

Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts

Chapter 1: Analysis of State Medicaid Plans

Overview

The purpose of this report is to provide HCFA with information related to state EPSDT coverage policies under state Medicaid plans. HCFA requested this information in order to assist in its efforts to estimate the cost of coverage 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.

Within broad federal parameters, state Medicaid programs have broad discretion over benefit design.¹ However, states are subject to minimum federal requirements. All states must cover certain categories of services, one of which is early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21.²

Federal law defines EPSDT to cover the following services, to be provided 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 and treatment services.

Under federal law, this last category of services requires states to cover other necessary health care, diagnostic services, and treatment services that are identified under the federal definition of medical assistance and that are medically necessary to correct or ameliorate physical and mental conditions discovered through a periodic or interperiodic screen. 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.

¹ For more information, see Schneider and Garfield, *Medicaid Benefits*, Kaiser Commission on Medicaid and the Uninsured (August 2000), www.kff.org.

² §1905(a)(4)(C) of the Social Security Act, 42 USC §1396d(a)(4)(C).

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.

Finally, 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.³ 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.

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.

Methods

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 are expressed.⁴

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.

Coverage under Medicaid is a function of certain basic variables in benefit design that are common to all forms of public and private third party coverage. The three principal variables for purposes of this analysis are (a) the *classes* of services that are covered; (b) applicable *amount, duration and scope* limitations on covered benefits (e.g., visit limits, day limits, diagnostic-related limits, and so forth); and (c) the definition of *medical necessity* that guides individual coverage determinations. For each of these variables, Medicaid requires the use of benefit design criteria in the case of children that are significantly broader than those found in standard commercial insurance contracts. As a result, states that contract with managed care organizations for coverage of children may retain residual liability for pediatric coverage to the extent that their MCO contracts do not parallel the coverage standards set forth in the state plan or under federal law.

³ 42 C.F.R. §440.230(b)

⁴ One would presume that HCFA’s state plan review and approval process would ensure that variation in state interpretation of federal requirements would be minimized. However, anecdotal evidence suggests substantial variation in regional office review procedures and standards for state plan amendments and the wording of the amendments themselves. As a result, it is possible that, despite the seemingly uniform nature of federal Medicaid law where coverage of children is concerned, state variations could be found.

For this review, researchers at GW's Center for Health Services Research and Policy (CHSRP) analyzed state Medicaid plans in effect in 1999, as well as the Medicaid plans from 25 of the states in HCFA's State Medicaid Research Files (SMRF) in effect in 1995. Where plans changed during the year in question, the changes were also 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.

From this review, researchers developed a series of tables that provide HCFA with state-specific background information on Medicaid coverage under state 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.⁵ The findings from Tables 1 and 5 are discussed in this chapter.
- 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. (For more information, see Chapter 2)
- 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 CHSRP⁶. 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

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⁶ See www.gwu.edu/~chsrp (Click on contract studies).

and those that are delegated either in whole or in part to managed care organizations. (For more information, see Chapter 3)

- 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. (For more information, see Chapter 4)
- Table 5 shows for the 25 SMRF states, 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. The findings from this table are included with the findings from Table 1.

Findings

Table 1 and Tables 5-A present the services and service limitations under state Medicaid plans in the case of categorically needy persons. Tables 1 and 5-A show the status of Medicaid services provided by each of the SMRF states as of 1999 and 1995 respectively.⁷ The status of each service is designated as either (a) provided, without limitations; (b) provided, with limitations; or (c) not provided.

EPSDT's override provisions and state plan service limitations

These tables also show the considerable variation in how states express the relationship between the EPSDT coverage rules and their basic state plans. This variation in how the EPSDT program requirements are expressed further complicates the task of estimating the cost impact of EPSDT. In some cases, the override language is relatively clear; in others, it is not clear how the level of coverage provided under the federal coverage requirements is communicated to either providers or beneficiaries.

For example, Colorado's 1999 Medicaid state plan contains a general statement regarding the relationship between the EPSDT override provisions and state plan service limitations. The plan also describes specific service overrides:

EPSDT: ...Medically necessary services not otherwise provided under the State Plan but available to EPSDT Participants

⁷To obtain additional information on Tables 1 and 5-A, contact CHSRP at 202-530-2305.

***Other necessary health care, diagnostic treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screening service will be provided when medically necessary to EPSDT participants. The services not provided under the State Plan are available to EPSDT participants if discovered by the EPSDT screening service and if medically necessary. ***

Prosthetic devices:

May be prior authorized as medically necessary for adult clients and for clients of the EPSDT program.

Some states, like Georgia, explain the override rule in the context of specific services:

Physician Services: ***All Medically Necessary, recognized, non-experimental physician's services are covered when provided for EPSDT recipients under 21.***
and

Psychologist Services: ***Medically Necessary psychological services are provided only to EPSDT eligible individuals.***

Still other states spell out the EPSDT override requirement and in a single place identify the classes of services where the override rule will be most important, as is the case of Iowa:

***Services not covered under the state plan that are specified in Section 1905(a) and the Code of Federal Regulation are being reviewed with medical consultants for inclusion elsewhere in plan for persons under age 21. Services not included in the state plan are private duty nursing, personal care services, respiratory care services, and other diagnostic, screening, preventive, rehabilitative and treatment services.
...*** Iowa Medicaid State Plan

Kansas provides general guidance on the impact of the override.

***Non-covered procedures will be covered for EPSDT participants if determined to be medically necessary. Limitations will be exceeded for EPSDT participants when determined medically necessary through the prior authorization process. ***
Kansas Medicaid State Plan

...If a mandatory or optional service is not covered to the extents the provider feels it is necessary, it will be covered for clients under 21 years of age if the Medical Services Administration Consultant agrees with the provider that the service is medically necessary....

Kansas accompanies this broad statement with a tabular presentation of §1905(a) services and indicates in the table whether the "same limitations apply for EPSDT as for other Medicaid Consumers" or if service is strictly an "expanded service for EPSDT participants".

A few states, like Rhode Island and Vermont, specifically incorporate the EPSDT statutory provision references into their state plans:

EPSDT: ***The State complies with the provisions of P.L. 101-239, Section 6403 and Section 1905(r) [of the Social Security Act]. The prior authorization requirements which are applicable to all other medical services and supplies provided in the Rhode Island Medical Assistance Program apply to EPSDT services.*** Rhode Island State Medicaid Plan

EPSDT: ***EPSDT services are provided to all Medicaid eligibles under age 21 in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act.

Coverage is provided for all medically necessary diagnosis and treatment services including the following services not otherwise provided under the State Plan:

- private duty nursing (item #8)
- respiratory care (item #22)
- personal care in home (item 24f)...

Coverage and service limitations described in this State Plan do not apply to medically necessary EPSDT services, although some services may be subject to prior authorization requirements.***

The Appendix to Table 5-A (in the Appendix Notebook available from CHSRP) presents descriptions of the amount, duration and scope limitations in effect in 1995 for each service for each of the 25 SMRF states studied. Unless otherwise indicated, the limitations presented are those which were in effect as of January 1, 1995. In those cases where the description of limitations changed at some point during calendar year 1995, the changes are included as well as the effective date. In those cases where the necessary information was not available, the limitations are noted, and the current version of the limitations is presented.

The information regarding limitations in amount, duration and scope of benefits presented in the Appendix to Table 5-A is frequently quite lengthy. In many instances, the actual limitations as reported by the states are more qualitative than quantitative in nature.

In order to discern the extent to which the EPSDT standard would result in greater cost, one would need to ascertain how EPSDT's "override" is carried out in State Plan descriptions. The task of determining whether the benefit has specific amount, duration, and scope limitations or if it is omitted altogether is difficult, because the EPSDT medical necessity standard would be overriding specific amount duration and scope limitations rather than an entirely omitted class of service. In these states, HCFA would need detailed information on how the amount, duration and scope limits work for adults in order to calculate the cost of overriding those limits where children are concerned.

For example, information regarding the optional Medicaid benefit "*Dental services*" is extracted and presented in an attachment to this memo. Four SMRF states (AK, AR, CO,

DE) do not appear to offer the optional “*Dental services*” benefit. That is, dental services are only available to children covered through the EPSDT benefit, not to adults. In these four states, it may seem that calculating the excess costs of EPSDT with regard to “dental services” should be straightforward. The other 21 SMRF states, however, have elected to cover the “*Dental services*” benefit under their Medicaid State Plans, but impose limitations that vary from state to state. The SMRF data would need to be compared to a specific state's limitations in order to calculate the extent and costs of extra services that were provided to children as a result of EPSDT requirements.

As another example, eight of the SMRF states report that their State Medicaid Plan does not cover “occupational therapy” under the optional benefit “*Physical therapy and related services*.” Under this benefit, one state (ND) provides occupational therapy without limitations, and sixteen states provide the benefit “with limitations.” However, this is further complicated in that some states offer “occupational therapy” under the mandatory benefits “*Outpatient hospital services*” or “*Physical therapy, occupational therapy, or speech pathology and audiology service provided by a home health agency or medical rehabilitation facility*.” This also may apply to physical therapy and speech and language therapy as well. Again, the SMRF data would need to be compared to these benefits.

Policy Implications and Conclusions

The findings from this review lead to several conclusions:

- First, because every state plan is so distinct, the exact impact of the EPSDT coverage rules will vary dramatically. This is because basic state plans themselves vary dramatically as well as because the EPSDT benefit contains so many elements that would affect a cost estimate. These elements include the service and coverage requirements, the periodic and interperiodic screening requirements, the coverage requirements imposed by each separate screening components, the amount, duration and scope override provision, and the medical necessity provisions. Since most states offer considerable Medicaid coverage for adults and have broad classes of benefits, the cost estimate differential for services provided to children under EPSDT is difficult to calculate. This is so because the EPSDT override primarily would affect the amount, duration and scope of an already covered service, rather than adding an entire service class. In these instances, HCFA would need considerably more detailed data to determine the impact of the EPSDT requirements on costs of covered services in the state.
- Determining exactly how costly the EPSDT program would be in any state relative to its basic Medicaid plan is further complicated by the fact that states vary so widely in how they express the coverage and coverage limits of their basic plans, as well as how they express the impact of the override on coverage limits. Some state plans are relatively clear. Others contain broad statements regarding the override and only limited information on how the override would affect a particular service.
- Finally, in the absence of information on how states actually apprise providers and families of the full scope of the EPSDT program, and the process for overriding otherwise applicable service limits, the actual cost impact of the EPSDT program benefit

package probably cannot be known. If providers and families are fully apprised of the existence of additional benefits and have a readily accessible process for claiming them, the value of the benefit may be great. If providers and families are unaware of the existence of the override or if the override process is not well understood, then the obligation to pay for additional treatment may be one that is exercised only in rare instances when a family or provider aggressively pursues additional treatment.

For these reasons, it may not be possible from the level of information furnished in state plans to ascertain the extent to which the EPSDT program actually leads to coverage costs beyond those that would be found in a state Medicaid plan in the absence of the enhanced screening, diagnostic and treatment provisions of the law.