The George Washington University
WASHINGTON DC

facsimile
TRANSMITTAL

to: Jennifer Klein
fax #: [redacted] 456-9412
re:
date: 11/27/95
pages: 9

From the desk of...

Sara Rosenbaum
Co-Director
Center for Health Policy Research
2021 K Street, NW, Suite 800
Washington,DC 20052
202-296-6922
202-296-0025

The George Washington University
WASHINGTON DC

CENTER FOR HEALTH POLICY RESEARCH

MEMO

To: EPSDT Files
From: Sara Rosenbaum
Subject: Potential Revisions to the EPSDT Statute
Date: November 26, 1995

A number of individuals have asked for information about Medicaid EPSDT benefits. This memorandum describes the basic elements of EPSDT and discusses issues that should be considered in any revision of these provisions.

1. An Overview of EPSDT

a. The 1967 benefit package amendments and the Nixon Administration's implementing regulations

The EPSDT benefit was added to the Medicaid statute in 1967 in response to widespread reports regarding the poor health of low income children.[1] The 1967 amendments created an entitlement in children to a Medicaid benefit package more comprehensive than that furnished to adults. The purpose of the amendment was to assure sufficient care for children to prevent the development of health problems and to provide early detection and treatment of conditions in children before they became serious and disabling

The 1967 amendments required states to provide:

> "such early and periodic screening and diagnosis of individuals who are eligible under the [state Medicaid] plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby as may be provided in regulations of the Secretary. "[2]

---

[1]One of the most compelling studies was conducted by the Department of Defense, which found that many low income young draftees during the Viet Nam War were seriously disabled by conditions that could have been prevented or ameliorated in childhood.

[2]Section 1905(a)(4)(B) as added by Section 233, P.L. 90-248.

2021 K STREET, N.W., SUITE 800 • WASHINGTON, DC 20052 • (202) 296-6922 • FAX (202) 785-0114

Regulations promulgated by the Nixon Administration in 1970 defined mandatory EPSDT services to include the following services:

- "periodic screens" (regularly scheduled health exams beginning at the time of birth);
- immunizations,
- vision, dental and hearing care (including preventive and restorative dental care, eye exams and eyeglasses and hearing aids); and
- other medically necessary care for which FFP was available and which was covered under state plans.

The original EPSDT rules also provided that at their option states could cover as an EPSDT benefit all items and services for which FFP was available, even if not covered for adults.

While the regulations were amended several times during the 1970s and 1980s, these core rules remained virtually untouched.

b. The 1972 EPSDT Amendments

- Concerned that few children were receiving EPSDT screens and treatment, Congress amended the Social Security Act in 1972 to require states to inform all AFDC clients about EPSDT and provide transportation and scheduling assistance to families that requested EPSDT services. These amendments originally were added to Title IV-A (the AFDC program), and states were penalized with a loss of AFDC funds if they did not provide this assistance to children. The provision subsequently was moved to the Medicaid statute as part of the Omnibus Budget Reconciliation Act of 1981 and informing and assisting all EPSDT-eligible children, not only those receiving AFDC, became a general compliance issue.[3]

c. The 1989 EPSDT Amendments

The 1989 amendments[4] addressed the coverage limits created by the Nixon Administration's interpretation of the original 1967 amendments. The 1989 amendments made the following reforms:

---

[3]Section 2181(a), P.L. 97-35 (1981).

[4]Section 6403, P.L. 101-239.

- The amendments added coverage for "interperiodic" screens to allow access to the expanded EPSDT benefit package in between regularly scheduled periodic exams in the case of children whose problems first manifested themselves at a time other than a regularly scheduled visit.[5]

- The amendments required states to cover all medically necessary treatment for which FFP is available regardless of whether the treatment is otherwise covered under the Medicaid plan for adults.

- The amendments codified states' obligations to cover all medically necessary vision, dental, and hearing care.

- Finally the amendments established EPSDT participation goals and required states to keep certain data on EPSDT participation.

2. The Structural Elements of EPSDT

This brief history of EPSDT reveals that the program has three basic structural elements:

- **A set of benefits:** EPSDT covers certain benefits for children under 21 even when not covered for adults.

- **Support services:** EPSDT covers certain administrative services designed to assist families obtain services for children (outreach, scheduling and transportation).

- **A pediatric medical necessity standard in coverage determinations.** Unlike adult benefits, the purpose of EPSDT is to prevent the development of conditions and disabilities. The term "early" is the hallmark of EPSDT, and prevention is the essence of the program. EPSDT's purpose is to ensure early intervention before problems become serious. As a result, EPSDT has been interpreted by both HHS and numerous courts to effectively prescribe a preventive coverage standard.[6] Under this standard, coverage is

[5] An example would be a child who appears normal and healthy at a two-year exam but who, after beginning day care, is suspected of having hearing problems by a teacher or child care worker. Normally no exam would occur until age three, and the child might have to wait a full year until services could be obtained for a hearing problem. The interperiodic exam provision permits the exam and treatment to occur at "medically necessary" intervals.

[6] *Bond v Stanton* (7th Cir., 1974); *Mitchell v Johnston* (5th Cir., 1983); *Philadelphia Welfare Rights Organization v Schapp* (3rd Cir., 1979).

required if necessary to *prevent* the onset of or worsening of a condition, even if coverage would not be required for an adult with the same condition.

This special standard of medical necessity applies not only to illnesses and injuries but to conditions, as well. The term "condition" is used throughout the EPSDT statute, thus underscoring that coverage is required regardless of whether the child's need for care is the result of an *"illness or injury"* (as is the case with benefits for adults under most private insurance plans) or *a "condition"* (such as a condition occurring at or prior to birth). Moreover, recovery or return to normalcy is not a requirement for coverage under EPSDT. The program is meant to aid at as early a stage as possible children whose conditions would benefit from treatment.

The following example illustrates the difference between the medical necessity standard that governs care for adults and that which governs coverage for children under EPSDT. Imagine two persons -- a 30-year old woman who has been in an automobile accident and has suffered facial injuries and a three-year-old child born with a developmental disability. Both have a speech impairment, in the woman's case the impairment is the result of her injury, while in the child's case the impairment is caused by the developmental disability. In the case of the woman, speech therapy might not be covered at all or, if covered, might only be available if the loss of speech is serious enough to prevent even minimal daily communication. In the case of a child whose need for speech therapy is detected through an EPSDT periodic or interperiodic exam, speech therapy would be considered a medically necessary "early" intervention in order to ameliorate the effects of the child's speech impairment and prevent further delay.

3. EPSDT and Medicaid Managed Care

In reviewing options for EPSDT reform, it is important to consider EPSDT as it exists today. This means considering EPSDT in a managed care context, since states increasingly are enrolling children in managed care plans that are under contract to provide most or all of the EPSDT benefit package as part of their service duties.[7] In other words, states are contracting their EPSDT benefit and administrative obligations to managed care plans. This trend has implications for EPSDT, given the special considerations that go into Medicaid managed care contracting, the chief of which is the desire on the part of states to align their coverage duties with the limits of standard Medicaid managed care insurance products.

---

[7]It is worth noting that with the exception of Oregon (which uses a special prioritization system for health service coverage) we have found no evidence from any state conducting a Section 1115 demonstration that the state has sought to waive any portion of the EPSDT benefit package as part of its demonstration.

There is no "typical" treatment of EPSDT under managed care. There are virtually no federal rules that prescribe a certain contractual format for states with respect to benefit and administrative duties. However, the Center' s studies of state Medicaid managed care contracting practices[8] indicate that there are definite contracting patterns when it comes to the purchase of EPSDT benefits for children.

- States commonly contract with managed care plans for EPSDT screening services, immunizations, and "basic" EPSDT treatment services (i.e., services used by most children, such as physician care, prescribed drugs, and simple therapies).

- States take a varied approach to EPSDT dental, vision and hearing services. Some states leave these services out of their managed care contractual arrangements altogether; these services continue to be covered on a fee-for-service basis with free choice of provider. Other states may have special bulk purchasing programs for vision care and eyeglasses in order to achieve price efficiencies that come with economies of scale.

- Currently most states "carve out" from their managed care contracts those EPSDT treatment services that are needed by children with severe disabilities and conditions. Commonly "carved out" services are mental health services for children with severe emotional disturbance, institutional care for profoundly disabled children, specialized therapies for infants, toddlers and children with developmental disabilities who need these services to attend school, and EPSDT services provided in school settings generally. States may establish "carve out" managed care plans for some of these services; most commonly, however, these services continue to be reimbursed on a fee-for-service basis, with few restrictions on free choice (in great part because competent and experienced providers of these services to children may be in short supply).

- As a general matter states contract with plans to provide scheduling, outreach and transportation services. These administrative services are a typical part of states' managed care contracts. [9]

---

[8]Our current findings are similar to findings in an earlier, more limited study of EPSDT under managed care that was undertaken jointly with the Children's Defense Fund several years ago.

[9]Some states supplement their contracts with direct payment to local clinics and health agencies for additional medical and support services in a sort of "wrap-around" framework. Typical "wrap-around" services are case management, transportation, family planning services, school health services, and other community-based services furnished by public and private not-for-profit agencies.

- Perhaps most notably in our reviews, we have found *no* contract between a managed care plan and health care providers (we have now reviewed approximately 200 such contracts from 17 states) in which a plan uses a standard of medical necessity that meets the federal EPSDT standard (i.e., coverage is furnished if, in the opinion of the child's physician, treatment is needed to *prevent* a problem or treat a problem earlier than they would in the case of adults).[10] Contracts overwhelmingly use an adult coverage standard (coverage only if needed to treat and illness or injury) and also overwhelmingly reserve to the plans themselves the right to determine if the coverage is medically necessary. Only about 20 percent of the physician contracts we have reviewed to date even indicate that the physician's opinion will even be taken into account in a plan's medical necessity determination on behalf of a child.

4. The Cost of EPSDT

There is virtually no reliable information on the cost of the additional EPSDT benefits that were mandated as a result of the 1989 amendments. As a practical matter the 1989 amendments added mandatory coverage only for complex services for profoundly disabled children. Vision, dental and hearing care have been mandatory since 1970, as have all health exams, immunizations, and other services otherwise covered by state Medicaid plans. Similarly, the special medical necessity definition dates back to the original 1967 amendment and subsequent judicial decisions.

The 1989 amendments may have resulted in the coverage of greater levels of care for children with mental illness and developmental disabilities. However, states already covered these services to a greater or lesser degree under their Medicaid programs and many furnished additional benefits to children even at the time of the 1989 amendments. Many of these services must be provided because of requirements under special education and early intervention programs under state law and the IDEA. Others are paid for by state Medicaid agencies for children under the care of child welfare agencies, state mental health agencies, agencies for persons with retardation and developmental disabilities and other programs for children with special health care needs. It is simply inaccurate to assume that prior to 1989 complex Medicaid services for special needs children were not covered by states.

Moreover, very few children need these advanced services. Less than 5 percent of all children have conditions serious enough to limit normal daily activities, these extra services are relatively rarely used.

---

[10]Indeed, we recently reviewed one contract that requires physician to obtain prior approval for *all* services furnished to Medicaid -enrolled children whether by the physician or by a referral provider. One such services for which prior approval is expressly required is resuscitation of a newborn.

Finally national data on expenditures for children show that between 1988 and 1993 Medicaid expenditures per enrolled child increased at an average annual rate that was slower than the average annual increase for non-disabled, non-elderly adults.[11] This figure suggests that the total impact of the 1989 EPSDT amendments was relatively small. Even with recent years' increases, the cost of caring for children remains half that for non-elderly adults and a fraction of the cost of caring for disabled and elderly persons. The vast majority of children are inexpensive to care for; those who are not are in deep need of the care .

5. Options for Revising EPSDT

The cost of care for children and the relationship between EPSDT and managed care suggest that the problem with the program EPSDT program today is not its coverage of added services. Most of these services were already covered by 1989 under earlier amendments and regulations. The main problem appears to be that the EPSDT benefit package extends beyond the package typically offered by a commercial insurer or company selling managed care products to state Medicaid programs. Given the advent of managed care and states' interest in buying a standard benefit package from plans, several options might be considered:

a. Delegate to the Secretary the responsibility to define a standard EPSDT benefit package for managed care contracting purposes. Require states to cover other EPSDT services on a fee-for-service basis. Under this option the Secretary would develop a rule identifying which EPSDT services should be included under various types of risk contracts as well as the medical necessity standard that contracts should include. States would continue to "non-contract" EPSDT services on a fee-for-service basis. Presumably the rule would also include basic support services in contracts. Under this option, states not using managed care risk arrangements would continue to furnish all EPSDT services on a fee-for-service basis.

Pros: This option maintains all EPSDT benefits but gives states the flexibility to limit their contracts with managed care plans to a standard package. States could still elect under this option to fold all services into a managed care premium.

Cons: The option would leave states liable for all existing services on a fee-for-service basis even if not included in a contract.

---

[11]Kaiser Commission on the Future of Medicaid, *Medicaid Beneficiaries and Expenditures: National and State Profiles and Trends (1984-1993)*. Data from the Health Care Financing Administration analyzed in this study indicate that between FY 1988 and FY 1993 expenditures on children rose at a 10.2 percent average annual rate, while expenditures for non-disabled, non-elderly adults rose at an average annual rate of 10.8 percent.

b. Permit states to limit pediatric coverage to whatever benefits are furnished to adults except for health exams, immunizations and vision, dental and hearing care. This approach would eliminate the 1989 amendments but would leave mandates for health exams, immunizations, and vision dental and hearing care in place. Children would receive whatever adults do with respect to treatment services. As with pre-1989 law, states could elect to cover services on an optional basis on a fee for service basis or as part of the managed care premium.

Pros: This option would give states added flexibility. It is unclear whether many states would opt to reduce benefits since the added benefits add little cost and are furnished under other state programs.

Cons: this approach would fall most heavily on children with specialized health needs who are few in number but whose access to comprehensive coverage is particularly important. It is also unclear that the approach would save money or resolve the underlying tension that exists between what children need and what the typical managed care insurer covers. Since many insurers do not offer vision, dental and hearing care, states' basic concerns over these added responsibilities would not be addressed. Since the problem will remain, there seems to be little justification for removing benefits from severely disabled children.

c. Permit states using risk-based managed care to cover non-contract EPSDT services (other than vision, dental and hearing care) on a grant or per-capita contract basis with specialized providers of services. Under this option` states using managed care risk contracts could furnish non-contract EPSDT services (other than vision, dental and hearing care) through grants to or contracts with specialized providers of services to children with mental illness and developmental disabilities. FFP for these specialized state grants and contracts could be held to an inflation adjuster with an additional adjuster for population growth. Under this option, services that are not part of a standard contract and that are not vision, dental or hearing could be covered for children on a grant or capitated contract basis. Federal financial contribution limits would control the overall cost of this added set of benefits.

Pros: This option eliminates the individual entitlement to advanced forms of treatment and permits states to convert special services into exclusive grant or contractual arrangement with specialized providers. FFP limits would control overall supplemental costs. A treatment plan requirement would help ensure that services are furnished in a cost-efficient and appropriate fashion and that care is coordinated with services already covered by managed care plans.

Con: This option eliminates children's entitlement to specialized services and could erode funding for specialized services essential to children with serious disabilities .