Executive Summary

Abstract

The EPSDT state coverage analysis project was designed to assist HCFA carry out a Congressionally mandated study regarding the cost of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. The original scope of work specified that the purpose of the project was to "provide HCFA with sufficient data on State Medicaid programs and Medicaid managed care contracts to allow the Agency to estimate the costs associated with EPSDT that are over and above what Medicaid costs for children would be in the absence of the enhanced EPSDT service benefit (e.g., Section 1905(r)(5), medically necessary services)." This report combines all of the work products from this project into 4 chapters:

- **Chapter 1:** Analysis of State Medicaid Plans;
- **Chapter 2:** Analysis of State Medical Necessity Standards and their Comparison with Contract Standards;
- **Chapter 3:** Analysis of Contract Provisions Relating to EPSDT Services; and
- **Chapter 4:** Analysis of State Medicaid Contract Provisions Relating to the Definition of Pediatric Medical Necessity.

The EPSDT Program

EPSDT is a mandatory service for all categorically needy individuals under age 21 who are enrolled in Medicaid. Federal law defines EPSDT to cover certain “screening,” “diagnostic,” and “treatment” services, which must be furnished to eligible children both at age-appropriate periodic intervals as well as interperiodically (i.e., as needed):
1. Screening services to detect physical and mental conditions. A screen is defined to consist of a comprehensive health and development history, an unclothed physical exam, appropriate immunizations in accordance with standards of the Advisory Committee on Immunization Practices, laboratory tests including lead blood level assessments, and health education.

2. Vision services, including eyeglasses;

3. Preventive, restorative and emergency dental services;

4. Hearing services, including hearing aids; and

5. Any “other necessary health care, diagnostic services, treatment, and other measures” that are described in §1905(a) of the Social Security Act (i.e., that fall within the federal definition of medical assistance) that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.”

All medically necessary diagnostic and treatment services that fall within the federal definition of medical assistance must be covered, regardless of whether such services are otherwise covered under the state Medicaid plan in the case of persons ages 21 and over. This provision of federal law can be thought of as an “override” provision that essentially requires coverage of medically necessary care that in the case of adults would be denied because it exceeds applicable coverage limits.

Furthermore, because the purpose of EPSDT is preventive, states’ medical necessity criteria must be consistent with the program’s preventive standard of coverage. While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved. Since the purpose of EPSDT is to prevent the onset or worsening of disability and illness and children, the standard of coverage is necessarily broad.

Finally, transportation and scheduling assistance as well as assistance in securing needed services that are not covered under Medicaid are mandatory administrative activities under the program.

In sum, although states have significant coverage design discretion in the case of adults, the EPSDT program creates a broad, uniform standard of coverage for children, bounded only by the outer limits of §1905(a) and by a preventive standard of coverage that is customized to the needs of children.

This project was designed to provide HCFA with information related to state EPSDT coverage policies and the relationship between such policies and states' managed care contracting practices. HCFA requested this information as part of its activities related to a Congressional mandated study under §4744 of the Balanced Budget Act of 1997. The data collected through this effort were intended to assist the agency better calculate the cost

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1 42 C.F.R. §440.230(b)
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of medically necessary services under the EPSDT program, as well as the extent to which federal EPSDT coverage standards potentially extend beyond those found in standard commercial insurance policies.

To carry out this task, it is important to understand the factors that influence the cost of Medicaid coverage. As with any financing program, Medicaid coverage and attendant costs are a function of certain basic variables in benefit design that are common to all forms of public and private third party coverage. Three of the principal variables are: (a) the classes of services that are covered; (b) applicable amount, duration and scope of limitations on otherwise covered benefits (e.g., visit limits, day limits, diagnostic-related limits, and so forth); and (c) the definition of medical necessity that is used to make coverage decisions in any specific individual case.

For each of these variables, Medicaid requires the use of benefit design criteria in the case of children that tend to be broader than those found in standard commercial insurance contracts. As a result, GWU’s prior research in this area concluded that states that contract with managed care organizations for coverage of children may retain residual liability for pediatric coverage to the extent that their managed care organization (MCO) contracts do not parallel the coverage standards set forth in the state plan or under federal law.  

Methods and Organization of Study

Researchers at GW’s Center for Health Services Research and Policy (CHSRP) developed a series of tables that provide HCFA with state-specific background information on Medicaid coverage under state Medicaid plans, as well as the coverage provisions contained in states’ MCO contracts. A brief description of each table is set forth below.

- Table 1 sets forth the Medicaid services covered under the current state Medicaid plans (collected as of Fall 1999/Winter 2000), including any applicable amount, duration, and scope limits listed in the state plan. This table will assist HCFA identify those EPSDT services that may extend beyond the limitations of a particular state plan. The findings from this table, along with the findings from Table 5, are found in Chapter 1: Analysis of State Medicaid Plans.

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3 While the federal legal framework of the EPSDT program would appear to suggest consistency among the states with respect to coverage, in fact the Medicaid program is so complex that, despite the broad nature of federal EPSDT requirements, it is possible that there might be at least some state-to-state variation. This variation flows from the absence of a precise federal definition of medical necessity, as well as state-to-state variation in how certain benefits and benefit limitations are defined and expressed. Because of this potential for variation, we examined state Medicaid plans and compared their coverage against that specified under §1905 with respect to both classes of coverage and the presence of amount, duration and scope limits. For this review CHSRP analyzed state Medicaid plans in effect in 1999, as well as the Medicaid plans from 25 SMRF states in effect in 1995. Where plans changed during the year in question, the changes were captured. If the status of a service changed at some point during the calendar year 1995, it is so noted and the change described in the Endnotes to Table 5-A. In those cases where the necessary information was not available, it is so noted.
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- Table 2 presents the medical necessity definitions currently in use under state Medicaid programs, and compares these standards to those set forth in Medicaid managed care contracts. Federal Medicaid law does not contain a precise definition of medical necessity in Medicaid. Instead, states are given latitude to develop definitions that are consistent with broad federal requirements, which in the case of children, embody the special preventive standard under EPSDT. The findings from this table are found in Chapter 2: Analysis of State Medical Necessity Standards and their Comparison with Contract Standards.

- Table 3 shows the coverage of Medicaid services in comprehensive managed care contracts between state Medicaid agencies and managed care organizations. The information for this table has been extracted from the 3rd Edition of Negotiating the New Health System, a nationwide point-in-time study of MCO contracts published on an annual basis by CHSRF. This table will help HCFA identify which EPSDT services are covered under comprehensive managed care agreements, as well as the extent of coverage. By comparing this table to Table 1 as well as federal legal requirements, HCFA will be able to identify those services for which states remain directly responsible and those that are delegated either in whole or in part to managed care organizations. The findings from this table are found in Chapter 3: Analysis of Contract Provisions Relating to EPSDT Services.

- Table 4 shows the pediatric medical necessity standards in use in MCO contracts, using the data from the 3rd edition of Negotiating the New Health System. This table shows the extent to which the contracts incorporate into their managed care contracts the preventive standard of medical necessity that governs Medicaid services for children under EPSDT. Under principles of contract law, the absence of such a standard would permit MCOs to utilize an alternative and potentially more narrow definition of coverage, thereby creating residual liability in state Medicaid agencies. The findings from this table are found in Chapter 4: Analysis of State Medicaid Contract Provisions Relating to the Definition of Pediatric Medical Necessity.

- Table 5 shows for the 25 states included in HCFA’s State Medicaid Research File (SMRF) database for 1995, the Medicaid services covered under the State’s Medicaid Plan as of 1995, along with any applicable amount, duration, and scope limitations. HCFA will be able to use this table, along with the SMRF data, to calculate the extent and costs of the “extra” services that were provided to children as a result of EPSDT program requirements. As discussed above, the findings from Table 5 and Table 1 are found in Chapter 1.

**Major Findings**

Based on the work completed, the findings can be summarized through the following categories:

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4 See www.gwu.edu/~chsrp (Click on contract studies).
5 A presentation to HCFA and GAO staff is included as an exhibit to this report.
State Medicaid Plan Review Findings

- State Medicaid plans are broadly drafted, and thus it is difficult to measure the extent to which EPSDT federal coverage standards "override" the limitations placed on services described in the State's Medicaid plan.

- It is difficult to tell whether classes of benefits were missing because of the manner in which certain benefits are expressed in state plans. In addition, amount, duration, and scope limits are vaguely expressed and it was unclear whether states imposed these limits despite the legal requirements of the override and the unique medical necessity standard that is used to govern coverage decision-making.

- The state plans do not provide information regarding whether families in fact are notified regarding the availability of the full EPSDT benefits despite limitations that apply to adults, nor do the plans indicate the extent to which families enrolled in managed care arrangements receive this level of detailed information. As a result, it is unclear whether as a practical matter, the expanded EPSDT benefit is in fact available to families.

- Similarly, the state plans do not provide information on how providers of health services are informed of the availability of additional benefits or the process that would be used to obtain such benefits.

- The state plan documents did not explain the EPSDT medical necessity standard or the extent to which this standard overrides the medical necessity standard used for adults. Consequently, the actual effect of the EPSDT medical necessity override on coverage compared to the level of coverage available under the standard applied to adults was impossible to gauge from State Medicaid plan reviews.

Contract Review Findings

- In general, states expect contractors to honor the full EPSDT coverage obligation. Twenty-three of 39 general service contracts specified full §1905(a) coverage duties.

- Almost none of the contracts explained to contractors either their obligation to inform families or pediatric providers of the availability of services that might extend beyond normal contract limits, nor did the contracts explain how contractors should make determinations regarding what their contracts normally call for and the level of coverage that is required under §1905.

- Less than half of all general service contracts (16 of 39 general service agreements) contained a pediatric medical necessity standard.
• No behavioral health contract contained a pediatric medical necessity standard.

• Most contracts give state discretion to override contractor medical necessity determination in individual cases in which the contractor denies a service.

Policy Implications and Conclusions
The findings from this series of reviews lead to several conclusions:

• The cost impact of EPSDT is derived from the broader classes of benefits specified under EPSDT requirements, greater amount duration and scope standards, and a preventive pediatric medical necessity standard.

• Ambiguities in State Medicaid Plans regarding precise distinctions between federal EPSDT standards and state plan coverage levels make determining EPSDT impact for any particular state virtually impossible when the state plan is used as the unit of analysis.

• States routinely hold MCO contractors to the full range of §1905(a) service obligations, but do not explain what this means and may not require contractors to provide explanations to families.

• Pediatric medical necessity standards are not always articulated in state contracts with Medicaid MCOs.

• States retain the authority to override coverage determination by MCOs, but it is not known from the methodology used in this study if such authority is exercised, the types of cases in which such an override is required, or whether override authority is exercised for services that would be covered even under conventional insurance or only through the unique requirements of the Medicaid program.

• It is not clear if families and providers in Medicaid managed care are apprised of broader EPSDT coverage.

For these reasons, we conclude that it is not possible to determine from a state plan and contract review the additional cost impact of EPSDT in relation to either conventional insurance or the level of coverage that would be available in the case of "standard" state Medicaid plan coverage for adults. Benefits are too vaguely described, certain key elements of benefit cost (such as medical necessity definitions) are missing entirely, and specifications regarding notice of benefit availability to families and providers are lacking.

We would recommend additional and more detailed analysis of actual coverage determination practices, provider manuals, informational materials, and other documents related to coverage and coverage decision-making in order to secure the type of detailed data that would be required for this cost estimation project to produce the desired results.