income from employment of herself or her family, shall, nonetheless, remain eligible for all such medical assistance provided under the State plan until the end of the 60-day period beginning on the date of the termination of her pregnancy.".

TITLE III—EFFECTIVE DATES; REGULATIONS

EFFECTIVE DATES; REGULATIONS

SEC. 301. (a)(1) Except as otherwise expressly provided, the amendments made by this Act shall apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning at least six months after enactment of this Act.

(2) Where the Secretary determines that State legislation is necessary to permit amendment of the State plan under title XIX of the Social Security Act to meet the additional requirements imposed by the amendments made by this Act, he shall not find a failure to comply with the requirements of such title solely on the basis of such State's failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(b) The Secretary shall issue the regulations required by this Act within six months after the date of enactment of this Act.

○

Senator TALMADGE. The hearing will be in order.

Today we are holding a hearing to consider many present Federal programs designed to provide or pay for screening, diagnosis and treatment to low-income mothers and children.

We can all agree on the need for commonsense approaches to improved care for mothers and children. But that is easier said than done.

Population groups targeted for assistance by these programs often overlap, resulting in confusion and duplication.

Moreover, many eligible persons are left without services. For example, one of the major federal programs providing child health services is medicaid's early and periodic screening, diagnosis and treatment, EPSDT, program.

Although this program is intended to serve all children under age 21 who are eligible for medicaid, only about 2 million of the 11 million eligible children are being reached.

The question of coordination and evaluation of the existing programs was unfortunately addressed on only the most limited basis during consideration of the administration's child health assistance plan during the last Congress.

Following the adjournment of Congress, the staff requested the Congressional Research Service of the Library of Congress to prepare a listing of all Federal programs involved in the provision and financing of health care for mothers and children. That analysis and summary is contained in a committee print which has just been released.

I am pleased that the Department of Health, Education, and Welfare shared our concern over the need to provide effective coordination of the existing programs as a precondition to any expansion such as the proposed child health assistance program which Senators Ribicoff, Danforth, Bradley, Baucus, Heinz, Javits, and Moynihan are sponsoring.

The initial summary of overlapping programs was informally provided to Secretary Califano last December. At his direction, the Department has since that time been working vigorously to develop and implement changes necessary to assure reasonable coordination and nonduplication of the program for mothers and children.

I want to commend the Secretary and the Department for those necessary efforts.

I would also suggest that an essential element to avoid duplication of services is the maintenance in each State of a profile of each child or parent receiving services under the existing programs or the CHAP plan, if enacted.

The profile would indicate which services had or had not been received by a given individual. The profile should be available, subject to confidentiality safeguards, to each qualified provider.

With respect to both the existing programs and any new proposed programs, I am also concerned that reasonable and effective controls be implemented to assure that costs of services are reasonable and that the services themselves are appropriate.

Finally, I am concerned over the prospective costs of the new program. The administration estimates the increased costs of the CHAP proposal at $700 million during the first full year, of which the Federal share would be over $550 million. By 1984 new costs are estimated by HEW to exceed $1 billion.

I understand that the Congressional Budget Office estimates that Federal and State spending will be in excess of the levels suggested by the administration.

Today we have with us a substantial number of witnesses to testify on both the existing programs for mothers and children and the proposed child health assistance plan. Following the testimony of the administration, in accordance with the notice of this hearing, witnesses will be expected to confine their oral presentations to not more than 6 minutes.

The committee will, of course, have the benefit of the complete statements of witnesses which will be made part of the record of this hearing.

[The opening statement of Senator Baucus follows:]

Opening Statement of Senator Max Baucus

Thank you, Mr. Chairman. I have a brief statement to make. I want to express my appreciation to you, Mr. Chairman, for scheduling hearings to consider the critical issue of improving health services for low-income children.

Our presence here today represents a commitment towards protecting our most valuable resource—our children.

I am co-sponsoring the child health assurance program because I believe it makes a significant step towards improving the health status of millions of American children. There are over 17 million needy children in this country. Six million of these children are not presently covered under medicaid; only 3 million of those who are covered are affected by the early and periodic screening, diagnosis and treatment program.

The bill under consideration today would replace EPSDT—medicaid's current child health program—with an improved package of on-going preventive and primary care services for low-income children. Significantly, CHAP focuses on the need to provide continuing care as opposed to the emphasis on assessment under the EPSDT system.

The current EPSDT program fails to reach millions of low-income children because of categorical restrictions on eligibility. The proposal sponsored by Senator Ribicoff will close these gaps in coverage by covering poor children up to eighteen regardless of family structure. Financial resources will become the criteria for eligibility. This reform will broaden medicaid coverage to include an additional 2 million poor children.

The CHAP proposal has significant implications for rural children—many of whom are now excluded from coverage under medicaid because of categorical restrictions. Sixty percent of rural poor families live in two parent households and are thus excluded from medicaid coverage; whereas 38 percent of poor families in urban metropolitan areas are part of two parent families.

Moreover, States with large numbers of non-metropolitan poor have the lowest income eligibility levels. Under the administration's bill the 15 States with the largest numbers of non-metropolitan poor will account for 74 percent of all new eligible children and 62 percent of all new eligible pregnant women. The effect of the CHAP bill for Montana will be to broaden coverage to include roughly 8,000 new eligibles. Of that number, approximately 2,300 people will actually receive services.

A key feature of the CHAP proposal rests with its emphasis on on-going continuing care for a specific medicaid population. Enactment of CHAP represents an investment in preventive care. Study after study demonstrates that expenditures for prevention and basic health care services realizes substantial savings in the future by preventing the occurrence of treatable diseases.

The current EPSDT system is marked by low provider participation rates. The CHAP proposal recognizes this weakness and is designed to assure the provision of on-going primary care services by encouraging providers to participate in the program.

The committee will hear a broad range of comments on the benefits and weaknesses of a child health assurance program. Some of the major questions I have include: The intent and potential of the outreach provisions; the incentives for provider participation; and reimbursement incentives.

The witnesses we will hear from today may address themselves to some of these issues. Ultimately, I hope we will come away from the hearing with some constructive recommendations for improving our capacity to deliver health care to low income children.

Finally, Mr. Chairman, as you know, this committee is considering a number of proposals designed to expand health insurance coverage for all Americans. Financial constraints and questions of affordability will influence the shape and scope of whatever bill we embrace.

I sincerely hope that our efforts to improve the health status for poor children is not delayed by virtue of the magnitude of developing more comprehensive health insurance legislation.

Is it fair to hold children hostage while we continue to debate the contours of a health insurance package?

I would hope the committee agrees with me and that we can expeditiously reach agreement on a program designed to improve the health status of millions of our most neediest children.

Senator TALMADGE. We are pleased at this time to recognize Mr. Leonard Schaeffer, Administrator of the Health Care Financing Administration, who will testify on behalf of the Department of HEW. Mr. Schaeffer, if you will be seated. We will insert your full statement and you can summarize in any manner you see fit.

STATEMENT OF LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY MARY TIERNEY, ACTING DIRECTOR OF OFFICE OF CHILD WELFARE PROGRAMS

Mr. SCHAEFFER. Thank you, Mr. Chairman.

I am accompanied today by Dr. Mary Tierney, Acting Director of the Office of Child Welfare Programs.

I will submit my statement for the record and make brief comments.

We feel that S. 1204, the administration's child health assurance proposal—CHAP—is a unique opportunity to accomplish two important goals in a single piece of legislation. CHAP will effect management improvements which will make medicaid work for the 11 million children currently eligible for the program. We feel those management improvements and changes in the design of the program are essential to reach all of the children currently eligible.

In addition, CHAP will make some program expansions to insure that the neediest children have an adequate level of basic health care.

In the 95th Congress both the Finance Committee and House Commerce Committee approved child health legislation. This proposal builds on earlier efforts of the administration and Congress—with significant management and operational improvements.

We are gratified by sponsorship of our bill by members of this committee and we hope all our efforts will culminate in swift enactment of this bill.

I cannot emphasize strongly enough the urgency I feel regarding the enactment of CHAP legislation. These children in families below the poverty level are some of the most vulnerable and most deserving members of our society. Children do not ask to be born into these situations. They cannot make choices about their destiny and they cannot be assured of adequate health care without our help.

Children in these poverty circumstances are more likely to be in poor health, to develop communicable diseases and to have disabilities. Studies show poor kids have increased levels of impairment due to lead paint poisoning, middle ear infections and a variety of problems that middle-class children receive medical care for early in life.

An improved child health program should be considered an investment in our country's future. Adequate health care for our Nation's poor children can save these kids from what is potentially a life of chronic disease and disability.

CHAP will also permit the Federal Government and the States to manage our child health efforts more effectively. We have made significant strides in improving health care to children through the Department's programs: 11 million children each year receive physician and hospital services through medicaid's EPSDT program. But EPSDT was originally designed as more than a payment program. It was enacted specifically to meet the health care needs of children through early detection and treatment and health status monitoring.

The program has grown dramatically from one-half million children assessed in fiscal year 1973 to over 3 million in fiscal year 1978. For children who get into EPSDT and are fully served by the program, the benefits are clear. For many, EPSDT provides the first thorough physical since birth.

Approximately half of the children receiving assessments are found to have conditions requiring further treatment. Once assessed, most kids do receive that additional followup treatment.

However, medicaid and EPSDT have not been able to go far enough. There are fundamental problems in the design of the program which impede our efforts to deliver the best health care possible.

Eligibility and benefits vary from State to State. Only about 3 million of the 11 million eligible have had up-to-date assessments. Some who are screened do not receive necessary followup care. The whole process of delivering care is often fragmented and most important, the current EPSDT program does not provide incentives for the critical factors in this process: The States, providers and the beneficiaries themselves.

We are moving to solve those problems which we can administratively. In May we published final EPSDT penalty regulations which attempt to focus on performance rather than the process.

Mr. Chairman, I believe you know that the Surgeon General and I, Dr. Richmond and I, are deeply committed to improving delivery of health care services to poor kids. We have spent a great deal of time reviewing the multiplicity of existing programs that touch on child health needs, and we have developed a strategy to coordinate financing mechanisms of medicaid with the service delivery aspects of other departmental programs, especially those of the Public Health Service.

We have developed a joint strategy submitted to the Secretary. It has been approved and HCFA has been given the lead role in insuring that the Department as a whole provides care and service adequately carries out its responsibility to make good health care available to poor children.

I think we are doing a great deal to improve our management of this program. I believe, however, we need your help to obtain the management tools which are in CHAP which will make medicaid and its child health component work the way it should.

CHAP redesigns many of the most significant parts the EPSDT program. It will result in enhanced ability to administer both Federal and State level activities and it provides incentives for higher participation by States, for providers and for beneficiaries.

One of the problems in many of our programs is the lack of incentives for all the players—the States and providers—to provide appropriate service to people in need.

Briefly, I will outline some of the problems we see and some of the solutions we propose and then be available for questions.

The most serious drawback in the current program is that there is no assurance that a child has one source of ongoing and continuous source of primary preventative care. The medicaid child receives services in emergency rooms more often than in the middle-class child. EPSDT as currently in operation focuses on screening and fails to assure the necessary coordination between screening and treatment.

From our point of view CHAP addresses and solves this problem by providing for continuing care providers. By signing child specific agreements, the continuing care provider offers a medical home for each child. This removes the fragmentation between screening and treatment.

The program also provides incentives which allow providers to be paid more for children in continuing care. It asks them to do more and it pays them for that added responsibility.

At the current time the program involves disincentives. There are no positive incentives for States to reach out and agressively bring children into the program. CHAP does provide incentives for improved participation. There is a graduated match for ambulatory services to children. The program provides an integrated system of rewards and sanctions based on a performance standard which measures the percent of medicaid children in continuing care or assessed and treated.

CHAP closes loopholes and makes States accountable for all medicaid children, not just those requesting service, and States are given more credit for children in continuing care, in order to provide incentives to encourage these relationships. States with superior performance may receive up to 20 percentage points above their current matching rates. States below the minimum performance may lose up to 5 percentage points of their current matching rates. During the implementation phase startup of the program, a flat 4 percentage point increase will be available to all States. This performance standard is designed to meet the same objectives as the original proposals in the 95th Congress. However, after reviewing last year's proposal, we are convinced that this approach is easier to administer, both for us and the States.

It will allow States to set performance and financial objectives. The relationship between increased matching rates and State performance is more direct. It is quite simple. The more children the State takes care of, the more money it will receive in Federal matching.

In terms of outreach, CHAP will encourage States to improve outreach by increasing the federal match to 75 percent for administrative costs incurred by States for outreach services.

Currently the availability and quality of health care to poor children varies because of State discretion in determining eligibility and benefits. Poor children in fact can be denied care because of the accident of his or her State residency.

CHAP addresses this by mandating a minimum benefit package, in addition to the current required medicaid service which includes routine dental care, vision, and hearing service including hearing aids and eye glasses, immunizations, prescription drugs and insulin, and ambulatory mental health services by clinics funded under the Community Mental Health Centers Act or those that meet the standards set by regulation.

CHAP eliminates assessment as a precondition to receiving these services and removes State restrictions on most of the required services.

Eligibility also depends on the State where a child lives. CHAP fills in gaps in coverage and insures uniform minimum eligibility by using a national income standard.

CHAP will extend eligibility to all children under 18 with family incomes under 55 percent of the poverty threshold unless the State standard is higher.

CHAP also removes the categorical restrictions which prevent so-called Ribicoff children in two-parent families who are otherwise eligible from receiving needed care.

One other point. CHAP recognizes the importance of prenatal care. It is essential that mothers receive care during pregnancy. CHAP provides eligibility for pregnant women at the same level as children, that is 55 percent of poverty or the State standard if higher.

Mr. Chairman, as you know, the CHAP program is not a new one, but it contains reforms that are absolutely necessary to realize the potential of the existing EPSDT program. It will correct deficiencies that limit our ability to administer EPSDT and will allow us to better coordinate with other child health programs.

And CHAP provides care now. Implementation can be very quick because we build on the existing program. Mr. Chairman, I urge a speedy and favorable consideration of this bit of legislation.

As I am sure you are aware, we have met with a variety of interest groups who will be heard by you today. We are very interested in the outcome of this hearing and I asked Dr. Tierney to remain so we can get the full benefit of the comments made to you.

I will be happy to respond to questions.

Senator TALMADGE. Thank you.

How is the Department getting along in its effort to mandate coordination of the many existing programs where we have duplication now?

Mr. SCHAEFFER. The entire list of child health programs which we developed and which your committee requested be developed by the reference service has been reviewed inside the Department. We have laid out all the potential areas for better cooperation and for using such programs as school programs for referring children into

EPSDT. We laid out a plan that indicates what each operating component in HEW will do to improve coordination.

Responsibility for managing and monitoring that work plan has been vested in the Health Care Finance Administration.

Senator TALMADGE. All under one head?

Mr. SCHAEFFER. We are responsible for reporting to the Secretary.

Senator TALMADGE. Won't it be difficult to expand a program that never operated at full effectiveness during its existence? Do you have the administrative capability, the necessary resources and the manpower and facilities out in the field to deal with the increased commitment this proposal would take?

Mr. SCHAEFFER. I think by better utilizing all the programs in existence now, the variety of PHS, titles V, XIX, and XX, even Office of Education programs, I think that we can indeed provide adequate resources to address the health care needs of children.

It will take a lot of good will and cooperative work between our programs and with the providers, but I think we have the resources; yes.

Senator TALMADGE. In terms of making some more sense out of the maternal and child health programs under the Social Security Act, wouldn't it make sense to simply combine the title V and the EPSDT programs into one block grant program to the States which would operate under Federal standards and guidelines?

Mr. SCHAEFFER. Well, I think it would be one alternative that could be investigated. I think our experience with EPSDT indicates that it is a very complicated area, especially in terms of assuring that all the providers, both acute care providers and those providers of continuing care, coordinate services and work together.

Our thrust under this CHAP proposal is to reorient the program from a purely screening model to the idea of a medical home. I think that the single block grant program might not be able to accomplish that. I think you will hear testimony today from a variety of other groups that will speak to the concept of continuing care.

I think we need a mechanism such as we envision under CHAP in order to get that kind of care delivered to kids. Our goal is to assure that poor children will have access and opportunity for counseling, treatment, and followthrough during their early years by a physician similar to that available to middle-class children.

I do not think you would get that under the block grant approach.

Senator TALMADGE. Given increased emphasis on case findings and outreach activities the two bills are intended to stimulate, how can you estimate there would be no increase in number of recipients served in such States as California, Hawaii, New York, Pennsylvania, and Wisconsin?

Wouldn't the proposal introduce new costs far in excess of those you have calculated because of increased spending under the existing medicaid program for the 5 to 10 million children who are now potentially eligible but not receiving service?

Mr. SCHAEFFER. It is our feeling, based on the data we have, that most of the children who are potentially eligible for medicaid are indeed in the program and do receive some kind of service. The problem is those services are typically delivered when the child is in some type of severe need, actually ill or requires acute care.

The goal of the CHAP program is to create some sort of relationship on an ongoing basis between a child and its family and a source of primary care so that some of these problems can be treated earlier in their course while the child is still healthy and perhaps more intensive treatment, more costly treatment will not be necessary later.

Further, we are very concerned that the preventive health care be delivered and an understanding of good health habits be taught, so I do not think a case can be made that more costs will accrue above our estimates because more kids will need care.

We will be bringing those kids in earlier and hopefully will be reducing the cost of acute care while increasing service at the right point in time, which is early in life. In addition, we will be helping to initiate good health habits.

Senator TALMADGE. The CHAP bill approved by the Finance Committee last year left States with the option of providing mental health services. The administration's bill would mandate ambulatory mental health services provided by physicians and by community mental health centers.

During the committee hearings on mental health proposals, serious disagreement within the mental health professions was indicated as to the validity of many of the assumptions and underlying theories involving the diagnosis and treatment of those described as having mental health problems.

For example, here is what the National Institute of Mental Health stated last year in an evaluation of the community mental health center, CMHC, programs, prepared for the Secretary of HEW:

> Unfortunately, the effects of CMHC's and of other components of the Nation's mental health system, including the private sector, upon the emotional well-being of their clients and their communities are not known at this time. Questions about the effectiveness of basic mental health treatment tools such as psychotherapy remain unresolved and scientific assessment of the effects of the complex organization on the mental health of their clients and their host communities is still in its infancy.

How do you reconcile the administration's position to mandate mental health coverage rather than leaving it up to the States' option in view of the testimony I just read?

Mr. SCHAEFFER. The CHAP bill, as we recommend it to you, has a couple of assumptions and goals in it. One, as you noted, is that these mental health services are to be delivered on an outpatient basis.

Second, States may indeed limit amount and duration and scope of these services so it is not open-ended. However, we want to make sure that mental health services are available to this particular population which may indeed be able to benefit from them.

Although I am sure the testimony you cited is accurate and those points of view are appropriate, the source of our recommendation flows from the President's Commission on Mental Health which made recommendations on the need for appropriateness and significance of this benefit.

Senator TALMADGE. Thank you very much, Mr. Schaeffer, and your associate for your contribution to our deliberation.

[The prepared statement of Mr. Schaeffer follows:]

STATEMENT OF LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and members of the subcommittee, I am delighted to be here with you today to discuss S. 1204, the administration's proposed "Child Health Assurance Act of 1979"—CHAP. This bill offers a unique opportunity to accomplish two critical goals for the delivery of health care services to the Nation's low-income children in one piece of legislation:

It effects management improvements which will make medicaid and its child health component—EPSDT—really work for the 11 million children currently eligible, and

It fills some of the most serious gaps in eligibility and benefits by providing a more uniform structure to ensure that the neediest children—no matter what state they reside in—receive an adequate level of care

In the 95th Congress, the Finance Committee as well as the House Commerce Committee considered and approved child health legislation. Unfortunately, time ran out before further action could be taken. After careful re-examination of the current EPSDT program by both the administration and the Congress, and in consultation with states, providers and consumers, we have developed the child health assurance proposal before you today. This proposal builds upon the earlier legislation, but provides significant improvements, especially in the area of program management.

We are gratified by the sponsorship of our bill by Senators Ribicoff, Moynihan, Baucus, Bradley, Danforth, and Heinz of your committee and by the interest shown by this subcommittee in beginning consideration of the administration proposal. We hope these efforts will culminate in swift enactment of CHAP.

Mr. Chairman, I can't emphasize strongly enough the urgency of enacting CHAP legislation this Congress. I have a strong personal concern for poor children. They are the neediest, most vulnerable and most deserving members of our society. They did not ask to be born into poor families. They cannot make choices about their own destiny. And they cannot be assured of adequate health care without our help.

Over one-fourth of children in this country under 18—17.4 million children—live in low income families—families which often lack the financial means to provide essential medical treatment for themselves and their children. The relationship between poverty and inadequate health care has been demonstrated in many studies. Poor children are more likely to be in poor health, more likely to develop communicable diseases, and more likely to have functional disabilities than children from families with higher incomes.

Providing adequate health care for a poor child—saving that child from what is potentially a lifetime of chronic disease or disability—enables that child to better use opportunities available to him or her and to become a productive, competitive adult member of society. An improved child health program is an investment in this country's future. CHAP provides us the means to more effectively reach and serve poor children. CHAP provides a chance for our most valuable resource—our children. It is the least we can do.

We have already made great strides in improving the health status of children through the Department's programs, those programs identified in a recent report of the Congressional Research Service. Many of these programs, however, cover children with specific conditions, such as the crippled children's program, or those who live in certain geographical locations, such as the appalachian or migrant health programs. These programs are not designed or funded to care for all poor children.

Medicaid is the primary program that makes health care available and accessible to poor children. It assures payment for needed physician and hospital services to approximately 11 million children a year. Within the broad framework of Federal regulations and guidelines, the states and territories have considerable flexibility in determining medicaid eligibility, payment structures and benefit packages. However, certain basic medical services and required to be provided by the States.

With the enactment of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), Congress recognized the need to do more than just pay the bill. EPSDT was intended to reorient medicaid's delivery of health care services to poor children. These EPSDT requirements were added to medicaid specifically to meet the health care needs of children through early detection and treatment of disease and outreach and health status monitoring. All children screened under EPSDT are provided needed eyeglasses, hearing aids, and other required treatment for visual and hearing defects, as well as limited dental care.

In the five years following EPSDT's full-scale implementation, the number of needy children served by the program has grown dramatically. From fiscal year 1973 to fiscal year 1978, EPSDT health assessments increased from about 500,000 to approximately 3 million annually.

For children who get into EPSDT and are fully served by the program, the benefits are clear. For many poor children, the EPSDT assessment is the first thorough physical exam received since birth. Approximately forty-five percent of the children receiving ESPDT assessments are found to have conditions requiring further treatment. Fifty percent are inadequately immunized. Nearly ten percent from urban areas are found to have elevated blood lead levels. Ten percent assessed have vision problems, thirty percent are found to have hearing problems and 25 percent are referred for treatment of severe dental problems. Once assessed, most children receive the treatment they need.

However, EPSDT and medicaid have not been able to go far enough. There are flaws in the design of the program which impede our efforts to deliver the best health care possible.

Because of State discretion in determining eligibility structure, benefit packages and reimbursement rates—access, availability and quality of care are to some degree an accident of state residency.

Only 3 million of the 11 million children eligible for the EPSDT program have up-to-date assessments.

Many of the children screened do not receive necessary follow-up care—many children have no regular and continuing relationship with a health care provider.

Care received is often fragmented and episodic and in some cases duplicates screening.

There are disincentives to participating for the three key sets of actors in the program, States, providers and beneficiaries:

Expanding participation in the current program increases the financial burden on States, in some cases, it is more lucrative and involves less paperwork for providers to provide medicaid services rather than the full range of EPSDT benefits, and medicaid-eligibles must take additional affirmative action to obtain EPSDT, even after they become qualified for medicaid.

Mr. Chairman, our goals of assuring adequate health care for all poor children and making needed management improvements can only be realized if new legislation is enacted.

However, we have not waited for legislation to take action—both administrative and regulatory—under current authority to improve children's health care services. In May, we published final EPSDT penalty regulations which—to the extent possible under existing law—focus on results rather than process to assure that States improve the delivery of services to children.

HCFA and the Public Health Service (PHS) together have examined every HEW program that touches upon the health needs of poor children to determine how best to coordinate the financing mechanism of medicaid with the care delivery aspects of other departmental programs. Included in the review were the programs addressed by the Congressional Research Service Study. As a result of our review, we have identified and are undertaking a series of administrative actions:

We will assure that the department's resources are used as fully as possible by EPSDT and medicaid:

> Medicaid-eligible children participating in other HEW programs—such as AFDC or head start—will be identified and provided with EPSDT services, if they wish to participate.
>
> Providers funded by PHS and other federal programs will be used to provide continuing care and other EPSDT medicaid services for children wherever possible. PHS grantees are already serving many medicaid children, and we will increase the numbers served in the months ahead.

We will make use of all HEW outreach programs to bring eligibles into medicaid and to determine the number of children in continuing care or otherwise assessed and treated.

In September we will begin demonstrations on how school systems may channel children into continuing care situations—and how, to the extent possible, they can also provide covered services.

Both the Surgeon General, Dr. Richmond, and I are deeply committed to improving delivery of health care services to children. We have spent a great deal of time reviewing the multiplicity of programs touching child health needs and developing ways to help rationalize them to help them function together more harmoniously.

Mr. Chairman, I need the help of this Subcommittee to give HCFA the management tools necessary to make our child health programs work effectively and reach all eligible children. The current structure of EPSDT frustrates the goal of meeting child health needs as effectively as possible. The administration's CHAP proposal redesigns the most significant parts of the program and will, when enacted, enhance the ability of both Federal and State Governments to administer the program. It provides incentives for higher participation by States, providers and beneficiaries.

CHAP will allow us to better direct our own efforts and give us the management controls we need to make States more accountable.

One of the most serious drawbacks to medicaid and its child health component—EPSDT—is that there is no assurance that a child has one source of ongoing, primary and preventive care. A medicaid child is more likely to receive routine medical attention in a hospital emergency room than a middle class child. EPSDT focuses on screening and often fails to assure the necessary coordination between screening and treatment.

CHAP addresses both of these probems by restructing provider relationships with medicaid children. It shifts the emphasis away from fragmented, episodic treatment to a single source of preventive and acute care for each medicaid child. In signing a child-specific agreement, the continuing care provider agrees to be a medical home for the child and to provide assessment, treatment and medical case management. This will assure one coordinated focus of care. CHAP authorizes HEW to provide incentives to continuing care providers to reflect the added cost and responsibility involved in this relationship.

Because some children live in communities where initially there will not be sufficient numbers of continuing care providers, CHAP also requires States to use assessment providers to reach eligible children. These providers will agree to provide to any eligible child periodic health assessments and a minimum range of diagnostic and treatment services, with referral for those services they cannot provide.

Currently, there are no incentives for States to reach out and aggressively bring children into EPSDT. CHAP provides the positive incentives necessary to improve State participation. CHAP introduces a graduated Federal matching rate for ambulatory services to children as part of an integrated system of rewards and sanctions.

It is based on a performance standard which measures the proportion of medicaid-enrolled children in continuing care or timely assessed and treated.

This performance standard is designed to meet the same objectives as in our previous bill, but after reviewing last year's proposal, we decided that the proposed structure would be easier for us and the States to administer.

It closes the loophole in current law by making States accountable for serving all medicaid children not just those who request services.

Greater weight is given to children under continuing care as an incentive to States to encourage these relationships.

A State showing superior performance can receive up to twenty percentage points added to its current Federal matching rate—with a ceiling of ninety percent—for ambulatory services to children.

Instead of a separate penalty, a State may lose up to five points in its Federal matching rate for ambulatory services to medicaid children—if its performance falls below a minimum standard.

During the implementation phase, each State will receive a four percentage point increase in the matching rate for ambulatory care to children to help cover costs due to start up of the program.

In order to help States reach more eligible children and bring them into the system, CHAP provides a matching rate of seventy-five percent for administrative costs to States for outreach performed by private agencies, under contract with the State, as well as public agencies.

Under the medicaid program, the availability and quality of health care to poor children varies considerably because of State discretion in program design. CHAP addresses this by mandating a minimum benefit package of essential care including the current required medicaid services—physician, hospital, lab, X-ray, rural health clinic and EPSDT—and adding the following new services:

Routine dental care, diagnostic, preventive, restorative and emergency dental services; vision and hearing services, including eyeglasses and hearing aids; immunizations; prescription drugs and insulin; and ambulatory mental health services, performed in centers funded under the community mental health centers act or meeting standards set by the secretary.

CHAP eliminates the requirement of an assessment as a precondition to receiving these services and makes most mandatory services—including those already required under medicaid—available as needed without regard to State limitations on amount, duration and scope. Removing the assessment requirement eases the burden of States and providers in determining which children may be served. In mandating a minimum benefit package and eliminating State limitations on most required services, we are moving toward uniform coverage for basic health care services for all medicaid children.

Eligibility for medicaid—and accordingly for EPSDT—also depends on the State in which a child lives. CHAP fills the most serious gaps in coverage for poor children, and establishes uniform minimum eligibility in all States by setting a National income standard:

CHAP mandates coverage for all children in families with income under 55 percent of the poverty threshold, unless the State income standard is higher. The National income standard of 55 percent of poverty—or roughly $4,200 for a family of 4—helps assure coverage to the poorest of the poor.

CHAP removes categorical restrictions which prevent children in 2 parent families—"Ribicoff" children who are otherwise financially eligible from receiving medical assistance. Under this proposal, a poor child is assured coverage whether his parents are together or apart.

In mandating eligibility for pregnant women, CHAP recognizes that good health begins even before birth. It is essential that a prospective mother receive care during pregnancy; 29 percent of the women giving birth in 1975 did not receive any prenatal care in the first trimester and 6 percent received none in the first two trimesters. Lack of adequate prenatal care increases by threefold the chance that the baby will be born with a low birth weight which in turn increases the baby's chance of dying within the first year or encountering other developmental problems. CHAP provides eligibility for pregnant women at the same level as CHAP children—55% of poverty or the State income standard if it is higher. It provides coverage to women who are pregnant for the first time and for women who live in two-parent families.

Mr. Chairman, CHAP does not create a new program; it is an important improvement in our current medicaid program. CHAP contains the reforms absolutely necessary to realize the intent embodied in EPSDT. It provides us with the management tools which will enable us to correct deficiencies that currently limit our ability to administer EPSDT and coordinate with other departmental child health programs. CHAP will give us a better tool for meeting the health care needs of poor children.

CHAP builds upon the current medicaid program and lays the groundwork for the national health plan. But the improvements in program operation and coverage under CHAP need not wait for the national health plan. CHAP is needed and should be implemented now.

Mr. Chairman, I therefore urge you to consider and enact the administration CHAP legislation as quickly as possible. We need this legislation to improve our programs. The poor children of America need this legislation to receive the health protection they deserve.

Senator TALMADGE. Our next witness is Clifton Cole, chief deputy director, medical care services, Department of Health Services, State of California. Your entire statement will be included in the record. Please summarize in no more than 6 minutes.

STATEMENT OF CLIFTON A. COLE, CHIEF DEPUTY DIRECTOR, MEDICAL CARE SERVICES, DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA

Mr. COLE. Thank you, Mr. Chairman.

I am Clifton Cole, chief deputy director of medical care services in the Department of Health Services of the State of California. The California Department of Health Services is pleased to have this opportunity to present our comments to the Senate Finance Committee on the child health assurance program proposed in Senate bill 1204.

The California Department of Health Services has long supported the development of a Federal child health assurance program which will provide States with an effective basis for delivery continuing primary care to low-income children. The benefits of preventive health services and early diagnosis and treatment are well documented, having the potential to not only improve the health status of our Nation's children but also to decrease the cost of health services by avoiding more costly treatment associated with later detection of illness.

California has met the EPSDT requirements through implementation of the child health and disability prevention program in 1974. This program, called CHDP, covers 1.5 million children, including all medicaid eligible children and children whose families are within 200 percent of the State's income maintenance levels. California has been able to offer these 200 percenters a health assessment at the time of entry into the first grade.

This time was chosen to assist low-income families in complying with California's child health legislation which recognizes the benefits of a school entry health examination and, therefore, requires all children to receive a health assessment upon entry into school.

In addition, children enrolled in Head Start programs and State preschools are also eligible for health screens. This fiscal year, the California Department of Health Services child health and disability prevention program provided over 230,000 health screens to medi-cal eligible children and over 90,000 health screens to children in the Head Start program, state preschools and in the 200 percent group. Forty-two percent of these health screens result in a referral for diagnosis and treatment of suspected conditions found by the screening procedures.

Senate bill 1204 supports the goals of the CHDP program to broaden the availability of child health services by expanding the population eligible for health screens, diagnosis and treatment service. In addition, S. 1204 parallels the California Department of Health Services program in many areas, including the coverage of pregnant women, the use of comprehensive care providers and the inclusion of a variety of providers in the child health program.

S. 1204 responds to many of the Department of Health Services concerns regarding previously proposed CHAP legislation and we appreciate the changes which have been made in response to California's concerns. We believe S. 1204 will solve some of the problems inherent in the current EPSDT program. For example:

Expansion of the eligible population will make medical services available to pregnant women and low-income children who are in need of comprehensive care.

The inclusion of low-income pregnant women in the medical assistance program is a great advantage toward assuring the health of our children. Providing adequate prenatal and postnatal care should not only improve the child's health but should also provide the opportunity to explain to the parent the need for the child to receive preventive child health assessments.

The California Department of Health Services also supports the extension of eligibility for pregnant women but requests that the language in section 201 and 203 be clarified. It is not clear if the intent of this language is to extend eligibility to those women who abort or miscarry as well as those who carry a pregnancy to full term. The language of the legislation refers to "termination of pregnancy" which would seem to cover both cases but it is not clear.

The child health program proposed in S. 1204 would also promote a continuity of care which is absent from the current EPSDT program. The 4-month extension of eligibility will help assure that children receive all necessary treatment which, in many cases, is not completed due to loss of eligibility.

The inclusion of a variety of providers is supported by the California Department of Health Services, as it allows the delivery of care in various settings which can be adapted to local situations.

The California Department of Health Services also supports the provision for incentives to States with good performance and for incentives to continuing care providers for increased responsibility in case management, diagnosis, and treatment.

We also support the emphasis placed on continuing care providers and the additional case management responsibilities placed on these providers. This should help to assure that continuity of care occurs and that services are not duplicated.

Initial estimates of the impact of S. 1204, developed by the Department of Health Services, indicate that no additional eligible persons would be added to California's medicaid population, as they are currently covered under the State plan. However, based on our estimates, the first year of CHAP would result in $4 million savings to California. If State costs remain at current levels, subsequent savings based on the receipt of the maximum incentive could reach $26 million per year.

Senator Talmadge. I have to call time. Your entire statement will be entered in the record.

I have some brief questions.

From the States point of view now, does S. 1204 provide for coordination of CHAP and the other federal programs providing health care to children?

Mr. Cole. It will in certain respects but we feel the bill needs to have more outreach mandated and also more community health education mandated.

Senator Talmadge. Should S. 1204 be amended to require and spell out specific coordination requirements?

Mr. Cole. I think it should.

Senator Talmadge. Do you foresee a problem in tying funding of the program to performance? Wouldn't some States find it cheaper to absorb a reduction in the Federal match in mounting an adequate CHAP program?

Mr. Cole. I do not believe the States could absorb a reduction in the Federal match. California is encouraging increasing the Federal match to provide incentive to broaden the program and to follow up with continuing care which is something the States would have to do on their own.

Senator Talmadge. Would it be better to tie performance penalties to administrative cost?

Mr. Cole. California is requesting or is advising that we do not have performance penalties in the bill. That instead that publicizing State performance in the State and local community for continuing Federal financing at established level but diverting a portion to general revenue sharing rather than to other purposes that the State might prefer would be a better way to penalize the States rather than to have penalties which would go to reduction in the amounts that were given for care of the children.

Senator Talmadge. Senator Durenberger.

Senator Durenberger. I have no questions but I have a statement I would like to insert in the record.

Senator TALMADGE. Your statement will be inserted in full in the record.

[The full statement of Hon. David Durenberger follows:]

STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, after the education which the Committee has been getting recently in the area of health insurance, today's hearings on child health represent a refreshing switch from medical catastrophes to the strategies of preventing some of those disasters from arising.

I'm proud to say that my home state of Minnesota has taken considerable initiative in the field of child health, much beyond the federally required services. In addition to Title V and Medical Assistance programs, we have developed a Preschool Screening Program for all children in the state, with each school district shouldering local responsibility.

Since 1976, we have developed a network of Early and Periodic Screening clinics, more than fifty at this time. These are available to Medical Assistance-eligible children and to all others in need, with payment calculated on a sliding-scale basis. This entire effort developed from the State Health Department's board authority to promote maternal and child health and relies on dedicated service of the nurses certified to operate the clinics.

Our involvement in the Early and Periodic Screening, Diagnosis and Treatment Program under Medicaid took a lot longer to get off the ground. Like other states, Minnesota was stalled by the late arrival of federal regulations and by the general problems of reaching families and involving providers. However, in the last serveral years we have made progress. Medical organizations have put together screening standards, defined requirements for participating providers, and specified case management responsibilities. Renewed efforts were made to enlist physicians, with the result that 62% of the primary care physicians in the state are now enrolled as providers.

Again, as in other States, there still remain problems in meeting the goals of child health care. These fall roughly into two categories, those problems having to do with organizational failures and those which concern respect for the privacy of families.

In the first category, coordination between and among Federal and State bureaus is crucial. At the Federal level, every new piece of legislation concerning maternal and child health seems to have produced a distinct and autonomous office. I look forward to some hopeful comments from Mr. Schaeffer on the Administration's plans to bring order to the chaos of child health administration.

On the state level, implementation of the various Title V, Title XIX and state-initiated program can get caught between the least two departments, Health and Welfare, and at times, a third, the Education Department. The result, which is not uncommon, is that the left hand does not always know what the right hand is doing. Yet without good cooperation between administrating agencies, the effective diagnosis and treatment of children suffers.

In the second category of problems in child health are those of the division of responsibilities between the State and the family. The recently published EPSDT regulations state clearly that ". . . the State has the responsibility to make it possible for recipients to receive EPSDT services", at which point "It is then the family's responsibility to make use of them if they wish". This general phrasing covers a complicated array of decisions which administrator must make about outreach and continuing care provisions. How does one determine when efforts have been sufficient?

As unpopular at it may be to raise the subject of cost when it comes to the health of needy children, I think we must be frank in our appreciation of fiscal realities. Marian Edelman, one of our witnesses today, recently published a spirited statement in the New York Times in which she decried government choice of defense over preventive health expenditures. Though broadly made, the point that we need to take a long, hard look at priorities is well taken. Despite the affluence of the United States, it remains true that the best predictor of infant mortality, of chronic illness, and of a short life span is being born poor. The most dismaying statistics on American health have identified our target population for us: it is children from low-income families.

At the same time, we have the responsibility to demand that the deservedly high priority which we set on child health be met by effective and cost-efficient programs. Our compassion for the vulnerability of the young should be balanced by the strongly felt obligation to find the best solutions to the health problems which affect them

I look forward to the assistance in meeting that obligation which today's witnesses offer.

Senator **Talmadge**. Thank you.

Senator **Heinz**. I do not have any questions. I appreciate your allowing me to sit in on your hearings.

Senator **Talmadge**. I am delighted. You are a member of the Finance Committee and you are welcome indeed.

[The prepared statement of Mr. Cole follows:]

STATEMENT OF CLIFTON A. COLE, CHIEF DEPUTY DIRECTOR OF MEDICAL CARE SERVICES, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Good afternoon. I am Clifton A. Cole, Chief Deputy Director of Medical Care Services in the Department of Health Services of the State of California. The California Department of Health Services is pleased to have this opportunity to present our comments to the Senate Finance Committee on the Child Health Assurance Program proposed in Senate Bill 1204.

The California Department of Health Services has long supported the development of a federal child health assurance program which will provide states with an effective basis for delivering continuing primary care to low income children. The benefits of preventive health services and early diagnosis and treatment are well documented, having the potential to not only improve the health status of our nation's children but also to decrease the cost of health services by avoiding more costly treatment associated with later detection of illness.

California has met the EPSDT requirements through implementation of the Child Health and Disability Prevention Program in 1974. This program, called CHDP, covers 1.5 million children, including all Medicaid eligible children, and children whose families are within 200 percent of the state's income maintenance levels. California has been able to offer these "200 percenters" a health assessment at the time of entry into the first grade. This time was chosen to assist low income families in complying with California's child health legislation which recognizes the benefits of a school entry health examination, and therefore requires all children to receive a health assessment upon entry into school. In addition, children enrolled in Head Start programs and state preschools are also eligible for health screens. This fiscal year, the California Department of Health Services' Child Health and Disability Prevention Program provided over 230,000 health screens to Medi-Cal eligible children and over 90,000 health screens to children in the Head Start program, state preschools, and in the "200 percent" group. Forty-two percent of these health screens result in a referral for diagnosis and treatment of suspected conditions found by the screening procedures. Senate Bill 1204 supports the goals of the CHDP Program to broaden the availability of child health services by expanding the population eligible for health screens, diagnosis, and treatment services. In addition, S. 1204 parallels the California Department of Health Services' program in many areas, including the coverage of pregnant women, the use of comprehensive care providers and the inclusion of a variety of providers in the child health program.

S. 1204 responds to many of the Department of Health Services' concerns regarding previously proposed CHAP legislation, and we appreciate the changes which have been made in response to California's concerns. We believe S. 1204 will solve some of the problems inherent in the current EPSDT program. For example:

Expansion of the eligible population will make medical services available to pregnant women and low income children who are in need of comprehensive care.

The inclusion of low income pregnant women in the medical assistance program is a great advance toward assuring the health of our children. Providing adequate prenatal and postnatal care should not only improve the child's health, but should also provide the opportunity to explain to the parent the need for the child to receive preventive child health assessments. The California Department of Health Services also supports the extension of eligibility for pregnant women, but requests that the language in Section 201 and 203 be clarified. It is not clear if the intent of this language is to extend eligibility to those women who abort or miscarry as well as those who carry a pregnancy to full term. The language of the legislation refers to "termination of pregnancy" which would seem to cover both cases.

The child health program proposed in S. 1204 would also promote a continuity of care which is absent from the current EPSDT program. The four-month extension of eligibility will help assure that children receive all necessary treatment which, in many cases, is not completed due to loss of eligibility.

The inclusion of a variety of providers is supported by the California Department of Health Services, as it allows the delivery of care in various settings which can be adapted to local situations.

The California Department of Health Services also supports the provision for incentives to states with good performance, and for incentives to continuing care providers for increased responsibility in case management, diagnosis and treatment.

We also support the emphasis placed on continuing care providers, and the additional case management responsibilities placed on these providers. This should help to assure that continuity of care occurs, and that services are not duplicated.

Initial estimates of the impact of S. 1204, developed by the Department of Health Services, indicate that no additional eligible persons would be added to California's Medicaid population, as they are currently covered under the state plan. However, based on our estimates, the first year of CHAP would result in a $4 million savings to California. If state costs remain at current levels, subsequent savings based on the receipt of the maximum incentive could reach $26 million per year.

The California Department of Health Services appreciates the recognition in S. 1204 that start-up time is required to plan and implement this complex program; especially helpful is the provision which delays performance assessments for a minimum of 24 months from the start-up of CHAP. In addition, California supports the 4 percent increase in the Federal Medical Assistance Percentage for the first six quarters of the program. We believe these provisions should help to avoid many of the start-up problems which California and other states experienced under the EPSDT program.

However, states will require support from HEW to assure smooth implementation of state programs, and we urge that federal technical assistance be available to adequately develop the more difficult administrative and program components of CHAP, including case management methods. CHAP forges new territory in the area of case management of health services. Although the value of case management is unquestioned, health care systems and private providers have had little success in developing case management systems except under ideal conditions. The eligible population in California is far from ideal—persons move frequently, change living arrangements and have fluctuating periods of Medicaid eligibility. The Department of Health Services has experienced difficulties managing this population under the current EPSDT program.

S. 1204 does not clearly address the important role of health education and outreach in attaining a successful child health program. If the program is to reach its goals, the recipients of services and their parents must be as motivated to receive child healh services as we are to provide these services. We hope that health education, the teaching of health related skills which create greater personal responsibility for health care, is included in the definition of outreach. The target population needs the benefit of outreach and health education to attain the long lasting results which occur from continuity of health care.

The expansion of the eligible population will require innovative and intensive outreach and health education efforts. The variety of providers included in S. 1204 creates a multitude of settings for the needed education and outreach activities. Past experience indicates that 75 percent FFP is inadequate to provide effective outreach services. It would seem that if the Congress is willing to provide 90 percent FFP to develop systems which link screening records to treatment records, there should be an equal effort to link people with services. We recommend that federal financial participation for outreach be funded at 90 percent and that health education activities be specifically included in the definition of outreach and also receive 90 percent FFP.

Finally, the California Department of Health Services has had serious concerns regarding the penalty provisions in previous CHAP legislation, and we are pleased that our concerns have been taken into account in developing S. 1204's reward-penalty system. This is a major step towards assuring the success of child health programs. California fully supports S. 1204's provision to increase federal participation when good performance is achieved. But, California believes that the removal of federal funds from states tends to adversely affect those in need by reducing the funds available for services. This tends to compound the problem rather than solve it. California hopes that Congress will retain the incentives but consider alternatives to financial penalties such as: Publicizing state performance in the state and local communities; or continuing federal financing at established levels but diverting a portion of general revenue sharing to the program rather than to other purposes the state might prefer.

The interest and consideration shown by Congress and the Administration in developing CHAP legislation that will meet the needs of children and the needs of state program administration is greatly appreciated. S. 1204 reflects many of California's concerns regarding the practicality and administrative feasibility of implementing child health programs. We trust that you will carefully consider the concerns and recommendation we have made today. Thank you very much.

Senator **Talmadge**. Next is Mr. James E. Jollie, director, recipient management, Department of Social Services, State of South Carolina.

We are delighted to have you here. You may insert your full statement in the record and summarize it in not more than 6 minutes.

STATEMENT OF JAMES E. JOLLIE, DIRECTOR, RECIPIENT MANAGEMENT, DEPARTMENT OF SOCIAL SERVICES, STATE OF SOUTH CAROLINA

Mr. **Jollie**. Thank you, Mr. Chairman and members of the subcommittee. I am Jim Jollie, director of recipient management, which includes the EPSDT program, for health care financing in the South Carolina Department of Social Services, Office of Health Care Financing.

I was director of the EPSDT program from 1973 until January 1979. I have, since my first contact with the EPSDT program, believed in its purpose and I am committed to its survival and success. We felt it necessary to speak in support of the bill.

The fact the subcommittee is considering the CHAP legislation gives great hope for this much needed program. I believe that we must build on the EPSDT program, given all its past ills. It is in place throughout the country in some form. With the appropriate specific legislation and clear regulations that will follow, those children who are awaiting the much-needed health care can begin to receive it.

The purpose of the program must be set forth and always maintained as the goal to be reached. There was never a goal oriented approach established with the EPSDT program. This program can provide the much-needed health care of the target population and produce savings in reducing expenditures for long term and continuous episodic care.

When this legislation has passed, HEW must be held accountable for the administration of the program. However, States must participate in developing the plan to accomplish the legislative mandate. The States cannot tolerate or be held responsible for the negative residuals of delays, inconsistencies, contradictions and the lack of a national approach to implementation of the program.

Our support of this legislation is based on the success of EPSDT in South Carolina and we believe this will improve overall performance.

We began participation in 1972 providing EPSDT services statewide to all eligibles under 21 years of age. We conducted a needs assessment to project future program plans and requirements out of which developed a unique screening, diagnosis and treatment form, a method of establishing program objectives—a goal of 35,000 screenings per year.

We have screened over 86 percent of that number each year, the difference being the no-shows, broken appointments, and those declining the service.

We did not have adequate dentists to support the demand. We began working with the local-dental association and have had for several years a committee which addresses the needs of the program. Today we have more dentists and appointment time than we can fill.

The same exists for visual care and hearing providers. Physicians have not historically supported the EPSDT program in South Carolina but we have solicited their participation and have very few referral problems.

A plan was developed by the EPSDT staff as to the approach necessary to accomplish our goals. In each local office EPSDT units were developed. A method of documentation was developed and the State EPSDT staff conducted technical assistance for local staff and other agencies.

We literally marketed and sold EPSDT wherever possible. A backup procedure was developed to determine compliance with State and Federal requirements. The State central office has field monitors who pull samples and compile documentation on cases from initial contact through completion of treatment.

This system has greatly aided the consistent application of program requirements and we intend to address the CHAP program with the same intensity.

With respect to the bill being considered here, I submit the following:

First, we believe Outreach is the key to client response and participation. Outreach must be provided with latitude for each State to adopt its own method. An increased match to exceed 75 percent for start-up would add a greater incentive and allow for the enrollment of as many eligibles as possible. Outreach must include followup for treatment.

Second, provider participation. Southern rural States often do not have the great variety of providers as larger States. However, CHAP should require States to identify and have documented the attempts to enroll eligible providers.

Third, financing: The financing of this program must be carefully weighed as States are struggling with shortages. South Carolina has experienced budget reductions by the legislature. Being a no-deficit State every possible increase in matching percentage points would be of immense aid.

The proposed 4 percentage points over State's current Federal matching rate for ambulatory care services will not cover the cost of a program expansion and will not provide sufficient incentives. The financial incentives tied to performance must be of such appeal to warrant States to initiate sufficient program changes. This concept is positive but must be clearly defined as to the actual percentage applied.

Fourth, as to administrative approach, a specific plan must be applied. The primary emphasis should not be placed on the penalty. It must be given to the approach of accomplishing the overall goal, a uniform method of administrative application. States would have with this approach a consistent application of the national plan with which they could interface.

The single State agency which would provide proper information, outreach, case management, followup, transportation and documentation is the one consistent approach which works.

Fifth, Federal enforcement: A clear definition of compliance issues and penalty application must be provided. There must also be a definition package to which the States can refer for clarity related to implementation of policy.

Financial incentives attached to performance will enhance participation and program expansion. The penalty must be applied in the same manner.

One State should not be required to invoke a procedure not required in another State. HEW must be uniform and consistent; a hand must be extended in cooperative spirit in addressing the needs of the child; the legislation, regulations and HEW must work with and for the States in accomplishing this much needed program revision.

The penalty and compliance must not become primary. Every effort must be made to assist the States on a consistent basis to develop and accomplish its performance standard and in so doing deliver the much needed health care to the low-income children of this Nation.

Senator TALMADGE. Thank you, Mr. Jollie. I have two or three questions. You stated CHAP legislation must be more explicit. Could you provide an example of your concern with the way the legislation is drafted?

Mr. JOLLIE. Yes; I think in the legislation the intent of the Congress must be so stated. There must be a direct outline as to, for instance, the intent of Outreach and how it should be set up basically. But we have experienced on a State level problems in the past that we have had to address with our representatives from the regional office through HEW.

This was the intent of Congress and we believe that if whatever intent is meant to be is so stated specifically it would be a greater aid to the success of the legislation.

Senator TALMADGE. Will requirements in S. 1204 be able to assure effective State administration of the CHAP program or should S. 1204 require the State plan to be more explicit about spelling out administrative requirements? In fact, should the legislation require States to set specific outcome standards and goals in their State plans in order to assure accountability?

Mr. JOLLIE. We have taken this approach of a plan for accomplishing the EPSDT program. We believe that more specifics should be stated in the State plan to accomplish this type program. We have developed a plan. We have identified individual entities as I stated in the local offices.

We have applied consistency based on procedural specificity to local entities, to other agencies, interagency agreements, and we feel we have made great strides in accomplishing the intent of EPSDT in our State.

Senator TALMADGE. Senator Durenberger.

Senator DURENBERGER. First, regarding the South Carolina experiment, what is the role of local government in the implementation of the State plan?

Mr. JOLLIE. There is no role.

Senator DURENBERGER. Isn't it a State agency administered program?

Mr. JOLLIE. There is no role as far as local government other than support of local governments, but no direct involvement per se.

Senator DURENBERGER. Then is that true of other community health programs in the State of South Carolina, they are all run by the State rather than involving local government?

Mr. JOLLIE. I would not want to say directly. I would rather—if you need additional information, I will be glad to provide that specifically.

Mr. DURENBERGER. I understand your State is one that stands to increase substantially in the number of eligible benefits under the CHAP program. Do you state your State is willing to meet the increased costs of this program?

Mr. JOLLIE. I think with the financial incentives that probably we would because there have not been financial incentives in the past. We lived with the circumstances of do it or be penalized. I think as far as the penalty based on EPSDT, it has been easy to consider the penalty. We are a no-deficit State. We do have to budget for whatever we are going to provide and I think with sufficient incentives—I know we have the support of the Department, the Commissioner of the Department and I think with adequate financial incentives the State would support the program.

Senator DURENBERGER. Thank you.

Senator TALMADGE. Any questions, Senator Heinz?

Senator HEINZ. Just one question, Mr. Chairman.

What techniques or strategy did you use to get providers who might otherwise have been characterized as reluctant providers to participate?

Mr. JOLLIE. Senator, we were remiss in that area. We as members of the bureaucracy in the State had not communicated with them basically in the past. I found that with staff assistance, we thought that we knew everything best and essentially all alternatives had not been addressed in relation to provider needs and inputs.

We then went to the various associations. We identified the individual committees within the associations. We have set up, as I said, tripartied organization committees of the Department, local dental associations, fiscal intermediaries to discuss problems and identify needs of the program.

We have gone to those individual groups to solicit participation in the program.

Senator TALMADGE. Let me ask you the same question I asked Mr. Schaeffer: In terms of making some sense out of the maternal and child health programs under the Social Security Act, wouldn't it make sense to simply combine title V and the EPSDT programs into one block grant program to the States which would operate under Federal standards and guidelines?

Mr. JOLLIE. Senator Talmadge, I do not think I have a very good response to that question. My personal view is that we in our State coordinate these benefits now. For the children who are enrolled in title V and the other, as stated, overlapping programs, we coordinate with the agencies and exchange information through the interagency agreement concept, which we are now involved with, we are coordinating benefits.

We have scheduled a meeting with the Department of Education very soon, in the next couple weeks, and we hope to involve the public health nurses, and some school districts would provide adequate health care delivery systems in further coordination of these services.

Senator **TALMADGE**. Do you think other States will coordinate them as well as South Carolina?

Mr. **JOLLIE**. I think that has been a problem. I think coordination of benefits—I have been in a lot of meetings—when you start talking about exchange of pieces of paper relevant to health care services delivered to individuals as opposed to budgeting processes by the various entities, it does make a difference.

I do not think there has been enough coordination. We tried to take the initiative and we have tried with a couple of departments for a couple of years. Due to change in administration, we have gotten in there and we are making greater strides than ever before.

But it is important that the push be up front. That coordination of benefits is very necessary. We always held that in our State.

Senator **TALMADGE**. Thank you very much for your cooperation and your contribution.

[The prepared statement of Mr. Jollie follows:]

STATEMENT OF JAMES E. JOLLIE, DIRECTOR, RECIPIENT MANAGMENT BRANCH, SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

Mr. Chairman and members of the subcommittee, I am Jim Jollie, director of recipient managment (which includes the EPSDT program) for health care financing in the South Carolina Department of Social Services. I was director of the EPSDT program from 1973 until January, 1979. I have, since my first contact with the EPSDT program, believed in its purpose and I am committed to its survival and success.

The fact that the subcommittee is considering the CHAP legislation gives great hope for this much needed program, I believe that we must build on the EPSDT program, given all its past ills. It is in place throughout the county in some form, with the appropriate specific legislation and clear regulations that will follow, those children who are waiting on the much needed health care can begin to receive it.

I believe that the CHAP legislation will have a greater chance at success if the shortcomings of the 1967 EPSDT legislation and its weaknesses are clearly analyzed before final preparation of the CHAP legislation and regulations. This new legislation must be more explicit to the point of detail as to reduce the demand on the policy writer of the requirement of interpreting the intent of Congress in the final legislation, Congress must assume a greater responsibility in overseeing this legislation when passed—its purpose, written or implied intent must be implemented.

The purpose of the program must be set forth and always maintained as the goal to be reached. There was never a good oriented approach established with the EPSDT program. This program can provide the much needed health care of the target population and produce savings in reducing expenditures for long term and continuous episodic care.

When this legislation has passed, HEW must be held accountable for the administration of the program. However, States must participate in developing the plan to accomplish the legislative mandate. The States cannot tolerate or be held responsible for the negative residuals of delays, inconsistencies, contradictions and the lack of a national approach to implementation of the program. It must be administered consistently throughout the Nation with sufficient flexibility for the States to adapt the program to its needs.

I would like to share with you the approach to EPSDT in South Carolina and the success we have experienced for which a regional certificate was presented for best managment practices. We began participation in 1972 under a pilot project with selected county health clinics. The State board of health had a very adequate history of health care delivery in this southern rural State. The pilot was a success and in January, 1973, we began providing EPSDT services statewide to all eligibles under 21 years of age. We began a needs assessment to project future program plans and requirements our of which developed a unique screening, diagnosis and treatment form, a prior approval requirement for mandated services, a method of establishing program objectives—a goal to be screened—the number to be screened each year. Since that time of establishing a goal of 35,000 screenings per year we have screened over 86 percent of that number each year. The difference being the no-shows/broken appointments and those declining the service.

We did have adequate dentists to support the demand. We began working with the local dental association and have had for several years a committee which addresses the needs of the program—today we have more dentists and appointment time than we can fill. The same exists for visual care and hearing provides. Physicians have not historically supported the EPSDT program, but we have met them halfway and have very few referral problems. Physicians are now beginning to participate as screenors.

A plan was developed by the EPSDT staff as to the approach necessary to accomplish the program. In each local office EPSDT units were developed with no other assignments. A method of documentation was developed and the State EPSDT staff conducted technical assistance in the district and county offices. We literally marketed and sold EPSDT wherever possible. A back-up procedure was developed to determine compliance with State and Federal requirements. The State central office has field monitors who pull samples and compile documentation on cases from initial contact through completion of treatment. This system has greatly aided the consistent application of program requirements. A similar procedure must be included in the legislation which would provide some uniformity to accomplishing the stated goals, nationally.

With respect to the present bill being considered here, I submit the following:

(1) Outreach—must be provided with latitude for each State to adopt its own method. An increased match to exceed 75 percent for start-up would add a greater incentive, outreach must include follow-up for treatment.

(2) Provider participation—southern rural States often do not have the great variety of provides as larger States. However, CHAP should require States to identify and have documented the attempts to enroll eligible providers. This would be monitored by HEW consistently.

(3) Financing—The proposed four percentage points over State's current Federal matching rate for ambulatory care services will not cover the cost of a program expansion and will not provide sufficient incentives. The financial incentives tied to performance must be of such appeal to warrant States to initiate sufficient program changes. This concept is positive but must be clearly defined as to the actual percentage applied.

(4) Administrative approach—A specific plan must be applied. The primary emphasis should not be placed on the penalty. It must be given to the approach of accomplishing the overall goal—a uniform method of administrative application. States would have with this approach a consistent application of the national plan with which they could interface. The single State agency which would provide proper information, outreach, case management, follow-up transportation and documentation is the one consistent approach which works.

(5) Federal enforcement—A clear definifion of compliance issues and penalty application must be defined. There must also be a definition package to which the States can refer for clarity related to implementation of policy.

A minimum acceptable level of performance must be established to be applied with such flexibility that States can display a program based on recipient needs and available resources.

Compliance issues must be applied with consistency and clarity without variation and conflicting interpretations. EPSDT has been plagued by these administrative deficiencies.

The penalty must be applied in the same manner.

One State should not be required to invoke a procedure not required in another State outside that particular region. HEW must be uniform and consistent—a hand must be extended in cooperative spirit in addressing the needs of the child—the legislation, regulations and HEW must work with and for the States in accomplishing this much needed program revision. The penalty and compliance must not become primary—every effort must be made to assist the States on a consistent basis to develop and accomplish its performance standard and in so doing deliver the much needed health care to the low-income children of this Nation.

Senator TALMADGE. Next we have Marian Wright Edelman, director, Children's Defense Fund, accompanied by Wendy Lazarus, consultant on health issues, and Judith Weitz, program specialist in health.

You may put your full statement in the record and summarize it as you see fit.

STATEMENT OF MARIAN WRIGHT EDELMAN, DIRECTOR, CHILDREN'S DEFENSE FUND, ACCOMPANIED BY WENDY LAZARUS, CONSULTANT ON HEALTH ISSUES, AND JUDITH WEITZ, PROGRAM SPECIALIST IN HEALTH

Ms. **Edelman**. We are here to state five compelling reasons why we favor immediate and separate enactment of CHAP.

First, we believe the health needs of 13 million eligible children cannot wait for still another session of Congress. In the 1 year since CHAP failed to pass, 3 million medicaid-eligible children have needed immunizations, 2 million care for vision or hearing impairments, and another 2 million treatment for anemia.

How long will we continue to deny children the care they so badly need? For many of the individual children, the effects of neglect can be life crippling; for taxpayers the long-term cost of nondetection and treatment may be staggering.

Second, EPSDT is the best program to build on to get needy children health services swiftly. The program is in place nationwide. No other sources of primary care are available to many of the poor children CHAP can serve.

In fact, other federally funded health programs combined reach less than one-third of the children medicaid reaches. With relatively straightforward legislative changes, CHAP can move swiftly to extend high quality primary care to millions of American children who now receive none.

Third the EPSDT program has been thoroughly studied. The issues have been aired by the public and Congress. There is wide consensus about the changes necessary to make the program work. And there is strong bipartisan support to enact these reforms now.

CDF grappled, after finishing our 2-year study of EPSDT, with whether it made sense to improve the program. After wide consultation, we concluded that if the goal is to get the most appropriate health care out to the most needy children in the quickest way possible, it makes sense to build on EPSDT.

Fourth, CHAP is consistent with Congress concern for containing health care costs. Indeed, its emphasis on preventative and primary care is the essence of cost containment. Studies show savings of roughly 40 percent in health bills for children who receive preventative and primary care.

Yes, CHAP involves some new money. But the expense is modest. CHAP's budget is less than 1 percent of the $52.2 billion in the President's budget for health care and less than 4 percent of the medicaid budget, most of which goes for care other than primary and preventative care.

Fifth, no matter what other health reforms you support—cost containment, medicaid reform, catastrophic coverage or a variety of others, CHAP is a crucial and entirely consistent piece. First, it recognizes and deals with the special needs of low-income children. This is an essential measure by itself or as part of any plan to reform medicaid or enact a universal health insurance program.

Second, its eligibility and benefit policies are consistent with the changes which medicaid reform would bring for people of all ages.

Third, CHAP's administrative structure is tailored to reach out and bring children into a system of care, foster provider participation and achieve outcome standards, all of which mesh with the administrative structures envisioned in other medicaid reforms.

Fourth, CHAP lays important groundwork for subsequent reforms in medicaid or more far-reaching national health insurance proposals. It builds a system of providers and an administrative structure through which future programs can operate. It is for these reasons that President Carter's national health plan assumes CHAP's passage.

With respect to S. 1204, the administration's CHAP proposal is a significant improvement over its previous version and contains many provisions which are fundamental to effective EPSDT reform. We have appended to our written testimony a thorough analysis of S. 1204, including modifications to strengthen the bill.

We would like to ask that this document become part of the record for the committee's consideration. However, if making these modifications would delay CHAP's passage this year, we would urge the committee to report out S. 1204 immediately in its proposed form as a separate bill in the interests of making CHAP available in fiscal year 1980 to children who will otherwise receive no or little health care.

We recognize that although CHAP is an indispensable first step, it will not remove all of the barriers standing between children and the health care they need. Our written testimony recommends a national children's health agenda beyond CHAP and highlights the need for a sound national health program.

We are heartened that children are beginning to be paid attention to in the health insurance debate and that a common feature in the proposals of President Carter, Senators Kennedy, Long, and Ribicoff is prenatal, delivery and infant care. We would like to submit for the record CDF's letter to President Carter on national health insurance from a children's perspective.

In considering the many suggestions before you, we hope you will use this document as a children's checklist and focus your deliberations on the provisions most crucial for children.

In the meantime, let us take an immediate and important first step to do something now of critical importance for American children and families. Do not let CHAP get delayed or lost in the NHI debate.

If we are serious about containing costs, insuring the health and stability of American children and families, this Congress and administration must begin to put in place now specific measures to help children grow up healthy. CHAP is an opportunity to do that.

At least six of your committee members agree to the extent of sponsoring CHAP, and we hope others will join them. Low-income children who were not yet born when EPSDT was enacted are now nearly 12 years old. These children must not go still longer without the chance to grow up whole.

I speak as a professional child advocate and as a mother of three sons. I cannot think of anything that parents are concerned about more than making sure they are able to provide good health care for their children. I think this Congress has the opportunity to provide that through CHAP.

Senator TALMADGE. Do you have any specific suggestions on how to coordinate existing health care programs for poor children?

Ms. EDELMAN. I will refer to Ms. Lazarus.

Ms. LAZARUS. It is a complicated question. There are a number of programs out there whose missions seem to be similar. We are in the process of taking a look at the range of programs and we are not alone in doing this.

I would like to point out that a select panel on child health care, which was established by last year's Congress, is studying this problem and in 18 months will submit to Congress a report on the matter. Similarly, CHAP provisions in bills now before the House call for specific local coordination.

Once the facts are in—and we believe they are not in—action can be taken, and passing CHAP now will not preclude later taking those necessary steps.

Senator TALMADGE. Any questions, Senator Durenberger?

Senator DURENBERGER. Yes. I understand there was a published study of EPSDT in 1977. Did the study have any impact on the program or prevent any unrelated changes in the program?

Ms. EDELMAN. We think it has had an impact. We followed it up with discussions with HEW and we are making real headway improving sensitivity and awareness of why the program is not functioning. There have been administrative changes. And we are working with State officials to make sure this program works the way it is supposed to.

And it has had a public education effect on unmet health needs of children.

Senator DURENBERGER. How do you suggest provider performance be monitored?

Ms. LAZARUS. We believe that much can be done by setting out clearly, for the first time, exactly what providers are expected to do under this program. The CHAP bill before this committee goes a long way in setting out those expectations.

We believe further that through careful provisions where HEW review teams monitor State performance and where States have a responsiblity for actually monitoring the agreements between providers and the State agency would result in a workable vehicle to assure quality. But the most important thing is to be clear with providers.

When we were out in the field talking with providers, we found a number who were simply confused about what they were supposed to be doing. A lot can be done by opening those lines between the providers, State agencies and HEW in what is expected.

Senator DURENBERGER. That is not at the State level.

Ms. LAZARUS. It certainly has to be a combination. We are convinced there has to be Federal guidance given to States and that should be in the legislation itself. But additionally States must work out agreeable fee levels, agreeable reimbursement arrangements with providers. The terms are best arranged by the providers and the State agency.

Senator DURENBERGER. And the monitoring as well?

Ms. LAZARUS. The monitoring as well, again with some Federal review. We recommend a twice-a-year review in which HEW actually goes out into the States and monitors performance. So it is both: States and HEW.

Senator Durenberger. Personnel from HEW going into the 50 States twice a year.

Ms. Lazarus. This is the procedure that has been used under EPSDT in the past. When the penalty provisions of EPSDT were passed in 1972, they called for the Department to actually monitor State performance on a quarterly basis. In fact, there were HEW review teams out of the regional offices which visited every State. They visited a selected number of counties. If such an approach is carefully designed, it can be done without inordinate manpower, strain or burden to providers as well.

Senator Durenberger. Do you have an idea of the cost of doing that?

Ms. Lazarus. I think the Department could supply figures on the staff they used and the staff required to do this in the past. We do not have these figures today.

Senator Talmadge. Senator Ribicoff.

Senator Ribicoff. Mr. Chairman, I want to thank you very deeply for holding these hearings. Under your leadership, I am confident this bill will pass this session. You were kind enough to hold this meeting at 2 o'clock today. Because I had to swear in Judge Newman for the Second Circuit Court of Appeals, we had arranged my flight schedule so that I would be here in time. But the Governor called a meeting of the congressional delegation to take care of the problems of the gas shortage in the State of Connecticut.

So, I had to take a later plane. My apologies to you and all these supporters of this legislation for my being late.

I am most appreciative, Mr. Chairman. I ask unanimous consent that my statement on this legislation appear in the hearing record in its entirety at the appropriate place.

Senator Talmadge. Without objection, it will be inserted in full in the record.

[The full statement of Hon. Abraham Ribicoff follows:]

Introductory Remarks of Senator Ribicoff

Mr. Chairman, as the principal Senate sponsor of the Administration's Child Health Assurance legislation, I want to thank you for scheduling this hearing. By taking the leadership on this key issue and providing the Committee an opportunity to hear a full list of witnesses on this important legislation, the ground work is being laid so that the Finance Committee in the coming weeks can decide whether it wants to again recommend CHAP legislation to the full Senate.

Last year the full Senate did not have time to act on the CHAP legislation reported by the Finance Committe. It is my hope that with the leadership of Senator Talmadge and the broad bipartisan support which this proposal has on the Finance Committee, we will be able to report CHAP legislation early this session of Congress. The relevant House Committee is prepared to begin its markup of similar legislation this week. Both the House and Senate Budget Committees allowed for some expenditure for CHAP in their basic assumptions underlying the first budget resolution. The President has strongly supported this legislation and provided money in his Fiscal Year 1980 budget for its implementation in Fiscal Year 1980. A consensus is developing that the Early and Periodic Screening Diagnosis and Treatment program should be replaced with a strengthened Child Health Assurance program. At the same time, it is appropriate to extend Medicaid coverage to 2 million of the nation's poorest children and pregnant women who are not now covered by the categorical eligibility requirements.

The Child Health Assurance Act of 1979 tries to draw on the recommendations and improvements which were developed during House and Senate committee consideration of last year's CHAP legislation. The bill I introduced this year is an improvement over the legislation which HEW submitted last year. It is also an improvement over the bill the Senate Finance Committee recommended to the full Senate. I know that the members of this committee will want to make additional improvements and changes. I look forward to the testimony of the exceptionally distinguished group of witnesses which the Committee has the privilege of hearing today.

Senator TALMADGE. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman. Ms. Edelman, let me ask, do you think there should be some performance standards for State participation in terms of minimum portion of eligible children?

Ms. EDELMAN. Yes, we do. Again, I will defer to Wendy because she has done a detailed study of this.

Ms. LAZARUS. From our look at the program, what became clear was: Based on past performance it should be possible to project what can be accomplished, the portion of eligible kids who can be brought under a system of ongoing care, assuming you provide them the kind of support that families need. That support includes very thorough measures for explaining what the program is and why it is important, helping these families actually find a clinic or doctor, and helping them get to it.

We have consulted with people in an attempt to arrive at numerical figures about what is reasonable. We certainly recognize that each State is operating at a very different level of performance right now, and any performance standard ought to take the current level into account but should at the same time have, say, a 5-year target which makes sense. We are recommending that within 5 years after enactment of this program, it is reasonable that 80 percent of eligible children be enrolled in some ongoing system of care.

Senator HEINZ. What about Outreach? I believe in part of the testimony it is suggested that there be a State earmark for Outreach, but do you want a Federal guideline regulation or legislative standard? What is your thinking?

Ms. WEITZ. We have recommended States be required to earmark a certain portion of program funds for Outreach. It is not in the best interest of the State to find children because, unless you have 100-percent Federal reimbursement, the more children in the program the more costs the State will incur.

We have not established what that level should be for the States.

Senator HEINZ. It seems to me if what you say is true that it is not in the States' interest to spend money on this; it is going to cost them money when they find the children. It would strike me the logic comes to some kind of standard set by the Federal Government for a State minimum set-aside for Outreach.

Ms. EDELMAN. We clearly favor a strengthened Outreach provision because we need to say it is important and people are aware of it and the support service is provided to get people into it and expectations or the purpose is to get service to children.

So, therefore, in order to do that you have to build in stronger Outreach provisions. We have suggested some of those in the appendix to our testimony.

Senator TALMADGE. Senator Bradley.

Senator **Bradley**. Ms. Edelman, why do you think that HEW will do better under CHAP than it has done under EPSDT?

Ms. **Edelman**. We have had 10 years of water under the dam, Senator Bradley, and because I think we have a much stronger, more well informed outside constituent group that does monitor HEW more effectively. In the Secretary of HEW now we have someone committed to making this program work for children.

Third, out in communities all over the country we have more public awareness of the needs of children and more attempts to make this program work. Because we have had 10 years of experience, because we have done studies and we know specifically why the program does not work and how it might be improved, this experience and knowledge combined with stronger local constituencies gives us a better chance of getting service to these kids.

Ms. **Lazarus**. The extensive airing of the CHAP issues is leading to a much more explicit piece of legislation. This was not the case when HEW was charged 10 years ago with administering the EPSDT program and what might be called a vague charge has also been an excuse for the Department—that it does not know what the goal of the program is nor how to carry it out.

CHAP would certainly correct those and specify very clearly the Department's role.

Senator **Bradley**. At the local level, say I am a consumer in Newark, how will CHAP be different than the present program, from my perception?

Ms. **Lazarus**. Hopefully, you will hear more about it. Hopefully the stronger outreach provisions will get the word out. Hopefully the bill will deal with the provider problems so a significantly greater percent of providers will be willing to see his/her children under this program.

In addition, there will be an emphasis on making sure that the first step, which is the assessment, is not a one-shot business which ends without treatment but that you will be directed to a clinic or provider who can not only find out the children's problems but give them treatment and call them back in on a regular basis.

Ms. **Weitz**. I would add, more children will be eligible so a lot of poor families who have not been able to get care will be able to. The whole point of the program is to get treatment for the problems found, but that has been a problem historically because of the benefit package available to families. The administration's bill goes some way toward correcting that problem.

Senator **Bradley**. Thank you Mr. Chairman.

Senator **Talmadge**. Thank you very much.

[The prepared statement of Ms. Edelman follows:]

STATEMENT OF THE CHILDREN'S DEFENSE FUND

I. INTRODUCTION

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 Assurance Program (CHAP): "A bill to strengthen and improve Medicaid services to low-income children and pregnant women, and for other purposes." There is no resource as precious as healthy children, and no proposal currently being acted on by the Congress has greater immediate significance for the health of children in this country than CHAP. This important bill deserves prompt and careful consideration and positive action by the Committee.

The Children's Defense Fund (CDF) is a national public-charity created to provide a systematic voice to improve the lives of children and place their needs higher on the nation's public policy agenda. Since 1973, CDF has conducted thorough research on major problems affecting millions of American children in its five program areas of child health, education, child welfare, child care and family support, and juvenile justice. This research has formed the basis for a series of CDF reports, each of which contains specific recommendations for change at the federal, state, and local levels and in the public and private sectors. These reports also form the basis for CDF's Action Program which includes correcting the problems uncovered through federal and state policy changes, monitoring, litigation, public information and support to parents and local community groups representing children's interests.

CDF has published two major reports on primary and preventive health care for children; "Doctors and Dollars Are Not Enough: How to Improve Health Services for Children and Families" and "EPSDT: Does It Spell Health Care for Poor Children?" The first describes the major obstacles in health care delivery that rob millions of American children of basic health care services, and presents working examples of quality child health programs around the country. The second is an in-depth evaluation of the progress and problems in EPSDT, the largest federal program which provides health care to poor children, and the program which S. 1204 is designed to improve. Our EPSDT report 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.

We appreciate the Subcommittee's willingness to set aside time to consider the health needs of the nation's children and mothers. No groups in this society are so vulnerable or so poorly covered by current programs. One out of every seven children—an estimated 10 million—has no known regular source of primary health care. One out of every three children under 17 (more than 18 million) has never seen a dentist.[3]

Chairman Talmadge and Senator Ribicoff are to be particularly commended for their leadership in again placing CHAP before this Subcommittee. We know that, in light of the Committee's careful and deliberate consideration of CHAP during the last session of Congress, completion of work on a new CHAP bill this year should be a relatively swift and simple task. We also applaud Senator Chiles for addressing the vital issue of how existing child health services can be properly coordinated and developed.

This testimony addresses three crucial issues: first, why CHAP should be passed immediately; second, an analysis of the current CHAP legislation pending before this Subcommittee; and finally, priorities beyond CHAP in the health agenda for children.

II. QUESTIONS FREQUENTLY ASKED ABOUT CHAP

In our meetings with members of Congress and their staffs, some have questioned the value and timeliness of CHAP. Their questions raise good, tough issues which can and must be answered. These are indeed questions which we ourselves faced after completing our EPSDT study, and our work has produced the following positive responses:

A. Why should EPSDT be improved by passing CHAP?

Probably the most difficult issue we faced after completing our EPSDT study was whether it made sense to improve the program. In nearly every sense, EPSDT has failed to realize the promise which many believed it held for poor children when it was enacted in 1967.

Our own findings have convinced us that truly effective health care for children can be best guaranteed 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 comprehensive national health program is enacted. Experts agree that even if such legislation were passed immediately, it would be several years until services become available. This delay is due to the time required to plan and implement any major new program. Improvements in the current EPSDT program are therefore necessary at this time.

The first reason to improve EPSDT immediately 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 the 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 we therefore urge this Subcommittee's continued support of these endeavors. It is unrealistic, however, to believe that these programs alone can meet the needs of all children, since millions of youngsters do not have access to their services. EPSDT reform will result in expanded and improved services for all eligible children, and we therefore do not hesitate to recommend an increased investment in EPSDT.

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 1 percent of the almost 7,500 children screened had had a previous examination comparable to that which is required under the program. Sixty to 80 percent of the health problems found in these children were previously unknown and untreated, even though 80 percent were chronic.

In another case, physicians affiliated with the University of Maryland screened 361 children. Of these, 335 had referrable conditions. In the physicians' opinion, "not one of these conditions would otherwise have been recognized so early in its course" without EPSDT.

The second reason to strengthen the program is that EPSDT cannot only improve the health status of children reached but also reduce the amount of money spent on health care. Studies have repeatedly shown that primary care services lead to healthier children and dramatically reduced costs. 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 to 18 percent), as a result of physical assessments (from 42 to 31 percent), and review of health histories (from 10 to 7 percent).

The third reason to improve EPSDT is that, in the process of making EPSDT function more effectively, we will confront and 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, especially 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.

B. Is there any assurance that CHAP will be administered adequately?

We believe that it can and will be.

First, in drafting the current CHAP legislation, there has been a much more extensive examination of the problems of mounting a program such as CHAP than there was when EPSDT was enacted.

Second, as a result, the legislation will include more explicit language on the program's purpose and how it will be achieved. HEW will have neither an ambiguous charge nor the excuse of a vague legislative mandate.

Third, there is a much more informed constituency. People eligible for services are more aware of the program and the benefits to which they are entitled. There are more outside groups interested in monitoring and promoting implementation than before.

Fourth, HEW has gained considerable experience from its administration of the EPSDT program. We have worked closely with the Department for a number of years in order to assure more effective implementation of the program, and we believe that HEW now has the expertise which will be necessary to implement CHAP.

We do not desire a pyrrhic victory for children. In our judgment, HEW can make CHAP a meaningful program for children and mothers.

C. Can Congress justify a new spending program now?

CHAP is not a new program. It constitutes a careful attempt to resolve specific deficiencies in a program which has now been in existence more than 10 years and which has the potential to save much more money later on. CHAP's goals, while absolutely crucial, are modest: (1) To modify EPSDT to enroll all needy low income children in a system of health care which assures them complete preventive services and necessary subsequent care; and (2) to correct the most serious inequities in eligibility and benefit policies for children and youth under Medicaid. These goals can be achieved through relatively simple legislative and administrative changes.

CHAP does involve modest new spending for primary and preventive services. But the expense is entirely justified given both the ultimate cost savings cited above and the critical physical and emotional relief which children will derive. The issue is whether to invest small sums now or pay substantially more later when preventable childhood handicaps become permanent and acute conditions that result in expensive treatment, institutionalization and loss of productivity.

The several hundred million dollars required for CHAP is less than 1% of the $52.2 billion in the President's budget for health care. These billions pay for expensive and sophisticated treatment which could be avoided or reduced by bolstering the system of preventive and primary care, especially for children. Similarly, the CHAP budget is less than 4% of the Medicaid budget which is spent primarily on the most expensive types of medical care and services.

D. Should Congress enact CHAP before it considers the whole range of child health programs and develops legislation to improve or expand them?

There are several compelling reasons why action on CHAP should not be postponed until related legislation is acted on. First, the issues have been thoroughly aired, and there is consensus on the necessary changes to make EPSDT work for poor children. Second, children cannot and need not go any longer without the basic health services CHAP would provide. Third, passage of CHAP does not preclude action on other health care programs affecting children. Not only will CHAP's aims be fortfied by new and improved programs, but additionally the CHAP reforms will provide a coherent groundwork, as described above, for future child health efforts. Indeed, the Medicaid reform provisions of the Administration's national health program assume enactment of CHAP.

III. ANALYSIS OF S. 1204

A. General

We believe that S. 1204, the Administration's new CHAP bill, contains many of the necessary reforms which we have recommended in the past. Among the features we particularly support in the bill are the following:

Inclusion in Medicaid of additional children who do not currently receive financial assistance but who would qualify if income alone were the basis of eligibility;

Inclusion in Medicaid of additional low-income pregnant women;

Establishment of a national minimum income level for determining the eligibility of children and pregnant women;

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

Provision of an expanded package of health services, including routine dental care, to all Medicaid-eligible children regardless of whether they have received health assessments;

Elimination of cost sharing for Medicaid-eligible children for CHAP services;

Prohibition against limitations on the availability of most CHAP service;

Extension of a child's eligibility for Medicaid to help assure that necessary follow-up care is received;

Extension of a pregnant woman's eligibility for Medicaid to help assure that needed prenatal and postnatal care is received;

Clearly defined provider and State agency responsibilities under the program;

Incentives to states to encourage providers to offer routine forms of treatment and primary care, as well as assessments;

Increase in the federal share of costs for ambulatory care services for children, and for outreach.

While we would be happy to provide this Committee with more information on any of these provisions, we will focus our remarks here on the key provisions now included in S. 1204 which are of particular concern to members of the Committee.

B. Medicaid eligibility for children ages zero to 18 years

Last year, the Finance Committee reported out a CHAP bill which took the much needed step of making eligible for Medicaid extremely impoverished children under 6 years of age. The bill failed to include older children, however, many of whom are in the same families. S. 1204 would cover children and youth up to the age of 18 who meet a national income standard, a provision we strongly support.

EPSDT data show that children and adolescents aged 6–18 have as high or higher rates of problems found in screening as children under age 6. They are as much in need of basic health care as younger children. Their typical health problems (including, for instance, obesity, venereal disease, and hypertension) differ from those found among younger children. Early detection and treatment of these ailments can avoid needless suffering and complications which ultimately require more expensive treatment. CHAP therefore must cover children and youth to age 18.

C. Utilization of a national income floor

Using income as the sole basis for Medicaid eligibility for children and youth will help remove 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 exclude some of the poorest children in the country from the program. In 1977, in ten states or territories, children in four-person families with annual incomes of $3,000 would *not* qualify for Medicaid.

We believe that CHAP should establish a standard minimum income floor which states must meet. The level recommended in S. 1204—55 percent of the poverty level or $4,125 for a family of four—is realistic and would substantially rectify one of the current inequities in Medicaid. According to HEW's projections, the provision would entitle approximately 2 million additional children and youth to Medicaid services.

We also urge the CHAP require states to allow families to qualify by meeting the income standard outright or by "spending down" to meet the established level. The intent of an income-based eligibility standard is to reach those children least likely to receive necessary care because of inadequate family income. Thus, a child in a family earning slightly more than $4,125 but faced with large medical bills is as needy (in terms of income available to meet the child's health needs) as children in families with income below the national floor. The failure to recognize incurred medical expenses in determining available income results in the exclusion of some of the neediest youngsters in the more than 20 states which do not cover "the medically needy" for Medicaid services.

D. Medicaid eligibility for low-income pregnant women

We strongly support the provision in S. 1204 which would extend Medicaid coverage to low income women during the terms of their pregnancy and for two month 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 prenatal care through Medicaid during their first pregnancy.

Statistics show that coverage of prenatal care for all low income pregnant women would have a significant and positive effect on the health of children and would bring considerable future cost savings:

> Prenatal care helps prevent fetal and neonatal 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 averaged 23.6 percent among mothers who made no visits at all.
>
> Adequate prenatal care reduced the particularly high incidence of problems associated with teenage pregnancy, including toxemia, premature labor, and low birth weight. These conditions are responsible for a variety of health problems found in infants and children.[1]

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.

Additionally, minority women, many of whom are low-income, go without needed prenatal care. During 1975, while 69.4 percent of all United States 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 United States received no care or received care only in the final trimester while 9.9 percent of all black women were in this category.

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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.

The impact of adequate prenatal care on the future health of a child is unquestionable. Mandatory Medicaid eligibility for all low income pregnant women will help assure the good health of yet-unborn children.

E. Dental care

S. 1204 includes significant improvements over the Administration's bill of last year with respect to dental care. It requires coverage of routine dental care for Medicaid eligible children and reimburses states for dental care at the same level as other ambulatory medical services. We strongly endorse these dental provisions in S. 1204.

There is 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 this policy will be more costly than the dental portion of EPSDT currently, HEW's estimates show that such additional costs are indeed modest. If all eligible children were entitled to routine dental 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.

F. Suggestions for strengthening the administration's bill

We believe that the Administration's CHAP bill contains many provisions which are fundamental to effective EPSDT reform. We urge the Committee to act immediately and report out the bill in its proposed form.

We have also included for this Committee's consideration a "Brief Analysis of the Administration's CHAP Proposal" (Appendix A). The Analysis includes modifications in S. 1204 which would, if the Committee chose to incorporate them, further strength the bill in the following areas: Provider participation; financing; outreach; developing States' capacity to deliver CHAP services; health services covered; dental care; maintenance of state effort; Federal enforcement; and building accountability into HEW's administration of the program.

IV. BEYOND CHAP: A NATIONAL HEALTH AGENDA FOR CHILDREN

CDF recognizes that although CHAP is an indispensable first step, it will not remove all of the barriers standing between children and the health care they need. Extensive experience over the past decade with both successful and unsuccessful children's programs underscores the need for further action. To cite only two examples, measures must be taken to remedy the shortage of available and appropriate health care resources and to unify the various child health programs in order to guarantee that every child is in a system of ongoing, comprehensive care.

These changes can be accomplished through a modest sum of new child health money if it is spent to harness and leverage the roughly $31 billion presently, and often ineffectively, spent on health care for children. For instance, by altering reimbursement methods, mandating benefit packages which emphasize primary care, and encouraging use of non-physician personnel to supplement physicians' work, the existing pot of money could be redirected to cover most, if not all, the care which children and pregnant women need but do not presently receive.

Beyond CHAP, we recommend two priorities for action. First on the agenda is enactment of a sound national health program. In considering the many suggestions which will come before you, we urge you to focus on provisions which are most crucial from a children's perspective—namely, comprehensive benefit packages, and methods of payment and other arrangements to assure children access to comprehensive primary care. Furthermore, by shifting the emphasis away from specialized, in-patient and high-technology services, these reforms represent the most potent cost containment method of all. Catastrophic coverage without provisions for primary care services is unsound. We would like to submit for the record a letter to President Carter (Appendix B) which develops these points in more detail and can be used as a children's checklist in your deliberations on national health proposals.

Second, we must learn more about how existing programs can be best coordinated to assure delivery of the most services in the most efficient manner to the most children. It is essential to develop an administrative structure which assures that all children and pregnant women receive appropriate care. Senator Childs' amendment to CHAP introduced last session, which proposes setting up a system of "lead agencies" to coordinate and develop child health services at the local level, represents a beginning point for discussing viable approaches.

In 1967 this Subcommittee, by enacting EPSDT, committed itself to improving the health of the nation's poorest children. Despite your effort and dedication, the program has failed to live up to its promise. Given the consensus on what needs to be done to reform EPSDT, we urge you to take the simple yet crucial step which passing the CHAP legislation represents.

Low income children who were not yet born when EPSDT was enacted are now nearly 12 years old. These children must not go still longer without basic health care.

Thank you.

THE CHILD HEALTH ASSURANCE ACT OF 1979: A BRIEF ANALYSIS OF THE ADMINISTRATION'S CHAP PROPOSAL

On May 10, 1979, President Carter sent Congress a new proposal to strengthen and improve the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), and to broaden Medicaid eligibility for children. The bill, called the Child Health Assurance Program (CHAP), is a revision of the one submitted to Congress by President Carter in April, 1977.

While, both the House Interstate and Foreign Commerce Committee and the Senate Finance Committee reported out CHAP bills last session, Congress adjourned before final action could be taken. As a result of last year's efforts, however, interest in and momentum for getting legislative reform of EPSDT is strong. President Carter has listed passage of the new CHAP bill as one of the Administration's top priorities and only initiatives in health this year. Furthermore, a broad range of outside interest groups support CHAP legislation and CHAP has bi-partisan support in Congress.

The new CHAP proposal makes a variety of changes in EPSDT and Medicaid which affect individuals under age eighteen including changes in: eligibility; benefits covered; financing of services; and the administration of the EPSDT program. We endorse many of the goals and provisions in the Administration's new CHAP bill and we believe it is a significant improvement over the Administration's bill of last year.

Specifically, the Administration's revised CHAP proposal would:

Include in Medicaid additional children who are not currently on welfare but would qualify if income alone were the basis of eligibility.

Include in Medicaid additional low-income pregnant women.

Establish a national minimum income level for determining the eligibility of children and pregnant women.

Provide for a clearly defined, comprehensive health assessment, rather than a health screening.

Provide an expanded package of health services, including routine dental care, to all Medicaid-eligible children, regardless of whether or not they have received health assessments.

Eliminate cost sharing for Medicaid-eligible children for CHAP services.

Prohibit limits on the quantity of most CHAP services.

Extend a child's eligibility for Medicaid to help assure that necessary follow-up care is received.

Extend a pregnant woman's eligibility for Medicaid to help assure that needed prenatal and postnatal care is received.

Clearly define providers' and States' responsibilities under the program.

Provide incentives to States to encourage providers to offer routine forms of treatment and primary care as well as assessments.

Increase the federal share of costs for ambulatory care services for children, and for outreach.

Despite these substantial improvements, however, we believe that this new proposal lacks certain elements without which the reforms will not be as effective as they should be. For instance, this proposal does not assure development of effective outreach services by States so that families understand what services they can receive through CHAP. And, it is questionable whether the system of financing provides sufficient incentives for program expansion or that the monitoring and compliance procedures will be effective.

MAIN FEATURES OF NEW CHAP BILL

The Administration's revised CHAP bill would make the following modifications:

Require States to extend Medicaid eligibility to children under eighteen years of age in families with incomes below fifty-five percent of the Federal poverty measure or the State's income standard for Medicaid to a family with dependent children, whichever is higher.

(HEW estimates that this would make approximately two million new children eligibile for Medicaid).

Require States to extend Medicaid eligibility to pregnant women with incomes below fifty-five percent of the Federal poverty measure or the State's income criteria for Medicaid to a family with dependent children, whichever is higher, for the duration of the pregnancy and for sixty days following the termination of the pregnancy.

(HEW estimates that this would extend Medicaid eligibility to approximately 100,000 more low-income women).

Require States to expand coverage of services for Medicaid-eligible children by including, in addition to those services covered under the State Medicaid plan, routine dental care, immunizations, vision and hearing services, prescribed drugs and insulin, and ambulatory mental health services delivered in Community Mental Health Centers and by other providers who meet standards established by regulation.

Extend Medicaid eligibility to children for four months following the date on which the income and resources of the family would otherwise make the child ineligible.

Set specific standards with which providers of assessments must comply and require that providers enter into written agreements with the State. Regular providers would be required to: provide periodic assessments; provide or refer children for basic diagnostic and treatment services; follow-up on referrals to insure the provision of services, or furnish the State with information to do follow-up; report to the State as required. Continuing care providers would be required to: provide periodic health assessments; provide continuing diagnostic and treatment services; provide continuing preventive and primary care; take responsibility for the medical case management of each child including providing reassessments as needed; report to the State as required.

Increase the federal match to States. During the first eighteen months, the federal matching rate for the costs of ambulatory care services for children would increase over a State's current rate by four percentage points. Subsequently, the federal matching rate for such services would be graduated for each State in relation to the State's performance in assessing children, providing care for conditions found, and providing continuing care. No State's federal matching rate would go higher than ninety percent or twenty percentage points above its current level nor lower than five percentage points below its current level.

Increase the federal match for outreach services to seventy-five percent. (Currently, the majority of these services are reimbursed at a fifty percent federal matching rate.)

Waive the application of the existing financial penalty for non-compliance (one percent of the federal share of States' AFDC payments) for all quarters before October 1, 1979. Repeal the existing penalty provision six months after enactment of CHAP.

MAJOR DEFICIENCES IN THE NEW CHAP PROPOSAL

During the decade EPSDT has been in place, a great deal has been learned about the problems of the program and what is needed to make it work best for children. These lessons should be applied to the design of CHAP. We urge the following shortcomings in the Administration's proposal be addressed by Congress as it considers CHAP legislation.

Provider participation

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. 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 too lax. As a consequence, for instance, many states rely primarily on county health departments, to the exclusion of other qualified providers, to screen eligible children. 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.

To remedy this problem, CHAP should require States to offer provider agreements to all qualified providers. These should include community health clinics, solo and group practice medical practitioners, day care or Head Start 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, including dentists, and to encourage their participation in the program by offering administrative arrangements (including adequate 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.

One of the main reasons providers have been reluctant to participate in EPSDT is that administrative responsibilities under the program are demanding. Many providers do not have staff to provide support services such as follow-up on referrals to see that needed care is received. Under CHAP, the responsibilities of providers are even greater. Yet in CHAP, the federal share of costs for case management and follow-up remains at the current level (generally at a fifty percent matching rate). To induce providers to participate and to develop the badly needed case management capabilities, it is essential that increased federal reimbursement be made available to States specifically for this purpose and that States cover the costs of follow-up in the reimbursement rates they negotiate with providers.

Financing

Increasing the federal share of expenditures for ambulatory care for children, including CHAP services, is a badly needed incentive for States to provide important basic care to children. We have, however, several concerns about the approach in the Administration's proposal. First, it is doubtful that the flat increase of four percentage points over States' current federal matching rate for ambulatory care services will cover the cost of an expanded program and provide the means or incentive to carry out necessay program changes. Second, while tying the financing of a program to performance is important, because the precise relationship of performance to financing is not spelled out in the bill, the impact of this approach is unclear. It is impossible to tell whether this system will be an incentive to States to mount effective programs or will even adequately cover the costs of performing at any given level. Nor is it clear whether the performance standards will be set at a level which indicates adequate performance. To the extent they do not measure program adequacy, CHAP will provide increased federal support for an inadequate program.

These details must be spelled out in CHAP in a manner which guarantees a workable and efficient system of financing

Outreach

Currently, States are required to inform families with Medicaid-eligible children about the program and to encourage and help them uses services. However, few States use the method of outreach proven to be must effective—personal contract with Medicaid families by members of their own community. Inadequate outreach is reflected in the extremely low rates of participation in EPSDT. Currently, only about one-quarter of the screens needed by eligible children are provided. Unless provisions for effective outreach are included, as in the past, few of the eligible children in need of CHAP services will actually get them.

The Administration's proposal includes a higher federal match than is generally available for outreach services. But as the current program has shown, mere availability of federal funds does not lead States to institute effective outreach programs. While we support flexibility for States to design programs specific to their needs, we believe certain minimal guarantees are essential to achieve the program's purpose. Therefore in addition States should be expected to earmark at least a certain portion of the program budget for outreach and; States which do not reach (i.e., assess) a reasonable proportion of eligible children who need assessments should be required to develop new outreach programs emphasizing the use of organizations located in the target community.

Developing States' capacity to deliver CHAP services

Unlike other Medicaid services, CHAP charges States with putting in place many services and seeing that children receive them. This calls for a kind of planning and administrative capability different from other Medicaid provisions. CHAP 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, building a statewide system for delivering the services, and gaining 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. Provisions should be added to strengthen State plan requirements. States should develop (with substantial public input) an annual State plan demonstrating the capacity to meet program requirements.

Health services

CHAP seeks to make available to children preventive and primary health services. The Administration's CHAP proposal includes a significantly improved benefit package for Medicaid-eligible children. However, many children, particularly children with handicapping conditions, will still go without needed care because States can opt not to cover a range of health services (e.g. physical therapy, speech therapy, prosthetic devices, and some clinic services). In addition, States are allowed to place limitations on the amount, duration, or scope of routine dental services, and ambulatory mental health services provided by clinics (unless precluded by minimum service requirements set by the Secretary), and all optional Medicaid services.

The purpose of a primary care program is to prevent or treat early on children's health problems. For CHAP to identify a child's health needs but not provide the services to treat the problems defeats the purpose of the program. Furthermore, the services unavailable through CHAP cannot necessarily be gotten through other programs. Other federally-funded programs reach only a small portion of the CHAP children who need their services. And, many of these programs are dependent on third-party reimbursement through Medicaid for financing.

Allowing limitations on the amount, duration, or scope of basic services is inconsistent with the goals of CHAP. First, one of EPSDT's most important departures from Medicaid was that it overrode State plan requirements in some treatment areas, including dental care, by calling for coverage of necessary treatment. CHAP is intended to build on this concept by expanding the scope of services to cover all needed care. Allowing limits in amount, duration, or scope undermines the receipt of necessary care and moves CHAP in some instances a step backwards. Second, in the case of mental health services and some clinic services, such limitations would be applied to services provided by organized care providers. These limitations will function as disincentives for health centers and clinics to participate in the program. Yet, these are the providers most likely to provide children ongoing health care and mental health services at the least cost.

Because the cost of adding these few services to the mandatory benefit package is modest, and because the need for a full range of primary health care services is great, CHAP should include at a minimum coverage of all needed ambulatory care for Medicaid-eligible children without limitations in the amount, duration, or scope of these services.

Dental services

There is a wide consensus that children need routine dental care. Including coverage of routine and emergency dental care as a Medicaid benefit for children is an important improvement in the new CHAP proposal. Despite this expansion of benefits, however, Medicaid-eligible children will still go without needed dental services because of several serious deficiencies in CHAP.

The Administration's proposal requires States to inform all eligible children of the need for and availability of dental services. States must additionally refer children to dental providers on a timely and periodic basis. Under this scheme, there is no requirement that States make maximum use of qualified dental providers, or develop methods of reimbursement and administration which assure the statewide availability of dental providers. The Administration's proposal fails to assure the availability of resources to deliver covered services.

Furthermore, under CHAP, responsibility for referring children or following up on the referrals is misplaced on nonexistent. No agency or provider is responsible for followup to see that needed dental care is actually received. Responsibility for referrals is given to the State agency. To be most effective and efficient, however, referral must be an integral part of the health assessment.

States should be required to assure the availability of dental providers, make maximum use of all qualified dental providers, and actively encourage participation of others by offering attractive administrative arrangements. CHAP should make direct referral to a dentist a provider responsibility and specify responsibility for follow-up on such referrals to assure that children are getting the care for which they were referred.

Maintenance of State effort

The primary purpose behind increasing the federal share of CHAP expenditures is to encourage States to strengthen and expand their programs. Yet, a significant portion of CHAP's $288 million federal budget will go to increased federal matching for CHAP services for children who are currently eligible. In order for the increased federal share to result in program improvement and expansion, States must maintain their current level of financial commitment. Otherwise, the new federal dollars will simply replace State funds and will not result in benefits for new children.

CHAP should require States to maintain their current level of State Medicaid expenditures (both total and per capita) for out-patient services for the under-21 population.

Federal enforcement

While we support using incentives to get States to implement the CHAP program and provide primary care to children, when States do not meet standards HEW should have ways of accomplished compliance with the law.

In the Administration's bill, enforcement is accomplished through the financing system. The "penalty" is a graduated adjustment of the Federal matching rate for ambulatory care to children no lower than five percentage points below a State's current federal matching rate.

The effectiveness of any compliance measure depends on the level of performance which triggers the enforcement mechanism and the impact of the penalty for not performing adequately. It is doubtful the Administration's approach will have sufficient impact to bring about compliance. In some States it will be cheaper to absorb the reduction than mount an adequate CHAP program. Second, since the reduction in the federal match is applied to expenditures for ambulatory care services to children which comprise a fraction of overall costs (as opposed to in-patient care, which makes up the bulk of state expenditures), it is less likely to have an impact on State performance. Third, since the reduction is applied to service-related funds, it is likely to be harmful to program beneficiaries.

CHAP should establish a minimum acceptable level of performance for purposes of determining whether a financial penalty should be applied. States not meeting this level should receive a substantial reduction in the federal share of Medicaid administrative costs.

Building accountability in HEW's administration of CHAP

The history of EPSDT has been characterized by foot dragging at the federal and state levels and a pronounced failure by HEW to 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% of eligible children be enrolled in the program within five years of enactment. In addition, an independent evaluation of HEW's administration of the program should be conducted and submitted to Congress on a biennial basis by an outside panel of experts representing the interests of recipients. Finally, in addition to the charge already in CHAP to review overall state performance on a biannual basis, HEW should be charged with monitoring state performance regarding provider participation and with reporting to Congress on provider participation in CHAP and the steps being taken to use all qualified providers in the program.

CHILDREN'S DEFENSE FUND,
Washington, D.C., April 18, 1979.

The PRESIDENT,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: As you complete your proposal for national health insurance, I want to set out CDF's views on the indispensable features from the standpoint of children and families. We are strongly committed to passage of CHAP this year as the single most immediate and doable health priority. But we also believe the nation's children and families urgently need a tightly designed, comprehensive

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[1] See "EPSDT: Does It Spell Health Care For Poor Children?" pp. 54-59.

national health program, structured to contain skyrocketing costs and responsive to the basic needs of American families.

We are extremely troubled that much of the national health insurance discussion and several of the proposed plans ignore principles fundamental to adequate care for American children and families. Primary care, which comprises the vast majority of services children need, has received minimal attention. Any plan for catastrophic coverage without provisions for primary care services is unsound and unacceptable. Equally unacceptable is any plan which fails to provide significantly better services for children and pregnant women.

COMPELLING STAKE OF CHILDREN IN NATIONAL HEALTH INSURANCE

1. The 64,000,000 children and youth under 18 are nearly a third of our population and all of our future. Their health care affects thirty-eight percent (38 percent) of households with children living in them and additional households with parents or relatives responsible for children.

2. Children and pregnant women are covered particularly poorly by the present mix of public programs and private insurance, in spite of the known value and modest expense of child health services. Many of the millions of Americans who have no health coverage whatsoever are children, youth or young pregnant women:

Low income families constitute over half of the uncovered group. Many are poor families with children who do not qualify for public programs because both parents live at home. Another 20 percent are young people between the ages of 19 and 24, an age group frequently in need for maternity-related services.

Only 15 percent of employment-based insurance plans cover children's eyeglasses, 9 percent preventive care, and 32 percent children's dental care.

More than half of private insurance plans exclude pre-natal care; 45 percent post-natal care; 90 percent family planning; and about 50 percent leave major gaps in newborn coverage during the first days of life. Under the Medicaid program, 17 states do not cover maternity care for women during their first pregnancy.

Seventy-five percent of American children are covered through private insurance for hospitalization, but less than 30 percent are covered for out of hospital, physician visits.

Ten million children in the United States get no regular primary health care; one out of three children under fifteen years of age has never been to a dentist;

Infant mortality rates are 50 percent higher for residents of poverty areas than non-poverty areas; poor children spend more days in bed and lose more days from school than children who are not poor.

3. Childhood is the time when health care has its greatest preventive pay-off. It would be wasteful to enact a national health insurance program which does not emphasize preventive services for children and pregnant women. Simple, inexpensive interventions often make the difference between fulfilled and productive citizens and disabled, often publicly subsidized adults. An HEW study found that 62 percent of the serious conditions found in a teenage population were preventable or correctable. CDF's reports have documented countless stories of children who never learn to read, develop hearing loss or become chronically disabled because they never got routine, simple health care which could have prevented or eased their handicap.

Poviding necessary services during childhood also benefits society. It saves billions of dollars in treating preventable complications later on:

Children have spent 40 percent fewer days in the hospital when complete preventive and follow-up care were provided.

An investment of $180 million in the measles vaccine program saved an estimated $1.3 billion in medical care and long term care (by preventing conditions such as deafness and retardation).

Children on Medicaid who received preventive care cost the program roughly 40 percent less in total medical bills than children who did not.

What should be done?

Beyond CHAP on the children's agenda is a universal national health insurance program incorporating the following key elements:

1. Universal eligibility.
2. Clear authority at the federal level for the basic design and goals of the program.
3. Standards for providing health services, defined and promulgated at the federal level.
4. Consumer or parent participation built in at every level of resource allocation, policy formulation, and health services delivery.
5. Progressive financing.

6. In each geographic area, one entity clearly designated to make sure that all beneficiaries, especially children and pregnant women receive needed care.

7. Benefit packages, methods of payment and other arrangements to assure children access to comprehensive primary care (See below).

The first six elements are essential not only from a children's point of view but for all Americans. The seventh is the most crucial element from a children's perspective.

PRIORITY PROVISIONS FOR CHILDREN IN NATIONAL HEALTH INSURANCE

A strong, coherent system of primary care which encourages appropriate use of primary care services would alleviate suffering and prevent illness; include the overwhelming majority of health services needed by children; and close the gap where the most striking disparities remain between the affluent and the poor in access to and quality of services. Incentives must be shifted away from an uncritical reliance on high cost technology, in-patient settings for care, and an over-emphasis on specialist's services.

Five provisions are crucial:

1. The program must include an adequate benefit package for children, youth and pregnant women.

The range of essential services for children and pregnant women must be covered. At a minimum, appropriate benefit packages for newborn care, comprehensive care for children up to an age level to be determined, pre-natal care, care surrounding childbirth, post-partum care, and female reproductive care (e.g., pap smears, family planning) must be included. In addition to traditional medical procedures, it is crucial that health-related support services such as nutrition education, outreach and health counselling be covered.

For children and youth, health support services are often indispensable to enable families to use health services and for medical procedures to be effective. For instance, counselling a parent carefully in how to follow a penicillin regimen can make the difference in whether the treatment cures the child's strep throat. Similarly, support services are sometimes more effective treatment than traditional medical measures. Proper treatment for learning difficulties may not require drugs but rather health professionals to work with teachers or parents to change practices in the school or home.

By defining health support services precisely and paying for them in circumscribed ways, comprehensive care can be provided to children economically and effectively. If well designed, the total cost of comprehensive care for children is roughly $250 per child each year. This compares to $737 presently spent for each American through our inefficient and often ineffective "non-system". To work properly, the support services we advocate should be reimbursed through a combination of special purpose grants and reimbursement to providers which meet specified standards. Appendix A sets out in more detail our recommended benefit packages and suitable methods for reimbursing benefits.

2. If there are direct financial costs for health services, these must not be imposed at the time services are needed. They must be in proportion to the family's ability to pay. No deductibles or coinsurance should be applied to children's services, pre-natal care, or family planning.

No family should suffer financial hardship as a result of health care payments. If cost sharing is included through premiums, coinsurance or deductibles, it must be in proportion to the family's ability to pay. We would oppose any fee at the time a child or pregnant women walks in the door of a hospital or clinic for services. Such policies often keep families from seeking needed care in the first place and lead to many families being rejected for necessary care.

We oppose coinsurance and deductibles for children's care, pre-natal care, and family planning. Neither unnecessary use of services nor high program costs are serious problems in children's services, pre-natal care, or family planning. The cost of children's care is modest and predictable, and there is no evidence that overuse of services results when children have access to free care. Imposing coinsurance and deductibles would harm children's health because the bulk of services children need would remain uncovered. The total cost of child health services often would not exceed the deductible, but might nevertheless keep families from obtaining the services. Using coinsurance and deductibles for children places precisely the wrong financial incentives in the program.

3. The program must include measures which make available the proper kinds of providers to all beneficiaries.

The mix of health providers and programs in this country leaves millions of children without access to primary care. For the 49 million Americans who live in medically underserved areas, a program which simply pays bills will not buy their children primary care. The program must correct resource shortages.

It is essential that a fixed proportion of national health insurance funds be applied to develop resources—to provide technical assistance, start up funds, and continuing subsidies if needed for qualified provider groups serving underserved areas. The first priority should be to create a nationwide network of primary care services.

Methods for doing business with providers must support this network of primary care services. First, there must be suitable certification standards which guarantee that all qualified providers can participate in the program. It is outrageous that public programs currently discriminate against and frequently exclude entirely the very providers best able to serve children—for example community health centers and primary care clinics staffed by physician extenders. Second, arrangements for paying providers should encourage primary care rather than more expensive specialists or inpatient services. Adequate reimbursement levels for primary care services and attractive payment methods, such as annual per capita payments, are essential.

4. National health insurance must support a range of personnel working in organized settings.

More and more of the health services children and youth need cannot be rendered by physicians working alone. Conditions like anemia, dyslexia, alcoholism, and allergies call for the skills of a nutritionist, or a mental health counsellor, or a social worker in conjunction with a medical expert. It is increasingly clear that health aides and other paraprofessionals provide crucial services most effectively and inexpensively. These facts argue conclusively for supporting these personnel in organized settings where they can work as teams. Yet services of some of the most effective primary care practitioners are still not reimbursed through private insurance and public programs. Reimbursement through national health insurance must pay for the services of qualified physician extenders and paraprofessionals who work in clinics and other group settings.

5. If the national health program is implemented in phases, any first phase must emphasize primary care and must be the base on which later phases are built.

While we believe a universal program can and should be enacted at one time, if it proves necessary to implement the program in stages, the priority should be to provide primary care to the largest possible population. We strongly oppose coverage of catastrophic care without basic benefits. Its results would be devastating for many children and their families, and indirectly for all Americans because of its inflationary impact.

Any first phase must create the structure into which subsequent phases of the program are placed. It would be unacceptable, for example, to begin a program for the poor or for children which would be separate from the program through which the remainder of the population is covered later. To guard against a two-tiered system, program administration and reimbursement methods must be the same in first and subsequent phases.

We believe that high quality, affordable health care can become a universal reality and that the only effective way to put a lid on costs is to enact a plan which contains these principles. We are eager to work with you, appropriate staff and appropriate members of Congress for immediate enactment of CHAP and to fashion a sound national health program as quickly as possible.

Sincerely,

MARIAN WRIGHT EDELMAN,
Director, Children's Defense Fund.

APPENDIX A.—ESSENTIAL AMBULATORY SERVICES FOR CHILDREN AND MOTHERS[1]

A. SERVICES TO BE INCLUDED IN THE BASIC PACKAGE TO BE REIMBURSED WHEN RENDERED BY ANY PROVIDER OF HEALTH SERVICES MEETING SPECIFIED STANDARDS

1. Care of pregnant women

(a) Prenatal Services: The first visit, irrespective of when it occurs, should include: Health history, including family history; Physical examination; Laboratory examinations; and Counseling regarding nutrition, smoking, use of alcohol, use of medica-

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[1] The services listed and their categorization are intended as an illustration of how the question of benefits for mothers and children should be approached, as well as a guide to specific services. The services listed are adapted from recommendations of the American Public Health Association (1974), the American Academy of Pediatrics (1974), the American College of Obstetrics and Gynecology (1974), and a study of the insurance system and fertility control funded by the Ford/Rockefeller Foundation Population Policy Research Program (1977).

tions, signs of abnormal pregnancy, and in response to concerns expressed by prospective parents.

Subsequent visits should occur: Once each month, through 28th week of pregnancy; once each two weeks, 28–36th weeks of pregnancy; and once each week after 36th week of pregnancy.

Subsequent visits should include: Laboratory tests and physical examination as needed; Counseling in response to concerns and conditions existing in the course of pregnancy, counseling regarding plans for labor and delivery, and for infant care; Amniocentesis for women over 35 and for those with genetic indications; and vitamin and iron supplements and medication as needed.

(b) Care Surrounding Childbirth: Necessary services associated with giving birth in an accredited hospital or other accredited institution; Group or individual supervised bedside instruction to the mother on self care and infant care, including breast feeding; and Family planning counseling and services.

(c) Postpartum Care: Home visit by a public health nurse, or other qualified health provider, within the first two weeks after discharge from the hospital in order: To assist with implementation of home care, and infant feeding, and to provide advice and counseling on parenting and To assess service needs and make referrals.

One office or clinic visit for routine examination and for: Advice and counseling; Laboratory procedures as indicated; Follow-up family planning services; and Help with meeting nutritional needs of mother and child.

2. Child Care

(a) Health visit within 10 days of birth, including: Physical examination, Counseling.

(b) Pre-school health checks: 4 to 6 visits during the remainder of first year, 2 to 5 visits between ages 2 and 6.

These visits should include: Physical examination and appropriate laboratory tests; Developmental assessment; Counseling and anticipatory guidance regarding nutrition, accidents, hygiene, and child development; Immunizations against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, according to the schedule recommended by the Committee on Infectious Diseases, American Academy of Pediatrics; Fluoride supplements as indicated; and Vision and hearing tests, by observation and report.

(c) School-age health checks: Visits at ages 7, 10, 13 and 15 for purposes of: Maintaining immunizations; Physical and developmental evaluations, including necessary laboratory work; Counseling regarding sexual development, alcoholism, smoking, and drug abuse, as indicated, and in response to parent's or child's concerns; and Provision of contraceptive services when indicated.

(d) Diagnosis and treatment of: Disorders of growth and development; Acute illness; and Chronic illness including rehabilitation and management of physical, mental, congenital and acquired abnormalities.

(e) Short-term counseling, consultation and referral as necessary for children and their parents around specific health problems like handicapping and other chronic conditions, learning disabilities, acute illness like venereal disease, and developmental and behavior problems.

(f) Routine dental service, from age 3 on, to include: Annual oral examination with judicious use of X-rays; Semi-annual topical fluoride applications; Fillings, adhesive sealants, space maintainers.

3. Female Reproductive Care:[1]

(a) All women within the reproductive ages should receive periodic: Breast and pelvic examinations; Papanicolau smears (for cervical cancer); and G.C. cultures (test for gonorrhea).

(b) In addition, covered fertility-related services should include: All methods of fertility control; Care of involuntary fetal loss; Treatment of infertility; Genetic counseling and follow-up as indicated; Pregnancy testing; and Contraception counseling.

B. SERVICES TO BE INCLUDED IN THE BASIC BENEFIT PACKAGE, WHEN PROVIDED IN AN ORGANIZED HEALTH CARE SETTING MEETING SPECIFIED STANDARDS

1. Mental health services.

2. Health education services, group and individual instruction to: Assist individuals to develop health-promoting behaviors and to adhere to a prescribed health

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[1] Female reproductive care is included in this list of recommended services, because by preventing disease of the reproductive system, and by allowing women to have the desired number of children when they want them, these services can be expected to improve the health of children

regimen, as indicated; Assist consumers to utilize services most appropriately; Lessen risks leading to health problems, minimize the effects of illness, and avoid its recurrence; and Assist pregnant women to obtain information on nutrition, fluoride supplements, family planning, self care, delivery and parenthood.

3. Home health care: Medical, nursing, dietary, rehabilitative, educational services in the home to mothers and children who are recently discharged from the hospital, ill or disabled

Home visit by a public health nurse, or other qualified health provider, to a pregnant woman for purposes of helping to prepare the home and family for the absence of the mother during confinement, and for the care of the infant afterwards.

4. Homemaker services: Assistance in routine household responsibilities for families in which there is illness or disability.

C. SERVICES WHICH WOULD BE FINANCED THROUGH GRANTS TO OR CONTRACTS WITH ORGANIZED PROVIDERS OF CARE MEETING SPECIFIED STANDARDS

Eligible providers would include schools, day care center, teen centers, etc., as well as organized providers of comprehensive ambulatory health services such as hospitals and health centers, organized providers of categorical health services such as family planning programs, and official health agencies:[2] 1. Immunizations; 2. Family planning services and counseling; 3. Mental health services; 4. Preventive dentistry, including topical application of fluorides; 5. Vision and hearing screening and follow-up; 6. Genetic counseling and follow-up; 7. Venereal disease testing and follow-up; and 8. Demonstrations of improved methods of delivering primary care in non-traditional settings.

D. SERVICES WHICH WOULD BE FINANCED THROUGH GRANTS TO OR CONTRACTS WITH ORGANIZED PROVIDERS OF CARE MEETING SPECIFIED STANDARDS AND SERVING AREAS WITH SIGNIFICANT UNMET HEALTH NEEDS

1. Outreach and community education.
2. Transportation as needed.
3. Provision for temporary child care as needed.
4. Nutrition counseling and services: Planning and advising on breast feeding, formula preparation, food purchase and preparation, routine dietary needs, and special diets.

Assistance in obtaining food supplements through WIC programs housed in health centers and through referrals to other food assistance agencies (such as food stamp office).

5. Environmental education and services: Education on rectifying housing and sanitary conditions which can lead to accidents, acute infections, and chronic diseases like lead poisoning; Assistance in using other community resources to improve these conditions.
6. Provision of help or referral for problems which are not medical but which may have serious health implications, including unmet housing, employment, welfare, child care and legal needs.

Senator TALMADGE. Next we have Dr. Nancy Stone and Nancy Porter-Morrill, on behalf of the Developmental Disabilities/Mental Health CHAP coalition.

You may insert your full statement in the record and summarize it as you see fit.

STATEMENT OF NANCY STONE AND NANCY PORTER-MORRILL, ON BEHALF OF THE DEVELOPMENTAL DISABILITIES/MENTAL HEALTH CHAP COALITION

Dr. STONE. Mr. Chairman, I am Dr. Nancy Stone. I am speaking this morning for a coalition of consumer and service provider organizations concerned with mental health and developmental disabilities. I am speaking on behalf of the groups listed on the front of our statement. I ask all their names appear and be included in the official record with our full statement.

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[2] Some of these services should be funded as part of basic benefits as well as through grants or contracts, and therefore appear in this category as well as in categories A or B.

As a coalition, we support full and equal coverage of service for mentally ill and disabled children. The proposed CHAP legislation is intended to replace the current medicaid EPSDT program and it can correct the inadequacy of original EPSDT legislation in providing a competitive health service system for children.

We believe, however, to be truly competitive it must mandate treatment for all diagnoses, be they developmental, emotional, or physical. To do otherwise would be discriminatory to the more than 12 million low-income children it is designed to serve.

Diagnosis and treatment of developmental and emotional illnesses are the first line of prevention, one of the stated purposes of CHAP. This can be one of the most cost-effective ways of dealing with the health of children. Perhaps the most critical questions arise when full cost coverage of mental health service reduces utilization of other health services and in fact reduces the total cost of health care.

A report of one of these studies is appended to our testimony. In this study there was a 36 percent decrease in number of medical visits by children with an average of only 4.9 mental health treatment sessions. The control group in this study who received no mental health treatment actually increased their medical visits during the study by 30 percent.

There are a number of other studies described in our testimony on pages 5 and 6, each of which have shown similar findings.

The groups supporting this statement urge the committee to build upon the legislation pending before it as follows: One, provide coverage without limits on amount, duration, and scope for organized care settings meeting the Federal definition of community mental health centers and for other organized care settings meeting standards prescribed by the Secretary.

One advantage of covering organized care settings under CHAP is accessibility. These programs are only available within rural and intercity areas. To limit services covered in organized care settings discriminates against the children.

Recommendation two is, to authorize coverage of in-patient psychiatric benefits in accredited mental health hospitals and residential treatment centers as well as in general hospital psychiatric units which have been appropriately accredited. Most emotionally disturbed children will not require in-patient treatment.

However, legislation should allow the children who do require this environment which in-patient treatment permits to be cared for in a setting appropriate for their needs. Accreditation should insure appropriate service, regardless of the setting, the facility in which they are provided.

Recommendation No. 3 is to mandate that HEW insure realistic rates as well as timely medicaid reimbursements for qualified mental health providers. Under medicaid many States reimburse providers at rates substantially below cost. This is a barrier to provision of quality care.

Senator Ribicoff stated, in the foreword to "Crisis in Child Mental-Health Challenge of 1970":

> American public faces double challenge, a challenge of caring for a child already sick and in need of help and a challenge of preventing sickness by fostering healthy growth. Societies can be judged on how they care for their children.

Mr. Chairman, 10 years have passed since Senator Ribicoff made that statement. It is time to act. Thank you.

If I might have just a moment more, I finished my prepared statement, but I see Senator Durenberger is here. I have just come back from visiting a number of EPSDT sites across the Nation and I want to say a word for the county nurses in Minnesota who do a superior job.

Senator TALMADGE. Do you have comments, Ms. Porter-Morrill?

Ms. PORTER-MORRILL. It is a privilege to represent the coalition, the organizations concerned with developmental diseases of children. We thank you for this opportunity.

I speak not as a parent or professional with any personal experience with developmentally disabled children but as a committed volunteer who cares about people, good health, and improving our health care system.

You have our testimony. I will only highlight the main points and may I add we know the Senate has a very busy agenda, but we are very hopeful markup and favorable action on this bill will follow this hearing very soon.

We are pleased that S. 1204 has expanded the number of services covered by medicaid for eligible children by including prescription drugs, immunizations, vision and hearing services, and dental care. However, S. 1204 fails to mandate coverage of other optional medicaid services that are essential for a developmentally disabled child.

Many of the health services a developmentally disabled child needs may not be included under a State's medicaid plan. In fact, many States have chosen not to cover these optional services or cover only a few of them. Consequently, the availability of health service varies considerably from State to State.

We would like to emphasize that for a developmentally disabled child, optional medicaid services such as physical therapy, speech-language pathology services, orthopedic devices, mental health care, and other screening, preventative, diagnostic, and rehabilitative services are essential to his or her health and well being.

It is important that developmentally disabled children have access to the kinds of medical services that are appropriate to their needs. We therefore encourage that the broadest possible coverage for all eligible children be provided under CHAP.

Current regulations permit States to set certain limits on health services. While developmentally disabled children share the same needs for basic health care as other children, in some cases their special problems require different kinds of treatment.

To allow limits to be placed on the delivery of health services undermines the receipt of necessary care and virtually assures that the children who need services the most will be made to suffer.

Untreated disabilities do not disappear. Without necessary health care most disabling conditions become worse and thus more costly to treat.

Early intervention and followup can prevent the development of some forms of developmental disability, can dramatically reduce the severity of the disability, can compensate for disability produced impairments, and can reverse symptoms.

Also, 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.

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.

We endorse the CHAP proposal for including coverage for pregnant women. Adequate medical care during pregnancy can prevent needless disability. We also are pleased that S. 1204 will allow children to receive certain health services regardless of whether or not they have gotten a formal health assessment.

Senator TALMADGE. Will you suspend just a moment please? I have another vote on the Senate floor. Senator Ribicoff, if your will preside momentarily. I will rush over and vote and rush right back and maybe we can keep the hearing going without interruption.

Senator RIBICOFF. I will be delighted. Senator Durenberger, do you want to vote or ask a question?

Senator DURENBERGER. I do have a question.

First, I would like to associate myself with the position of the Coalition and also with your recommendation, particularly about the need to amend this bill to expand coverage in the area of mental health services. But I do have a couple of questions.

One, are you in favor of psychologists, as well as psychiatrists, being reimbursed?

Dr. STONE. I think that is a question the whole Coalition can answer rather than I as an individual. I would like to have this Coalition have an opportunity to answer that.

Ms. FINE. I am Teddy Fine, with the American Psychiatric Association, speaking on behalf of the Coalition, which represents organizations representing psychologists, social workers, and psychiatrists. It is one issue which we have not grappled with simply because we feel mental health care per se for the children is more important at this level when we are working as a coalition than to get into internal fights as to who should get reimbursed.

Senator DURENBERGER. I appreciate that answer. One of your recommendations is to provide coverage without limit on the amount of duration and scope. I do not know how practical that is. I am wondering if there would be any way to clarify the appropriateness of the length of mental health treatment that might be available to children?

Dr. STONE. I think the length varies both with the condition and with the time in which it is discovered. I think this is one of the strong arguments for early discovery. I do not think we have the data that states such and such a number of sessions are necessary for this condition.

One of the strongest arguments is the studies that are reported in our testimony that, indeed, in the HMO's, who looked at total health of the child, the case is this actually reduces the total cost of health care.

Senator DURENBERGER. Basically, the answer to that is we are left with the judgmental question and judgmental answer as far as duration.

Dr. STONE. I cannot give statistics if that is what you are asking for.

Senator RIBICOFF. I know that all of you represent a very important group of organizations. Many of these organizations do excellent voluntary work. Physicians who would serve as providers under CHAP have expressed deep concern about signing a written agreement making them responsible for case management.

The child actually gets followup and referral services needed which involve phone calls, personal visits, and other efforts to make sure the child gets the needed care. Now doctors feel—and I feel rightfully so—that they are not equipped to do this.

Isn't there a way that community groups such as yours could assist physicians with this followup task. If you give them all of this administrative work it is going to bog down. How about your groups helping the physicians on the phone calls, visits, and other efforts to make sure the child is getting the care?

Ms. PORTER-MORRILL. I think I can speak on behalf of Coalition members when I say we believe health care of our children is a partnership effort and must be between the public and the private sectors. There are an enormous number of services that the organizations that have joined this Coalition can provide, and we would like and would offer I am sure the opportunity for CHAP to become a reality, to work with providers and parents to see that this partnership becomes a reality so that the concern that you have expressed would be met.

We would certainly offer our services.

Senator RIBICOFF. So you feel that your organizations could remove this question, this doubt from doctors by working out arrangements with medical societies to take some of those burdens off their shoulders?

Ms. PORTER-MORRILL. The first step is to talk about it certainly, but I am sure there is an enormous amount of good will and commitment on the part of coalition groups to do this.

Senator RIBICOFF. This is a question that Senator Talmadge left with me for Dr. Stone. I will read the question. Certainly no one could be opposed to appropriate treatment for properly diagnosed mentally ill children. And certainly many of those who support mandatory unlimited health benefits have the best of intentions.

As you know, last year the Finance Committee held a hearing on the general subject of coverage of mental health under medicare and medicaid.

That hearing indicated serious disagreement within the mental health professions as to the validity of many of the assumptions and underlying theories involving the diagnosis and treatment of those described as having mental health problems.

You are proposing unlimited mental health benefits. In the interest of protecting defenseless children, my questions are these:

One: Exactly who would be qualified to diagnose mental illness?

Dr. STONE. I think that the answer that was just given for the coalition related to the fact some of these are internal decisions that I think the coalition has not come to agreement on but there are a number of people who are qualified providing the general terms of social work, psychology, and psychiatry at this point in time, but I think this is a position that perhaps the coalition should give you an answer on rather than my giving you a personal opinion.

Senator RIBICOFF. If you people don't know who should do the job and who is qualified, are we going to be able to name who is qualified, if you have doubts in your own minds—if you don't have the answer, and you don't have it?

Two: Exactly what diagnoses would be considered reasonable and what diagnoses considered unreasonable?

Dr. STONE. I am not sure I understand the question.

Senator RIBICOFF. I did not write the questions so I don't know. Exactly what diagnoses would be considered reasonable and what diagnoses considered unreasonable?

Dr. STONE. I am not clear enough about the question to answer.

Senator RIBICOFF. When Senator Talmadge comes back he will clarify it or maybe staff could clarify it.

Senator HEINZ. Let me take this moment to welcome the panel. I am particularly pleased Ms. Morrill is here, a Pennsylvanian of great experience. It is also nice to see Dr Stone here. As somebody who has taken a forced 2-year leave of absence from health concerns—I used to serve on the Health and Environment Committee in the House of Representatives for 4 years—I now have a chance to be active again in the Finance Committee and this subcommittee, although I am sitting in at Senator Talmadge's and Senator Ribicoff's sufference.

It is good to be back on Health and Mental Health. I wanted to get those good words on the record before I had to leave.

Senator RIBICOFF We will stand in short recess until Senator Talmadge returns and I will return.

[A brief recess was taken.]

Senator TALMADGE. We will be in order. Dr. Stone, I understand Chairman Ribicoff started asking one of my questions and that there was some confusion over one of them. I will read them to you.

Who would be qualified to diagnosis mental illness? Exactly what diagnoses would be considered reasonable and what diagnoses would be considered unreasonable? Exactly who would be qualified to treat children and what modes of treatment would be deemed acceptable? In view of the potential for improper or unjustified diagnosis of mental illness in a child, exactly what procedures are established for independent personal examination of a child by qualified people other than the person making the decision?

I will send these questions to you, if you don't mind, and ask that you respond to them in writing for the record.

[The following was subsequently supplied for the record:]

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS,
Washington, D.C., July 9, 1979.

Senator HERMAN TALMADGE,
Chairman, Senate Health Subcommittee,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: During the recent Senate Finance Committee hearings on the Child Health Assurance Program, you asked certain questions of the mental health witness, Nancy Stone, M.D. The following is the response from several organizations, who in consulations with Dr. Stone, have prepared this answer. We wish to have it printed as part of the official recordings of the hearing.

"The mentally ill child must be considered as a whole human being. He/she must have access to a complete range of health and mental services, including treatment furnished in the most appropriate settings, and furnished by a team of mental health professionals. Controls on the quality of these services should be established through appropriate professional review and evaluation.

Children have unique mental health needs. Therefore, the methods of intervention are different from those for adults and require differences in diagnostic methods, treatment techniques, training of clinicians and the nature of institutional arrangements. It is important to remember that children are not little adults.

Human development consists of three components: the biological, the psychological, and the social. In children, as opposed to adults, the three levels of development are intertwined in very complex ways. The fact that many of these symptoms occur in the normal child who does not need mental health intervention complicates diagnostic procedures. Symptoms for referral for diagnosis and treatment should constitute a major interference of normal development and functioning of the child. Particular attention must be paid to symptoms that persist and interfere with everyday functioning.

The important thing is to assure prompt and proper diagnosis. Proper diagnosis is an objective of all health professionals. Ensuring focus on all aspects of the child's development will assure the availability of appropriate treatment.

Subsequently a treatment plan must be developed for each child and services furnished in accordance with that treatment plan. This may require the services of highly trained specialists, in variety of appropriate settings. In a recent Supreme Court decision concerning commitment of minors (Parham v. J.L.-J.R.) in Georgia, the Court held that while the diagnostic decision-making process for physical and mental illness may or may not be error-free, nevertheless, the independent decision-making process, which includes a thorough investigation followed by additional periodic review of a child's condition, will identify children who should and should not be treated for physical and/or mental illnesses. The child should have access to appropriately trained qualified professionals, licensed or accredited in their specialty. As Roy Menninger, M.D. stated before this Committee last August 18 during the hearings referred to on mental health coverage: "Psychiatry and the issue of mental illness are too complicated to assume that one person has all the answers. We (at the Menninger Foundation) rely very heavily on the services of the members of a team."

Utilization of a team of professionals permits each specialty to be used in the most effective manner. This takes advantage of the different educations, knowledge, and skills each profession brings with them.

We share the Committee's concern that children, both mentally and physically ill, should not be improperly diagnosed or treated. This issue is best addressed by ensuring that services are provided by appropriately trained clinicians in appropriate settings. As Dr. Menninger outlined in last year's hearings: "Quality is a function of putting together three things: what the problem is, what the outcome should be, and what the approach should be . . . To address all of these with a simple definition of diagnosis will do a great injustice to a great many patients."

What is needed, Dr. Menninger pointed out, is a system to determine, within reasonable measures, what a particular patient needs. For this, he urged a system of peer review. Such a system would have rigid requirements to ensure quality of care, appropriate length of stay and treatment, and appropriate setting. Where appropriate, second opinions are, as Senator Talmadge suggests, most valuable.

The first question asked of the witness seemed to ask what are the relative competencies of the several mental health disciplines and which has the greatest diagnostic ability? The answer is that each has areas of special competency which ideally leads to team approach to treatment. Any single skill of any discipline can be matched or duplicated by another. Mental illnesses are complex and require a multifaceted diagnostic appraisal. The question, e.g., whether the psychologist or the psychiatrist is the most knowledgeable is comparable to asking whether the anatomist of the physiologist has a better understanding of the human body. Unfortunately, in spite of the rhetoric, the real issue being asked and being debated is one of status and compensation rather than competence and skill. The Congress and much of the public are aware of this being asked as the principal issue and we would be foolish not to acknowledge it.

In the second question, we believe we are being asked to make a distinction between a documentable illness and a social or environmental problem—or can we be more precise? These distinctions cannot be made on diagnosis alone, but can be best judged by response to treatment or intervention. If there is a limitation of service based on diagnosis alone, practitioners could be expected to fit the diagnosis to the need. With a multidimensional problem, emphasis is placed on the area where resources are available. This does not constitute an inability to make an accurate diagnosis. It is based on a desire to help.

In the third question, we are asked as to ideal modalities of treatment. Again, treatment is not limited to one element of providers. With any patient, after an initial screening the appropriate modalities and treatment settings would be established. Given the fact that psychiatric care is so individualized, the issue is to assure that all factors be taken into account at the initial screening. These issues—social, economic, familial, community resources, severity of the patient's illness would be weighed in conjunction with the acuity of the illness and an appropriate treatment plan would be drafted which would assure the appropriate utilization of resources at hand. To specify ahead of time what modalities should be used, denies the patient access to all possible modalities and settings. One model perhaps that should be looked at is the Joint Commission Accreditation Standards for Psychiatric Facilities. These standards describe settings, staff delineations, case management, patient rights, etc. They take into account all the factors needed to assure sound, quality patient care.

In the fourth and final question, we were asked what procedures exist to assure proper diagnosis and treatment. Emphasis on the team approach in the development of a diagnosis and treatment plan offers the greatest assurance of appropriate care. When one profession or one individual makes all decisions without consultation or assistance, the opportunities for mistakes increase. Ultimate responsibility should not be confused with sole responsibility.

There are several avenues available for assuring proper diagnosis and treatment. For example, the PSRO program provides criteria for admission and discharge procedures. The Joint Commission standards for psychiatric programs delineate staff privileges, utilization review, case management, etc. Public Law 95-142, Education of the Handicapped, leaves to state option the choice of setting and provider. There are many avenues from which to choose the various alternatives available to answer the question. However, no legislative body should endeavor to determine the modalities and treatment settings available. Such decisions must remain in the hands of the professionals.

We look forward to working with you as you deliberate. We welcomed the opportunity to respond.

Sincerely,

NANCY STONE, M.D.,
Washington, D.C.
JOY MIDMAN,
National Association of Private Psychiatric Hospitals.
CHRIS KOYNAGI,
National Council Community Mental Health Centers.
ISABEL BRENNER,
LUDIE WHITE,
Mental Health Association.
WILLIAM STONE, M.D.,
American Association of Psychiatric Services for Children.

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, D.C., July 16, 1979.

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

DEAR MR. CHAIRMAN: On behalf of the American Psychiatric Association, a medical specialty society representing over 25,000 psychiatrists nationwide, I would like to respond to the questions you posed during the recent hearing on the Child Health Assurance Act to the CHAP Coalition, an informal group of national mental health care consumer and provider organizations of which the APA is a part.

While we agree with many of the concepts enunciated in the response submitted to you by several members of the Coalition, we are concerned that such response was not sufficiently directed to the precise questions propounded. We hope to provide further clarification in the following specific responses.

We assume that the questions asked of the CHAP Coalition mental halth witness are restricted to childrean's "mental health problems" in particular.

Question 1. Exactly who would be qualified to diagnose mental illness?

Response. While we do not want to denigrate psychologists, or any other trained non-physicians who engage in the treatment of mental illness, it is critical to recognize that diagnosis should be made by psychiatrists. The psychiatrists, as the result of his or her medical training, is not only trained to do psychotherapy, he or she is also trained to make differential diagnoses, to prescribe medication, and, if need be, to hospitalize a patient for treatment. Medical psychiatric skills are not "substitutable" by those of non-physician mental health professionals in diagnosing mental illness.

As a recent Federal Court decision found: "It is true that both psychologists and psychiatrists professionally render psychotherapy to patients. But in the treatment of nervous and mental disorders, psychiatrists are capable of providing a full range of treatments not just psychotherapy. *In addition, as medical doctors, psychiatrists may render medical treatment and diagnosis. It is undisputed that clinical psychologists are not qualified to diagnose nervous and mental disorders and to decide from what source these disorders stem.*" (emphasis added).

The ability to provide a differential diagnosis, a skill resulting form a psychiatrist's medical training, is of paramount importance since only such a diagnosis will be able to determine if a problem is the result of a physical or mental illness and not minor, transitory mental health (not illness), sociological or educational problems. Moreover, the medical differential diagnosis is equally important in its ability to rule out a positive diagnosis of physical illness as the etiology of a psychologically based problem.

Question 2. Exactly what diagnoses would be considered reasonable and what diagnoses considered unreasonable?

Response. We refer you to the Diagnostic and Statistical Manual II, or its more recent new draft, III, the document utilized by psychiatry and the medical profession to establish diagnoses of mental, nervous or emotional disorder. We believe that diagnoses established in accordance with either DSM II or III, which spell out specific criteria for diagnostic decision-making, are "reasonable" diagnoses.

We assume the use of the word "reasonable" was carefully chosen and our response does not address, therefore, issues of "preciseness," "reliability," "correctness," or "appropriateness" of diagnosis.

A February 3, 1979 article in Lancet, entitled "A Reappraisal of American Psychiatry" notes that realism is replacing the exaggerated claims which were made of psychiatry's ability to produce personal, social and even political change. The diagnostic criteria established under DSM III reflect such realism—demanding a constellation of criteria to be met before a diagnosis may be reached and treatment outcome predicted.

We were pleased by the positive appraisal of U.S. psychiatry in the abovementioned article. We agree with the article's praise for the scientific advances in U.S. psychiatry but realize the need for increased empirical research to provide an even better answer to this question.

Question 3. Exactly who would be qualifed to treat children, and what modes of treatment would be deemed acceptable?

Response. The psychiatrist's role and function remain those of a physician especially trained to administer to the needs of patients suffering from nervous or mental disorders. Child psychiatrists, through specialized training beyond the 4-year psychiatric residency bring such specialized skills to the diagnosis and treatment of children's mental disorders. Non-physicians rendering treatment for mental disorders can bring other, non-medical skills to such treatment.

Historically, psychiatry has recognized and regarded favorably the growing trend to work collaboratively with other physicians and non-medical professionals in the delivery of many services to the mentally ill, once a medical diagnosis has been reached. The help of such non-medical professionals is most valuable in providing specialized skills and services in such areas as clinical testing, casework, administration and basic research; many are also trained to do other than medical psychotherapy.

However, it is critical to emphasize that the psychological and physical components of an illness are intertwined; at any point in the disease process, psychiatric symptoms of an illness may give rise to, substitute for, or run concurrently with physical symptoms; the reverse may also occur.

Therefore, because of such intermeshing of physical and mental illnesses and the growing concern about the maintenance of quality of services to the public—a concern shared by psychiatrists, other physicians and many leaders of the non-medical professions—the APA believes that while the development of a treatment plan for certain mentally ill may be collaborative, while some treatment may be appropriately conducted by other than a psychiatrist, and while a team approach to treatment is often valuable, such treatment plan should be developed and treatment rendered under the medical case management of a psychiatrist.

Insofar as the "modes of treatment which would be deemed acceptable" are concerned, we believe that all medically necessary treatment services (i.e., drug therapy, psychotherapy, psychiatric hospitalization, and others) are "acceptable" modes of treating specific, diagnosed mental illnesses.

A clarifying analogy may help make the distinction between those treatments which we believe are medically necessary and therefore reimbursible, and those which are not clear. The physician of a football player who exercises regularly to keep fit would not be providing a medically necessary treatment services to that football player by encouraging such exercise. A physician who conducts with that same football player a regimen of exercise after the player has undergone knee surgery is providing appropriate, medically necessary treatment for the elimination of a disorder.

Question 4. In view of the potential for improper or unjustified diagnosis of mental illness in a child, exactly what procedures are established for independent personal examination of a child by qualified people other than the person making the diagnosis?

Response: Since psychiatry, as all medicine, is not entirely a precise science but to a significant degree an art, there is a potential for misdiagnosis. Indeed, as noted in the Textbook of Medicine: "Medicine is not a science, but a learned profession deeply rooted in a number of sciences and charged with the obligation to apply them for man's benefit. . . . Thus, the responsibility of medicine (is) . . . to judge the moral and ethical propriety of each medical act that directly affects another human being."

"Improper" or "unjustified" diagnoses, if the imputation of premeditation is intended, stand in opposition to the proper practice of medicine, and are unethical per se.

To avoid the inappropriate labeling of a child as mentally ill—whether as the result of misdiagnosis or purposive "improper or unjustified diagnosis"—the APA has long supported, and indeed been in the forefront of peer review. We are particularly sensitive to such issues, since, regrettably, mental illness remains a stigma. We would support the concept of second opinions to assure that a child is not inappropriately stigmatized with the label of mental illness, just as we would support similar activities across all medical diagnoses of consequence. Other helpful efforts might include utilization review and greater support for peer review and physician continuing education.

We hope you will make this response part of the hearing record.

Sincerely,

MELVIN SABSHIN, M.D.,
Medical Director.

NATIONAL ASSOCIATION OF
STATE MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C., July 19, 1979.

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

DEAR SENATOR TALMADGE: This is in response to the four questions you posed to the coalition of mental health organizations during the recent Senate Finance Committee Hearings on the Child Health Assurance Program—S. 1204 (June 25, 1979).

The directors of state mental health services for children and youth have reviewed those questions and on behalf of the state mental health program directors submit the attached response.

These answers to your questions are submitted for the present and future record even though the Finance Committee has already reported out the CHAP bill.

The issues you raise are valid and will be relevant for a long time whether or not CHAP becomes law and whether or not mental health coverage for children under CHAP is good, bad or indifferent.

For this reason we want you and your staff to have the position of the state government mental health programs.

Sincerely,

HARRY C. SCHNIBBE,
Executive Director.

NASMHPD RESPONSE TO SENATE FINANCE COMMITTEE ON MENTAL HEALTH COVERAGE UNDER CHAP

A coalition of mental health organizations presented testimony before the U.S. Senate on the child health assurance program. At the conclusion of the oral statement Senator Talmadge posed 4 tough questions relating to the scope of mental health coverage under "CHAP." The coalition witness deferred from presenting an answer preferring the M.H. organizations confer and prepare a written response.

U.S. Senate Finance Committee asks: "Exactly who would be qualified to diagnose mental illness?"

NASMHPD responds:

(1) The final diagnostic decision on a mentally ill/psychotic child should be the responsibility of a psychiatrist (or any other professional certified as qualified to treat mentally ill children by state statute or by the State Title XIX plan) providing the psychiatrist and/or other certified professional meet the following qualifications:

have an M.D. or a graduate degree in a mental health specialty from an accredited educational institution, as a minimum

have at least two years of demonstrated, supervised mental health experience following the graduate degree

be designated as a qualified professional through an approved validation program developed and administered under the auspices of the appropriate national professional organization

be licensed/statutorily certified in state

be relicensed/statutorily recertified as required by the state. Meet state requirements for maintenence and improvement of professional competence (contingent upon demonstrated, competent practice and continuing education according to established standards developed by the national professional organization).

(2) Diagnosis also should be a composite decision which is derived from input from a team of qualified mental health professionals, and may include input from psychiatrists, psychologists, psychiatric social workers and nurses.

U.S. Senate Finance Committee asks: "Exactly what diagnoses would be considered reasonable and what diagnoses considered unreasonable?"

NASMHPD responds: "Reasonable diagnoses" would be those contained in the American Psychiatric Association's "Diagnostic and Statistical Manual II" or other diagnostic manual(s) that a state deems to be equivalent.

U.S. Senate Finance Committee asks: "Exactly who would be qualified to *treat* children and what modes of treatment would be deemed acceptable?"

NASMHPD responds:

(1) Of equal importance to identification of specific treatment personnel is the development of an "individualized plan of treatment" with appropriate professional input and review.

(2) Professionals deemed qualified to carry out the objectives of the "individualized plan of treatment" are psychiatrists, psychologists, social workers, nurses and other disciplines as might be designated in state statute or the Title XIX plan providing they met the following criteria:

have an M.D. or a graduate degree in a mental health specialty from an accredited educational institution, as a minimum

have at least two years of demonstrated, supervised mental health experience following the graduate degree

be designated as a qualified professional through an approved validation program developed and administered under the auspices of the appropriate national professional organization

be licensed/statutorily certified in state

be relicensed/statutorily recertified as required by the state. Meet state requirements for maintenence and improvement of professional competence (contingent, upon demonstrated, competent practice and continuing education according to established standards developed by the national professional organization).

(3) Modes of treatment would include individual, group and/or family therapy in the most appropriate (least "restrictive") setting and include periodic peer review.

U.S. Senate Finance Committee Asks: "In view of the potential for improper or unjustified diagnosis of mental illness in a child, exactly what procedures are established for independent personal examination of a child by qualified people other than the person making the diagnosis?"

NASMHPD responds:

(1) Requires states to establish and implement state and local (facility) level utilization and diagnostic review procedures. Such requirements are already in place in facilities accredited/certified for participation in the Title XIX program for inpatient psychiatric services for children under age 21.

(2) Option to build a "second opinion" into the CHAP program particularly if the involved choice of treatment includes placement in a "restrictive setting" (inpatient facility).

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY,
Washington, D.C., July 16, 1979.

Senator HERMAN E. TALMADGE,
Chairman, Senate Finance Health Subcommittee,
U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: We are responding to four questions concerning S. 1204, the Child Health Assurance Act of 1979. The questions were posed by you to an ad hoc CHAP coalition during hearings on June 25, 1979.

These answers are submitted for the record though rendered moot by the Committee's precipitous resurrection and reporting out of the 1978 Senate bill which was not supported by one single witness in the course of the Committee's hearings this year.

Following are the questions and our responses:

1. Exactly who would be qualified to diagnose mental illness?

2. Exactly what diagnoses would be considered reasonable and what diagnoses considered unreasonable?

3. Exactly who would be qualified to treat children, and what modes of treatment would be deemed acceptable?

4. In view of the potential for improper or unjustified diagnosis of mental illness in a child, exactly what procedures are established for independent personal examination of a child by qualified people other than the person making the diagnosis?

1. Proper diagnosis is the key to determining the most effective treatment for both physical and emotional illness. This is particularly true in cases of the latter, where similar symptoms may be manifested for a variety of problems. Children with emotional problems often use physical symptoms as an outlet. This circumstance sometimes makes it difficult for parents or teachers to recognize the emotional nature of the child's difficulty. Moreover, while physicians are trained in medicine, they are not required to have any education, training or expertise in dealing with human behavior, particularly mental and emotional problems. In order to avoid inappropriate diagnosis—and more important, ensuing improper treatment—the child must have access to a qualified mental health diagnostician who has received his or her training under rigorous standards.

We can speak only for psychology in this question. Clinical psychologists must fulfill extensive educational requirements, including a minimum of four years of study plus a clinical internship. Professional psychological training is designed to develop in practitioners the ability to understand another person's difficulties far more fully than any but the most unusually intuitive and sensitive nonprofessional. This training also provides techniques for communicating this understanding in ways the other person can comprehend and accept. The more extensive the training the more flexible he or she can be in employing the most appropriate help for each individual and each condition. For this reason, the professional standards for psychologists demand extensive study of the different theories, diagnostic tools and treatment approaches which have proven successful.

Because of this extensive training, child psychologists are especially attuned to the needs of younger people. Children's mental health needs differ greatly from those of adults and children require a qualified practitioner such as a clinical psychologist to recognize and diagnose their particular emotional problems.

2. Although there are existing diagnostic guidelines for mental illness, we seriously question the wisdom of adopting them as federal standards. The DSM manuals and the GAP manual all are highly controversial. Few mental health professional organizations, including both the American Psychological Association and the American Psychiatric Association, have adopted the GAP instrument, and although the DSM III currently is being considered, one of the major points of controversy is in the area of labeling children's behavioral and emotional conditions.

The risk of assigning a permanent incorrect label to an individual increases dramatically when the DSM or GAP or other such methods are used. It is our belief that the most appropriate and effective diagnosis is one that is based on a functional assessment of the child's problem, rather than attempting to conform the child's condition to some pre-determined category set forth in one of the diagnostic manuals.

We recommend that CHAP include a provision similar to the definition of developmental disability contained in P.L. 95-602, which describes a condition that: (D) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction.

3. Within each of the four core mental health professions—psychologists, psychiatrists, psychiatric social workers and psychiatric nurses—there are amply qualified practitioners who offer a wide range of treatment services. By including all four

groups, CHAP will assure access to a comprehensive, and thus most effective, mental health program.

In recent years, the frequency of hospitalization for mental illness has decreased as it has been shown that ambulatory facilities are effective settings for providing treatment. Particularly for children, because their problems are identified early in life, when the problems are perhaps not yet so thoroughly entrenched as to require residential care, outpatient facilities such as CMHC's are ideal settings for CHAP to cover. The requirement for inpatient care among the CHAP age group is not statistically identified, but we believe that there are some severe conditions for which CHAP should cover inpatient services.

4. A peer review system is the most effective method of reducing the potential for improper or unjustifed diagnoses of mental illness in a child. A review panel consisting of representatives from the four core mental health professions would insure integrity and reduce the margin of error in diagnostic procedures.

Thank you, Mr. Chairman, for the opportunity to respond to these questions. If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

CLARENCE J. MARTIN,
Executive Director and
General Counsel.

Senator TALMADGE. As you know and as I pointed out earlier people in the mental health professions disagree on what is acceptable and what is not acceptable. I have only one other question. Do you know of any mental health centers where unqualified personnel are providing service?

Dr. STONE. From my personal knowledge, no, I don't.

Senator Talmadge. Thank you very much. I appreciate the contribution you have made to our deliberations and if you will respond to my other questions for the record I will be grateful.

[The prepared statement of Dr. Stone follows:]

STATEMENT OF NANCY STONE, M.D., MH CONCERNS, AND NANCY PORTER-MORRILL, DD CONCERNS, ON BEHALF OF THE DD/MENTAL HEALTH CHAP COALITION

ORGANIZATIONS CONCERNED WITH DEVELOPMENTAL DISABILITIES

American Speech-Language—Hearing Association.
Epilepsy Foundation of America.
National Association for Retarded Citizens.
National Association of State Mental Retardation Program Directors, Inc.
National Easter Seal Society for Crippled Children and Adults.
National Society for Autistic Children.
United Cerebral Palsy Association.

MENTAL HEALTH ORGANIZATIONS

American Academy of Child Psychiatry.
Association for the Advancement of Psychology.
American Association of Children's Residential Centers.
American Psyschiatric Association.
American Psychological Association.
Mental Health Association.
National Association of Private Psychiatric Hospitals.
National Association of State Mental Health Program Directors.
National Council of Community Mental Health Centers.
National Congress of Parents and Teachers.
American Association of Psychiatric Services for Children.

SUMMARY

PART B—DEVELOPMENTAL DISABILITIES

1. Mentally ill children need a full range of services to ensure adequate treatment.
2. Mental health services are cost effective.
3. The CHAP Coalition is opposed to any limits on amount, duration and scope of inpatient and outpatient services.

4. *Recommendations:* S. 1204 should be amended to:
   (a) provide coverage without limit on amount, duration and scope for services furnished in organized care settings meeting the federal definition of a community mental health center or standards established by the Secretary;
   (b) authorize coverages of inpatient psychiatric benefits in accredited mental hospitals and residential treatment centers as well as in general hospital psychiatric units which have been appropriately accredited;
   (c) mandate that HEW insure realistic Medicaid reimbursement rates for qualified health and mental health providers.

PART B—DEVELOPMENTAL DISABILITIES

1. Developmentally disabled children require the full range of services, without limitations on amount, duration or scope of such services.
2. Early intervention does save money.
3. Coverage for pregnant women can prevent disabilities.
4. Removing requirements for a formal health assessment prior to treatment make services more accessible.
5. Effective outreach is essential to ensure that children get health services.
6. State plans for CHAP should require consumer participation in the development of the plan.
7. Reimbursement rates should be adequate and structured in such a way as to encourage provider participation.
8. Penalties for non-compliance should be levied on program administrative costs.
9. *Recommendations:* S. 1204 should be amended to:
   (a) provide all optional services to disabled children, with no limitations on amount, duration and scope, including inpatient care;
   (b) strengthen requirements for an effective outreach program;
   (c) provide for consumer participation in the development of a CHAP plan;
   (d) mandate that HEW insure realistic and appropriate reimbursement rates for qualified health and mental health care providers;
   (e) levy penalties for non-compliance on administrative costs—not service dollars.

STATEMENT

Mr. Chairman, I am Nancy Stone, M.D., child psychiatrist, project director of two projects concerning mental health and development of pre-school infants and preschool children. One deals with recommendations regarding the developmental assessment component of EPSDT and the other mental health primary prevention effort of Head Start. I formerly served as director of retardation services, Gulf Coast Regional Mental Health/Mental Retardation Center and served as associate professor in the department of community psychiatry at the University of Texas Medical Branch. Prior to that time, I was in private practice and served at one time as an instructor in the department of psychiatry at Louisiana State University School of Medicine in New Orleans, where I was a resident in both pediatrics and psychiatry.

Today I am representing a coalition of consumer and service provider organizations concerned with mental health and developmental disabilities. I am speaking on behalf of the groups listed on the front of this statement and ask that all their names appear and be included in the official record with our full statement. These groups have been working for more than a year in an ad hoc CHAP coalition to improve health and mental health care for our children. As a coalition, we support full and equal coverage for mentally ill and developmentally disabled children. We are opposed to limitations in the Administration's bill, S. 1204, on amount, duration and scope of health and mental health services.

The first part of this statement addresses mental health concerns and the second part developmental disabilities issues.

PART A—MENTAL HEALTH

Nine years ago the Joint Commission on Mental Health of Children stated in its report: "One of our major thrusts must be identification of mental and physical disorders in the earliest stages of life—ages 1 through 5. We must detect and treat malfunctioning before it freezes into severe disorder. Failure to provide new and reordered resources will most certainly result in another generation of children with large numbers not able to 'make it'."

Unfortunately these findings are still valid. As many as 9.6 million children suffer from varying degrees of emotional problems, and less than 10 percent of children with such problems are receiving adequate help. Three times as many children committed suicide last year as did ten years ago. The U.S. Civil Service Commission on Civil Rights reported that children are receiving mental health services at one third the rate of the 22-44 age group.

The children who suffer from mental illness and developmental disabilities have all too often been relegated to second class citizenship in programs in which children themselves are afterthoughts, appended to larger health programs. The Child Health Assurance Program (CHAP) could provide a first step to ensure that developmentally disabled and mentally ill children do not suffer from discriminatory provisions.

Diagnosis and treatment of mental, developmental and emotional illnesses among children are the first line of prevention—one of the stated purposes of CHAP. We wish this committee to understand an important consequence of delayed treatment. A child suffering from a mental disorder will have concomittant developmental problems. If his disorder goes untreated, the developmental lag will be significant enough to become a problem in and of itself. In treating a four-year-old psychotic child, a clinician must deal not only with the psychosis, but also with the consequences of a significant period of time when development has been stopped, regressed, or retarded. The committee should further realize that to a four-year old, even six months is a significant period of time—it is one-eighth of a child's lifetime.

Experience indicates that failure to provide a full range of treatment opportunities has already had severe consequences and will continue to have a damaging effect in future years. However, if a child's mental or emotional illness is attended to as near as possible to its inception, the result will be more normal development through childhood and a far better chance for later entry into society as a productive adult.

Conversly without early treatment such children often do not succeed academically, often drop out of school, and often become a burden within either the social service or juvenile justice system. We cannot begin to estimate the numbers of such children who might have been diverted from years of inappropriate institutionalization or from the criminal justice system if they had been able to receive early diagnosis a timely care. It should be realized that early and appropriate intervention can safeguard against the inception of a chronic mental illness.

The concept of early screening diagnosis and treatment is perhaps one of the most cost-effective ways of dealing with the health, both physical mental, of children. Not only is it less costly to deal with both physical and emotional problems in their early stages, but it is also perhaps one of the best ways to produce healthy adults who can be productive in our society. Failure to provide treatment for the child diagnosed as mentally ill, or developmentally disabled, while saving dollars initially, will clearly cost the Federal government more in the long-run, whether in future, higher health care costs or in social service or juvenile justice system dollars.

The proposed CHAP legislation is intended to replace the current Medicaid/EPSDT program. The declared purpose of the EPSDT legislation, enacted in 1967, was to provide health checkups and subsequent treatment to approximately 13 million children and youth under 21 whose families could not afford basic health care. It had the potential to provide the services so vital to the well-being of children. Our physical and mental well-being are certainly completely interrelated. However, the program today, by the Administration's own estimates, reaches only 30 percent of those currently eligible children. Moreover, 22 percent of those screened and found to be in need of treatment do not receive the kinds of services required to ameliorate the physical or mental problems identified.

It has been widely recognized that the EPSDT program has not been working; that data are not available with regard to the scope, quality and extent of treatment provided; and that programs vary in quality from state to state based upon what is in the state plan.

Such unfortunate problems with EPSDT have particularly significant for the mentally ill child.

The proposed Child Health Assessment program can vary well correct the inadequacies and inequities of the original legislation by addressing the need of providing a comprehensive health service system for children. This system will not only provide health care but assures health assessments, diagnosis, treatment and periodic reassessment to all eligible children. We believe, however, to be truly comprehensive it must mandate treatment for all diagnoses, be it mental, emotional, or physical. To do otherwise is discriminatory.

All major health problems are compounded by poverty and the CHAP legislation has a real opportunity to raise the level of physical and mental health of children who could not afford care otherwise.

The Administration's bill (S. 1204) sponsored by Senator Ribicoff, who was so deeply involved in the Joint Commission on Mental Health of Children, is a significant improvement over previous legislation. S. 1204 does not discriminate against mentally ill children, but yet does not mandate inpatient services in mental hospitals and allows for limits on the amount, duration, and scope of mental health services. We appreciate this move forward but hope that this committee will go further and adopt the recommendation of the Joint Commission and the President's Commission on Mental Health to give full and equal coverage to mentally ill children.

Coverage of ambulatory services

The singling out of mental health clinics in the Administration's bill for limitations on covered services provided to mentally ill children is particularly puzzling. Third-party reimbursements, including Medicaid, are critical to the long-term survival of these programs. A recent GAO report concluded that "State, local, and third-party revenues (client fees, private insurance, Medicare and Medicaid) must increase so that existing centers may become financially viable."

Although state, local and federally-funded community programs provide substantial services to children, there is still a serious shortfall nationwide between the need and the services these programs are able to provide. There are many reasons for this. Some programs have failed to give sufficient attention to the needs of children.

Reimbursement programs, including Medicaid, tend to impact upon the type of service which can be provided. Under Medicaid, for instance, 13 states have elected not to provide clinic services from their Medicaid plans. Certain mental health services are also often excluded under Medicaid plans, including one which is particularly important for children—day treatment (excluded in 1975 in Alabama, Maine, Maryland, Virginia and other states). Advance review and approval are sometimes required of mental health services but not of other Medicaid services. Services furnished by non-physician professionals is not reimbursable, sometimes even when furnished under the supervision of physicians.

The Federal government has already invested more than $1.5 billion in the current community mental health center (CMHC) program and in those same centers the state, local and county governments have invested $2 billion on top of that.

Existing CMHCs, state and local community based programs, the proposed new agencies, and other mental health service organizations offer many advantages in dealing with the mentally ill child. Through these local, organized care settings, comprehensive services are made available—including prevention, consultation and education, various ambulatory care services such as emergency, outpatient and partial hospitalization, and inpatient care.

One advantage of covering organized care settings under CHAP is accessibility. Frequently these programs are the only services available within rural or inner-city areas. To limit services covered in organized care settings further discriminates against those children living in areas with few, if any, readily accessible health services.

Thus, coverage of ambulatory care services in organized care settings, would increase the availability of appropriate services for these children.

Cost effectiveness

Perhaps the most critical question which arises when full coverage of mental health services is proposed is cost. However, numerous studies have demonstrated that coverage of mental health services reduces utilization of other health services and in fact reduces the total cost of health care.

A study specifically concerning children, "Effects of Psychological Treatment on Medical Utilization in Multi-disciplinary Health Clinic for Low Income Minority Children" is appended to our testimony. This study identified how treatment for mental health problems can significantly reduce medical care utilization costs. This study broke new ground for children as it was in a completely subsidized setting. There was a 36 percent decrease in the number of medical visits by those children who had an average of 4.9 mental health treatment sessions. The matched control group who received no mental health treatment increased their medical visits by 30 percent.

Other studies have shown similar findings:

1. In Texas, a longitudinal study (1973-1977) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean lengths of stay in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

2. Group Health Association of Washington indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and x-ray services declined by 29.8 percent.

3. Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.

4. Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psycho-therapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06.

5. A study by Rosen and Wiens at the Medical Psychology Outpatient Clinic at the University of Oregon Health Science Center studied both children and adults (using a control group) and found significant group effects for changes in the number of medical outpatient visits, pharmaceutical prescriptions and diagnostic services. For each of these three measures, those receiving mental health services reduced their use of medical outpatient services by 41 percent. Data indicated that this change was taking place with all patients, not just high-utilizers of medical services.

Coverages of inpatient services

The specific exclusion for inpatient psychiatric benefits in settings other than general hospitals continues to be discriminatory and ignores the wide range of quality services available.

The attached Medicaid chart indicates 20 States and 2 territories do not opt to provide care for children under 21 in psychiatric hospitals. As CHAP attempts to form a comprehensive delivery system for a specific target population, it should not continue the delivery care patterns of Medicaid.

Children should not be channeled into only limited types of psychiatric care. They should have access to all effective modalities which, depending upon the age and individual needs of the child, may be more effective and appropriate. It should be noted that most emotionally disturbed or developmentally disabled children will not require inpatient treatment. Only the most disturbed children with obvious severe behavioral disorder of long standing duration and those in need of immediate intensive services for crisis intervention will require highly structured concentrated treatment.

Legislation must allow such children to be cared for in the inpatient environment which is more appropriate to the individual child's need, and must not limit access to only inpatient units of general hospitals.

Thus, we propose that when inpatient treatment is necessary, any psychiatric facility including children residential treatment centers and free-standing psychiatric hospitals, which are subject to the children and adolescent psychiatric standards of the Joint Commission on Accreditation of Hospitals, be included as an accepetable setting of treatement under CHAP.

Therefore, we propose that inpatient psychiatric services under CHAP be mandated in any setting which is accredited under the appropriate standards of the Joint Commission on Accreditation of Hospitals (JCAH). Specifically, this would mean that a general hospital offering such services to children or adolescents would be accredited programmatically according to the children and adolescent psychiatric program standards of the JCAH Accreditation Program for Psychiatric Facilities. Similarly, the same criteria would apply to private and public psychiatric hospitals or residential treatment centers for children.

The bottom line is that appropriate accreditation assures sophisticated treatment planning, admission triage, treatment review, discharge planning, and follow-up. This care and treatment should be consistent regardless of setting.

Reimbursements

Under Medicaid, the reimbursement rate for treatment is generally so low that there is no incentive to treat any child and certainly no incentive to treat the emotionally disturbed or developmentally disabled. For example, in 1975, Virginia reimbursed $7 per hour for group therapy. Many States reimburse clinics at rates substantially below cost. The GAO report cites such problems, including reimbursement rates set ten years ago and never increased. Arbitrary limits are set on the length of treatment, either through limits on numbers of visits or through a total reimbursement limit to any one program.

To prevent the same situation from occurring under CHAP, the legislation should mandate HEW to insure realistic Medicaid reimbursement rates for qualified health and mental health providers.

Schools as providers

We are concerned with the designation of schools or school systems as providers. For the purposes of outreach, schools are excellent; they are frequented by both children and their parents and provide a familiar, nonthreatening setting at which CHAP services could be delivered. However, if schools are to be deemed eligible providers, we recommend the legislation be amended to provide that medical services delivered in such settings must be administered by qualified health and mental health professionals, or that contractual arrangements between schools and qualified health and mental health providers be made and honored. Safeguards must also be provided to assure that any child receiving mental health services in a school, through CHAP, will not be stigmatized because of his emotional illness. The fact that he or she needs and/or is receiving such services must be kept confidential as must all records of the health or mental health services with which the child is provided.

Confidentiality

Provisions to protect the confidentiality of children receiving services through CHAP must be included in the legislation. Also, as data are collected for reporting purposes, provision must be made to assure confidentiality for children and their families. No patient identifiers should be included as data is collected.

Recommendations

The proposed CHAP legislation could do much to increase access to a full range of mental health services by children of low-income families. The groups supporting this statement urge the committee to build upon the legislation pending before the committee by:

Providing coverage without limits on amount, duration and scope for organized care settings meeting the Federal definition of community mental health center and for other organized care settings meeting standards prescribed by the Secretary.

Authorizing coverage of inpatient psychiatric benefits in accredited mental hospitals and residential treatment centers, as well as in general hospital psychiatric units which have been appropriately accredited under psychiatric standards.

Mandating that HEW insure realistic Medicaid reimbursement rates for qualified mental health providers.

Since children are our greatest resource and our future, the investment needed to mandate a full range of mental health services for children seems small compared to society's costs incurred by children denied early and appropriate screening, diagnosis and treatment.

As Senator Ribicoff stated in the foreword to the 1969 publication "Crisis in Child Mental Health: Challenge for the 1970's": . . . Thus the American public faces a double challenge—the challenge for the caring of the child who is already sick and in need of help, and the challenge of preventing sickness by fostering healthy growth . . . societies can be judged on how they care for their children. The Joint Commission asks us to judge ourselves and act upon our verdict."

Mr. Chairman, 10 years has passed since Senator Ribicoff made this statement. It is time to act.

Thank you.

PART 8—DEVELOPMENTAL DISABILITIES

Mr. Chairman and members of the Subcommittee, the organizations concerned with developmentally disabled children participating in the CHAP Coalition would like to commend the Subcommittee for its keen interest and concern for the health of our nation's children. The Child Health Assurance Act (S. 1204) sponsored by Senator Ribicoff and other distinguished members of this body, will ensure that no disabled child goes without necessary care and treatment.

The Child Health Assurance Program will help to "fine tune" the Medicaid Early, Periodic, Screening, Diagnosis and Treatment program (EPSDT), which has thus far failed to reach many of the children who are desperately in need of health care. We know for a fact that there are children in our country who go without the basic preventative care and treatment which can mean the difference between suffering and disability and a healthy impairment-free life.

It has been well documented that disabling conditions occur with greater frequency among the low-income children which EPSDT is designed to serve. Such conditions often first appear during infancy or the preschool years. Without immediate and ongoing therapeutic intervention, these conditions will become permanently disabling. It is particularly important that children with conditions specifically related to problems of growth and development, including autism, cerebral palsy, epilepsy and mental retardation, be eligible to receive a full range of health services so as to ensure the amelioration of their condition before damage or degeneration becomes irreversible.

SERVICE/ELIGIBILITY CONCERNS

CHAP services for developmentally disabled children

We are pleased that Mr. Ribicoff's CHAP proposal (S. 1204) has expanded the number of services covered by Medicaid for eligible children by including prescription drugs, immunizations, vision and hearing services and dental care. However, S. 1204 fails to mandate coverage of other optional Medicaid services that are essential for a developmentally disabled child.

It is important to be aware that many of the health services a developmentally disabled child needs may not be included under a state's Medicaid plan. In fact, many states have chosen not to cover these "optional" services or cover only a few of them. Consequently, the availability of health service varies considerably from state to state. We have attached a chart to this statement showing which optional services states covered in 1978. As you can see, there is a considerable disparity between the types of services offered in each state.

We would like to emphasize that for a developmentally disabled child, optional Medicaid services such as physical therapy, speech-language pathology services, orthopedic devices, mental health care and other screening, preventative, diagnostic and rehabilitative services are essential to his or her health and well being. For example, it is estimated that almost three-fourths of the persons with epilepsy have multiple handicaps. This means that, in many cases, bringing a child's seizures under control will solve only half the problem if other services such as speech therapy or rehabilitative programs are unavailable. Moreover, it does not make sense to provide a child with cerebral palsy or other crippling conditions with basic health and dental care while ignoring his or her need for physical therapy.

It is important that developmentally disabled children have access to the kinds of medical services that are appropriate to their needs. We therefore encourage that the broadest possible coverage for all eligible children be provided under CHAP.

Current regulations state that Medicaid services provided by a state must be sufficient in amount, duration, and scope to reasonably achieve their purpose. In other words, states have been allowed to set certain limits on health services. It is important to note that while developmentally disabled children share the same needs for basic health care as other children, in some cases their special problems require different kinds of treatment. For example, some states place strict limits on the kinds and/or amounts of drugs covered under the Medicaid program. Yet 71 percent of all children with epilepsy require two or more drugs, some of which a state may not make available, to control their seizures. While the annual cost of this medication averaged only $188 per year in 1977, it is essential that these children have access to all the types of drugs they need, with no restrictions, to prevent the recurrance of uncontrolled seizures.

To allow limits to be placed on the delivery of health services undermines the receipt of necessary care and virtually assures that the children who need services the most will be made to suffer.

We are adamantly opposed to a limitation on inpatient care, and we must question whether basing that limitation on a specific handicap (mental illness or mental retardation) is not in fact a violation of section 504 of Title V of the Rehabilitation Act. Once again, we realize the motivation is to limit costs but we would like to point out that the majority of mentally retarded and mentally ill children do not require costly, long-term, inpatient care. For most, no inpatient services are required; for others, structured, twenty-four hour intervention for a relatively brief period (not a lifetime) can mean the difference between being able to function in the community and being relegated to custodial care in an institution—another instance of when the costs of "saving" money are incalulably high.

Let me give you an example. Zandy, a youngster with autism, was in a twenty-four hour program in a near-by state. We are not identifying the state because its service problems are not unique to it, nor are they entirely its fault.

Zandy's program was only partially paid for with public money; the education component was covered by state and federal funds, but not the medical costs. His parents had health insurance, but like most policies, its mental health coverage was limited. They were billed for the difference, could not pay it all, and ran up a debt to the state of several thousand dollars. Zandy was transferred to a less costly, and much less appropriate facility. His new program was for less handicapped children; its staff/patient ratio was too low and its program totally inadequate. Within a month, Zandy was dead. He had wandered away into a near-by woods during an outdoor playtime (autistic children are notorious for their ability to disappear unnoticed and walk for miles); after two days of wandering, he became mired in a muddy swamp where, after another twenty-four hours of misery, he died—not of suffocation, but exposure.

Treatment does save money

Untreated disabilities do not disappear. Without necessary health care most disabling conditions become worse, and thus more costly to treat.

Early intervention and follow-up can prevent the development of some forms of developmental 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 occurrance); 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). For example, the availability of neonatal intensive care and follow-up services to low-income high-risk newborns has reduced the incidence of spastic diplegia (a severe manifestation of cerebral palsy) from 80 per 1,000 to 10 per 1,000 within the past few years. Such a reduction through appropriate early intervention and treatment has saved thousands of medical dollars and untold costs in human suffering.

Expenditures for special education can also be reduced by providing early and appropriate care for a disabled child. The Congressionally Mandated Commission for the Control of Epilepsy and Its Consequences estimated that 80 to 90 percent of all children with epilepsy could attend regular school in lieu of more costly special education if given early treatment.

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.

Coverage for pregnant women

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 poisoning and mercury toxicity, and and above all, lack of or insufficient use of health services.

We endorse the CHAP proposal to include coverage for pregnant women. HEW estimates that some 25,000 women with incomes below the poverty level are not covered by Medicaid. The chances are good that these women are not receiving adequate prenatal care. Injury, infection, or systemic illness of the mother during pregnancy can cause an otherwise healthy baby to be born disabled. In addition, teenage pregnancies present a growing concern since children from such pregnancies have a greater chance of developing a handicapping condition. It is a fact that the number of mentally retarded children born to teenage mothers is seventeen times as high as the national average. Adequate medical care during pregnancy can prevent needless disability. Moreover, it is important that this most basic aspect of prevention, good prenatal care, be available to all low-income women regardless of the family structure or the fact that it is the first pregnancy.

Health assessments

We would like to note that Mr. Ribicoff's CHAP proposal will eliminate a significant barrier to the receipt of services for all children, including the developmentally disabled. S. 1204 will allow eligible children to receive certain health services regardless of whether or not they have gotten a formal health assessment. Since only a fraction of the eligible children are being assessed through the EPSDT program, many are not receiving preventative or routine health care. It is important that children not be required to wait for a health assessment before seeking health or dental services. The requirement that a child receive a formal assessment prior to receiving care virtually assures that there will be a significant gap between the onset of the illness or disability and treatment. Moreover, such delays can aggravate the condition making it more costly to treat, and increase the likelihood that the child will not be returned for treatment at all.

ADMINISTRATIVE CONCERNS

Outreach

Only about one-quarter of the eligible children are screened under the EPSDT program. We believe that effective outreach is essential if CHAP is to actually reach the women and children it is designed to serve. Increasing the Federal share of outreach costs will offer states an incentive to develop outreach programs. However, certain minimal guarantees are necessary to ensure that states design and implement effective outreach programs. States need to be required by law to identify and provide treatment for a reasonable proportion of the eligible women and children in their jurisdiction.

First, we encourge more effective utilization of the present service delivery system with stronger requirements for individual personal contact. In testimony before a House Subcommittee last month, Secretary Califano announced that beginning immediately, eligible children identified in other health, education, and welfare programs would be automatically enrolled in EPSDT. We believe this approach should be incorporated as a mandatory provision of whatever CHAP legisla[illegible] is enacted.

Second, we encourage the use of community based organizations including non-profits for the provision of outreach and follow up services. Community organizations often have established information networks that are familiar and comfortable to neighborhood residents. Such organizations can be an invaluable resource for informing and inducing families to take advantage of CHAP services. Moreover, the use of community based organizations offers a desirable alternative to strict reliance on large, distant, and often impersonal state and/or welfare agencies for providing families with information about CHAP and assuring that these families do in fact receive services.

State plan requirements

We enthusiastically endorse the inclusion of provisions in the CHAP legislation that would strengthen state planning requirements by providing for substantial public input in the development of the state plan. Advocates for developmentally disabled children both parents and professionals, should be encouraged to become part of the planning process for CHAP services. These individuals are a valuable resource for informing the community about the availability of CHAP services. In addition, parents and professionals who understand the special needs of disabled children will help ensure that a state develops and effectively implements a CHAP program that will meet the needs of developmentally disabled children. For these reasons, we strongly support the state plan requirements in the Waxman/McGuire CHAP bill, HR 2461.

Reimbursement rates

Because states, under CHAP, will be required to provide more services (we hope) to more children if is essential that they receive adequate federal support. We endorse the initial 4 percent increase called for in all three bills and the concept of an increased match based on subsequent performance. However, requirements for maintenance of state effort must be built into the program, so that the increased federal share swill not result in the same level of service at less cost to the states. In addition, we would urge the adoption of incentives in S. 1204 to encourage the participation of continuing care providers and allow such providers to be compensated for essential services such as case management. Moreover, reimbursement rates should not be rigidly set by service, but should reflect the actual costs involved in furnishing a particular service.

Penalties for noncompliance

Penalties for non-compliance or substandard performance should penalize the party at fault, not the victim. Mr. Ribicoff's bill would do the latter by withholding service dollars from populations already inadequately served; the state would be no more than a conduit for this inequity. We urge the adoption of the methods called for in Mr. Carter's (HR. 2159) and Mr. McGuire's (HR. 2461) bills: a reduction in the federal share of administrative cost. That, coupled with strong maintenance of effort language, will prevent subversion of the intent of this legislation.

Current Federal programs do not meet the health needs of disabled children

Unfortunately, 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.

Crippled Children's Services are a case in point. States must provide evaluations but may select which services they will provide and which disabilities they will cover. For example, some states have elected to restrict the type and duration of restorative services they will provide for mentally impaired children, even though those children may be eligible because of a physical handicap. Then there is the additional restriction of income eligibility, which varies from state to state. In our mobile society, it is well within the realm of probability that a child receiving needed care could, by virtue of his family's moving to another state, lose all those medical services even though the family's income remained the same.

Another example of our half-hearted approach to health care are the restrictions written into section 1615B of Title XVI. The intent of the program, to habilitate low-income disabled children, is excellent; however, services (medical and habilitative) are limited to SSI children six years old and younger (with some exceptions) on the assumption that children above that age are in school and therefore fully served. Yet, the regulations for P.L. 94-142 specifically prohibit the provision of medical services with education dollars. These services are also reserved for children who will have the best chance as for self-sufficiency as adults; translated, that of course means the least impaired. In our legislating for human need, we have acquired a remarkable ability to disqualify those most in need, while giving the appearance of responsible beneficence.

Part of the problem is that we are not fully comfortable with spending monies from one pot to reduce expenditures from another. Many children with epilepsy could attend regular school, thus saving thousands of education dollars per child, if their seizures were controlled through the expenditure of relatively modest amounts of health dollars. Yet, when a state does not cover prescription drugs, or requires a co-payment for them, or discontinues payment due to a modest increase in the family's income or—worse yet—because the seizures are controlled, it believes it is saving money. No one ever seems to look beyond his immediate area of responsibility to assess the real costs of an apparent "saving."

CHAP, on the other hand, assures that a uniform package of health services, will be made available to all children. Moreover, since eligibility criteria and mandated services will be exactly the same throughout the country, a strong Child Health Assurance Program will prevent disabled children from "falling through the cracks" in our present health care system.

In conclusion we urge approval of legislation which:

makes all necessary care and services available to developmentally disabled children,

removes limitations on the amount, duration and scope of such services, including inpatient care,

includes coverage for pregnant women,

mandates that HEW insure reimbursement rates that encourage providers to treat disabled children,

assures an effective outreach program,

includes provisions for public participation in the development of a CHAP state plan,

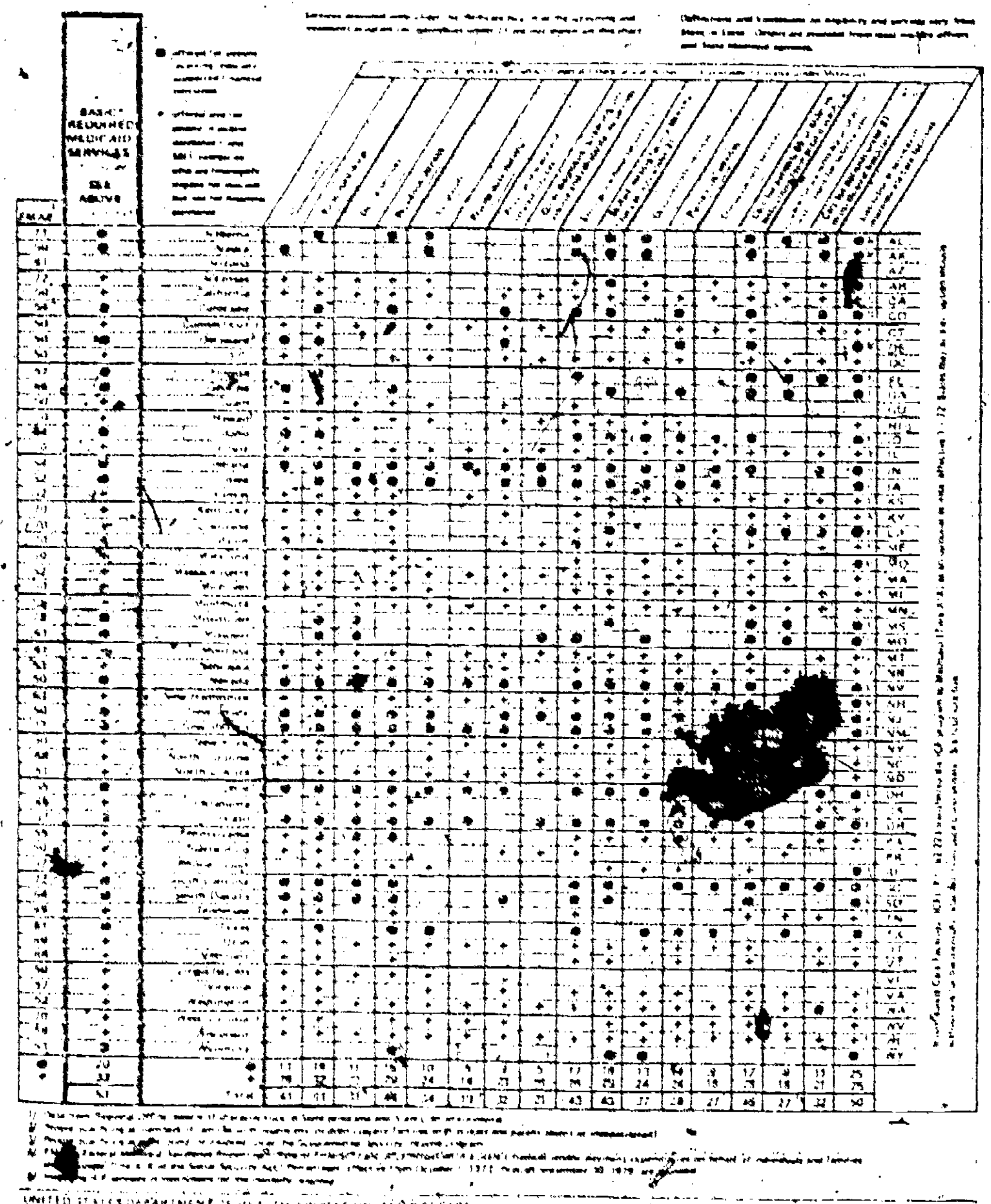
levies penalties for non-compliance on administrative costs.

Prevention and good intervention, as early as possible, will reduce the long-term cost to society. Failure to intervene will guarantee the total social and financial dependence of people who could be at least partially self-sufficient as adults, many of them potential taxpayers. Not all of the help they will require as adults is the responsibility of this Subcommittee, but the costs of their programs will fall with equal weight upon the taxpayer, who pays for them without regard to categorical responsibility. The only valid economic principle for CHAP is this: the disability which is prevented costs nothing to treat; the disability which is mitigated costs far less to treat than the one which is ignored.

Thank you

MEDICAID SERVICES STATE BY STATE,

JUNE 1, 1978



BASIC REQUIRED MEDICAID SERVICES

SEE ABOVE

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Health Care Financing Administration — Medicaid Bureau

Division of State Management

APPENDIX 4

(Excerpt (pages A-39 and A-40) from an April 1978 Southwestern Psychological Association Meeting Study)

12. Minority Children Study: Richard Graves and Janice Hastrup, "Effects of Psychological Treatment on Medical Utilization in a Multidisciplinary Health Clinic for Low Income Minority Children," paper presented at the April, 1978 Southwestern Psychological Association Meeting (New Orleans).

(a) Aim of Study: To determine whether medical care utilization by children and adolescents decreases subsequent to psychological referral and treatment in a completely subsidized health care plan.

(b) Setting: A comprehensive neighborhood health clinic in a major southwestern city.

(c) Benefit: Children and adolescents living in the clinic's designated area automatically qualified for completely subsidized outpatient health care. Mental health therapy was primarily behavioral in approach with an emphasis on changing dysfunctional family interaction patterns that maintained problematic behaviors in the children.

(d) Study Population: The 21 children and youth who were referred to and had received treatment from the psychological component of the clinic during the eight month period from October of 1975 through May of 1976 and for whom the clinic had medical records for one year before and after the referral. Thirteen of the treatment group were male and sixteen were Mexican-American. The treatment group had a mean psychological distress score of 5.1 on a scale conceptually similar to the one used by Follette and Cummings. The scores were based upon the somatic complaints noted in the children's medical records. Mean age was 8.5 years.

(e) Types of Therapists: Two Ph.D. psychologists.

(f) Time Span: One year before and one year after referral.

(g) Comparison Groups: Two other groups were studied:

1. Matched Control Group: 21 clinic registrants who were matched to the treatment group subjects according to age, sex, ethnicity, psychological distress, and medical utilization. The mean psychological distress score was 4.1, slightly lower than that of the treatment group.
2. Random Control Group: 21 clinic registrants who were matched to the treatment group only according to age, sex, and ethnicity. The mean psychological distress score was 2.2.

(h) Findings: Table A-19 records the study's findings.

TABLE A-19. MEAN OUTPATIENT MEDICAL CARE UTILIZATION 1 YEAR BEFORE AND AFTER REFERRAL TO PSYCHOTHERAPY OR STUDY ENTRY DATE

Group	Medical visits: Before	Medical visits: After	Percent change
Treatment group	5.8	3.7	36
Matched control group	4.7	6.1	+30
Random control group	2.3	2.1	9

Source: Derived from Graves and Hastrup (4/78), Figure 1.

Only the change in medical care utilization by the treatment group was found to be statistically significant. Also, those in the treatment group were significantly higher utilizers of medical services before referral to psychotherapy than were those in the random control group. However, after referral, the treatment group were still higher utilizers but no longer significantly so.

Average length of mental health treatment for the 21 subjects was 4.9 sessions. Nine of the 21 subjects received only one or two sessions of therapy.

The study also ruled out the possibility that the study group's drop in utilization was due to their families having reduced involvement with the clinic after psychological treatment. The study determined this by checking whether the children had been brought into the clinic for their routine health maintenance appointment during the year following psychological referral. Nineteen of the treatment group had kept these appointments. This compared with 20 for the matched control group and 14 for the random control group.

(i) Critique: This study broke new ground by injecting the elements of studying children and using a setting where the care was completely subsidized. The major limitations of the study were its extremely small sample sizes and its short time span. However, a good attempt was made to develop a matched comparison group. Such a group is, nonetheless, open to many of the same criticisms that have been made of the Follette and Cummings comparison group. The study itself mentioned a couple possible improvements. One would be to determine whether there are any consistent patterns in the types of somatic complaints which decreased in the period following psychological treatment. The other would be to look for similar reductions in medical care utilization among other high utilizers in the families of the treatment group. Finally, the study could also be improved by including utilization of hospital and ancillary services and by estimating the net cost of the psychotherapy provided.

Senator TALMADGE. The next witness is Dr. William C. Felch, chairman, council on AMA's Council on Legislation. Dr. Felch, will you submit your statement and summarize it.

STATEMENT OF WILLIAM C. FELCH, M.D., CHAIRMAN OF THE AMA'S COUNCIL ON LEGISLATION

Dr. FELCH. My name is William Felch and I am a practicing physician from Rye, N.Y. I currently serve as the chairman of AMA's Council on Legislation. With me today is Ross Rubin, assistant director of our legislative department.

We are pleased to submit the views of the American Medical Association on S. 1204, the administration's child health assurance program—CHAP.

The program that is presently in effect was designed to respond to health care needs of children by affording them access to health assessments and care and treatment for conditions that were diagnosed in such assessments. Unfortunately more than 22 percent of the children screened under EPSDT and found to need treatment do not receive the required treatment. It is clear that there must be more attention paid to the need for followup care, and that EPSDT should be improved if the program is to meet its objectives.

The legislation before the committee would replace EPSDT, however. It seeks to meet the objectives of EPSDT by changes in the medicaid law, and in doing so would establish within medicaid, for one group of beneficiaries, a special set of benefits, a special definition of providers and conditions of provider participation and special rules of medicaid payment to providers and Federal payments to States.

There is no generally accepted understanding of the reasons for the partial failure of EPSDT, and no base of experience as to what effect the changes proposed in CHAP might have on medicaid and on the provision of care for children.

We know of no well-conducted studies that establish any guidelines for program development. Yet this legislation would introduce a major new program with dstinctive needs and numerous administrative requirements into a medicaid program already beset with complex problems.

The shortcomings of EPSDT should not be addressed through a major restructuring of medicaid, in the face of the magnitude of the difficulties implicit in an undertaking within medicaid to mesh and administer two separate and distinct programs. Moreover, in our view, the features of EPSDT contributing to its difficulties and shortcomings are not overcome in the proposed legislation.

We do not believe that partial failure of a program to meet all of its goals should outweigh its partial success and lead to total replacement. Rather, we feel it appropriate to build on the successes and correct current errors, rather than starting from scratch with a brandnew and untried approach.

The Federal Government is already deeply involved in a large number of health care programs, each addressed to a particular segment of the population in a targeted approach to meeting the health care needs of our citizens. For example, there are two special programs devoted to assuring maternal and child health—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 complementary, they are also to some extent duplicative. Each of these programs has a function that we believe should be strengthened and retained to assure quality health care to eligible children and their mothers. Neither was intended to, nor can it, reach all deserving potential beneficiaries. We urge that the two programs be reconsidered and viewed together in seeking an answer to the problems of reaching the children and others in need of health assessment and treatment.

We would like also to call attention to certain specific features of S. 1204 that we view with concern. These are discussed in detail in our prepared statement. They center around such administrative matters as the contractual agreements, the requirement that provides access to followup service, reimbursement mechanisms and reporting requirements.

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. The program should be improved, but changes should be made so as not to discourage full opportunity of patients to have access to care, and should 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 creation of the new CHAP program as proposed in the legislation.

We urge that, in developing modifications of the current EPSDT program, consideration should be given to the availability of maternal and child health care under title V of the Social Security Act.

The title V program would be expanded under legislation introduced by Senator Dole (S. 1430) that was developed with the cooperation of the American Medical Association, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

We do not believe that the CHAP program as proposed should be enacted. The effect of such legislation would be to add further confusion to an already heavy burden of administering medicaid laws. Different sets of rules, provider benefits, reimbursement and cost-sharing would add to the already major problems that States have in administering medicaid.

In support of the current EPSDT program, this program is partially fulfilling a vital need and providing certain health services to children of low-income families. 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.

We urge that the subcommittee consider modifications consistent with our specific conerns with the proposed legislation. While we support the general concept embodied in the child health assurance program legislation, we urge that the subcommittee not adopt this proposed legislation as it is presently constituted.

Senator TALMADGE. I have only two questions:

You mentioned in your statement title V in the EPSDT program, complementary and to some extent duplicative. You also stated the child health program is distinct and should not be imposed on the medicaid program further.

Are you suggesting these programs be combined and administered independently of the medicaid program?

Dr. FELCH. Yes. In our amendment proposals for title V, we suggest that there be an office in HEW that would coordinate all existing maternal and child health programs.

Senator TALMADGE. Dr. Schaeffer said he already has done that. Did you hear his response?

Dr. FELCH. I did hear it. We think the role of such an office could be different than what Mr. Schaeffer suggests. It should set guidelines that would be helpful to the States in determining what they should include in their programs. It could receive monitoring reports yearly, and that sort of thing.

Senator TALMADGE. What is your view concerning mandating ambulatory and inpatient mental health benefits under CHAP?

Dr. FELCH. We have a general policy that psychiatric services should be treated at parity with other health care services or services delivered by other providers.

Certainly, in any legislation that we have considered we have included psychiatric services at parity with other services.

Senator TALMADGE. Any questions, Senator Durenberger?

Senator DURENBERGER. Yes, thank you.

Doctor, I have not had a chance to read you[illegible] entire statement. You did talk about the need to correct errors in the EPSDT program. On page 9 you refer to problems with EPSDT which may not be within the scope of benefits but in the administration. Would you give me some illustration of the current problems with the administration of EPSDT and would you also illustrate what you mean by making the program more attractive to providers?

Dr. FELCH. A simple instance is the matter of reimbursement schedules for physicians under medicaid programs. In my office, which is by no means a Cadillac office, it is pretty efficiently operated, our accountants tell us it costs nearly $10 a patient visit now, including all of our overhead costs.

When our State medicaid reimbursement formula is [illegible]0 percent of that, that—to use the jargon of the day—is a disincentive for providers to participate in such programs.

Senator DURENBERGER. Are there any others?

Dr. FELCH. When we do get paid under medicaid, it often comes in months later than the bills are submitted, so that our cash flow position may not be as advantageous as that of the State.

Senator DURENBERGER. So in summary your statement is, we would not have problems with physician participation in this program if there were adjustments made to the reimbursement?

Dr. FELCH. It is not just the reimbursement; there are other administrative problems, to be perfectly honest, there is a certain frustration factor in dealing with these State medicaid agencies that cannot be quantified. However, if these problems, including reimbursement, could be remedied, there would be greater incentives to participate in the program.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Felch follows:]

STATEMENT OF WILLIAM C. FELCH, M.D., AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the committee, my name is William C. Felch, M.D. and I am a practicing physician from Rye, New York. I currently serve as the Chairman of AMA's Council on Legislation. With me today is Harry N. Peterson, Director of our Legislative Department.

We are pleased to submit the views of the American Medical Association on S. 1204, the Administration's Child Health Assurance Program (CHAP). This legislation would increase the number of children and pregnant women eligible for Medicaid and replace the current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under the Social Security Act.

BACKGROUND ON THE PROPOSED LEGISLATION

This proposed legislation would amend Title XIX (Medicaid) of the Social Security Act to provide for a Child Health Assurance Program. By these changes, many children in low income families who are ineligible currently for Medicaid because they are members of intact families, would come under Medicaid. In addition, eligibility for Medicaid would be extended to cover pregnant women with low incomes who do not presently qualify because they do not have a dependent child living with them.

Children covered by the CHAP provisions would be persons under the age of 18 (and States could elect to include children between 18 and 21). They would be entitled under Medicaid to periodic health assessments and a broad range of health services. Pregnant women covered under the extended Medicaid provisions would be entitled under Medicaid to care and service during pregnancy and for 60 days following the termination of pregnancy.

For children, mandatory services (that is, services that a State must provide under Medicaid) would include, in addition to hospital and physician services and skilled nursing care, services such as routine dental care and vision and hearing services. Moreover, services other than mental health care and dental care could not be limited as to amount, duration or scope.

CHAP services could be provided by a variety of providers, among them: physicians, community health centers and migrant health centers, projects funded by Title V, Indian Health Service facilities, State and local government health departments, and schools.

In advance of performing services under CHAP, a provider would have to become an eligible participant. This would entail entering into a written agreement with the State agency responsible for administering Medicaid whereby the provider would agree to provide to eligible children services including periodic health assessments, diagnostic and treatment services to those assessed, and when indicated, referral to appropriate providers for needed treatment. The provider would also undertake patient follow up to ensure the provision of services for which a referral has been made, or furnish follow-up information to the appropriate State agency.

S. 1204 creates a class of providers designated as "continuing care" providers, with only the "continuing care" provider assuming the responsibility for the management of the medical care of the assessed child.

Payments to a State for services of "continuing care" providers would be made in accordance with methods and standards prescribed by the Secretary. Under this authority, the Secretary could set minimum reimbursement levels (nationally or by area) and could permit or require payment based on a prospectively determined capitation rate with payment on a periodic basis. The Secretary would also have authority to permit or require payment incentives to "continuing care" providers.

The extent of federal cost-sharing under the Medicaid program for services under CHAP would depend upon a State meeting federal levels of performance.

The effectiveness of the State program would be measured under a formula which is based on assessments, care and treatment provided to children, with added weight being given to children who received services under agreements with "continuing care" providers. Applying the formula, the State's federal medical assistance percentage otherwise determined under the Medicaid law could be reduced by as much as five percentage points or increased by as much as 20 percentage points (to a maximum of 90 percent).

COMMENTS

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program that is presently in effect was designed to respond to health care needs of children by affording them access to health assessments and care and treatment for conditions that were diagnosed in such assessments. Unfortunately, 22 percent of the children screened under EPSDT and found to need treatment do not receive the services required. It is clear that there must be more attention paid to the need for follow-up care. Improvement in EPSDT is surely needed if the program is to meet its objectives.

The legislation before the Committee would replace EPSDT, however. It seeks to meet the objectives of EPSDT by changes in the Medicaid law, and in doing so would establish within Medicaid, for one group of beneficiaries, a special set of benefits, a special definition of providers and conditions of provider participation, special rules of Medicaid payment to providers and federal payments to States.

At this time, there appears to be no clear understanding of the reasons for the failure of EPSDT, and no base of experience as to what effect the proposed changes might have on Medicaid and the provison of care for the children. We know of no well-conducted studies that establish any guidelines for program development. Yet this legislation would introduce a major new program with distinctive needs and copious administrative requirements in a Medicaid program already beset with complex problems.

In assessing the shortcomings of EPSDT, it should be remembered that that program is even now being administered through Medicaid. We do not believe that it is appropriate to establish broadly expanded Medicaid involvement before added study and better understanding can be combined to recognize and meet the problems. While there are weaknesses in the present EPSDT program, that is fulfilling a needed service and deserves support to accomplish its objectives. Modification of EPSDT to address identified problems would be appropriate. The shortcomings of EPSDT should not be addressed through a major restructuring of Medicaid, in the face of the magnitude of the difficulties implicit in an undertaking within Medicaid to mesh and administer two separate and distinct programs. Moreover, in our view, the features of EPSDT contributing to its difficulties and shortcomings are not overcome in the proposed legislation.

We do not believe that partial failure of a program to meet all of its goals should outweigh its partial success and lead to total replacement. Rather, we feel it appropriate to build on the successes and correct current errors, rather than starting from scratch with a brand-new and untried approach.

The federal government is already deeply involved in a large number of health care programs, each addressed to a particular segment of the population in a targeted approach to meeting the health care needs of our citizens. For example, there are two special programs devoted to assuring maternal and child health—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 complementary, they are also to some extent duplicative. Each of these programs has a function that we believe should be strengthened and retained to assure quality health care to eligible children and their mothers. Neither was intended to, nor can it, reach all deserving potential beneficiaries. We urge that the two programs be reconsidered and viewed together in seeking an answer to the problems of reaching the children and others in need of health assessment and treatment.

We would like also to call attention to some of the specific features of S. 1204 that we view with concern.

Child health assessments under the program could be provided only by a health care provider who entered into a specific agreement with a State Medicaid agency. This provision is highly undesirable and could result in differences in the availability and level of health care available to CHAP beneficiaries, as compared to health services available to others. The provider agreement requirement could result in reduced provider participation, thereby narrowing the availability of CHAP services. The resultant concentration of the provision of CHAP services in a limited range of providers, quite possibly special "CHAP clinics," would be a disservice to CHAP beneficiaries. It would operate to retrict the medical resources available, thereby impinging on the patient's right of selection of physician or other health care provider, and impact adversely on the scope and quality of care available to CHAP beneficiaries.

Another problem concerns the responsibility of the provider to assure that all necessary medical services that are provided under the State Medicaid plan are made available in a timely manner, and to assure that reassessments are performed on a timely and periodic basis, as required by regulations of the Secretary.

While it is desirable for a patient to have a primary physician on whom that patient may rely for coordination of his medical care, we take strong exception to any specification in the law that would require the health care provider to assume responsibility for assuring that a patient received follow-up treatment. The physician-patient relationship is a voluntary one, and the physician maintains no control over whether a patient will return for follow-up treatment and/or consultation, or even follow the physician's advice. To mandate by law that a health care provider is responsible for a patient over whom the provider has no control is at best a gratuitous requirement incapable of fulfillment; at worst, it is a condition that may well deter physician participation in a program because of practical difficulties and ostensible legal implications.

Adding to the discouraging aspects of the CHAP legislation, from the standpoint of physician participation, are the limitations on reimbursement for services that are built into the program. Payment for services under CHAP, as an integral part of Medicaid, would be governed by Medicaid rules and, accordingly, would be restricted in many states to insufficient levels. Under Medicaid laws, no reimbursement can exceed what Medicare would pay (already at arbitrarily set levels), and Medicaid rates of payment are generally even lower. Retention of the artificially restricted payment levels under Medicaid will accentuate current problems facing the Medicaid program. This impediment to physician participation should be removed if the CHAP program is to provide full access by individuals to the intended benefits of the program. S. 1204 would allow the Secretary unilaterally to establish a schedule of fees fixing reimbursement levels. We would urge, as an appropriate standard, that customary and reasonable reimbursement be made for physician services.

Providers participating in CHAP would also have the added burden of making reports, such as the State or the Secretary might require, to assure compliance with the requirements of the program. No specific guidance is provided, however, with respect to the content of these reports nor the extent of the data that must be furnished. Reasonable bounds as to the scope of such reporting and the material to be provided should be described in the legislation. We also ask that careful consideration be given, in the development of the report requirements, to the burdensome paperwork and administrative tasks that will be created as well as the confidentiality of patient medical records

CONCLUSION

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. The program should be improved, but changes should be made so as not to discourage full opportunity of patients to have access to care, and should 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 creation of the new CHAP program as proposed in the legislation.

We urge that, in developing modifications of the current EPSDT program, consideration should be given to the availability of maternal and child health care under 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 developed 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 that 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. A draft of the legislation is attached, and we commend it to the attention of this Subcommittee.

We do not believe that the CHAP program as proposed should be enacted. The effect of such legislation is to add further confusion to an already heavy burden of administering Medicaid law. The CHAP program is designed specifically to meet medical needs of children, and is addressed to this segment of the population, distinct from the general population that may be covered under Medicaid at the present time. Different sets of rules, provider benefits, reimbursement and cost-sharing would add to the already major problems that States have in administering Medicaid. Child health programs are distinct and should not be imposed upon the Medicaid program any further.

In support of the current EPSDT program, 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.

For optimal care for children within the scope of S. 1204, the program must be attractive to providers with the necessary skills. The proposed provider agreement will not add to the quality of care and services to be performed, but will discourage provider participation that could sharply reduce access by beneficiaries to participating providers with the needed skills for performance of the highest quality of services in the implementation of the program.

We urge that the Subcommittee consider modifications consistent with our specific concerns with the proposed legislation. While we support the general concept embodied in the Child Health Assurance Program legislation, we urge that the Subcommittee not adopt this proposed legislation as it is presently constituted.

Senator TALMADGE. Next, Dr. Birt Harvey on behalf of the American Academy of Pediatrics.

You may insert your full statement in the record and summarize it.

STATEMENT OF BIRT HARVEY, M.D., ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Dr. HARVEY. Thank you, Mr. Chairman.

Mr. Chairman, Senator Durenberger, we appreciate the opportunity to testify before you today on S. 1204.

The American Academy of Pediatrics supports the basic concepts of this bill. We support better coverage of more children and we support the concept of getting children into continuing care.

We like the idea of coverage of unmarried, low income, adolescent pregnant women. Now in many States they are not eligible; under this program they will be eligible during the pregnancy rather than after the child is born. In this way we foresee fewer children born prematurely and born with congenital defects; so we support this particular provision as well as, the whole concept of broader coverage.

There are several areas of coverage this bill does not address that we would appreciate your consideration:

Migrant farm workers are not included. Incarcerated juveniles are not included. These groups both need inclusion. Formerly, the bill continued coverage for 6 months' coverage after the child became ineligible. It has been reduced to 4 months. We feel that in many circumstances this will not give care as long as for necessary to complete treatment.

We would ask consideration of a different concept, that once a child has been screened and referred for physician treatment the coverage continue until that diagnosis and treatment be completed or until the title 19 agency who is administering this has made arrangements with title V, or with other State agencies to see that the ongoing coverage will take place.

Once a child becomes ineligible for this program, he is not automatically wealthy; he may not automatically be able to afford the care that is necessary for continuation of treatment that may be started under this bill.

We would ask you to address this problem.

One of the major problems, as you have brought up repeatedly, Mr. Chairman, to people who have testified, is the question of the coordination of this program with the title V program and with other child health programs.

Senator TALMADGE. Speaking extemporaneously, would you make specific recommendations as to how we can improve that?

Dr. HARVEY. We believe there needs to be a child health agency designated within HEW and it should be in the Department of Health, not in HCFA, to address the problems of child health. HCFA has payment as a primary overstation; the Health Department is primarily oriented toward providing of medical care and has medical expertise.

We would like to say a few words about provider participation that we think needs to be addressed in this bill.

The bill as presently written says there should be a written agreement between the State and the providers who participate in this program. We feel a written agreement will be a barrier to provider participation. Providers are not used to having written agreements which require that they insure that the child gets to places for followup, and requires that they assure the children return for periodic examinations.

Instead of getting more private providers involved, this will get less nongovernmental providers and will make it a State program. That is one of our chief concerns.

We believe when a provider signs a billing form, this in itself assures that the provider has performed the services that are mandated in this program by the regulations of the State and that nothing further beyond that should be necessary.

If the State government wishes to have a written agreement for providers, this may be appropriate. If the provider is going to do capitation care he would then sign a written agreement committing himself to development case management facilities within his group or office to provide followups but under ordinary circumstances in a fee-for-service setting most providers are not able to offer this kind of service.

We believe that the definition given of "comprehensive care providers" is poor. It defines comprehensive care, providers by the location at which they provide care, by the type of service they offer, or by disciplinary training. These cannot define a comprehensive care provide; a comprehensive care provider should be defined by his services. If he gives comprehensive services, he should be eligible. We have listed in our testimony a number of things that could be used to determine who provides comprehensive care. There are many providers who can't do that. There are nonlisted providers who can. It should logically be decided on this type of basis.

We think States need to be more accountable, they need to be accountable for what techniques they use to achieve outreach goals how successful they are in reaching the goals in the same way followup should be very carefully monitored and States should be required to report on the means they use to achieve adequate followup and how successful the followup efforts are.

In the same way States should be required, to show how they are recruiting and removing barriers to encourage private providers and other nongovernmental groups to participate in this program.

Mr. Chairman, thank you very much for giving me the opportunity to testify.

Senator TALMADGE. Thank you.

You addressed yourself to all three issues that I wanted to ask you questions about, so I will pass those.

Senator Durenberger?

Senator DURENBERGER. He covered my concerns as well.

Senator RIBICOFF. You were here were you not, when I asked a question of Dr. Stone and Nancy Morill about the problems and responsibilities doctors would have doing the administrative followup? I understand that you object to that responsibility?

Don't you think it would be possible to draft written agreements requiring the doctor to lay out the course of treatment and what followup would be needed, and then let one of these voluntary agencies do the followup for you, so you would not have all the administrative work?

Don't you think you could work something out that way?

Dr. HARVEY. I think that might be an acceptable alternative. My envisioning of followup is that it becomes the State's responsibility to see that effective outreach for periodic examinations and followup occurs.

The State could contract with the provider for this service if he has the facilities and the ability. It could contract with volunteer agencies to perform this function. It could be done in a number of different ways, sir.

Senator RIBICOFF. I would be hoping that in this type of followup work we could have a deeper involvement of the volunteer agencies. I think in many ways if you could do that, it would have a softer approach. Since you are dealing with children, I think there are many people, certainly many women who do volunteer work, have time and would be in a good position with children and their the mothers, to see to it that these efforts are coordinated.

Dr. HARVEY. I would agree with you, sir. I think the main thing is, it has to be spelled out as to who is going to do this, and they have to assume the responsibility and accountability for seeing it does get done.

Senator RIBICOFF. It is your feeling that if we put the burden of followup services on the doctors, the doctors would probably be unhappy and unwilling to undertake this type of service if they had these administrative responsibilities?

Dr. HARVEY. We are trying to get more and more pediatricians to participate. Now, 83 percent of the pediatricians who are members of the academy see children on medicaid, and two-thirds say they will accept new patients.

We want this to go up more. We are afraid if the bill passes as written, participation will go down, not up.

Senator RIBICOFF. I think that is a weakness and I am sure that the committee could work something out. To do it this way on this strict type of rule would be self-defeating on this program, both for the doctors and the children and the communities as a whole.

Dr. **Harvey**. Thank you.

Senator **Talmadge**. Thank you very much, Doctor. We appreciate your contribution.

[The prepared statement of Dr. Harvey follows:]

Statement of Birt Harvey, M.D., F.A.A.P., American Academy of Pediatrics

Mr. Chairman, I am Birt Harvey, M.D., a practicing pediatrician from Palo Alto, California, here today representing the American Academy of Pediatrics. The Academy is an international medical association and children's advocate representing 20,000 physicians dedicated to the care of infants, children and adolescents.

The American Academy of Pediatrics supports in principle the basic concepts embodied in S. 1204—that all children in this country deserve the opportunity to have preventive medical care, that defects and diseases should be discovered early, and that remediation should occur promptly. We believe that all children deserve an ongoing source of medical care and have testified in the past in support of these ideals. Our chief concerns have been that the ramifications and problems associated with past legislation were not thoroughly studied before passage. This has resulted in a failure of EPSDT to properly function. Inadequate and ineffective past administration has only further compounded a floundering program. We have noted the recent efforts on the part of the Department of Health, Education and Welfare to improve the administration of EPSDT, and we will continue to work with them in an effort to resurrect the program. But we do believe that marked changes are necessary in several areas of the proposed legislation to avoid compounding several existing problems and to avoid creating another set of difficulties.

FEDERAL CHILD HEALTH ACTIVITIES

Before entering into a discussion of specifics that need attention in this bill, we would like to point out that CHAP needs to be considered in broader context. CHAP will focus solely on children meeting eligibility requirements and cannot be seen as a health program for all children in a community. In fact, this is only one of the myriad of federal programs directed toward improvement of the health of this nation's children. A primary problem shared by this myriad of federal programs is the fragmentation of effort with resultant gaps and inefficiency. As such they are representative of incompletely developed approaches to meet the health needs of mothers, children and adolescents. The effect is that they promise far more than they can deliver or they act as devisive efforts in a community by competing for inadequate manpower and facility resources.

Your attention is directed specifically to the Maternal and Child Health programs under Title V of the Social Security Act—the dominant legislative expression of this country's commitment to health care for the maternal and child population over the past four decades. For the Congress to address revisions in Title XIX separate and apart from Title V would result in a failure of this Congress to fully utilize resources at hand to provide complete care to as many children as possible. The Title V program also needs to be refocused legislatively and its purpose redefined to develop both a generic approach to health care for maternal and child populations and a capacity to respond with special, focused efforts to insure a coordinated, comprehensive program for all mothers and children. Such a proposal was introduced in the Congress last year by Senator Dole and we would urge that it be considered by the 96th Congress. This proposal has been supported by the American College of Obstetricians and Gynecologists and the American Medical Association.

By focusing on both Title V and Title XIX, the intent of this legislation can be fully realized. We would point out that the potential benefits to be derived from better cooperation between Title V and the CHAP program include: ". . . promotion of continuity of care, sharing of scarce expertise, avoidance of unnecessary duplication, efficient allocation of financial resources, and achievement of greater accountability. In short, more effect utilization of existing resources and development of more extensive health care resources." (Operational Guidelines for Interagency Agreements, proceedings of the National Conference on EPSDT and Title V Programs, January, 1977, p. viii.) Therefore, it is recommended that S. 1204 be modified to include a new section which will require that the Secretary shall evaluate and submit to Congress a report on a) the coordination and integration of health care services to children under Titles V and XIX of the Social Security Act and b) on actions undertaken and recommendations for actions that should be taken by the states and the Federal government to improve the coordination and integration of child health services provided under these titles and services provided under other federally funded programs substantially involved in the provision of health services to children. (Similar language is found in Section 11 of H.R. 2461.)

In addition, it would improve the efficiency, lower governmental costs, and better serve the health needs of children and adolescents were all programs administered by one agency. We believe that the Department of Health, Education and Welfare should centralize responsibility and authority for all child health programs at a high administrative level. Competent staff at both central and regional offices capable of developing and implementing coordinated approaches to the delivery of authorized programs need to be developed.

ELIGIBILITY

The Academy is supportive of the improvements in eligibility and financing that this legislation will bring. The inclusion of women who are pregnant for the first time who would otherwise not be eligible until after delivery will result in improved prenatal care and, consequently, healthier newborns. Infants who may realistically have problems with young, unmarried adolescents for mothers are less likely to have the further disadvantages of ill health, small size, congenital anomalies or many other problems. Including such women applies the CHAP resources in a truly preventive manner.

We are further pleased to note requirements states must reach on the amount, duration and scope of services in order to be eligible for federal matching assistance. This expansion of eligibility for CHAP services should help provide more complete preventive care to a significant segment of underserved and nonserved children.

Proposed changes in this section should include mandatory rather than optional coverage in the 18-21 age group. Since Title XIX covers this group, it would be wrong to deny them services merely because the State has decided not to include them. The continuation of coverage for six months after the loss of eligibility is preferable to the four months in the Administra[illegible]n bill. The process of diagnosis and treatment after examination is complet[illegible] frequently require six months. The bill might be more appropriately amended [illegible] require coverage until diagnosis and treatment are completed should a child become ineligible after screening or examination is performed. Alternatively, the State plan could be required to establish an administrative arrangement between the Title XIX and Title V agencies to assure continuance of care for children declared financially ineligible. Modifications should be made for coverage for children of migrants and incarcerated children.

PROVIDER PARTICIPATION

We applaud the stated purpose of the proposed legislation, namely to introduce children into a continuing comprehensive health care system within their community. Giving a child a "medical home" provides the family with a feeling of security and support when medical need arises. Families with a medical home or personal physician are less likely to delay seeking care, hence illness can be treated earlier, before it becomes catastrophic. Subsequently, families gain confidence in the source of their care and are more inclined to seek preventive care. Thus an ongoing source of health care for each child avoids unnecessary duplication, fragmentation, episodic and incomplete care, as well as being less costly and more humanitarian, and immeasurably improves the health status of children. Unfortunately, language in this bill fails to effectively implement its stated purpose. To give as many children as possible a medical home requires the utilization of all types of comprehensive, continuing care providers. The private sector has under EPSDT been systematically excluded from participation in 22 States, and certain sections of this bill will erect a further barrier to this large segment of continuing care providers. Section 1913 of the Administration bill requires written agreements with providers in which they insure that follow-up service is received on a timely basis and assure that child health assessments are performed on a timely basis. Those physicians in private practice may not have the properly trained personnel to perform the tasks set forth under the "written agreements." These responsibilities have been left in most instances to the families and in certain circumstances to the county and city health departments with appropriate expertise and experience. This is not to say that case management is not important, but that accountability should lie with governmental agencies unless the provider has the ability and desire to assume this function. Physicians assume responsibility to provide care but cannot under ordinary circumstances assume the responsibility to see that the family utilizes available services. While such requirements with written agreements may be appropriate for private providers who contract for care on a capitation basis, details of how resources will be made available to finance and support such services are not addressed.

Our greatest concern lies with the definition of health care provider as outlined in Section 1913(e)(1) of S. 1204. As defined, these providers are to deliver continuing, comprehensive ongoing care for children. The identification of who can provide such care cannot be made categorically, simply by listing types of providers. Rather a listing of specific requirements for any individual or group who may wish to qualify must be developed. At the request of the Administrator of the Health Care Financing Administration, the Academy has prepared a definition of a comprehensive continuing care provider (see Appendix I). There will be private practitioners, day care centers or others listed who do not qualify. Conversely, there may be groups not listed who can well provide such care. The important criteria are not the setting or the title of the group, but the services it can offer to meet the needs of children. We would suggest the following amendment to this section:

> The term "comprehensive continuing health care provider" applies to an individual or group who provides: (1) initial and periodic health examinations, (2) treats conditions amenable to treatment, if possible, or refers for appropriate care, (3) accepts continuing responsibility for providing care to maintain physical, mental and social health, (4) coordinates all medical services the child receives and interprets the processes and findings to the child and/or family, (5) maintains and has available whenever needed, health records of the child, (6) provides anticipatory guidance and health education for the child and/or family, (7) provides day and night, weekday and weekend availability for advice and access to care of acute and emergent problems.'

The bill at present—stipulating written arrangements for insurance of follow-through and assurance of appearance for periodic examination and listing of qualified comprehensive continuing health care providers by category only—will foster institutionalized arrangements for the provision of care to poor children by mediating against involvement by non-governmental providers. This will promote government-run clinics as the sole mechanism to provide health care to the poor; it runs counter to the concept of a pluralistic system of health care involving a multiplicity of provider resources and freedom of choice for the consumer to choose a provider of care. The reality is that all providers must be involved to accomplish this task.

While it is our desire, as it is yours, to help all children find a source of comprehensive continuing health care, we realize that it is unrealistic to believe this can be accomplished at this time. There are many pockets in this country, both rural and urban, where the supply of comprehensive continuing health care providers is not equal to the demand. However, this should not offer States an excuse to funnel as many children as possible into screening clinics, nor to set inadequate standards for such clinics. The Administration must not rely on numbers of screens as an indication of success when such screens often pay only lip service to the objectives of this program while not effectively even really screening the children. Thus there need to be criteria for assessment providers just as we have recommended for criteria for comprehensive continuing health care providers. These criteria should include competency of staff, standards of necessary equipment, a reasonably fail-safe plan to refer children to an appropriate comprehensive health care provider for a needed diagnosis and treatment in situations beyond the capacity of the screening provider, and a sensitivity to the emotional needs of the families of the children screened.

CLAIMS FORMS

At present the reporting and billing forms vary in content and complexity from State to State. The lack of equivalence between States with regard to records and paperwork impedes the continuity of care. We support the Administration's efforts to develop a uniform reporting system and a uniform claims form. These could prove advantageous in simplifying the system and thus improving provider involvement.

MINIMUM REIMBURSEMENT

The inadequate fee structure in many States has been the deterrent in participation by many provider groups. We approve in principle the Administration's plan to develop a basic, minimal, national fee structure to make reimbursement rates more consistent with current practices, but believe it must be flexible and based on regional and State differences. We would like to see fees negotiated separately in each State but with a floor established by the Secretary at a level that would permit participation of comprehensive continuing health care providers.

PENALTY PROVISION

The development of financial incentives to stimulate involvement of more poor children in screening and in comprehensive continuing health care is an excellent idea. For too long the mentality of the program has been punitive. Rather than attempting to help States develop viable, effective programs, the primary involvement was to see if penalties were in order. As a consequence, the attitude of most States has been directed toward avoiding penalties rather than toward serving the health needs of children. It has become a numbers game rather than a health improvement game.

STATE ACCOUNTABILITY

State accountability for an effectively functioning program is a serious shortcoming of this bill. Requiring state plans to inform and attract all eligible families in a timely manner, to facilitate obtaining comprehensive or screening examinations and to see that necessary follow-up is achieved is an important objective. While the Administration's proposal to provide incentives to involve children in a continuing care system are excellent, states should be required to report on methods and techniques used to achieve this objective. They should be required to disclose methods used for facilitating involvement of all potential local health care resources for the program and to show cause if there is no private provider participation. A description of state provider outreach, adequacy of fee structure and mechanism of provider input into the program should be included. Since a major objective of the program is to have all children enter a continuing health care system, it is the responsibility of the state to justify the use of assessment providers. Such an approach should be used only when comprehensive continuing health care providers are unavailable.

The intent of Congress to see that all children should eventually have a permanent medical home needs to be clearly spelled out so that states will not stop at putting children through screens but will be compelled to find medical homes for all children in this program. We must recognize that assessments represent a temporary and inferior health care, and that each state which finds it necessary at this time to have some eligible children served only by assessment providers, should submit as part of the state plan steps and timetables to move aggressively to have all children in continuing comprehensive care settings. If it is not made clear that assessment is a temporary expedient, we will find some using assessment providers almost exclusively. States should be required to set outcome standards and goals in their state plans and should further be required to report their progress in relation to their goals. What we seek from the state in such a requirment is a data base providing not only gross numbers of children examined and treated, but an accounting of what happened to those children in the program's system. By the same token, goals and progress reports covering practitioner participation should be required each year.

Since the essence of the program is adequate follow-up to achieve remediation of potential defects or diseases discovered in the examination, state or provider efforts to see that successful follow-up is achieved emerge as the critical facets of the program. That success cannot be assessed in numbers alone but requires a detailed reporting system, so that the true effort expended to help these children can be determined. We do not believe that this bill is presently written to achieve the objective of making the states truly accountable and effectively evaluating their efforts to improve the health of eligible children or facilitating their entrance into a continuing care system. States should be required to disclose methods used for informing families, what plans are being developed to expand the percentage being informed, and what their annual goals are. States should be required to report on the number of children examined by comprehensive continuing care providers as an indicator of entry into a system of continuing care as well as to show plans for increasing the numbers assessed and the numbers entering continuing care and to show what efforts they are making to implement these plans. The numbers and percentages of different types of comprehensive care providers involved in each state should be reported. States should also be required to show what plans they have developed and what efforts they are making to increase the involvement of a variety of different comprehensive, continuing care providers. Annual goals for increased provider participation should be required. States should report not only the provision of medical care for diagnosis and therapy, but what techniques are used to obtain this care—how adequate it is, what plans are being made to expand availability of such care and what efforts are being made to implement these plans. Finally, provisions should be made to require that the Secretary report to Congress annually on the performance of the program. We believe this to be of utmost importance, particularly in view of the sorry state of this program after so many years. Recent renewed interest in the program by the Health Care Financing Administration is to be commended, but is no substitute for ongoing congressional surveillance and requirements for accountability for successful implementation on the part of the Secretary. Such a report should contain data on cost effectiveness, analysis of the program's components, assessment of the program goal attainment, and clarification of the problems inherent to the program. The requirement should allow changes to improve the program, eliminate problems, and pave the way for future child health legislation.

EVALUATION AND RESEARCH

S. 1204 does not give appropriate attention to the collection of meaningful data on the CHAP program. The number of children screened and the number of examinations performed tells us nothing of the value of the program. Similarly, the number of defects found, referrals made or treatments completed are meaningless. The defects might be as insignificant as a birth mark or as catastrophic as a congenital heart defect. The disease might be as unimportant as diaper rash or as significant as leukemia. Funds must be provided to accumulate meaningful data on the impact of CHAP on the health of children. Without those funds, we will not know if the entire program is cost-effective or if certain aspects are particularly beneficial or particularly valueless. We would not be able to identify the most appropriate expenditure of funds, where more should be allotted and where less.

After all the time EPSDT has been in place, we are at a loss to determine what, if any, value it has. This should not be the fate of CHAP. When another Congress decides further revisions are in order in five or ten years, it should not be faced with the same problems of attempting to evaluate an ongoing program and authorizing significant changes without adequate information.

We should urge the allocation of some percentage of the funds for formal, ongoing evaluation of CHAP. Data gathering, system development and analysis should be federally funded programs in a manner similar to ongoing research in this important program. The research requires sound scientific conceptualization and methodology which can be clearly set forth in formal field research applications through the data evaluation and research arm of CHAP.

COMPREHENSIVE CARE PROVIDER PERSONAL PHYSICIAN

A Comprehensive Care Provider/Personal Physician can be defined by the following eleven points:

1. Provides initial and periodic health assessment services which include: (a) a complete history which encompasses prenatal, birth and perinatal history, growth and developmental history, dietary history, family and genetic history, history of past illnesses, injuries and hospitalizations, review of identified allergies and symptoms of organ system, immunization history, family history of disease, medically relevant social history; names of other current providers of care, summary or records of current chronic disease conditions, identity of medications or treatments currently used, history of any present illness; (b) a medical evaluation (including an unclothed physical examination) which assesses: general physical status, growth and development, including learning, vision and hearing status, status of mental and social health; (c) screening and diagnostic tests appropriate for age and population groups; (d) immunizations appropriate for age and health history.

2. Treats conditions that are amenable to therapy and to the extent that they are within his capability; otherwise, refers to another provider who is able to provide appropriate treatment services.

3. Accepts continuing or longitudinal responsibility for the whole child in health and in disease, and provides constantly available access to care and continuing guidance regarding acute and chronic problems of physical, mental and social health (see 11).

4. Coordinates medical services which are provided by others, interprets medical care processes and findings to the child and his or her parents, assists parents in communicating about the child's health status and needs to other physicians, schools and community agencies, and guides the parents in continuing supervision of the child's health.

5. Maintains records of the findings, corrective measures, and other health services received by the child.

6. Provides anticipatory guidance and health education services appropriate to the child's developmental status, acute and chronic health problems, and family social condition.

7. Educates the family as to the benefits of preventive care and informs them and assists them in scheduling preventive services of appropriate type and time.

8. Cooperates with the Medicaid program, or other designated agency, with appropriate previously obtained parental permission, if particular children have missed several appointments and are not able to be contacted.

9. Submits reasonable reports, previously agreed upon, and without violating the confidentiality of physician-patient contract, as required by the state.

10. Continuing medical care of children is provided by physicians whose interest, training and experience appropriately prepare them to provide a broad spectrum of health services to infants, children and youth, and by nurses, physician extenders, and allied health personnel appropriately prepared and working under supervision of such physicians.

11. Provides 24-hour, 7 day per week, availability for advice and access to care of acute and emergent problems.

Where comprehensive care providers/personal physicians meeting the above definitions are not available in a given service area, the Medicaid program should identify disincentives which prevent providers from locating in that area, propose and develop incentives which will correct such deficiencies, and utilize providers having lesser qualifications only on a temporary basis until comprehensive providers/personal physicians are available.

Outreach.—All Medicaid agencies should directly, or by contract with other agencies or providers, provide outreach services to all families of Medicaid-eligible children. These outreach services should include:

Information regarding recommended preventive, acute and child health care services.
Assistance in obtaining medical history and records.
Assistance in arranging appointments and follow-up on missed appointments.
Transportation assistance when needed.
Arrangements for care of other children when needed.

The Medicaid agency, as a part of its outreach effort, should also cooperate with comprehensive care providers/personal physicians in assuring that there is availability in each community of services for family counseling, nutritional guidance, and child developmental education.

OUTLINE OF MAJOR POINTS

I. Need for ~~better~~ cooperation and coordination between Title V (Maternal and Child Health) and Title XIX (Medicaid) of the Social Security Act. Comments will point to the benefits of such an arrangement as well as point to the need for centralization within HEW of all child health programs.

II. Barriers to participation of private physicians. The "written agreement" provision will be highlighted as well as the definition of a health care provider. Recommendations will be made to modify these sections.

III. State Accountability. Discussion will focus on state responsibilities for the implementation of CHAP. Recommendations will be made for annual reports by the states and by the Secretary.

IV. Evaluation and Research. Comments will address the need for the collection of meaningful data and will urge the allocation of federal funds for formal, ongoing evaluations.

Senator TALMADGE. The next witness is Dr. William E. Allen, chairman, Council on Legislation, American Dental Association.

Dr. Allen, you may insert your full statement in the record and summarize it.

STATEMENT OF WILLIAM E. ALLEN, D.D.S., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY HAL CHRISTENSEN, DIRECTOR, WASHINGTON OFFICE, ADA

Dr. ALLEN. I have with me Mr. Hal Christensen, director of our Washington office.

The American Dental Association urges the enactment of this CHAP legislation which we feel is necessary because the medicaid and early and periodic screening, diagnosis, and treatment programs which are in existence today and not met the dental health care needs of children from low-income families.

Dental care for 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.

We have three major recommendations we would like to make today, Mr. Chairman:

One is the mandating of dental care under CHAP, to insure the compliance of the States. We believe this can only be accomplished by placing dental care at the same level of matching Federal funds that are available for other mandated health services.

As a corollary, there needs to be appropriate penalties to the States for failure to comply. The administration bill fails to provide these sanctions for mandated dental services.

The Finance Committee last year recognized the need for this compliance and we would urge the committee to enact similar provisions so that these penalties against the noncomplying States are applied to the administrative budgets rather than against the funds available for needed dental care for children.

Our next recommendation is that there be direct referral of children to the dentist. All authorities agree the need is obvious and predictable and the screening appointment is unnecessary and placed additional administrative burdens on both the patient and the provider.

We believe the direct referral to a dentist, as provided in the language of S. 2104, is the most effective manner for assuring the availability of necessary dental care for children, and it is important that the legislation mandate this direct referral. Without this emphasis of the specific referral, we are concerned that potentially large numbers of eligible children will not get to the dental office.

Although the administration's bill does include a dental referral provision, we believe the current structure of the bill contains no satisfactory enforcement authority or sanctions for those States which do not fulfill these dental requirements and, therefore, we would urge that these provisions be mandated into this legislation.

The third recommendation is that we believe it is essential that the reimbursement and method of payment be sufficient to attract practitioners to participate in the program.

It has been our observation that when the available funds provide for reasonable fees in relation to the usual and customary fee in the area, we have good participation by providers.

I would like to cite to you the experience in California with the dental program administered under medicaid through service corporations. In 1974 we had 8,300 participants, and in 1977 we had 12,500. We believe this is evidence that the dentists in this country are willing to take the medicaid children into their practices where they are set up to treat them and provide the same level of dental care as they would for all their other patients.

Those are our three recommendations.

We certainly would be glad to try and answer any questions.

Senator TALMADGE. Thank you. Any questions, Senator Durenberger?

Senator DURENBERGER. No.

Senator RIBICOFF. Would you briefly state the role proper dental care has in the overall health of the child?

Dr. ALLEN. I will be glad to try, Mr. Ribicoff.

I believe there are two factors at least that are influential in the dental care of the child: One is the ability to eat the proper foods and nutrition and to have a pleasant smile and all of the things necessary; but I think the psychological effect on a child who has had a great deal of dental caries is certainly one we can't overlook. By and large you can see quite a transformation in a child who has had rampant dental caries when you can restore him to normal health and appearances. We have had school systems and teachers tell us the benefit of this for these children because it seems to change their personalities, a great many of them overnight.

I think the health and the psychological impact are the main factors in providing these kinds of services, particularly to the underserved children.

Senator RIBICOFF. What are the statistics as to the dental coverage, dental care and failure to have dental care of children?

Dr. ALLEN. As you know, the EPSDT program has not provided a large amount of restorative service. A lot of the funds that went into that program were for administrative use, and on the screening which did not really get into the restorative care, so that I don't know that there are nationwide statistics available at this point. Hal, do you know?

Mr. CHRISTENSEN. We know a large number, perhaps more than half, of the children from these income groups we are talking about have never seen a dentist. The President of the United States referred to that in his comments on the International Year of the Child. Part of the responsibility for that is that we have not had a program under Medicaid to reach these children, or even try to do a good job. The statistics on the extent of dental disease among those children, and the number who have not seen a dentist, the number who need dental care, we can give you a precise figure, but I can tell you it is a bad record for us and, we think, for the Government.

Senator RIBICOFF. It is my experience that poor children, children on welfare, and minorities, are probably the most neglected segment of the whole health profession. They are neglected. Dental problems really affect the entire body, not just losing a tooth, but it drains down your whole system.

Mr. CHRISTENSEN. There are a number of studies precisely on minorities and other groups in the low-income areas that substantiate exactly what you are saying. We would be glad to build a record on that.

Senator RIBICOFF. Would you please supply that for the record?

Senator TALMADGE. Thank you, Doctor.

[The prepared statement of Dr. Allen follows:]

SUPPLEMENTAL INFORMATION, AMERICAN DENTAL ASSOCIATION, TESTIMONY ON S. 1204

Statistics have been developed from a variety of sources to demonstate the extraordinary need of children from low income families for dental care. Statistics developed from experience under the Maternal and Child Health Program indicate that only 40 percent of children under the age of 17 who are from low income families have ever been to a dentist and that 97 percent of such children require some dental care before the age of 6. A report of the American Academy of

Pediatrics states 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."

A study of the health status of black teenagers in Harlem in 1972 showed that dental disease was overwhelmingly the most common health problem. These and numerous other similar statistics are compelling evidence for the necessity of significantly improving the efforts of the federal government to provide dental care to this population group.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Dr. William E. Allen of Pasadena, California where I am engaged in the practice of dentistry as a pedodontist. I serve as Chairman of the Council on Legislation of the American Dental Association and am pleased to have this opportunity to present the views of the Association on the necessity to improve our nation's commitment to providing health care to children of low income families.

As I believe this Committee is well aware, the American Dental Association has traditionally placed its highest priority on the dental care of children. Development during childhood of effective regimens of diet, professional treatment, and home care is the foundation of 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.

The record of last year's hearings before this Subcommittee documents the Association's long-standing support of efforts to improve medicaid coverage of dental care for needy children. This includes the Association's original and continuing support for the intent and purpose of the existing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program as a mechanism for addressing the dental and overall health care needs of low income children covered by medicaid. Unfortunately, as made clear by the need for these hearings, that program has not been effective in meeting the needs of poor children particularly with respect to dental services.

Included in the regulations promulgated under EPSDT is a requirement that each state 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)). While this would appear to be a clear cut directive and commitment to the states, for one reason or another its implementation has been far less than satisfactory in assuring the availability of needed dental care for eligible children. Statistics compiled by the Congressional Budget Office indicate, for example, that only 25 percent of the children who are screened may actually be referred for dental care because some states are reluctant to "find" dental problems they would be required to treat. Even this statistic is somewhat misleading, in that only 2 million of the approximately 11 million children who are eligible for EPSDT are screened.

The other compelling statistics are that only 40 percent of children under the age of 18 who are from low income families have ever been to a dentist and that 97 percent of such children have been found to require some dental care before the age of 6. The need is clearly there. An improved mechanism for adequately addressing that need must be developed. We believe this can be done through the CHAP legislation which is before you.

There are several areas which we feel are of critical importance if CHAP legislation is to result in a satisfactory program of health care for low income children. In the course of our statement we will be commenting on the Administration's new Child Health Assurance Proposal, S. 1204. However, we also would like to refer to the Child Health Assurance legislation which this Committee approved last year as part of H.R. 9434.

With regard to the general provisions of S. 1204 and last year's Finance [illegible]tee bill we support efforts to base eligibility for the program on income and not on other factors such as the presence of the father in the home. We also believe that in order for the program to be effective eligibility should at least be through age 17 as is proposed in S. 1204.

I would also like to comment on the provisions of new section 1913(b)(3) as proposed in S. 1204. This section would allow the HEW Secretary to establish minimum reimbursement levels for continuing care providers and would give the

Secretary various other broad authorities relative to reimbursement under the program. As I am sure you are aware one of the major current deficiencies in the overall medicaid program and in EPSDT is the inadequate reimbursement provided.

The emphasis in this new legislation should be placed on finally assuring access to the mainstream of the health care system for low income children. Reimbursement levels must be improved but the establishment of single levels or imposing other reimbursement requirements which apply only to one population group—low income children—can only encourage a two level system of health care.

I would now like to address several major areas of this legislation which we think are of critcial importance if in fact the program is to effectively make the changes which are necessary to make dental care available to eligible children.

DENTAL BENEFITS

The Administration's proposal and the bill approved by the Finance Committee last year recognize the necessity for providing dental care to children by mandating this care as a medicaid benefit for low income children and by including dental care under CHAP. We are pleased that neither of the proposals would require a dental screening prior to allowing a child to receive needed dental care. As we have stated the extent of need is so predictable among these poor children that an initial screening step is simply unnecessary and therefore not cost effective. Direct referral to a dentist as provided in S. 1204 is the most effective manner for assuring the availability of necessary dental care for assessed children.

We would urge that if the structure of the Finance Committee approved bill of last year is again followed by the Committee, direct referral to a dentist be included as a CHAP requirement. The committee bill last year would have required the provision of routine dental care directly to eligible individuals or giving individuals who have been assessed a list of dentists who are participating in the program. We firmly believe that all eligible children should be assured of seeing a dentist. This can be done through the direct provision of dental care by the assessing provider or, without significant burden on that provider, through direct referral to a participating dentist. Without this emphasis of a specific referral we are concerned that potentially large numbers of eligible children will not in fact get to the dental office.

If the structure proposed in the Administration's bill is followed we strongly urge modification of the dental provisions so that the state and federal commitment is the same as for other required health services. As currently written the Administration bill appears to mandate referral to a dentist, but includes no satisfactory enforcement authority or sanctions for those states which do not fulfill the dental requirements. It is important that dental care be included among all those health services which must be provided under the legislation and which are included in the performance standards formula which determines the extent of federal matching assistance to the states. Without a significant modification in the current provisions the Administration's proposal could result in no improvement whatsoever, and perhaps a step backward in the level of dental care provided to low income children.

We believe that the development of lists of participating dentists can help to reduce the administrative burdens on providers who perform assessments. We would suggest that the lists be of dentists in the area of the assessing provider and not of dentists in the whole state as required under S. 1204.

FEDERAL MATCHING ASSISTANCE

We favor the approach of last year's Finance Committee bill relating to the federal level of matching assistance for care provided under CHAP. We believe it is important that there be a significant increase in federal incentives and that the increase be definite in amount in order to allow the states to appropriately plan and carry out this program. That bill meets both objectives. We would point out however that it is imperative that the level of assistance provided to the states for the provision of dental care under CHAP be at the higher matching rate in order to provide adequate incentives to the states to carry out this dental aspect.

S. 1204 on the other hand, would appear to give the states an indefinite commitment of matching support based upon an after the fact evaluation of compliance with performance standards. It would seem to us that in order for the program to be succeessful the states should know with certainty from the outset the specific level of matching funds that will be provided for the services to be delivered. In other words, it is our opinion that bonuses or penalties based upon performance standards should relate to administrative efficiencies or deficiencies and should not reduce the funds available for the care [illegible] needy beneficiaries.

We have noted that the Committee bill would not provide the higher CHAP level of federal matching assistance for dental care. As indicated previously a major concern of the dental profession is that all medicaid children be eligible for dental care whether or not they have been assessed. However if this program is to be effective there must be a clear indication to the states that the federal government is in fact committed to the provision of dental care. This commitment is lacking unless the federal CHAP matching for dental care is at the same level as it is for other covered services. We also would suggest that the federal matching for all dental care provided to eligible children be at the higher CHAP percentage with the added requirement that each dentist inquire as to whether or not a child has been assessed. If the child has not been assessed the dentist would so inform the state agency. This approach would utilize an additional possible point of entry into the health care system, the dentist, as a source for assuring that eligible children receive assessments. In addition, it will provide needed added emphasis on the importance of dental care and should provide a needed incentive to the states to carry out appropriate dental care programs.

PROVIDER PARTICIPATION

Successful implementation of the EPSDT program has been hindered by the series of burdens placed upon practitioners who are willing and able to participate in the program. One of these, of course, is the generally inadequate level of reimbursement provided under the medicaid program in the various states. Another is the often inordinate delay in receiving reimbursement. Added to these, of course, are excessive paper work and other questionable requirements. While all of these problems cannot be eliminated, it is in all of our best interests and particularly the interests of the beneficiaries that such burdens be kept to the absolute minimum consistent with reasonable accountability. We believe it is appropriate to include provisions which seek to attract sufficient participating practitioners to render the required services particularly through reasonable reimbursement levels and prompt payment requirements.

At the same time we suggest that there be very careful consideration or any requirements which can become burdensome on participating providers and upon the states. Most practitioners who would provide assessments under this program already make referrals as necessary and would not view this as a burden. Assistance such as providing a list of local dentists who participate in the program to such providers would help them cary out this activity. In order for the program to be successful some follow up activities also will be necessary. However, in developing this program great care should be taken so that recordkeeping and similar requiremens relating to follow up activities do not become so burdensome and so restrictive as to potentially reduce the number of providers who will be able to participate.

In summary while both bills are well intended, the indefinite nature of many of the major provisions of the Administration bill could result in a program which is no better and perhaps a step backward from the curent EPSDT program with respect to the provision of dental care for poor children. We believe the Committee's bill from last year, with certain necessary changes, would establish a much more effective basis for a successful program to replace EPSDT. As a final comment, I would emphasize again that the investment we can make in the children covered by this legislation will bring them greatly improved health for their lifetimes and will save untold millions of dollars in health care costs in the future.

Mr Chairman, on behalf of the ADA I wish to personally thank you and the other members of the Subcommittee for the very diligent efforts your have made on behalf of this legislation.

Senator TALMADGE. The next witness is Dan Blumenthal of W.T. Brooks Clinic, Department of Preventive Medicine and Community Health, and Department of Pediatrics, Emory University of School of Medicine, Atlanta, Ga.

Dr. Blumenthal, I have read your statement in full and I notice you are associated with the Emory University School of Medicine, Grady Memorial Hospital, and Fulton County Health Department, so you ought to know whereof you speak on this particular problem.

I have read your statement in full. I am going to have to leave momentarily for an important appointment. Senator Ribicoff will chair in my absence.

I welcome you here as a constitutent. You may insert your full statement in the record and summarize it, Doctor.

STATEMENT OF DAN BLUMENTHAL, M.D., W. T. BROOKS CLINIC, DEPARTMENT OF PREVENTIVE MEDICINE AND COMMUNITY HEALTH, DEPARTMENT OF PEDIATRICS, EMORY UNIVERSITY SCHOOL OF MEDICINE, ATLANTA, GA.

Dr. BLUMENTHAL. Thank you, Senator Talmadge. I do appreciate the opportunity to be here and testify on CHAP, which is a program which I hope and which I think will improve the preventive and early detection service we provid to low-income children.

I think that preventive services are really at the heart of pediatrics; they are services which can make an impact on health status and that is not an opportunity that we get very often.

You expressed a concern earlier with the potential cost of this program. I would like to say that I think this is one area in which we can truly deliver cost effective service. It is an area in which we can take some kids who have not become productive members of society and turn them into people who will be productive members of society, rather than people who will be dependent upon society.

I think it is obvious that we can immunize thousands of kids against the polio, or screen thousands of kids for lead poisoning, for the cost of rehabilitating a single child who falls victim to one of these diseases.

EPSDT has failed to deliver the kinds of preventive service we would like to have delivered, and it has failed because of several barriers which Mr. Schaeffer has alluded to previously, barriers which stand between kids and the services we are trying to bring them.

These barriers include fragmentation of service, both within the health care delivery system and without the health care delivery system. That is. EPSDT is one of many services we try to provide low-income people, including food stamps, title XX service and so on.

There is lack of continuity of providers in the EPSDT program. This has been pointed out by others. Children have no medical home. There is a lack of physicians who accept medicaid and this has constituted a barrier to providing service to kids.

There is a lack of knowledge by eligible recipients of the services that are available, and a lack of knowledge of the importance of these services.

I think Senate bill 1204 will overcome many of these barriers. It is, I think, a good bill and should be passed.

There are a few ways in which it could be strengthened, and I would like to mention those:

First, with respect to providing continuity and eliminating as much as possible fragmentation, I would like to see the bill encourage the provision of services through public comprehensive care centers, neighborhood health centers, BCHS facilities, public hospital satellite clinics, and similar facilities, and I would like to encourage these over individual practitioners.

I think we have heard it said several times today that individual practitioners are reluctant to take on the responsibility of coordinating services. They are certainly not able to provide the kind of comprehensive services some of these public facilities can provide. I think that this kind of reluctance will perpetuate the fragmentation we have now if these individual practitioners become CHAP providers.

In those cases in which individual practitioners are willing to take on that responsibility, are clearly able to demonstrate they can do that, I would be in favor of those practitioners becoming part of the program.

Second, I would like to see the encouragement of public health departments which currently provide EPSDT screening services to become primary care providers. I think this will help alleviate shortages of providers in rural areas and, again, will help increase continuity and comprehensiveness where we can encourage health departments to take on this role.

Third, I am very much in favor of provision of outreach services. I think that should be strengthened. As I read the bill, the outreach services specified do not include outreach with respect to followup. Outreach services are intended under the bill only to recruit kids into the program. I would like to see outreach workers also play a role in insuring that the children receive followup care.

I would like to see outreach services provided as much as possible through community groups. I think these nonprofit community organizations have shown the ability to provide effective outreach service.

Senator RIBICOFF. Have you had experience with these community groups in your work?

Dr. BLUMENTHAL. Yes, I have.

Senator RIBICOFF. How do you appraise their ability to do the followup work that a doctor would require instead of placing this responsibility on the shoulders of a doctor?

Dr. BLUMENTHAL. I think community groups have that capability. I think that many community groups have demonstrated excellent ability to do that. I think it works best for the community group that is affiliated with the provider of services; that is, where you have a health center with a community board, if it is also responsible for the outreach that becomes a community activity rather than a professional activity.

Senator RIBICOFF. Would you rather have outreach be the responsibility of voluntary agencies rather than a State welfare agency?

Dr. BLUMENTHAL. When you say "voluntary agency," I think of something like the Cancer Society or the American Heart Association or something like that. That is not what I had in mind.

Senator RIBICOFF. Or Easter Seal. There are representative groups appearing here. I am looking at the list here: The American Speech, Language, Hearing Epilepsy, National Association of Retarded Children, Easter Seal, National Autistic Cerebral Palsy, a number of these organizations.

Dr. BLUMENTHAL. That is not the sort of community organization I had in mind. Those are very disease-specific organizations and using them in followup would result in perhaps greater fragmentation.

I was thinking more of the kind of organization that is represented in my area. Atlanta has reached out and has grassroots area blocks on many levels. I would like to see these local, broad-based community organizations be involved in followup and in outreach.

These are organizations which involve the people to whom the service is supposed to be provided.

The Easter Seal Foundation is not an organization of poor people, and CHAP is a program which is intended to reach poor people. This is not a knock on the Easter Seal program.

Senator RIBICOFF. Would you be willing to supply the committee with the type of organizations you have in mind?

Dr. BLUMENTHAL. Definitely.

[The information to be furnished follows:]

TYPES OF COMMUNITY ORGANIZATIONS THAT MIGHT PROVIDE OUTREACH SERVICES UNDER CHAP

1. Community Boards.—Most federally-sponsored facilities are governed by community boards or community corporations. Where properly constituted, these boards represent the population served by the facility. Federally-sponsored comprehensive-care factilities are often ideally suited to become CHAP continuing care providers; and their sponsoring boards or corporations are ideally suited to provide outreach. The board should hire outreach workers from the community whose children are to be served by CHAP. In this way, outreach services will be closely linked to medical services.

2. CAP Agencies.—Most cities and many rural areas have Community Action Programs which are supported by a grass-roots community strucure. In Atanta, the agency is known as Economic Opportunity Atlanta, and it is supported by a structure which reaches the neighborhood level through Area Block Clubs. These agencies have a long history of working in low-income communities, and could in many cases do an excellent job of providing outreach for CHAP.

3. Other organizations of low-income people.—Tenants' associations, neighborhood organizations, Welfare Rights Organizations, and other "free-standing" community organizations are in close touch with the population CHAP is intended to serve and could provide effective outreach.

4. Advocacy Groups.—In Georgia, the Georgia Citizens' Coalition on Hunger is a group which has provided effective food stamp outreach. Similar organizations could provide outreach for CHAP.

Dr. BLUMENTHAL. I did have one more point I wanted to make as a recommendation, and that is, the eligibilty ceiling should be raised.

I think 55 percent of poverty is very low. I think particularly with respect to pregnant women who are often not eligible for medicaid until after delivery, that the eligibility ceiling should be raised so these women can receive prenatal care under the auspices of this program.

Senator DURENBERGER. I take it, Doctor, what you are talking about, in terms of outreach, is geared more to some of these organizations that are working with the poor and disadvantaged, for example, Model Cities programs in urban areas, than trying to deal with how to meet housing, help with educational and transportation needs?

Dr. BLUMENTHAL. I think the finest example I am familiar with, secondhand, is a group called "Operation Life" in Nevada—I think Las Vegas, perhaps Reno—that assumed control of the EPSDT program there that was previously being run by the medical society, and the medical society was reaching only a small percentage of the eligible children. When the community group welfare mothers took over as the sponsors of the program, almost all the children were reached.

I think this is a function of communty trust and involvement in the organization that is providing the outreach, and an understanding by the organization of the people they are trying to reach.

Senator DURENBERGER. Now, I am getting confused as to your definition of "outreach." To what degree could the organizations that Senator Ribicoff has been suggesting be more involved, actually provided services other than identifying people in need and then identifying, as you and others put it, medical homes for these people?

Dr. BLUMENTHAL. I envision an organization using community workers who live in the neighborhoods involved, who reach the people in those neighborhoods that have eligible children, who explain the program to them, explain the importance of the program and help them get their kids to the place where the program is being provided. Then if problems are discovered in the course of the screening, problems that are going to require referral elsewhere, or will require the involvement of other agencies or programs, these community workers would again act as the patient's advocate and make sure he or she got plugged those programs or services.

Senator DURENBERGER. We are taking it through the screening problem when you move beyond care?

Dr. BLUMENTHAL. Right; that is why I say outreach should not just be involved in recruiting kids, but also followup, making sure the kids got treated for problems that were discovered.

Senator DURENBERGER. I was happy to see your reference to HMO's, but do we have other ways in the private sector as well as public sector, do we have very adequate medical homes outside of private practitioners in most areas of the country?

Dr. BLUMENTHAL. My concern here is that there are facilities such as my own, that have developed a lot of experience in caring for the poor. We understand it is important to be able to certify kids for WIC when they are seen for their checkup. It may be important to provide transportation. It is important to have a social worker or other trained person on hand who can very actively coordinate the other services, not all of which are medical, that the child is going to need.

Private practitioners who deal with middle class kids don't have that experience, don't have those kinds of people on hand. I have heard it said here several times, they are not very anxious to take on the responsibility of coordinating these activities.

So I am saying, if the private practitioners don't want this responsibility, I don't want to push it on them; I don't think they will do a very good job of it if we compel them to take on this responsibility; and I am afraid we will again have fragmentation and poor followup, and we will have kids not getting services they require. So that is why I am saying we should encourage those facilities that can provide comprehensive service, where those facilities are available, as providers of CHAP services. To be sure, there are rural areas and other areas where there are only individual private practitioners, and I think we should encourage those private practitioners to attempt to provide the services that are needed, and we should also encourage the Bureau of Community Health Services to establish new projects in areas where such services are lacking.

Senator DURENBERGER. What I heard was—to make it more attractive for the financial provider, he can meet the demands placed on him by EPSDT or some other program—what I heard you say is that there are other services beyond just the kinds of health care service that would be provided by the physician that are important to the child health care particularly?

Dr. **BLUMENTHAL.** Absolutely. I think health care is much more than medical care. I think low-income kids are particularly in need of the whole spectrum of services that encompass health care, and I think it is important that CHAP be able to get the kids plugged into the services they need.

Senator **DURENBERGER.** Thank you.

Senator **RIBBICOFF.** Thank you.

[Prepared statement of Dr. Blumenthal follows:]

STATEMENT OF DANIEL S. BLUMENTHAL, M.D., ATLANTA, GA.

Mr. Chairman and members of the committee; I am Daniel S. Blumenthal, M.D., a practicing pediatrician. I am on the faculty of the Departments of Preventive Medicine and Community Health and Pediatrics at the Emory University School of Medicine, and am medical coordinator at a Grady Memorial Hospital and Fulton County Health Department satellite clinic which provides primary care to a low-income population. However, I am not representing any of these institutions today, and my opinions do not necessarily reflect those of Emory University, Grady Memorial Hospital, or the Fulton County Health Department.

I will not review here the statistics and indices of health status which demonstrate that low-income children in the United States often do not receive adequate health care. I will, however, point out that children are our most valuable resources, a resource which we as a society have an obligation to protect.

We have not protected this resource sufficiently, despite programs such as Medicaid and its EPSDT component. EPSDT was designed to provide preventive services for low-income children and to detect problems in their early and treatable stages. Yet, of some 12 million children eligible for these services under EPSDT, only about a quarter have actually received them. Of these children screened and found to need referral for treatment, only about 60 percent have, in fact, been treated.

The Congress is now considering a CHAP bill which would extend preventive and diagnostic services to many additional children. Yet, unless it corrects the defects which have led to the failure of the EPSDT program, the enrollment of additional children will only mean additional undelivered services.

EPSDT has been unsuccessful because of the barriers which stand between eligible children and access to the program. Among these barriers are:

1. Fragmentation of services to the poor. EPSDT is one of a vast array of disconnected programs upon which the poor depend for survival. These programs include AFDC, food stamps, WIC, CAP agency services, Title XX services, Medicaid, Medicare, etc. The EPSDT program itself is fragmented: a single screening performed by one provider may result in several referrals to several specialized providers of treatment services. The need to negotiate this labyrinth clearly represents a barrier to obtaining any given service, particularly a service, such as preventive health care, which does not meet an immediate and pressing need.

2. Lack of continuity in health care. The EPSDT program as established in Georgia and in many other states does not allow a child to secure a medical "home." Preventive services are provided by the health department; treatment services are provided by any number of private and public sources of care. The lack of opportunity for the family to establish a relationship with a single primary care provider discourages use of the system.

3. Absence of participating providers. Many physicians still refuse to accept Medicaid; this is particularly a problem in rural areas, where there are no alternative sources of care. Screening is obviously useless if treatment for any problems discovered is unavailable.

4. Lack of knowledge and understanding of the program. Many low-income parents are unaware of the importance of preventive health care; others are simply unaware of the EPSDT program and its provisions.

The administration's CHAP bill goes far toward alleviating most of these barriers. It is overall a good bill, and I would urge its passage. I have however, several suggestions which I feel would strengthen it:

1. CHAP attempts to alleviate the barriers of fragmentation and lack of continuity by providing for "continuing care providers" who will contract with the state to provide both preventive and treatment services. However, it must be recognized that some providers are more continuous than others. In general, individual private

practitioners are not able to provide or coordinate the range of services that low-income patients require. While they provide narrowly-defined medical services at a single location, they do not usually relate to the many other services that clearly impact on the health of the poor. The public sector, on the other hand, often provides social services, WIC certification, transportation, outreach, etc., as a unified, or at least coordinated, service.

CHAP should therefore encourage the use of neighborhood health centers, BCHS facilities, public hospital satellite clinics and the like as continuing care providers where these are available. In the private sector, the use of HMOs should be encouraged because of their relative comprehensiveness and cost-effectiveness. The use of individual private practitioners should be discouraged except for these practictioners who can demonstrate the ability to provide comprehensive services. The Secretary of HEW should set standards in this regard, much as the administration bill requires the Secretary to set standards for mental health services. Exceptions, of course, would have to be made for locales (particularly rural) where no sources of comprehensive care exist.

2. Similarly, health departments which now provide screening under EPSDT should be encouraged to develop complete primary care services and become continuing care providers under CHAP. This will at least partially alleviate the lack of providers in many areas.

3. Outreach is very important in teaching low-income parents the importance of preventive health care and informing them about the available programs. S. 1204 specifies that outreach services must be available to bring children into the program; it should also mandate outreach services in insuring adequate follow-up. Moreover, it has been shown that outreach is most effective when done by a local community organization. CHAP should encourage the provision of outreach services through approved nonprofit community-based organizations.

4. CHAP will make more children and pregnant women eligible than did EPSDT, but many of those most in need of services may still be omitted. The proposed ceiling of 55 percent of poverty is clearly too low. This is particularly true with respect to pregnant women, who may not qualify for Medicaid until after delivery and who are facing a relatively large medical expense.

The administration bill should be particularly commended for its inclusion of mental health services in its program. With the decline of infectious disease as the most important part of pediatrics, behavioral problems and emotional disturbances have become more significant. Coverage for these problems should be included in any child health plan.

Again, I would encourage you to strengthen the Child Health Assurance Plan and vote its passage. It is clearly a move in the right direction. CHAP can be a success, but it must be more than simply an enlarged EPSDT.

Senator RIBICOFF. Our final witness is James T. Speight.

STATEMENT OF JAMES T. SPEIGHT, EXECUTIVE DIRECTOR, EAST OF THE RIVER HEALTH ASSOCIATION, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Mr. SPEIGHT. Mr. Chairman, committee members, I am James T. Speight. I am executive director of the East of the River Community Health Center, located in Washington, D.C.

I have been asked to testify on behalf of Mr. Louis Garcia, who is president of the National Association of Community Health Centers.

We are very happy to have this opportunity to represent this organization before you, and we urge your support and quick action on the child health assurance program, referred to as CHAP.

On behalf of the National Association of Community Health Centers, I would like to spend a brief moment describing the organization. It represents over 600 community-based ambulatory health-based programs providing health services to medically underserved populations.

I believe most of you are aware that we are an organized health care setting for 5 million people who reside in urban and rural areas. The quality of care and effectiveness of this program is well documented by current data we have submitted to the committee previously, and I would like to point out most centers have demonstrated capacity to meet at least the 90 percent immunization for their patient care population.

Mr. Chairman, we support the administration's version of CHAP, H.R. 4053, but would suggest some modifications:

Eligibility: The national CHAP income standard should be set at two-thirds of the nonfarm official poverty line, as defined by OMB, and revised annually in accordance with section 624 of the Economic Opportunity Act: One of the biggest problems with medicaid from its inception was that it did not cover all needy people unless they were categorically qualified. Even at 66 percent of the poverty level, a family income of $4,800 is very low, if not total poverty, in today's market and many areas.

Services: We strongly support the administration's provision which makes the expanded package of services available to all medicaid-eligible children, regardless of whether or not they have received a health assessment.

But CHAP should include, at a minimum, coverage of all needed ambulatory care, including outpatient mental health services, for CHAP-eligible children without limitations on the amount, duration or scope of services.

Dental services: Routine dental care should certainly be a required service to include at a minimum diagnostic, preventive, restoration, and emergency dental services.

CHAP providers should be required by written agreement either to provide routine dental care or provide direct referral and case management for dental services to assure treatment is received.

Provider definition: It should be clearly stated that CHAP providers shall include, "Community and Migrant Health Centers, Rural Health Clinics, HMO's, Indian Health Services Clinics, Maternal and Infant Care projects and Children and Youth projects." No State should be able to exclude these Federal programs which clearly were intended to provide access to this population group. Clearcut discrimination against these programs as experienced in the past, cannot be allowed.

Ongoing care providers: A special category should be created for "Ongoing care providers," who agree to take the responsibility for both the assessment, continuing care and case management of CHAP children.

These providers should be required to sign a written agreement for each child under his care in which he agrees to provide preventive and general acute medical care to the child as needed. The ongoing primary care provider would be responsible for notifying patients and making appointments for all assessment, followup visits, and referrals as a result of the agreement to serve as a source of ongoing care. The provider is responsible for notifying the medicaid agency if the child is no longer under care and the case management functions for that child then revert to the State.

Incentives for ongoing care providers: As an incentive to encourage providers to agree to serve as an ongoing source of preventive and primary care to CHAP children, the Secretary of HEW should be given the authority to mandate the types and levels of reimbursement that must be offered to the ongoing care provider for continuing care and case management services. These ongoing care reimbursement levels could be uniform nationally or varied by State or regional jurisdictions. Reimbursement could be determined by a fee schedule for preventive and ongoing services; an all-inclusive rate for preventive services, adjusted by age; an all-inclusive rate for ambulatory services; or some combination.

The reimbursement arrangements and levels would be determined by the Secretary in regulations.

States may use a prospective, capitation rate to reimburse ongoing care providers, or may submit alternative payment arrangement to the Secretary for approval.

Providers would be required to submit itemized bills for each patient contact; however, ongoing care payments could be made on periodic basis, with a higher final payment at the end of a complete series of assessment visits within a year.

Continuation of eligibility: The bill should require that children who have become eligible under the program remain eligible for 6 months following the point at which the individual or his family become ineligible because of increased income from employment.

Not only would this be better for continuity of care for the patient but also it would reduce administrative burdens for those families who continually go on and off qualification because of temporary, seasonal or marginal employment.

Outreach: We recommend including in any CHAP bill the provision in H.R. 2461 which requires States to earmark a portion of the program budget for outreach services.

If this program is to succeed, you must recognize the importance of outreach and provide adequate funding to do the job, both case finding and followup. The higher Federal match for outreach services is important; however, the availability of Federal funds does not lead States to institute effective outreach programs. Since each child brought into the program represents an expenditure for the State, it is not in the State's financial interest, despite higher Federal reimbursement rates, to bring additional children into the program.

Further, CHAP should require States to develop outreach programs emphasizing the use of organizations located in the target community.

CHAP must also build in ways of shifting outreach activities away from the heavy reliance on welfare agencies. It should promote the use of community organizations and health centers which employ trained paraprofessionals who are from the target community.

Senator RIBICOFF. Why do you state that Outreach should be shifted away from a heavy reliance on welfare?

Mr. SPEIGHT. Primarily because of the way that the agencies tend to be viewed. They tend to be viewed—while they may help some people—as regulators or enforcers, and what you are talking about is health care which is personal and tends to be treated personally, when you talk about being able to influence a person to obtain service even if the service is not in your particular community or health center.

Senator RIBICOFF. Would parents be reluctant to send their children for this care if it were understood that they are under the control of welfare agencies?

Mr. SPEIGHT. You are not talking about public health clinics when you make that question, are you? Do you have reference to public health clinics?

Senator RIBICOFF. No. You say that welfare agencies are enforcers and that many would be reluctant to use services from them. Is that what you are saying?

Mr. SPEIGHT. Right. The staff from welfare departments, while some may have personal contacts and be able to persuade some individuals, generally they are viewed as enforcers or people who ride herd on you to determine when your eligibility ends.

It goes back to the man in the house rules and all those things. So they oftentimes are not very persuasive outreach types to get people to come in and use a particular service such as this patient is suspicious.

Senator RIBICOFF. Will you give me examples of what you consider to be the types of community organization which would be able to do this task? Give me some examples.

Mr. SPEIGHT. There are several types: First, I would like to start with the community health centers. They are organized in a fashion that lends themselves to this kind of activity. There are community action agencies (primarily funded by the Community Services Administration), sometimes referred to as neighborhood development programs, that have been set up in various communities, and these people operate at grassroots levels. They are good at this kind of outreach. Voluntary service agencies, some are often funded through United Way. Those out of that category of volunteer service agencies best suited for outreach tend to be the ones that are community or neighborhood based, and/or in the target area.

So these organizations are the kind that tend to make the greatest impact in outreach.

Senator RIBICOFF. Do you confine your recommendations to community organizations that are not publicly funded, or would you include publicly funded community organizations as well?

Mr. SPEIGHT. Yes; community organizations that are not publicly funded. There are community organizations that tend to be viewed as quasipublic, that is, they are outreach programs that were set up through—for example—the Community Services Administration, and some through HUD when they were doing model cities activity. These quasipublic organizations that have heavy involvement ~~on~~ the part of the target area community tend to be able to do this kind of outreach effectively.

Senator RIBICOFF. Would you give us a sampling of both types of organizations that you think could do this outreach task and do it well? I don't expect you to go through the whole country, but a few samples of both types of agencies throughout the country.

Mr. SPEIGHT. You want me to name specific——

Senator RIBICOFF. Not now, but provide it for the record.

Mr. SPEIGHT. I will be happy to do that.

[The information requested follows:]

(1) Community Health Centers, (2) Community Action Agencies (primarily established by CSA and HUD), (3) Settlement Houses, (4) Day Care Associations, (5) Local Boys Clubs, (6) Boy Scouts and Girl Scouts (local), and (7) 4H Clubs and New Farmers of America.

It is important that the focus be on local organizations instead of national counterparts as this approach would be more cost effective and productive.

Choices should be dependent upon what is available in local communities.

Senator DURENBERGER. Two questions:

I see you drew the line on mental health services for outpatients. Was that done deliberately?

Mr. SPEIGHT. In part. We are promoting outpatients. That is not to say that the inpatient may not be needed, but most of our group felt if we at a minimum could deal with outpatients—particularly since we are talking about children—we might head off a great need for inpatient service in the later ages, young adults or the teenage bracket.

Senator DURENBERGER. It is not to say inpatient services are not needed and needed by the poor?

Mr. SPEIGHT. No. By no means, that was not to suggest that inpatient services are not needed by the poor. We do see today—not on this day, but in today's time—in some of our recent meetings where community health centers have congregated, we see the need increasing for outpatient service in mental health, and I think we all know some of the reasons why; but it seems to be increasing dramatically.

Senator DURENBERGER. From the issue of income eligibility, what would you think of a sliding scale of copayments?

Mr. SPEIGHT. Now, with regard to the sliding scale, practically all the community health centers do use a sliding scale, or we provide the service free. If you are talking about copayment, you mean the patient pays the difference, and to that extent we do use the sliding fee scale and we use CSA department guidelines to develop that scale.

Community health centers do charge those patients who can pay according to family income as measured by the CSA poverty index. Those whose income is above the poverty level but below twice the poverty level pay on the basis of a sliding fee.

We try to keep that up to date, so the patient pays something if they are able, but that it is not a deterrent to receiving the care.

Mr. VAN COVERDEN. I am acting executive director of the National Association of Community Health Centers.

We suggest that a sliding fee may be imposed to families above 66 percent of the poverty level, but not below that.

Senator DURENBERGER. You cut it off at 66 percent?

Mr. VAN COVERDEN. At whatever point there might be no copayment required.

Senator DURENBERGER. I am just wondering about the concept of the use of a copayment, will that discourage people or not? Judging from what you say, the other service is being rendered by the community health centers. It does not necessarily discourage participation in the program?

Mr. SPEIGHT. No. It does not. Those centers that administer this sliding fee scale tend to get pretty good response from it. Basically, people are willing to make some contribution to obtain services and would like to be able to pay for all the services. That is the experience we have had.

We want to be sure the sliding fee scale or any copayment is not a barrier to treating the kid.

Senator RIBICOFF. Thank you very much.

[The prepared statement of Mr. Speight follows:]

STATEMENT OF JAMES T. SPEIGHT, EXECUTIVE DIRECTOR, EAST OF THE RIVER COMMUNITY HEALTH CENTER, ON BEHALF OF LOUIS S. GARCIA, PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. Chairman, my name is James T. Speight. I am Executive Director of the East of the River Health Center here in Washington, D.C.

I am here today to urge your support and quick action on the Child Health Assurance program, referred to as CHAP.

On behalf of the National Association of Community Health Centers, which represents over 600 community-based ambulatory health programs providing health services to medically underserved populations, I would urge your support and immediate action on this important legislation.

I believe most of you are aware of the Community and Migrant Health Center Programs. Currently, there are 824 centers providing primary health services in an organized setting to five million people who reside in urban and rural medically underserved areas.

The quality of care and effectiveness of these programs is well documented by current data. For example, most centers are in compliance with indicators that 90 percent of all children served by a center are completely immunized. Centers are required to screen children for vision and hearing. The health centers have been shown to reduce hospitalization in areas they serve by 28-34 percent; and despite substantial federal and state reporting requirements have reduced administrative costs to 22 percent of total operating costs. The annualized cost per person served last year at a Community Health Center was $157 which compares to a cost of $298 per capita costs for comparable services for all U.S. patients.

Mr. Chairman, we are fully supportive of the Administration's version of CHAP, H.R. 4053, but would suggest some modification:

Eligibility.—The national CHAP income standard should be set at two-thirds of the non-farm official poverty line, as defined by OMB, and revised annually in accordance with section 624 of the Economic Opportunity Act.

One of the biggest problems with Medicaid from its inception was that it did not cover all needy people unless they were categorically qualified. Even at 66 percent of the poverty level, a family income of $4,800 is very low, if not total poverty in todays market and many areas.

Services.—We strongly support the Administration's provision which makes the expanded package of services available to all Medicaid-eligible children, regardless of whether or not they have received a health assessment.

But CHAP should include, at a minimum, coverage of all needed ambulatory care (including outpatient mental health services) for CHAP-eligible children without limitations on the amount, duration, or scope of services.

Dental services.—Routine dental care should certainly be a required service to include at a minimum diagnostic, preventive, restoration, and emergency dental services.

CHAP providers should be required by written agreement either to provide routine dental care or provide direct referral and case management for dental services to assure treatment is received.

Provider definition.—It should be clearly stated that CHAP providers shall include "Community and Migrant Health Centers, Rural Health Clinics, HMOs, Indian Health Services Clinics, Maternal and Infant Care Projects, and Children and Youth Projects." No state should be able to exclude these federal programs which clearly were intended to provide access to this population group. Clear-cut discrimination against these programs as experienced in the past cannot be allowed.

On-going care providers.—A special category should be created for on-going care providers who agree to take the responsibility for both the assessment, continuing care and case management of CHAP children. These providers should be required to sign a written agreement for each child under his care in which he agrees to provide preventive and general acute medical care to the child as needed. The ongoing primary care provider would be responsible for notifying patients and making appointments for all assessment, followup visits, and referrals as a result of the agreement to serve as a source of ongoing care. The provider is responsible for notifying the Medicaid agency if the child is no longer under care and the case management functions for that child then revert to the State.

Incentives for ongoing care providers.—As an incentive to encourage providers to agree to serve as an ongoing source of preventive and primary care to CHAP children, the Secretary of HEW should be given the authority to mandate the types and levels of reimbursement that must be offered to the ongoing care provider for continuing care and case management services.

These ongoing care reimbursement levels could be uniform nationally or varied by State or regional jurisdictions. Reimbursement could be determined by a fee schedule for preventive and ongoing services; an all-inclusive rate for preventive services, adjusted by age; an all-inclusive rate for ambulatory services; or some combination. The reimbursement arrangements and levels would be determined by the Secretary in regulation.

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If this program is to succeed, you must recognize the importance of outreach and provide adequate funding to do the job, both case finding and follow-up. The higher federal match for outreach services is important. However, the availability of federal funds does not lead States to institute effective outreach programs. Since each child brought into the program represents an expenditure for the State, it is not the State's financial interest, despite higher federal reimbursement rates, to bring additional children into the program.

Further, CHAP should require States to develop outreach programs emphasizing the use of organizations located in the target community.

CHAP must also build in ways of shifting outreach activities away from the heavy reliance on welfare agencies. It should promote the use of community organizations and health centers which employ trained para-professionals who are from the target community.

Mr. Chairman, there are a number of other key issues which need to be addressed, such as financing and performance standards, but we do not have the time here.

Again, I thank you for this opportunity and urge your consideration of our recommendations. I would be pleased to respond to any questions.

Thank you.

Senator RIBICOFF. On behalf of Senator Baucus, I ask unanimous consent that his statement be placed in the hearing record at the beginning of these hearings.

I want to take this opportunity on behalf of Senator Talmadge and the committee to thank the excellent panel of witnesses that we have today who have testified on behalf of this most important piece of legislation.

This concludes the hearing and the committee will stand adjourned.

[Whereupon, at 4:40 p.m. the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

TESTIMONY OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists commends the Finance Committee for its recognition of a need, and support for efforts to provide comprehensive health care to low-income children and low-income eligible women. Currently, federal programs designed to support health services for this population are fragmented and poorly coordinated at both the Federal and State level as has been documented by recent Congressional investigation. Congress addressed this issue and successfully moved through legislation to establish the Select Panel for the Promotion of Child Health which was realized by enactment into P.L. 95-626. We applaud this action and look forward to the Panel meeting its goal of developing a national policy for the heatlh care of mothers and children which will serve to dissemble and eliminate overlap and administrative duplication among federal programs.

During this Congress' consideration of the Child Health Assurance Program (CHAP) proposals submitted thus far, the American College of Obstetricians and Gynecologists strongly feels that this streamlining process can begin before the completion of the Select Panel's task.

Among the Federal programs created to improve the health of this nation's women and children, the Title V Maternal and Child Health Program stands out as the first effort to attend to these needs by initiating; at the state level, a distinct administrative unit to promote the health of the maternal and child population. Clearly, the mandated intent of Title V, when it was enacted in the original Social Security Act, was to provide grants to States for planning, assessment, and coordination of the existing health services resources present at the community, county and state level. To assure this function, each state was required to submit a statewide plan demonstrating the state's commitment and attention to all of the above concerns. Congress extended the mandate of Title V and in the 1960's authorized additional monies for development of special projects to address maternity and infant care, the health of school-age and preschool children, as well as the dental health of these children. We strongly support such demonstration projects in the states and feel that establishment of such projects in remote and underserved areas of a state is a sensible and worthwhile approach to the promotion of health for residents of that area. However, we caution Congress to bear in mind that operation of such projects and provision of personal health services is not the primary objective of the Title V program. If Congress looks first to Title V programs to account for the numbers of women and children served per state by such projects, the state may risk losing focus on its original mandate to coordinate and assist in the administration of existing projects which can combine to supply the comprehensive services for the population in need. Title V mandates that the state program directors, who are ultimately responsible for coordination of these medical services, will be physicians and that there will be sufficient medical and health professional staff at the state level to assure the good quality and comprehensiveness of the state program. We feel that this is a sound basis from which to build a state program.

Contrast this structure with the Title XIX mandate to serve as a health care financing mechanism for the actual provision of health services for low-income individuals and it becomes apparent that any Child Health Assurance Program enacted by Congress, which will utilize Title XIX medicaid monies for the provision of comprehensive preventive medical care for mothers and children, is not conflicting with Title V programs but instead will compliment Title V activities. To this end, we urge Congress to review these programs together.

The specialty of obstetrics and gynecology has as its primary goal excellence in the provision of maternity care for women. Inherent in this objective is the desire for quality health care available to all women regardless of age, marital or family status, or financial resources.

The combination of existing programs, health professionals working in the delivery system, and legislators working to reform inequities, are making valuable efforts to attain this objective by supporting changes in policy and behavior of health professionals, as well as their patients, which will remedy problems resulting from lack of access, acceptance and financial assistance. The American College of Obstetricians and Gynecologists strongly supports the proposed extension contained in CHAP for Medicaid eligibility to all low-income pregnant women meeting proposed income requirements or the state income standards, whichever is higher.

The Department of Health, Education, and Welfare has estimated that because some states have limited Medicaid eligibility for pregnant women, approximately 100,000 women go without essential prenatal and postnatal care at a critical time for both mother and child. As the organization of physicians who are best qualified to provide maternity care for women, ACOG feels that these estimates of women who carry a pregnancy to term without ever coming into contact, or having limited contact, with appropriate health professionals are indeed valid and significantly demonstrate the sound argument in favor of lifting existing financial barriers. Remaining barriers which contribute to the number of unattended pregnancies must still be addressed. Geographic maldistribution of appropriate health profes sions is clearly a factor and needs to be approached by the profession and others, inside of Congress and out, who can work to assure quality programs in all regions of this country. In the interim, we urge Congress to address and support this extension of Title XIX which can have immediate impact upon a significant problem facing thousands of pregnant women in need of health services.

This provision of the CHAP legislation, supported by the Administration, is not new to Congress. Revision of Medicaid eligibility for pregnancy has been proposed many times by Senator Alan Cranston, Chairman of the Subcommittee on Child and Human Development, as an effective first step in assuring the quality of health of our children. We urge that the Committee support this contained provision in CHAP and separately introduced in the form of S. 1211, in order to allow enactment during this session of Congress.

We suggest that, during consideration of CHAP and Title V revision, the subcommittee examine and consider the recommended revisions contained in a bill introduced in the 95th Congress by Congressman Rogers and Congressman Tim Lee Carter (H.R. 10704) which has been supported by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Medical Association. As major organizations representing physicians and the specialities responsible for the health care of the maternal and child population, we consider their health concerns deserving of a centralized administrative office receiving high-level priority within the Department of Health, Education, and Welfare. By mandating this reorganization and creation of a central Office of Maternal and Child Health, Congress will establish a unit able to implement the policy recommendations submitted by the Select Panel for the Promotion of Child Health. New (or perhaps it would be more appropriate to say renewed) emphasis should be placed on the development of the state plan. Over the recent years, regulations have weakened and, in fact, dismissed the requirement for states to annually submit their state plan for Title V activities. We strongly recommend that this requirement be reinstated in the Title V mandate and that a state plan be submitted yearly to the Central Office for Maternal and Child Health which includes a state's survey of needs, present capabilities, and intentions to address the individual state's needs for additional health services for women and children.

We appreciate this opportunity to comment and contribute to your deliberations.

PREPARED STATEMENT OF DAVID AXELROD, M.D., COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH

MAJOR POINTS

1. Draft bill will have relatively little impact on child health initiatives in New York State.

2. Support: (a) Increased coverage of pregnant women, (b) incentives for outreach, (c) additional aid for ambulatory health services, and (d) greater involvement of schools in health delivery.

3. Oppose: (a) Giving authority to Secretary to set minimum reimbursement levels.

Mr. Chairman and members of the Committee, I am pleased to have the opportunity to appear before you today and convey the New York State Health Department's support of the Administration's Child Health Assurance Program.

Nowhere do we stand a better opportunity of improving the health of the American people than through the delivery of comprehensive preventive health care to low-income children and pregnant women. Our children are our most precious human resource. Through them, their safe and healthy birth and upbringing, and their knowledge, adoption and life-long pursuit of good health practices, we are presented with the best possible chance of realizing our cherished goals of health betterment.

Let this be the year that Congress gives the nation's children the most beneficial birthday gift a concerned and responsible society can present: a strong CHAP bill.

In his 1979 State of the Health Message, Governor Hugh Carey said (quote) we (in New York State) intend to set the standard for the nation in showing that quality pre-natal care is a basic realizable . . . right. The most basic right for an infant is the right to be healthy, and I shall spare no effort to correct the terrible wrong of inadequate or even no prenatal care in minority communities. (end quote)

As the father of a large family, Governor Carey promised to lead the fight for passage of CHAP this year. I am his emissary in this important mission.

Mr. Chairman, we believe CHAP is an important and forward stride in the process by which we in government seek to remove the barriers that limit access to health services for low-income children and pregant women. Passage of this legislation, will bring more basic health services to more of the people who need them most. This bill also holds the promise that every child born in America will be given the opportunity to reach her or his fullest human potential.

In saying this, may I add that the proposed legislation will have a relatively small impact on New York State, in large part because Governor Carey and the State Legislature have built within Medicaid a CHAP program in New York which offers a full range of child health services, including preventive measures. Our CHAP program covers all Medicaid-eligible children in the Public Assistance, AFDC, and Home Relief categories.

I do wish to comment on some of the bill's specific provisions.

We are particularly pleased with the increased coverage of pregnant women called for in Section 201 of the draft bill. This will provide Medicaid coverage for many poor women, regardless of family composition, and will fill a serious gap in service that currently exists.

Section 1903 of the act would be amended to authorize Federal payment of 75 percent of the cost to the State agency of outreach activities designed to increase eligible children's access to Medicaid. Such federal incentives are particularly desirable in New York State, since they will free State funds which were committed to that very purpose last year.

The draft bill will increase federal matching aid to all children rather than the number of children assessed. This also is an improvement, since it is extremely difficult to keep track of assessed individuals and totals.

We are enthused about the plan to increase by four percentage points the State's federal medical assistance percentage for ambulatory health care services for children. However, with the annual costs of children's ambulatory services now pegged at $150 million in New York State, an increase of four percent will provide only $6 million in additional support, and this is far too little to provided better fees and other incentives.

We are concerned about what seems to be a precedent under Section 1913, wherein the Secretary is authorized by set minimum reimbursement levels. This has always been a state prerogative in what is largely a state-run and financed program. We oppose this sub-section of the draft bill.

And we have constantly lobbied for simplified guidelines that permit schools to become CHAP providers in those areas where traditional health services and providers are lacking. We believe the school is a perfect setting for the delivery of preventive health services.

In summary, the new federal CHAP legislation would have minimal impact on New York State's present emphasis of providing a full range of health care services, including preventive measures, for children. The federal CHAP bill would, however, give us new financial incentives to expand delivery of services since it would permit NYS to receive increased federal matching funds. Higher Medicaid reimbursement to physicians and other health care professionals who agree to provide continuing health care services to children would also be possible as incentives for greater participation in Medicaid by such providers.

STATEMENT OF AMERICAN NURSES' ASSOCIATION

The American Nurses' Association believes that S. 1204, the Child Health Assurance Program, is an important first step toward a national health policy of comprehensive health services for all children. We support the purpose of this legislation to: expand the availability of health care to low-income women and children, assure continuity of care, and increase the numbers of those eligible, and provide incentives to states to design and implement more effective assessment and treatment programs. S. 1204 contains many of the reforms needed to ensure that all eligible women and children are properly assessed and treated.

We do, however, believe that there are several problems with S. 1204 as presently written, and we suggest the following changes:

A. PROVIDERS

If CHAP is to work, S. 1204 must expand its concept of the types of care and the types of providers eligible under the proposed legislation.

A recurrent failure of the EPSDT Program has been in ensuring that providers—both in the public and private sectors—participate in sufficient numbers to screen and treat all eligible women and children. Past experience has shown that the complexity of the EPSDT Program, as well as current Medicaid reimbursement rates, discourage eligible providers from participating in sufficient numbers for the program to be at all successful. Given the expanded screening and services package of S. 1204, and given the additional case management and other responsibilities imposed on providers, it simply is not realistic to expect that this legislation will encourage increased participation of eligible providers.

Nurses have been intimately involved in the EPSDT program, and many of the types of screening and health care services authorized by S. 1204 are currently provided by nurses. Much of the health care services needed by low-income women and children need not be given by a physician. The required services fall within the scope of nursing practice. For example, statistics from the state of Wisconsin show that only one of every five children screened in the EPSDT program required referral to a physician. Nurses, furthermore, occupy a central position in the health delivery system, a position where it seems logical—and cost effective—to place the case-management responsibilities discussed in Sec. 102(b) of the Act.

ANA therefore recommends that Sec. 102(e) of S. 1204, defining eligible providers of assessment and continuing care services, be amended to read: ". . . physicians, physician assistants, nurse practitioners (including nurse midwives), and such other providers as may be specified by the Secretary in regulations." Likewise, all references to "medical care" wherever they may appear in this Act, should be amended to read "health care.".

ANA's concerns that the school system be integrated into CHAP appears to have been addressed by listing the school as an eligible provider in Sec. 102(e).

B. SERVICES

1. *Primary and preventive.*—S. 1204 should codify a minimum preventive service package that must be provided by state programs. Experience has shown that leaving the identication of services to the discretion of the Secretary results in slow and unsatisfactory process as demonstrated by HEW's track record in developing EPSDT regulations.

2. *Assessment and treatment services.*—The treatment service package should match the assessment service package. For example, it makes little sense, and is also costly, to provide hearing testing if speech therapy is not an allowable service. Some thought should be given to mandating linkages to services available through existing programs other than Title V.

Currently the EPSDT program creates duplication of services, gaps in services, and inadequate reporting. This is not cost effective and makes the addition of any new services, such as recommended in the legislation, prohibitive in terms of cost. Patients do not benefit from this approach, indeed, the present system is underutilized. Existing MCH services should be consolidated and coordinated before new services are added. The majority of federally financed health programs are provider based and not based on the health needs of the population. In order to assure cost effectiveness and quality of care, the legislation should provide for demonstration projects based on a thorough assessment of community needs.

ANA supports S. 1204's provision of ambulatory mental health services to eligible children. An estimated 30 percent of children entering first grade have identified behavioral and emotional problems, and their growth and development would be hampered by any limits placed on mental health services. We recommend that outpatient and inpatient mental health services, in addition to ambulatory services, be made available under CHAP without limits on the amount, duration, and scope of such services.

3. *Case Management Responsibility.* The identified provider, whether a school system, individual practitioner, health department, or other, should be accountable for continuity of care. This does not mean that the provider must be able to provide all services, but that the provider must accept responsibility for seeing that the patient receives required services as well as followup care. However, provision of both assessment and treatment services by the *same provider* should be encouraged not only for program efficiency but to prevent the confusion and inconvenience to patients of being shuffled from one provider to another. Likewise, ANA supports amending Sec. 102(e) of the Act to encourage, wherever possible, the provision of both asessment and treatment services at the same site.

C. OUTREACH

We endorse S. 1204's provision of financial incentives for intensified state outreach programs. However, to ensure that an acceptable number of eligible women and children are reached, the increased federal matching rate for outreach should specify a minimum performance level. For example, any increased federal financial incentives could only be triggered by state which had reach a specified percentage of all eligible children in the state.

State outreach efforts should be personalized. Statistics indicate that the more personalized the outreach, the greater the participation rate in the program. According to Early Periodic Screening, Diagnosis and Treatment, the Possible Dream, published by HEW, "personal contacts with outreach workers were responsible for 75% of the children screened during a three year period in one Pennsylvania county. South Carolina, which has enrolled 85% of its eligible children, sees its transportation contact with the local Community Action Program as a major factor in its high rate of participation. In Maine, 1200 people were contacted over a three month period. With personal contacts, only 1% refused EPSDT services; without outreach workers to explain the value of the program, service refusals jumped to 15%."

ANA recommends that Sec. 102(b) of the Act be amended to read: "The program must provide for personalized outreach . . . . Outreach under this subsection must include identifying and locating families of eligible children and personally informing them . . . with this personalized outreach to take such form as prescribed by the Secretary in regulations."

D. FINANCING

We agree with the approach, outlined in Sec. 106(d), tying the federal matching rate to performance levels of state programs. What constitutes an acceptable level of performance is not, however, detailed in the formula. Such things as a minimum percentage of eligible children who must be assessed and treated before increased federal support would be forthcoming should be specified. Section 106 does not adequately factor in overall program success in terms of quality of care and timeliness in providing needed services. We would support amending Sec. 106(d) of the Act to provide specific time limits for determining the percentage of eligible children that have been assessed and treated: i.e., assessing within six months those children covered by an agreement, providing within six months all treatments found necessary in the assessment, etc.

Section 106 also provides that during the first 18 months of the program, the federal matching rate for services to eligible children would be 4% higher than a state's current rate. We must question whether this provision will provide sufficient financial incentive to encourage the extensive state program changes necessary to make CHAP work. Recent history with EPSDT has shown that stronger federal financial incentives may be necessary for effective implementation on the state level.

E. ELIGIBILITY

Eligibility is closely related to the fiscal aspect of S. 1204. One consistent criticism of both Title V MCH services and EPSDT has been underutilization of the services by the eligible population. Services are viewed as second class health care for second class citizens and are, therefore, shunned. The non-medicaid population should be allowed to participate in CHAP on a fee-for-service basis. This would provide an additional source of financing for the program, particularly at the state level as well as improving public perception of the program.

Section 105 (2) of the Act will allow a 4 month extension of services beyond the original eligibility period. This is an arbitrary and unrealistic limitation of a course of treatment and recovery. We support a one year extension of services as a more realistic time frame. A similar provision should be added for pregnant women (currently set at 60 days after termination of pregnancy). Likewise, Sec. 101 (a) (1) (B) (ii) and related sections of S. 1204 should expand the age limit for eligible individuals from 18 to 21.

F. REPORTING

Patient records, preserving confidentiality, should be readily available and accessible to the various Federal health programs without regard to the service under which the record originated. Duplication of services is rampant because of the difficulties encountered in transferring from one program to another.

Integrated reporting systems should begin at entry into the system whether the entry point be outreach or treatment. Outcome must be documented at each stage of the process. Experience has shown that this is one of the weakest points in the system. There is currently no uniform way of determining the outcome of services. Therefore, system monitoring for effectiveness is impossible.

In summary, the American Nurses' Association would support S. 1204 with the changes recommended above. We will be happy to supply any additional information and assistance that would be helpful to the committee.

WISCONSIN HEALTH CARE REVIEW, INC.,
Madison, Wis., June 21, 1979.

MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington D.C.

DEAR MR. STERN: This letter is in response to the United States Senate, Committee on Finance, Sub-Committee on Health Press Release, date June 7, 1979, publication No. H-33.

This letter is in lieu of a request for oral presentaton at a hearing to be held on June 25, 1979 in the Dirksen Senate Office Building.

The problem for which Senator Talmadge is convening the above stated meeting is stated as the inability of government to target public funds for assistance to entitlement programs, EPSDT in this case, to assure that such programs do not overlap, resulting confusion and duplication of benefits, and most importantly leave out eligible persons who could be receiving needed services.

I wish to comment on those issues of accessibility and detection of eligible children for Title 19 program (EPSDT) (CHAP).

If in the past accessibility to EPSDT has reached only 2 of the total population of 11 million eligible children then I suggest the following as one course of action:

1. Offer under terms of competitive bidding to the private sector, the administrative and provider service functions using as a payment formula: (a) administrative cost—*x* dollars per eligible child screened, and (b) provider services—capitation payments through HMOs (closed panels, staff/group or IPA models), or where no HMO is available, or prepared to offer services on a prepaid basis, an annually negotiated fee schedule with various provider groups eligible for services.

It is simply a fact in Wisconsin that for those who administer Title 19 funds have no incentive either in terms of federal matching funds or in terms of state health authority priorities, to provide the extraordinary efforts needed to serve those who are eligible for Title 19 benefits. Using the Medicaid program, as an example one could cynically believe that one means of cost containment used is to assure a sizeable/eligible population who are unaware of the benefits that they are entitled to receive.

I would see in Wisconsin as one possibility a demonstration grant to test this hypothesis to assure that all children that are eligible for the Title 19 program are screened and secondly, a determination made as to the necessity, type and quality of health services provided to eligible children.

I am most appreciative of the opportunity to provide my thoughts to the Senate Committee on Finance.

Sincerely,

CAMERON G. BROWN,
Executive Director.

STATEMENT OF DONALD P. CLOUGH, EXECUTIVE DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

The American Social Health Association is a national non-profit organization founded in 1912, and is the only such group singularly focused on the prevention, control, research and eventual elimination of epidemic venereal disease in the United States. Through a combined program of intramural and extramural activities, the association directly engages in biomedical research, behavioral research, educational materials development, policy analysis, professional training, pilot demonstration projects, and public awareness programming with respect to sexually transmitted diseases, with a particular emphasis on young people. We appreciate the opportunity to present testimony on S. 1204, the Child Health Assurance Act of 1979.

An estimated 10 million cases of sexually transmitted diseases occurred in the U.S. in 1977—33 percent of these cases were among adolescents, 86 percent among people 15 to 29 years of age. That means that one out of every seven adolescents in this country now suffers from a sexually transmitted disease. More than two-thirds of all cases of gonorrhea occur in the 15 to 24 age group. This year gonorrhea alone will cause young women to miss more than one million school days.

The real tragedy of venereal disease is not in the statistics of incidence, staggering as they are, but in the consequences of the diseases.

Venereal disease is now the single greatest cause of unintended sterility among women of child-bearing age, and this year 100,000 young women will be pathologically sterilized by VD, at least 18,000 of them adolescents. Perhaps more tragically, others will pass along the diseases to their unborn babies, causing severe mental retardation or death to these offspring.

Nongonococcal urethritis (NGU) is more difficult to detect and treat than gonorrhea. While the medical consequences for women are similar to those of gonorrhea (that is, sterility and pelvic inflammatory disease) it is now known that NGU has serious consequences for males as well, including sterility and prostate disease.

Genital herpes, unlike any bacterial venereal disease, cannot be cured. The reservoir of infection is estimated at 10 million persons. Aside from the distress of this recurrent painful disease, female victims bear an inordinately increased risk of developing cervical cancer, or of passing the virus to their babies during birth, resulting in death or brain damage in 7 out of 10 infants.

Mr. Chairman, to term this an epidemic is clearly a gross understatement. VD represents one of the most serious health problems of adolescents today. It is therefore imperative that the program authorized by this bill, which will provide services to young people up to the age of 18 or higher, provide adequate venereal disease services.

The bill's provision of "such services and procedures appropriate for an individual of his age" provides for these services, and we call on the Committee to include strong report language directing the Secretary to directly address the issue of adolescent venereal disease by requiring through regulation that venereal disease services be offered by providers or that adequate referral agreements be made.

We are concerned that the current program has thus far been strongly directed toward services for infants and very young children. It is most important that states begin to aggressively expand their program services to include adolescents, whose health needs are unique, and too often fall through the cracks of the various service programs.

In terms of venereal disease, young people are particularly likely to delay treatment and thus run greater risk of serious complications from the diseases for several reasons. First, they lack accurate information about the symptoms, treatment, and transmission of the diseases. Second, eight out of ten women experience no symptons, and thus are unaware anything might be wrong. Finally, young people mistrust the existing medical system, which is geared either toward adults or to the very young. There is nowhere they can go where they feel comfortable that their needs are understood, and most importantly, where they feel sure their confidentiality will be preserved. In almost every state minors can be treated for venereal disease without parental consent.

The Child Health Assurance Program could provide a valuable opportunity to screen young people and thereby collect important data regarding adolescent venereal disease as well as to detect and prevent disease. Such figures would assist in determining need for venereal disease education programs and assess effectiveness of those programs which may already exist.

We recommend that report language also direct the Secretary to require careful coordination with the venereal disease division of the Center for Disease Control with respect to services and data collection in this program.

Too little attention has been paid to incorporating the needs of adolescents into health programs, coordinating the care adolescents receive, or developing programs which actively encourage young people to use a broad range of preventive health care services. We are aware that such a new emphasis will require increased funds and a number of reforms in legislation and regulation. But we urge you to begin to address this need and to develop inventives for states to do likewise. Teenagers should be expressly mentioned in the legislation as a populations whose needs are a priority.

Venereal disease among teenagers, and in even younger children some of whom may be the victims of sexual abuse, is a problem which has reached staggering populations. We cannot afford to miss a single opportunity to provide screening and treatment to young people who are too often uninformed, misinformed, or afraid. For it is this population which is at the highest risk of contracting a venereal disease.

The epidemic of venereal disease is a public health issue which warrants and commands the collective attention and resources of society. The Child Health Assurance Program which will provide services to medicaid-eligible youngsters could provide a very important component in the nation's effort to combat teenage venereal disease.

We urge this committee to assume the leadership necessary to carry out this task and stand ready to offer whatever assistance might be necessary.

Thank you very much for this opportunity to express our views.

STATEMENT OF JACQUELYN D. BATES, CHAIRMAN, CHILD ADVOCACY PROGRAM, FOR THE ASSOCIATION OF JUNIOR LEAGUES, INC.

The Association of Junior Leagues is submitting this written testimony to affirm its support for an effective Child Health Assurance Program (CHAP) which would expand and strengthen the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and strengthen and improve Medicaid services to low income children and pregnant women.

The Association of Junior Leagues is a non-profit organization with 229 member Leagues with approximately 125,000 individual members in the United States. Its three-fold purpose is: To promote voluntarism; To develop the potential of its members for voluntary participation in community affairs; and To demonstrate the effectiveness of trained volunteers.

Our commitment to effective training is reflected in the requirement that every Junior League member must participate in a training program before she begins work in her community. The majority of Junior League members continue to take training courses throughout their years of Active League membership. In addition, every Junior League member must make a commitment to a volunteer position during her Active years. A substantial number of Junior League members today sit on the boards of other voluntary organizations throughout the United States because of the leadership training which their community volunteer experience has given them.

THE ASSOCIATION OF JUNIOR LEAGUES AND ADVOCACY FOR CHILDREN

Our commitment to the improvement of services for children is long standing. Junior League volunteers have been providing services to children since the first Junior League was founded in New York in 1901. Through the years, Junior League volunteers have provided a variety of direct services to children, including the establishment of settlement houses, emergency shelters, child health and well baby clinics and have served in a variety of positions such as tutors, case aides and counselors.

In the early 1970's, The Association of Junior Leagues became increasingly aware that its services could reach only a fraction of those in need. In addition, League volunteers identified many unmet needs among those children they served. A decision was made to supplement the Leagues' services by broadening the Association's activities to include advocacy on behalf of the children. As a first step in its advocacy efforts, the Association in 1975 developed a study to be conducted by Junior Leagues in their own communities to determine the state of children's needs and the services available to meet them. Community surveys were conducted in 214 communities by League members trained in interviewing techniques and educated in the five focus areas chosen for the Association's Child Advocacy Program: child health, child welfare, special education, day care and juvenile justice. In the areas of perinatal care and child health, the survey results revealed a need for every woman to seek perinatal care, including good medical care and nutritional guidance. In addition, the surveys revealed a lack of facilities for monitoring high risk pregnancies. The survey also identified many inadequacies in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), a preventive health care program for Medicaid eligible children under 21. Outreach for the program was inadequate or non-existent in many areas. A great number of needy children were not reached by the program either because they and their families did not know about the program or because they did not meet their states' eligibility requirements for Medicaid. As a result of the surveys, several Junior Leagues became involved with the EPSDT program in their own communities. For instance, a survey conducted by the Junior League of Fargo-Moorhead in 1976—nearly 10 years after the enactment of the EPSDT program—revealed that the program in North Dakota had not passed beyond the developmental stages. League members identified a number of problems that had prevented the state agency from moving ahead on the program. Policy formation, organizational restructuring and personnel changes all contributed to the delay in implementation.

More than 1,000 of the some 10,000 youngsters eligible for the EPSDT program lived in the Fargo area, but there was no record of the number of the children who were actually served by the program. Members of the Fargo-Moorhead League concluded that many eligible recipients were unaware of the program. Deciding that an adequate information program about the EPSDT would increase the program's effectiveness, the Junior League of Fargo-Moorhead chose EPSDT outreach as a project.

Aware that many low income parents tend to use crisis or emergency care rather than long-term preventative care for their children, League researchers concluded that to be successful, an outreach program must do more than simply locate the parents of children eligible for the EPSDT program; it must educate the parents about the value of early detection and medical treatment for each child. Proposals for possible projects were drafted and presented to the Cass County Social Services of North Dakota.

After more than a year of meetings with state and county personnel, the Junior League of Fargo-Moorhead and the Cass County Social Services signed a contract for the development of an outreach program in which Junior League volunteers serve as mandated agents of the social services agency. League members partiticpating in the program sign personnel contracts, receive I.D. cards and when requested, attend staff conferences and state meetings concerning EPSDT procedural revision. The client's right to confidentiality is protected by having League members serve as mandated county agents with the responsibility of observing the standards set for county agents. Each volunteer is responsible for a number of clients. If a client does not respond to an informational letter about the EPSDT program, the volunteer follows up with a phone call or home visit to explain the benefits of the program and encourage a screening appointment. The volunteers take the health and social histories of each client a week before the screening occurs and keeps detailed time logs on each client. If the screening reveals a need for medical treatment, the volunteer checks to see that appointments are kept and provides transportation if it is needed. When the outreach program began in 1978, there were only two to three screenings a week in the Fargo area. By 1979, the screenings averaged more than 50 a month.

The Association's program of advocacy for children was formally launched in 1976, at which time 440 delegates from 223 Junior Leagues and representatives from 15 other organizations attended a four-day Institute on Child Advocacy co-sponsored by the Association of Junior Leagues and the Junior League of Baltimore, Maryland. With technical assistance from the Association, individual Leagues launched a variety of advocacy programs ranging from the design of parenting courses and educational campaigns on child abuse to working for legislation for subsidized adoption and foster care review systems. The experiences of individual Leagues in their advocacy programs made them aware of the need to move for reform at the federal level. For instance, many of the difficulties in obtaining health care for needy youngsters and perinatal care for low income pregnant women stemmed from federal fiscal policies that allowed states to determine eligibility on other than a strictly financial basis. In many states, financially needy children were not eligible for Medicaid because they resided in two-parent families. Many needy pregnant women were denied access to perinatal care because they were not eligible for AFDC. Especially hard hit by the limitation on perinatal care were teenagers and young women, groups with whom Junior Leagues have traditionally been involved. Moreover, aside from the factual data gathered by the surveys, Junior League members, all of whom are women and the majority of whom are mothers, have a special interest in obtaining adequate medical care for children and pregnant women. They know from first hand experience the importance of providing good health care for children and obtaining adequate perinatal care, especially during the first pregnancy when serious problems often arise.

The growing awareness of the need for change in federal policies led the delegates to the Association's 1978 Annual Conference to vote that the Association should "advocate to see that . . . opportunities and services essential for the optimal physical, mental and social growth of children are provided." Recently, the Association moved to fulfill this mandate by voting support of legislation in child welfare reform and child health and establishing a legislative network to secure passage of legislation in these areas. To date, 86 Leagues and 4 State Public Affairs Committees have joined this network.

PRIORITIES FOR CHILD HEALTH

As a first step toward obtaining adequate health care for children, the Association's board voted to support passage of legislation such as the Child Health Assurance Program (CHAP) introduced in the last session of Congress. We are pleased that CHAP legislation has been introduced in this session of Congress and hope that the Subcommittee on Health of the Senate Finance Committee will recommend strong CHAP legislation that will include the three priorities established by the Association: Strengthen and expand the EPSDT program, including the development of an adequate outreach program; Provide medical coverage for all financially eligible children, regardless of family composition; and Provide medical coverage to all financially needy pregnant women.

We are confident that such legislation would both improve lives and save dollars We believe it is both inhumane and fiscally irresponsible to deny children access to medical care because their parents are unable to provide it. To deny a needy pregnant woman perinatal care because she does not fit into the AFDC category threatens both her life and the life of the unborn child. Sickly children grow up to be sickly adults who cannot become productive citizens.

We appreciate this opportunity to submit this testimony and look forward to working with you to ensure passage of sound CHAP legislation during this session of Congress.

STATEMENT OF CLYDE E. SHOREY, JR., VICE PRESIDENT FOR PUBLIC AFFAIRS, THE NATIONAL FOUNDATION—MARCH OF DIMES

PRENATAL AND IMMEDIATE POSTNATAL CARE UNDER MEDICAID (S. 1204)

The National Foundation—March of Dimes urges Congress to amend the Medicaid program to include a provision for prenatal and immediate postnatal care to all low income women. Such an amendment has been proposed by the Administration and included in Title II of S. 1204, the Child Health Assurance act of 1979.

Elligibility for health benefits under Medicaid is left up to the States in accordance with broad guidelines. In order to be eligible for Medicaid, a patient must also be eligible for Aid to Families with Dependent Children (AFDC). At the present time, 18 states plus Puerto Rico and the Virgin Islands have taken the position that a pregnanat woman, during her first pregnancy, does not have a family until the child is born. Therefore, 18 states and 2 territories do not provide Medicaid coverage for prenatal care.

This matter is of major concern to the Foundation and other organizations whose principal focus is preventing birth defects and improving the outcome of pregnancy. In striving to achieve this, the March of Dimes, through its many programs and volunteer activities, seeks to assure that there is some means for all pregnant women to receive early quality prenatal care. The failure of 20 jurisdictions to provide this coverage is an extremely serious loss in attempting to achieve this objective.

50,000 babies are threatened each year by markedly low birthweight. This is the cause of the greatest number of deaths in the first year of life and is the major cause of disability in childhood. These dangerously small infants weighing 4 lbs. 6 oz. or less often have severe problems with breathing, heart action, and control of temperature and blood sugar. Unless these difficulties are controlled, they may cause brain damage or death.

Learning disabilities, accompanied by emotional and behavioral problems are often a life time burden for the baby born too soon or too small.

Structural defects occur 5 times as much among those babies born with extremely low birthweight.

Prenatal care which includes proper nutrition is a major factor influencing birthweight. Recent studies prove conclusively that low birthweight and infant death rates for babies born of mothers in all age groups are markedly higher for those who had no prenatal care. These results are particularly applicable to teenage mothers.

The poor are the least likely to receive prenatal care unless payments for these services are provided by some outside source. For many with their first pregnancy, Medicaid is the only source. This is particularly true of pregnant adolescents.

The failure of 18 states and 2 territories to provide prenatal care and proper nutrition through Medicaid can only result in the continued high rate of U.S. infant mortality and no real reduction of birth defects, mental retardation or low birthweight babies. It is vitally important for Congress to make this change in the Medicaid provisions so that all low income women in this county will now be eligible for prenatal care. We urge adoption of Title II of S. 1204.

STATES AND TERRITORIES WHICH DO NOT MAKE PAYMENTS UNDER MEDICAID FOR PRENATAL CARE

Alaska, Arizona, Arkansas, Connecticut, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Mississippi, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Texas, Virginia, Virgin Islands, and Puerto Rico.

STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

The American Dental Hygienists' Association is pleased to submit a statement on S. 1204, the Child Health Assurance Act, presently being considered by the Subcommittee.

Association policy has long encouraged the enactment of federal health care programs for children which include comprehensive dental health care. Of course, we enthusiastically support programs which direct health care to children of low-income families eligible to receive Medicaid assistance. However, the Association believes that any such program should include dental care as an integral part of total health care.

The effects of inadequate dental health care on children are often overlooked. Children with dental diseases often have systemic infections that are traceable to dental disease. Premature loss of primary teeth from decay and neglect can be seriously deterimenatal to the growth and quality of a child's permanent teeth. Loss of teeth means potential for facial disfigurement which can be socially and psychologically damaging to a child. Children with dental disease and missing teeth cannot chew food properly which may result in digestive problems as well as poor nutrition habits. Furthermore, improper care can mean that a young child must cope with dentures to maintain normal chewing and diet.

Yet, dental disease is clearly preventable. Routine preventive dental care and treatment of children can stave off tooth decay and periodontal disease which can become painful, debilitating and expensive to treat if left unattended. This last point cannot be overemphasized: preventive dental care is known to be a cost-effective health service. Illustrating this point is the Children's Comprehensive Dental Health Program, implemented and funded by the State of Vermont between 1974 and 1976. This program, aptly named the Tooth Fairy Program (TFP), was directed toward children of low and middle-income families. An evaluation report of this program has now been published and the findings are significant.

The report notes that the total cost of the Vermont program was $480,000, $450,000 of which represented payment to dentists for dental care (80,000 services for 12,000 children. Only $20,173 was spent for program administration. The total annual cost of the TFP was equal to 0.3 of one percent of the state budget.

The program was considered successful by the families of enrollees (97 percent recommended continuation of the TFP) and also by Vermont dentists (88 percent provided support). In a state with a preponderance of rural towns and villages, the need for dental care was substantial (48 percent of the enrollees had never received dental care or had experienced only emergency care; 32 percent of the enrollees had never received dental care).

The evaluation report further states that the Tooth Fairy Program demonstrated that dental expenditures decrease after the initial year of treatment. In the TFP, third year enrollees consumed an average of $54 in dental services. The same group used $69 in dental services in the previous or second year (an average of 21 percent reduction of expenditures after two years enrollment in the TFP). Further, the program demonstrated that the rate of school referrals declined from 40 percent in 1975, to less than 20 percent in 1976.

ADHA members believe that it is extremely important for federal programs such as CHAP to include adequate provisions and financial support for oral health care and services. The current Early Periodic Screening, Diagnosis and Treatment Program which provides health care for Medicaid-eligible children, has been sluggish in providing dental care and grossly underfinanced. We are pleased that dental care is mandated in the bill now being reviewed by the Subcommittee although we feel strongly that incentives to states to improve existing children's preventive dental care should be at parity with other health care services included in the CHAP. Furthermore, we support the position of the American Dental Association, Children's Defense Fund and other groups which have testified on S. 1204, that reimbursement sanctions and incentives should affect only those funds earmarked for administrative costs, rather than those for outreach, assessment and continuing care services.

In addition, while we applaud the Administration's proposal to standardize eligibility requirements and base them solely on income thus allowing children of two-parent homes to become eligible for care, we support an income standard at two-thirds the level of the non-farm income poverty line as established by the Office of Management and Budget.

We would like to make a final point on the importance of the outreach portion of the Child Health Assurance Program and how members of our profession could be implemented at this critical stage. Again citing the Vermont Tooth Fairy example, the evaluation study of the program showed that projects which exhibited the following features had the greatest patient participation: Convenient location; flexible hours; outreach and follow-up programs; pleasant atmosphere; and seriously evaluated goals and objectives.

We would hope any implementing rules and regulations would require that provider applicants be evaluated on the basis of staff and equipment as well as these above-mentioned criteria which so contributed to the success of the Tooth Fairy Program. Such a comprehensive evaluation of provider applicants would help insure improved child health care and increased program participation.

A primary concern of Association members in advocating a proposed Child Health Assurance program is that all children eligible for services under the Act will be reached. One of the weaknesses of the EPSDT program is the complicated and unwieldy eligibility standards. We are pleased that these standards have been significantly simplified in the Child Health Assurance proposals before the Subcommittee.

Another weakness of the present EPSDT program is that all health screenings are done by physicians and nurses who, despite their knowledge and training, are not oral health experts. ADHA endorses the direct referral concept in each of the bills that requires state health officials to maintain lists of participating dentists who will provide CHAP services.

Registered dental hygienists should be considered as part of the potential solution to the problem of access to dental care—they are academically prepared and licensed to provide preventive care and therapeutic services. Therefore, they are a unique manpower resource in the dental profession and are qualified to work with dentists in providing the highest level of preventive dental care to Medicaid-eligible children. Since many states authorize hygienists to perform preventive and therapeutic services in schools, hospitals, penal institutions and nursing homes, it would be a logical transition to incorporate hygienists in an innovative outreach program under CHAP.

It is the Association's opinion that the public health policy view encompassed in the CHAP proposals, which holds that dental care and preventive oral health services are an integral part of the total health care of the nation's children, is a sound policy. It is a policy which we believe will be endorsed by the Congress. We believe that the investment of public funds in a total preventive health care program for disadvantaged children is cost-effective insurance for the future good health of the next generation of Americans.

PREPARED STATEMENT OF FAYE WATTLETON, PRESIDENT, PLANNED PARENTHOOD FEDERATION OF AMERICA

Mr. Chairman and members of the subcommittee, I am Faye Wattleton, President of the Planned Parenthood Federation of America. Founded more than 60 years ago by Margaret Sanger, whose centennial birthday is being celebrated this year, Planned Parenthood is the nation's oldest and largest voluntary family planning organization. In 1978, its 186 affiliates in 43 states and the District of Columbia provided family planning education, counseling and medical services to 1.2 million Americans, including 445,000 teenagers.

We believe the knowledge and experience acquired by public and private agencies, including our own, in successfully providing family planning services to over a million adolescents each year can help chart broader programs to meet the health needs of our nation's young people. Accordingly, the focus of our statement will be on services for adolescents through the Early and Periodic Screening, Diagnosis and Treatment Program/Child Health Assurance Program (EPSDT/CHAP).

Mr. Chairman, 40 percent of the 73 million Americans under the age of 20 are in their teens, that is 29.5 million teenagers.[1] If we are serious in our desire to promote preventive health care, there is no more important group in our population than these young people who are forming life-long health care habits.

Adolescents, as you know, are a generally healthy group. The leading causes of death among them are accidents, homicide and suicide.[2] Yet, this does not mean that they have no need for health care. For example:

4.1 million young women aged 15-19 are sexually active and in need of contraceptive care to avoid an unwarranted pregnancy;[3]

1 million young women become pregnant each year and require pre- and post-natal care or abortion services;[4]

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[1] U.S. Bureau of the Census: Population estimates and projections. *Current Population Reports*. Series P-25, No. 643, U.S. Government Printing Office, January 1977.

[2] U.S. Department of Health, Education and Welfare, Public Health Service, Health Services Administration, Bureau of Community Health Services. *Approaches to Adolescent Health Care in the 1970's*. U.S. Government Printing Office, 1975.

[3] Joy G. Dryfoos and Toni Heisler, "Contraceptive Services for Adolescents: An Overview," *Family Planning Perspectives*, Vol. 10, No. 4, pp. 223-233.

[4] Christopher Tietze, "Teenage Pregnancies: Looking Ahead to 1984," *Family Planning Perspective*, Vol. 10, No. 4, pp. 205-207.

at least 2.7 million teenagers need treatment for venereal disease;[5]

between 2 and 3 million teenagers have alcohol problems;[6]

according to the President's Commission on Mental Health, the need for mental health services is disproportionately high among adolescents, yet they are one of the most underserved population groups.[7]

And, more than any other age-group, they need health education and encouragement to use preventive health care services. However, left to their own devices, adolescents seek only those kinds of care they absolutely need and want. Part of the reason for this is that the special needs of youth are, to a great extent, neglected in our nation's health programs. Federal health programs—and EPSDT is no exception— have traditionally focused either on adults or on young children, failing to recognize that adolescents have unique health needs. The result is that relatively few young people receive care.

Although the EPSDT program is designed to provide regular screening and health treatment for Medicaid-eligible children and youth up to age 21, in practice the program has been oriented toward infants and small children. Some of the reasons it does not effectively reach adolescents are: that the program's goal of identifying and treating potentially serious health problems is at odds with adolescent health needs; treatment is provided primarily in comprehensive settings, whereas adolescents tend to gravitate toward programs which provide the specific services they are seeking; providers who are already serving adolescents, such as family planning clinics, drug treatment centers, etc., do not, on the whole, participate in EPSDT; outreach conducted through families rather than directly to young people is unlikely to elicit participation in EPSDT by adolescents who are generally concerned about confidentiality for the kinds of services they need and want; and parental consent is required. Furthermore, federal regulations and guidelines provide scant guidance to EPSDT providers on reaching and serving adolescents.

It is impossible to determine accurately to what extent EPSDT is actually serving adolescents since statistics are not collected for any group of children age six or over. However, 1975 data from South Carolina (where more detailed information about age is collected) showed that the program fell far short of its screening target for older adolescents.[8] South Carolina is probably not atypical in this respect.

For any CHAP bill to meet the needs of adolescents, it would have to ensure that, at a minimum, the following conditions would be met:

Because of the confidential nature of many of the services sought by adolescents, confidentiality would have to be guaranteed. Every effort should always be made to encourage young people to communicate with their families about any care they feel they need or about services they are actually receiving. However, services cannot be contingent upon parental consent or even parental notification where this might serve as a deterrent to needed services, information must be held confidential and released only with the young person's consent, and confidentiality must be protected in establishing fees, billing for services, and notifying families of services provided;

Outreach would have to be targeted toward young people themselves, rather than just their families, in order to encourage teenagers to seek many kinds of needed care;

Subsidized services would have to be available based on the young person's own income when he/she is unwilling or unable to have family income taken into account in determining eligibility. Requirements for documentation of family income (e.g. by asking a parent for a paycheck stub or other evidence of income) are as effective in deterring adolescents from seeking care as are parental consent requirements;

There would have to be incentives for a wide range of providers, especially those which are *already* serving large adolescent caseloads (e.g. family planning and VD clinics, drug treatment centers, etc.) to participate in CHAP. There is a clear role for providers of *comprehensive* care to conduct screenings and treatment for serious and potentially serious health problems However, for services such as family planning and drug abuse or VD treatment, teenagers tend to gravitate toward agencies which provide the *specific* service they are seeking rather than comprehensive care. Thus, to meet the full range of adolescents' needs effectively, *all* types of providers, including hospitals, health departments, free-standing clinics, etc., would need to participate.

Education and counseling would have to be reimbursable services, since adolescents often need detailed information to understand their situaton and to appreciate the principles of preventive health care;

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[5] American Social Health Association, personal communication.

[6] *Third Report on Alcohol and Health*, Office of the Secretary of DHEW, June 1978.

[7] *Report to the President from The President's Commission on Mental Health*, 1978.

[8] Children's Defense Fund, *EPSDT Does It Spell Health Care For Poor Children?*

Provision should be made for services to be provided in age-specific settings where this is possible. Young people feel isolated and out of place in pediatric settings as well as facilities which serve the sick and ailing.

Based on the necessity of complying with these "threshold conditions" in order to attract substantial numbers of adolescents to the program, you will appreciate, Mr. Chairman, that S. 1204 will not result in any significant increase in service levels between EPSDT and CHAP as far as adolescents are concerned. Meeting the needs of this population would require extensive revisions in the bill. In order not to jeopardize passage of this important program by embarking on such radical reforms, we do not recommend action to strengthen CHAP with regard to services for adolescents at this time. We do, however, have three recommendations for action by this subcommittee:

We urge you to acknowledge in report language that adolescents' needs will not be substantially met through CHAP. Such language would lay the foundation for future action through CHAP and/or other programs to improve services to teenagers;

We recommend that the provision requiring all states which participate in the Medicaid program to provide coverage for first pregnancies be adopted this year. Currently 20 states do not provide such coverage.[1] While this provision would benefit a great many poor women of all ages, it would be particularly important for adolescents, most of whom are pregnant for the first time and, all too often, have very limited financial resources. Given the importance of early and regular prenatal care in improving maternal and infant health, this provision could have a significant impact on the outcome of pregnancies to adolescents who constitute a particularly high-risk population. We take this opportunity, however, to voice our concern about the continuing stringent restrictions placed on Medicaid funding for abortion in the annual Labor-HEW Appropriations bill. The so-called "Hyde Amendment" has a particularly harsh impact on adolescents who, prior to enforcement of restrictions, had obtained a third of all abortions nationwide. Since teenagers are less experienced than adults in the effective use of contraception, they are more likely than older women to need abortion services and, because of their general lack of independent financial resources, they are disproportionately dependent on public financing. Any public policy which does not allow individuals in conjunction with their physicians, to make a free choice with respect to childbearing is both cruel and myopic. When the individuals affected are very young, the impact is especially severe. The adverse consequences of early childbearing—health risks for mother and infant, the likelihood of curtailed educational opportunity and welfare dependency, etc.—may effectively jeopardize a young person's life chances for many years to come.

We also suggest that CHAP providers and DHEW be required to collect and compile data about services provided to adolescents. The current data system which places all young people age six and over in a single category is entirely inadequate when one considers the many developmental stages which occur between ages six and 21. We would suggest the following age break-down as the minimum acceptable standard: ages 6-12, 13-15, 16 and 17, and ages 18-21.

Mr. Chairman, EPSDT/CHAP is but one example of a program which purports to provide for a broad range of the health care needs of children, including the older age-group, but, when scrutinized more closely, turns out to be directed almost entirely at very young children. The Maternal and Child Health and Community Health Centers programs are two other cases in point. Adolescents have been shortchanged long enough. We urge this subcommittee to turn its attention to the comprehensive health care needs of teenagers as a priority in 1980. We will be glad to assist in that endeavor in every way we can.

DELTA DENTAL PLANS ASSOCIATION,
Chicago, Ill., July 5, 1979.

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

DEAR SENATOR TALMADGE: As it was not possible for the Delta Dental Plans Association to give testimony at the recent Senate Finance Committee hearings on S-1204, The Child Health Assurance Act of 1979, I am taking this opportunity of providing you with a copy of the statement that was prepared by Dr. F. Gene Dixon, president of the Delta Dental Plans Association.

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[1] Office of Family Assistance, SSA, DHEW, personal communication

May I particularly call your attention to the enclosed spiral-bound material which describes a unique and successful program in the state of California which provides dental care benefits to 2.8 million Title XIV Medicaid recipients. The program which is underwritten and administered by California Dental Service, the Delta Dental Plan of California, has been in effect for five years and has successfully blended the fee-for-service system with HMO cost containment incentives.

The "Denti-Cal" program as it is known has been responsible for the delivery of dental care to both children and adults on a broader basis, has increased accessibility to dental providers for eligibles and, at the same time actually lowered the cost per beneficiary receiving care. The California Delta Plan administrative rate is 5.5 per of the program's total dollars, a remarkably low rate for a dental program.

It is our contention that any national program that provides health care benefits for poor people should include a dental component. The Delta system has demonstrated that an effective, cost-controlled; quality program can be provided to the poor through a partnership of government and the private sector. We urge your close examination of this material and its potential in proposed national legislation. If you or your staff would like any additional information or data, please let us know.

Sincerely,

JAMES BONK,
Vice President, DDPA Affairs.

STATEMENT OF THE DELTA DENTAL PLANS ASSOCIATION

Mr. Chairman, I am Dr. F. Gene Dixon, of San Mateo, California. I am President of the Delta Dental Plans Association with headquarters in Chicago, Illinois. I am here representing the Delta Dental Plans Association, the national coordinating agency for the country's not-for-profit dental service corporation system which today provides prepaid dental care programs on a group basis to 15 million subscribers in both the private and publicly funded sectors.

The Delta Dental Plans Association strongly subscribes to the goals of this legislation. A national investment in the health of children who are in need is long overdue. Our statement will deal with those provisions of the legislation which are our particular area of competency and experience, dental care.

The dental profession in the United States and in most other countries of the world has long recommended that, because of the special nature of dental diseases, the development of a dental program for children should have a priority call on a nation's resources. It is generally accepted that the prevention and control of dental diseases in the younger age groups represents the most significant contribution to long term oral health as well as the most effective long range use of economic resources in terms of treatment cost.

In the second part of my statement starting on page 5, I have included some details and history of the Delta Dental Plans and their 25 year experience as the originators of pre-paid dental care in America.

Mr. Chairman, though as we will indicate, the Delta Plans are presently providing dental benefits to several million Americans under various federal and state government programs, we wish to discuss the program in California because of its special relevance to the legislation before you. At present, the California Delta Plan is providing dental benefits to 2.8 million needy persons under Title 19 of the Social Security Act. This five years experience indicates the potential of the Delta approach. Accompanying my statement is a documentation of the California experience which is called Denti-Cal. You will see the impressive growth in the number of dentists who are rendering care under the program. Needy children seek and receive dental care in the private offices of dentists throughout the length and width of that state. Note particularly, the figures on the increase in services provided to children. During the first three years of the program, 1.2 million needy children received dental care. The quality assurance program, cost effective administration, and the other accomplishments of the program are set forth in the attached document. This actual record of experience should recommend itself to the Congress as a desirable means for accomplishing the purposes of the legislation before you. To achieve the goal of assuring a comprehensive-preventive dental care program for children, the experience of the Delta system recommends that the program should have the following major elements:

1. A provider agreement, such as the participating dentist agreement that exists between member dentists and their Delta Plans. In the Delta system, a participating dentist is a licensed dentist who has signed a service agreement with Delta. Under this agreement, the participating dentist agrees to provide stipulated services to eligible subscribers. He also agrees: to prefile in advance his individual fee

schedule with the Plan, and to permit verification of these fees; to be bound by established methods of determining fee ranges and to accept payment as payment-in-full for services rendered to eligible subscribers; to complete and submit treatment planning forms, when appropriate, for predetermination procedures and for contract benefit determination; and to cooperate with state or local peer review committees or with consultants designated by the Plan to review the appropriateness and adequacy of care provided.

2. A comprehensive scope of benefits including full diagnostic, preventive, emergency and basic operative care. Any limitations or exclusions placed on the scope of benefits should be a reflection of generally accepted dental practice standards. The following benefits, identified through Delta experience over the years, are suggested: Diagnostic and preventive benefits including examinations, radiographs, prophylaxis and topical fluoride applications, emergency care for the relief of acute conditions and pain, space maintainers. Oral surgery services. Restorative services including: amalgam and plastic synthetic porcelain fillings; stainless steel or acrylic jacket crowns to be provided when teeth cannot be restored with above materials. Endodontic services.

All other services would be authorized only when professional evaluation of the radiographs or other documentation substantiated the necessity of the service.

3. The administration of the program should assure the quality of the service provided, and at the same time, provide cost-effective controls. These procedures would include the routine checking of fee profiles of individual providers, the examination of all treatment plans and their documentation to establish the necessity of service and the utilization of computer edits to compare previous patient history with current treatment to identify duplicate or incompatible services.

The data base of dental treatment should be used to generate profiles of provider patterns of care. Cross checking of these profiles should make possible identification of any instances of provider or patient abuse of the program. In addition, quality assurance and cost containment goals can be served through a utilization review system that would provide routine clinical examination of a representative patient sample before and after treatment. These examinations should be performed by practicing dentists serving as review consultants in the community where the patient lives. The results of these clinical examinations would, in effect, represent a "second opinion" on special cases regarding treatment and would produce valuable information to determine the necessity and/or quality of services.

4. The fourth major element should be the employment of a provider reimbursement system which would be consistent with the program's goals of accessability, single level of care, quality of service and containment of program cost including treatment and administration. Through the use of a reimbursement system based on individual provider fee schedules developed from the collection of verified pre-filed fee listings, a cost-effective as well as accessible delivery system can be operated. The fee paid to a participating provider as payment in full should not exceed a prevailing level of fees filed for providers of similar training and experience in a given geographic area. Such an allowance level would ensure broad provider participation and concommitant wide patient accessibility to service, while at the same time stabilizing the fiscal integrity of the program.

PROPOSED PROGRAM ADMINISTRATION

A program of dental care for Medicaid eligible children, based on the unique administrative methods developed by CDS—Delta Dental Plan of California, over the past five years in their successful Denti-Cal program could be made available in all states under the auspices of the Delta Dental Plans Association.

The program envisioned would involve an interplay between four discrete entities: the federal government; a designated state governmental agency, the Delta Dental Plans Association and the state Delta Dental Plan. the broad general responsibilities of each of the entities described above would be as follows:

Federal Government.—The role of the federal government under the proposed program would be to develop appropriate legislative and administrative guidelines for the program to ensure the uniformity of all aspects of the program nationwide. This would also include oversight responsibilities to assure that the state agencies are carrying out the functions and detailed administration as described in the legislation.

The federal government would contract with the Delta Dental Plans Association directly to serve as national coordinator for the program. DDPA would, in turn, serve as the accrediting and approval agency to assure that the appropriate standards and guidelines for program administration were being adhered to by its member Plans.

State government.—A designated state governmental agency, under the oversight of the federal government and subject to appropriate federal regulations and guidelines, would serve as the disburser of funds allocated for treatment costs and administration of the program to the state Delta Plan.

State Delta Plan.—The role of the state Delta Plan would be to administer the program and provide the approved dental benefits to eligible children within its area of operation under the guidance of applicable guidelines, regulations and membership standards of the federal and state governments and its national association respectively. The state Delta Plan would maintain its contact and relationships with its member and participating dentists and provide appropriate periodic reports as specified to the state, federal and association agencies involved.

Delta Dental Plans Association.—The role of the national Delta organization would be to serve as prime contractor with the federal government on behalf of the member Plans of the Delta system, and to serve as national coordinator for the program.

DDPA would also serve as the accrediting agency and approval body for its member Plans in order to assure that government guidelines and association membership standards are being followed and complied within the administration of the program. DDPA would maintain direct contact at the federal level and provide all necessary data, reports and records required for the administration of the program nationally.

RECOMMENDATIONS

We urge that the legislation be structured so that it gives consideration to the major elements we have outlined and which we believe are essential if the purpose of the legislation is to be fulfilled.

PART II.—DELTA DENTAL PLANS, THEIR HISTORY AND EXPERIENCE

The Delta Dental Plans Association is the national coordinating agency for the country's not-for-profit dental service corporations. It was incorporated in 1966 in the State of Illinois as a not-for-profit trade association.

The object of the Delta Dental Plans Association as defined in its bylaws and membership standards is "to increase the availability of dental services to the public by encouraging the expansion of dental prepayment programs administered through nonprofit dental service corporations, and providing the means for active or associate members to cooperate with this Corporation in providing multistate and national group coverage."

More than 25 years ago, the American Dental Association and individual state dental societies, aware of the massive needs of the American public for dental treatment, began encouraging the formation of dental service corporations to provide group programs in the various states. Since then, dental societies in nearly every state have taken steps to incorporate and activate dental service Plans.

These Plans, formed in 47 states and the District of Columbia which adopted the "Delta Dental Plan" name and symbol, are presently underwriting or administering dental care programs for an estimated 15 million Americans under both private and publicly funded programs in all 50 states. The Delta system annual premium volume has been projected to reach $640 million during 1979.

While formed and supported by the organized profession, Delta Plans are separate prepayment organizations under the jurisdiction or regulation of state insurance commissioners or attorney generals. As such, Delta Plan boards of directors are highly cognizant of their multiple responsibilities to program purchasers and subscribers in addition to the providing dentists who have contracted to deliver care under the terms of Plan programs. Evidence of this concern can be seen in the composition of Delta Plan boards, all of which include significant consumer representation.

Delta Dental Plans, as a result of their support by the dental profession and their unique contractual relationships with private dental practitioners, provide "service" benefits to covered subscribers, in contrast to indemnity dollars or fee schedule payments to cover the cost of care.

Delta Dental Plans design their programs to provide maximum dental care benefits to subscribers at reasonable cost. No portion of the Delta income dollar is held for dividends to share holders. All funds received by Delta Plans are used to pay for services rendered to covered subscribers and their eligible dependents and for administration of the program.

Moreover, the Delta system successfully pioneered such innovative cost containment and quality assurance procedures as a fee concept based on filed and verified fee profiles of individual participating dentists, "predetermination" of proposed treatment and pre- and post-treatment review of proposed or completed cases.

Delta Plan administrative techniques, which have evolved from a first-hand awareness of the "elective" character of most dental treatment, embody a cost-containment philosophy most visible in the determination of covered benefits by Plan dental directors and consultants. Basing their claims processing policies on professionally accepted standards of dental care, Plan professional supervision personnel are able to control effectively areas of program over-utilization, non-essential and repeat services and areas of potential abuse, exercising a level of cost-effectiveness not presently available from other carrier entities.

These characteristics of the Delta Dental Plan system have captured the interest and attention of informed purchasers in private industry, organized labor, as well as governmental agencies at the local, state and federal levels. The Delta system presently provides group coverage for more than one of every four Americans with prepaid dental benefits and is the largest single carrier system for dental coverage in the United States.

In addition to serving millions of Americans under private programs for corporate employees, union members and their dependents, the Delta system has also been responsible for the administration and delivery of care to eligible recipients of public assistance under a variety of tax supported health care programs.

For many years, the Delta system has been the fiscal intermediary for numerous publicly funded programs throughout the country. These programs administered by state Delta Plans have made possible the delivery of dental care to the medically indigent, particularly the child population, on an efficient and cost-effective basis, in the private office setting. These programs have demonstrated the ability of a non-governmental system to deliver needed health care services to this sector of the public, with provider involvement and cooperation, without necessitating the expenditure of tax dollars for the construction of costly clinical facilities by federal or state government.

Delta Dental Plans in some 23 states are presently covering nearly 5 million Americans for dental benefits under federal and state programs including over 3 million under Title XIX Medicaid, and others under Veterans Administration programs, the Indian Health Service, Project Head Start, migrant worker programs, Job Corps, state employee programs and host of others.

In addition to providing benefits under publicly funded programs, the Delta system, nationally, covers an estimated 10 million American under private programs, including more than one million United Auto Workers and their dependents, hourly and salaried employees in the Aerospace, Tire and Rubber, meatpacking, and other major industries. Delta subscribers constitute a cross section of Americans from all walks of life, and fields of endeavor as employees of major corporations or medium or small companies or service organizations.

Over the past quarter century the Delta Dental Plan system has been the choice of a number of major corporations and international labor organizations as the underwriter and administrator of group dental programs for their employees and members. These programs, many of which evolved through the collective bargaining process, incorporate benefit designs, cost and quality assurance mechanisms, and other administrative procedures pioneered by the Delta system over the years.

An outstanding example of a successful dental program covering a large number of subscribers is that which was negotiated in the auto industry in 1973 by the United Auto Workers. Today, well over a million UAW members and their families receive dental benefits under Delta programs purchased by General Motors Corporation and Chrysler Corporation in the states of Michigan, Missouri and California. The UAW-Auto Program has become a prototype for similar dental programs in a number of major industries and has been responsible for elevating the level of oral health for literally millions of Americans.

Other major corporations and unions that have selected Delta programs include Rockwell International, Kaiser Steel, Lockhead Corporation, McDonnell Douglas Corporation, Armour & Company, Western Greyhound Lines, Northrop Corporation, Crown Zellerbach Corporation, Goodyear Tire and Rubber Company, the International Association of Machinists, the United Rubber Workers, Oil Chemical and Atomic Workers and others.

The Delta Dental Plans Association appreciates the opportunity to present our views and recommendations in respect to this legislation. We ask that our statement be included in any published documentation of this hearing. We would be pleased to be of any further assistance to the committee and the staff.

STATEMENT OF THE CHILD WELFARE LEAGUE OF AMERICA

The Child Welfare League of America has long been concerned with the welfare of children. We, therefore, welcome the opportunity to comment on S. 1204, the Child Health Assurance Program (CHAP). We thank the Subcommittee on Health for your consideration of this bill. At present, the health needs of 11 million poor children are in question. The provisions in CHAP will begin to improve their situation.

The Child Welfare League of America, established in 1920, is the national voluntary organization for child welfare agencies in North America. It is a privately supported organization devoting its efforts completely to the improvement of care and services for children. There are nearly 400 child welfare agencies directly affiliated with the League, including representatives from all religious groups as well as non-sectarian public and private non-profit agencies.

The League's activities are diverse. They include the activities of the North American Center on Adoption; a specialized foster care training program; a research division; the Hecht Institute which focuses on Title XX and related services; the Office of Regional, Provincial and State Child Care Associations—which represents a potential of more than 1,000 additional child and family serving agencies in this Nation; and the American Parents Committee, which lobbies for children's interests.

In 1977, the American Parents Committee, which has a special interest in CHAP, merged with the Child Welfare League of America and became an advocacy division within the League. The American Parents Committee, founded in 1947 by George Hecht, is the oldest Washington group lobbying exclusively on behalf of federal legislation for children.

As an organization which has historically attended to legislation for children, we support the basis purpose of CHAP. CHAP will strengthen and broaden the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

In 1967, EPSDT was added to the Medicaid law as a required service. The original focal point was to detect chronic disabling conditions and serve handicapped children or those with potentially handicapped conditions. However, HEW statistics show that only one-third of the 11 million Medicaid eligible children have been screened under EPSDT, and of this one-third, 30 percent did not receive treatment for the diagnosed condition.

The Child Welfare League of America considers CHAP a legislative initiative which will hopefully meet the health needs of impoverished children in a more systematic way.

CHAP would maintain the original purpose of EPSDT but also:

1. Expand eligibility to children who are not presently on Medicaid but whose families cannot afford basic health care;
2. Extend dental, vision, hearing, prescription drugs, and ambulatory mental health benefits to all Medicaid children;
3. Improve the administration of the program so that a greater proportion of eligible children would actually receive the health care to which they are entitled;
4. Institute a performance-based system of graduated incentives to states based on the number of children in continuing care as well as the number of children screened and in treatment;
5. Increase the share of program costs paid by the federal government.

In addition, CHAP, coupled with the Adolescent Health Services legislation will significantly expand prenatal health care to young, low-income pregnant women.

We would like to comment on specific CHAP provisions.

MINIMUM ELIGIBILITY LEVEL

As currently stated in S. 1204, children in a family with an income at fifty-five percent of the national poverty line would be eligible for CHAP services.

The League believes this is too low. We favor an eligibility level at two-thirds of the poverty line which would be adjusted on a scale according to the annual rise in the cost-of-living. HEW estimates the higher eligibility level would add approximately 2.6 million more medically needy children to CHAP than are presently eligible under Medicaid's EPSDT law.

COVERAGE OF HARD-TO-PLACE CHILDREN

There is no provision in S. 1204 which would allow States to provide Medicaid coverage to children who are available for adoption but who also have a handicapping condition making them "hard-to-place" in an adoptive home. Under current law, an adopted child isn't Medicaid eligible unless the family in which the child is placed is covered by Medicaid.

The League supports a provision to S. 1204 that would require all states to cover "hard-to-place" adopted/adoptive children under Medicaid. This action would encourage potential adoptive parents who are reluctant to adopt a child with a handicapping or medical condition. We believe expenditures for foster care would be reduced if more families were given this incentive to adopt.

CHILDREN IN FOSTER CARE

In its present form, S. 1204 does not include universal Medicaid coverage for foster children. Current Medicaid law holds that a foster child is not Medicaid eligible unless he or she has been removed from an AFDC-Medicaid eligible family.

The League believes in the principle that all children should have access to adequate medical care. We also support the concept that the natural parents, whenever possible, should finance their own child's health care when the child has been placed in foster care. However, if a family cannot do so, and, if the family isn't Medicaid eligible we believe there should be a provision for medical care for these children. We urge that all states be required to extend Medicaid eligibility to foster chilldren whose medical needs are not met in any other program or through their parents. CHAP coverage of all foster children would help close the eligibility gaps which currently exist.

COVERAGE OF CHILDREN IN INSTITUTIONS

S. 1204 does not include coverage for children in public or private nonprofit group homes or halfway houses. Under current Medicaid law, states may not receive Federal matching reimbursement for children in institutions unless that institution is a public one and for medical purposes.

The Child Welfare League urges the Subcommittee to adopt a measure requiring states to cover Medicaid eligible children in public and private non-profit group homes, halfway houses and residential treatment centers. This provision would allow the treatment of child's medical or emotional illness without limiting the available care to that offered by a public medical institution.

COVERAGE OF ADOLESCENTS UNDER CHAP

The current EPSDT program and S. 1204 allow coverage for low-income children under the age of 21.

We recommend that statutory or report language cite the particular health needs of adolescents, recognize current inadequacies in services to adolescents, and suggest that adaptation in the administration of CHAP expand in outreach and new approaches to treat older children and young people more effectively.

In practice, EPSDT has primarily served infants and young children. Medical personnel emphasize pediatric care. Outreach occurs through traditional adult channels, and the particular characteristics of adolescence are not seen as health-related. Adolescents need regular comprehensive medical care. This includes nutrition information, dental examination, vision and hearing testing, up-to-date immunization, and health education. Statistics on adolescent suicide, alcohol and drug use, pregnancy, venereal disease, and mental and emotional problems reveal that for many adolescent, health care and health education came too late.

ELIGIBILITY OF PREGNANT WOMEN

Title II of S. 1204 allows CHAP eligibility of low-income pregnant women at fifty-five percent of the national poverty line.

The Child Welfare League urges the Subcommittee to set this at eighty percent of the national mimimum poverty level in order to include more low-income women.

The HEW report, Health—United States—1978, revealed that "low birth weight infants are at a greater risk of future health problems than are other infants." In 1976, HEW reported that 7.3 percent of all infants were born with low birth weights. Providing low income pregnant women with prenatal health care can be a preventive health measure as well as a cost-effectve strategy. This provision, in combination with the Adolescent Pregnancy Prevention, Treatment and Care act, would ensure comprehensive prenatal care for pregnant adolescents.

COVERAGE FOR MENTAL HEALTH SERVICES

The proposed S. 1204 includes coverage for ambulatory mental health services in community mental health centers and inpatient coverage for children in general hospitals and would allow states to limit the amount, duration and scope.

144

The Child Welfare League supports these provisions. However, we do not agree that states should have discretion regarding the amount, duration and scope of these services. The League supports some inpatient treatment for emotionally disturbed children. In addition, we strongly encourage the coverage of outpatient mental health services without regard to amount, duration and scope and would support this as a requirement of all states in implementation of their CHAP plans.

Of the million low-income children in this country, 15 percent suffer from mental illness that could severely impair their normal development and functioning.

In order to identify and treat these children, we recommend CHAP include a component to strengthen the outreach done by community mental health centers. Community mental health centers presently serve a minority of children and adolescents. Yet, this is the population that could benefit most from early detection and treatment of emotional problems.

COVERAGE FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

The present Senate CHAP bill makes no assessment and ambulatory or inpatient treatment for a developmental disability.

The League would welcome a preventive CHAP measure to cover the diagnosis and treatment of children with developmental disabilities without regard to amount, duration and scope. This type of treatment is generally long-term and too costly for parents to finance. Furthermore, screening and treatment of a developmental disability early in a child's life can prevent more serious and costly intervention later.

OUTREACH

Under the Senate CHAP legislation, the state would be required to provide outreach services to children and pregnant women eligible for assessment and treatment.

We recommend the legislation be specific as to who may actually do this outreach. It has been common knowledge in the field of social work that some recipients of services will respond more favorably to peer contact than to professionals. The legislation should support efforts to identify those who can be best reached by paraprofessionals and other alternative approaches and to ensure that after the initial outreach, there will be some follow-up.

SUMMARY

The following provisions need to be included in S. 1204 in order to make it genuinely useful to this nation's 11 million CHAP eligible children and their families. These features are:

1. A minimum eligibility level at 66 percent of the national poverty line.
2. CHAP eligibility for all children who are ready for adoption but have a condition making them "hard-to-place" in an adoptive home.
3. Universal and mandatory Medicaid coverage of all foster children, when parents cannot finance their medical care and when the family they came from was not AFDC eligible.
4. CHAP coverage of all Medicaid eligible children in public as well as private non-profit institutions such as group homes, halfway houses and residential treatment centers.
5. That statutory language cite the particular needs of adolescents, recognize the inadequacies of services to adolescents and require expansion of approaches to treat this older population of children.
6. An eligibility level established for low-income pregnant women at 80 percent of the national minimum poverty level.
7. Unlimited coverage for ambulatory mental health services and some inpatient treatment for emotionally disturbed children.
8. Assessment and treatment of children for developmental disabilities without regard to amount, duration or scope.
9. Legislative support which would allow the appropriate paraprofessionals and others to offer outreach services to those who are CHAP eligible.

We support the passage of CHAP to correct the problems encountered under EPSDT. This legislation provides an opportunity for us to invest in our most valuable resource: children. While other groups may be able to advocate for their own medical needs, children can not. Therefore, we appreciate your consideration of our recommendations.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, appreciates this opportunity to present its views on legislation to establish a program designed to meet children's health needs.

We would like to address S. 1204, the Administration's Child Health Assurance Program (CHAP) proposal, which was introduced by Sen. Abraham Ribicoff (D-Conn.) and which is under consideration by this Subcommittee. This measure 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 assessment and follow-up treatment. In addition, we would like to call to the Subcommittee's attention some of the provisions of H.R. 2461, a CHAP proposal introduced in the House of Representatives by Rep. Andrew Maguire (D-N.J.). The AHA wholeheartedly supports such efforts to encourage preventive care and early medical intervention on behalf of children.

Hospitals have made significant efforts to provide primary care through the expansion of outpatient and ambulatory clinic programs. The AHA has expressed its support for various legislative programs which would narrow the gaps in health insurance coverage for low income groups through the standardization of eligibility and benefits under the Medicaid program. Efforts to improve access to comprehensive diagnostic and treatment services for low income children are consonant with our policies and goals.

We believe, however, that any program to improve the health of children should consider the full range of issues which will confront the patients and providers involved. Previous federal legislative activities to improve child health have been hampered by difficulties in implementation which have frustrated the original intent of such efforts. Some of these difficulties include: In terms of program jurisdiction, fragmentation of and conflict among different levels of related governmental, as well as private, agencies; failure to provide sufficient financial incentives to encourage provider participation in federal programs; failure to target specific populations; and lack of adequate data collection for program assessment.

In the context of our concern for addressing the full spectrum of these and other issues, we would like to offer the following specific comments and recommendations on both S. 1204 and H.R. 2461.

PROGRAM CONCERNS

Eligibility

Criticism of the existing Medicaid program has been directed to the fact that significant numbers of economically disadvantaged persons have been left without adequate health care services due to the uneven eligibility and varying benefit packages of the states. Among the most disadvantaged are children, for whom proper diagnosis of adolescent conditions, dental care, immunizations, nutritional counseling, and health education could prevent a substantial amount of chronic and debilitating disease in later life. We support the intent of each of the proposals to standardize eligibility requirements among the states so that children of intact families, as well as of single parent households, would be covered under the program.

The AHA urges the Subcommittee to adopt H.R. 2461's income standards for eligibility, which will bring the benefits of basic medical services to a greater number of children. The extra costs associated with broader eligibility will, we believe, be returned manyfold in the savings from reductions in hospitalization, chronic medical care, and lost work time in future years.

Comprehensive services

The AHA strongly supports the screening of eligible children in settings which provide a full range of comprehensive diagnostic services. Such settings should also provide for necessary treatment in a timely manner, since screening programs are of little value unless timely follow-up care is assured. We feel the overall approach of H.R. 2461 is preferable to that of S. 1204: the former bill, in contrast to the latter measure, requires state plans to assure the availability of appropriate support services and places a primary responsibility on all CHAP providers to (1) assure necessary corrective treatment, (2) take case management responsibility for assessed individuals, and (3) maintain continuing accessibility to participants. Assurances of timely and continuous treatment reduce the need for more expensive modes of medical care which may become necessary when medical conditions reach an emergent or acute stage. We believe this to be one important means of controlling medical care costs over the long run.

We realize, however, that not all health care providers have the full range of diagnostic and treatment services in a comprehensive health center. This is particularly true in sparsely populated rural areas. In such circumstances, it is appropriate that local public agencies assist providers in the accomplishment of follow-up activities. It is logical that community agencies will be able to perform this function effectively since they generally possess more detailed knowledge of their service areas than state agencies. We therefore support the language of H.R. 2461, which would allow participating providers to furnish information necessary for follow-up actions to local public or nonprofit community health agencies, as well as the designated state agencies.

Finally, in regard to comprehensive services, we are deeply concerned that S. 1204 does not specifically include hospitals within the definition of "provider." As we indicated at the outset, many hospitals have well organized outpatient departments and clinical programs designed to provide primary care services to their communities. Indeed, in urban areas, where the shortage of private physicians has become especially acute, hospital outpatient departments are often the only source of continuing primary care. Since our common goal is to develop a more rational system of health care in this country, there should be no question as to the eligibility of this major segment of primary care providers to participate in the program.

Prenatal and postnatal care

The success of any program to improve child health will depend greatly upon the adequacy of efforts to ensure proper prenatal and postnatal care for low income expectant mothers. 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 and reducing further the nation's infant mortality rate.

Studies have shown that many environmental and social factors, such as poor housing and the lack of proper nutrition, prevalent among the low income population, are directly linked to a high incidence of physical and mental disabilities in infants. In addition, the frequency of alcoholism and drug abuse in low income groups makes it imperative that expectant mothers be screened so that high risk pregnancies can be promptly identified. The identification and treatment of high risk pregnancies is a priority concern of many hospitals, physicians, and health planners. We believe the CHAP approach to be well suited to the alleviation of these concerns.

We therefore support the expanded coverage of low income pregnant women for basic Medicaid services proposed in both S. 1204 and H.R. 2461. AHA also supports the provision in both bills that will help reduce infant deaths and disability by providing coverage for infants at birth, in contrast to some current state Medicaid programs that begin coverage at six months of age.

Dental care

The AHA believes that adequate dental care is an important component of a child health program. The problem of dental neglect, and its long-term consequences, cannot be overestimated. We firmly support the intention of both proposals to include dental care for children in a manner comparable to other medical services under the Medicaid program.

Health education

Health education strategies should be an integral part of the CHAP approach. Since public awareness will be an essential element of the program's success, we suggest that the proposals 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 on the appropriate use of services.

The health education strategies should target information to both the parent and the child. It is important that the parent receive information relating to the child's growth, development, and health care, in order to provide a more healthy environmen for the child. Moreover, facts should be made available to assist the child in making sound health decisions, thereby reducing dependency on the system.

An excellent time to provide appropriate health education information is during the periodic screening of the child. Incremental education models could be designed for implementation by a number of different health professionals. In addition, health education should also be a part of any continuing medical care that is provided.

Hospitals have traditionally conducted inpatient education activities. With increased community emphasis on outpatient and preventive care programs, a large number of institutions have extended their educational programs beyond the hospital, with the result that a substantial capability in program design and administration now exists in community hospitals. It is appropriate that these health education activities, as well as those traditionally provided by governmental and voluntary health agencies, be integrated into the comprehensive services provided under CHAP.

Immunization efforts

S. 1204 and H.R. 2461 would create a national child immunization effort by including immunizations among the required assessment services. We believe this effort to be important and hence worthy of congressional support. However, we would point out that the immunization program may be jeopardized by its failure to provide patients and providers with adequate indemnification for vaccine-associated injury, which is a predictable risk of any widespread vaccination effort. In light of the serious economic and legal implications of malpractice actions, providers may require assurance of indemnification as a condition of participation in the program.

Regulatory authority

S. 1204 and H.R. 2461 would grant significant rulemaking authority to the Secretary of HEW for the implementation of the program. This authority pertains to, among other things, the specific terms of the child health assessment and the definition of other required services. AHA believes that it is essential that the Secretary seek broad input from providers, including hospitals, in the development of these regulations. Without careful consideration of the effect of the programs on other provider responsibilities, some provider disincentives may be created.

For example, if the assessment period is too long, providers may be discouraged from performing other primary care services, such as school or summer camp medical reports for their CHAP patients. If the providers relies on dated assessment information, malpractice liability could arise if a new disease or injury is subsequently discovered. On the other hand, if the provider performs a new assessment for these purposes, reimbursement may be denied, since the examination would not be "timely" in accordance with the regulations. To avoid such situations, we urge the Subcommittee to direct the Secretary to consult with provider groups prior to the publication of proposed rules for the programs.

ADMINISTRATIVE CONCERNS

Financing and payment system-provider incentives

Experience with the financing and payment system utilized by the Medicaid program is of serious concern to hospitals. While the entitlement to health benefits for low income individuals has resulted in their access to needed health services, the unevenness of eligibility requirements and variations in payment methodologies among the states often have led to failure of the program to meet the full costs of providing high quality care.

The existing Medicaid program permits some states to pay less than the full costs incurred in rendering services. As a consequence of Medicaid rate freezes, benefit limitations, and partial payments under some state plans, other hospital patients and third-party payers have, in effect, subsidized the costs of services rendered to Medicaid beneficiaries. Such inequitable circumstances could make it difficult for providers to participate in CHAP. We would like to point out that it has long been a policy of both providers and the government to avoid a "two-tiered" health delivery system, which may result if a significant number of providers are discouraged from serving beneficiaries.

Moreover, we strongly support the state plan requirement of H.R. 2461, which specifies that agreements with providers must include "terms of prompt payment and high reimbursement."

Moreover, the method of payment must recognize the full costs actually incurred by these Medicaid patients. Arbitrary fee schedules, which are commonly used by the states under some Medicaid programs, do not assure providers that their full costs will be met as increase in demand and changes in the costs of resources (including new technology) occur. We recommend that agreements with providers specify that the full reasonable costs of services provided for program beneficiaries be paid.

Increased demand for pediatric services will inevitably result from a broad screening effort. It has been estimated that only about one-sixth of the over 12 million children eligible for screening services under the current early periodic screening and diagnostic treatment program actually have been screened. The increased case load under a new and expanded program 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 medical care needs; and (3) the provision of additional services to current participants as a result of more thorough and comprehensive screening and follow-up requirements.

Although the long-run effect of screening and treatment programs may be a net decrease in pediatric inpatient utilization, it must be recognized that an increase in inpatient volume will also occur from two sources: (1) the treatment in the hospital of serious conditions discovered in the initial screening of program participants; and (2) a demand for follow-up diagnostic and corrective procedures which can only be performed on an inpateint basis. While the former component can be expected to diminish over time, the latter cannot.

We are pleased to note that both S. 1204 and H.R. 2461 recognize the need to provide adequate financial resources for the program by authorizing an increase in the federal matching rate for CHAP services. These additional resources will help the states address the demand and payment issues which will also affect provider participation.

In this regard, we believe the approach of H.R. 2461 to be the most effective. It would authorize a federal matching rate of 90 percent of expenditures for outpatient services under the program. S. 1204, the Administration's proposal, would add percentage points to existing state assistance levels. However, in those states in which Medicaid reimbursement is already seriously inadequate, the addition of four to twenty-five percentage points to the state matching level may not be sufficient to meet the increased number of eligible children. Experience has shown that when state resources are limited, benefits are maintained at the expense of provider reimbursement levels. Many providerss may not choose to participate if it is perceived that state resources will be inadequate to meet the costs of providing the increased volume of services.

In order to encourage support from those providers offering comprehensive services, there must also be assurances that the additional costs attributable to the inpatient component will be adequately reimbursed. For this reason, we urge the Subcommittee to provide an appropriate amount of additional federal matching for inpatient services under this program. We strongly support the intent of H.R. 2461, which specifically provides an increase of 10 percentage points in the federal medical assistance level (up to 90 percent) for amounts expended for necessary inpatient services under CHAP.

As we noted in our discussion of outpatient service reimbursement above, however, this incremental approach may not be sufficient in states with already low reimbursement levels. The incremental approach may result in uneven treatment, and therefore uneven participation, of providers in different states. We therefore urge the Subcommittee to consider the alternative of establishing a uniform federal matching level for inpatient CHAP services. We beleive that the level of assistance must adequately reflect the need in all states to meet the costs of inpatient care provided as a result of the assessment program.

Both proposals would provide 75 percent matching for the costs of outreach services. We believe this to be an important provision and wholeheartedly support its inclusion in the legislation. Especially in rural settings, outreach programs (in which providers or community agencies take the initiative in making contact with the patient) are frequently the only means of assuring that these populations are served. We believe that outreach activity should be a required component of state CHAP plans and we specifically support the language of H.R. 2461 which emphasizes the use of community-based nonprofit organziations for this purpose. As we noted earlier in this statement, we believe the familiarity of local institutions with their service area will assure more effective outreach services.

Finally, based on our foregoing comments, the AHA also supports the provision in H.R. 2461 which requires the Secretary of HEW to study provider participation in CHAP and methods for improving that participation. We believe both providers and program beneficiaries will benefit greatly from such a study.

Allied health professionals

In order to encourage efficient and economical provision of services under the program, the AHA believes that the legislation should specifically recognize the role that nurse practitioners and physician extenders can play in some screening and follow-up activities. We suggest that the state plans encourage, to the extent permissible under state law, the participation of allied health personnel in CHAP.

Coordination with other programs

A number of programs receiving federal support provide related services for children, among them various health, nutrition, and social services. The AHA believes that the legislation should provide for the administrative and clinical coordination of CHAP and other federal programs for the provision of health and related social services to children. Such coordination would measurably increase the combined impact of the services on the target population and decrease administrative costs.

To that end, we support the provisions of H.R. 2461 which require the states to assure such coordination and require the Secretary of HEW to report to the Congress on the coordination of CHAP, Medicaid, the maternal and child health programs, and other federal programs.

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We appreciate the opportunity to present our views on S. 1204, as well as H.R. 2461, the intent of which we support. We will be pleased to provide any additional information or assistance the Subcommittee requests.