

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

Chapter 2: Analysis of State Medical Necessity Standards And their Comparison with Contract Standards

Overview

The purpose of this report is to provide HCFA with information related to state Medicaid coverage policies and their relationship to coverage standards set forth in MCO contracts. Specifically in this chapter, we examine the extent to which the preventive standard of coverage that governs the federal EPSDT benefit¹ is expressly incorporated into a state's Medicaid program through enabling legislation or program regulations and if so, whether this standard is further expressly incorporated by the state into its MCO contracts. To the extent that a state program incorporates a preventive pediatric standard into its own operations, as required by law, but does not expressly direct its contractors to adhere to such a standard in making coverage determinations involving children, a state would effectively retain residual liability for uncovered classes of services, as well as for services that are ostensibly listed in a contract but that fall outside of the medical necessity definition used by the contractor.

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.² (For more information, see Chapter 1)

¹ The EPSDT program requires that state plans cover all medically necessary items and services enumerated in §1905(a) of the Social Security Act. §1905(r)(5) of the Act. The Act itself does not define medical necessity but does require that state standards for medical assistance be "reasonable." §1902(a)(17). The Secretary has interpreted this reasonableness test to require that limitations on the amount duration and scope of medical assistance be sufficient in amount, duration and scope to reasonably achieve its purpose. 42 C.F.R. §440.230 (b). Since the purpose of the EPSDT program is preventive, courts in passing on the sufficiency of state limitations have consistently measured coverage against a preventive standard. Sara Rosenbaum et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3rd Ed.) (Washington D.C., 1999) Vol. 1.

² 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. 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 also captured. If the status of a service changed at some point during the calendar year 1995, it is so

- 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 Table 2 are discussed in this chapter.
- 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 CHSRP³. 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. (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 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. (For more information, see Chapter 1)

The EPSDT Pediatric Standard

EPSDT services are required for all Medicaid enrolled categorically needy individuals under age 21.⁴ The EPSDT benefit is defined at §1905(r) of the Social Security Act⁵ and consists of periodic and interperiodic "screening exams"⁶, vision services,⁷ dental services,⁸ hearing services,⁹

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.

³ See www.gwu.edu/~chsrp (Click on contract studies).

⁴ §1902(a)(10)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(10)(A); 1905(a)(4)(B), 42 U.S.C. §1396d(a)(4)(B)

⁵ §1905(r) of the Social Security Act, 42 U.S.C. §1396d(r)

⁶ §1905(r)(1) of the Social Security Act, 42 USC §1396d(r)(1)

⁷ §1905(r)(2) of the Social Security Act, 42 USC §1396d(r)(2)

⁸ §1905(r)(3) of the Social Security Act, 42 USC §1396d(r)(3)

and “such other necessary health care, diagnostic services, treatment, and other measures described in §1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions *** whether or not such services are covered under the State plan.”¹⁰ The statute does not define the term “necessary.” However federal Medicaid regulations require that all coverage standards be designed to “reasonably achieve” the purpose of the benefit.¹¹ Both the Department¹² and the courts¹³ have interpreted the purpose of EPSDT to be preventive; consequently, the standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities.

Methods

In order to carry out this phase of the study, we first examined state statutes and regulations to identify those states whose *own laws* (i.e., statutes and/or regulations) satisfy two basic criteria:

- The state law itself includes an express medical necessity definition; *and*
- That definition includes a clause that specifically refers to children and thus can be said to contain a specific pediatric standard of coverage.

⁹ §1905(r)(4) of the Social Security Act, 42 USC §1396d(r)(4)

¹⁰ §1905(r)(5) of the Social Security Act, 42 USC §1396d(r)(5)

¹¹ 42 C.F.R. §440.230(b)

¹² Departmental history on the nature and purpose of EPSDT dates back to 1966, before enactment of the original EPSDT amendments. The Program Analysis Group that was assembled within HEW in 1966 to develop a child health initiative for President Johnson identified “preventable” mortality, bad teeth, and chronic handicapping conditions as the principal targets for a combined federal initiative that ultimately culminated in the enactment of the 1967 amendments to both Title V and Title XIX. Joseph Wholey, *The Absence of Program Evaluation and an Obstacle to Effective Public Expenditure Policy: A Case Study of Child Health Care Programs* (Urban Institute, Washington D.C., 98-121-24, 1969). A major “subordinate objective” of the initiative was to “reduce *the incidence of preventable handicapping conditions* and the prevalence of uncorrected handicapping conditions. Id at p. 454 (emphasis added) Specific conditions to be prevented *or* treated were mental retardation, vision, hearing and speech defects, and mental and emotional disorders. Thus, the complete prevention of handicapping conditions was targeted as an early goal, quite apart from the treatment of existing conditions.

This theme of preventing conditions in order to achieve normal growth and development has continued throughout the life of the program and has been consistently recognized by courts in EPSDT litigation. HCFA also has emphasized both the preventive and treatment nature of EPSDT. Most notable perhaps, was the agency’s seminal 1981 Action Transmittal regarding developmental assessments (Transmittal No. 80-93). This transmittal expanded upon earlier explanations of program purpose and intent and clarified the agency’s concerns regarding the preventive nature of EPSDT and the goal of transcendent goal of normal growth and development. The developmental assessment guidelines underscored that the fundamental purposes of their issuance (as well as the entire EPSDT program) were to ensure “a child’s overall growth and development” MAM 80-93, p. 3, and to promote treatment *before* a condition became handicapping, not merely to “treat or ameliorate” a diagnosed condition. This theme of access to treatments that promote normal growth and development and not merely those that treat illnesses and conditions was carried through into subsequently issued regulations (See e.g., Preamble to final regulations at 44 Fed. Reg. 29420, (May 18, 1979): “Since 1966 the federal government has thus stated its intent to design, implement and enforce a program that would assure comprehensive, preventive health care for Medicaid children.”)

¹³ See the cases cited in Sara Rosenbaum et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3rd Ed.) (Washington D.C., 1999) Vol. 1, www.gwu.edu/~chsrf.

We then compared these state program terms to the terms found in the MCO contracts for these states. The results are summarized on Table 2. Once this task was completed, we examined the MCO contracts for those states whose own programs laws and regulations did not include an express pediatric standard of coverage in order to determine whether such a standard was nonetheless included in the state's contract.

The information pertaining state Medicaid laws and regulations was gathered through data bases maintained by the National Conference of State Legislatures and through two legal data bases, Lexis and Westlaw.

Findings

Table 2 summarizes the results of our research. Our findings can be summarized as follows:

- 47 of 51 states have statutes and regulations that contain an express medical necessity definition.¹⁴
- Of the 47 states that have statutes and regulations containing an express medical necessity definition, only 19 state statutory or regulatory definitions include what might be considered a preventive pediatric component.
- Among those states with statutory and/or regulatory definitions of medical necessity that contain a pediatric standard, 6 maintain contracts with one or more MCOs. Among these 6 states, 2 expressly incorporate their statutory/regulatory definition into their contracts. Another 4 states either are silent in their contracts or else use an alternative definition. In these states, the contractor would have the legal discretion to vary its definition from that used by the state, thereby leaving the state with residual liability.
- Of the 32 states that either have no statutory or regulatory definition of medical necessity at all or else no specific pediatric standard, 9 maintain contracts with one or more MCOs and contain a preventive pediatric standard in their contracts. We presume that states do so in recognition of the fact that even in the absence of a definition under their own laws, they are nonetheless responsible for coverage up to the pediatric standard as a matter of federal law. The inclusion of a pediatric standard in the contract would be a means of ensuring that the federal obligation clearly is assigned to their contractors.

¹⁴ The four states (IA, KY, MS, NE) whose statutes and regulations do not contain an express medical necessity definition, as well as the large number whose definitions do not contain a preventive pediatric component, should not be particularly surprising. Many states may simply elect to be governed by the broad federal standards without restating a separate version of those standards in their own laws. Unless HCFA specifically requires a state to set forth its medical necessity and preventive pediatric definitions in its state plan documents, the state would not have a legal obligation to formally legislate or promulgate standards. A state separately might be obligated under state administrative law to have such a standard. Presumably the utilization review staff of a state agency would operate in accordance with informally promulgated written standards, whose legal sufficiency could be open to challenge under federal law. In addition, under due process principles, state agencies would have to disclose their standards to beneficiaries whose request for assistance is denied or reduced or whose coverage is terminated and who appeal the denial, reduction or termination.

- Of the 28 states that neither include a pediatric standard in their own laws nor provide for such a standard in their contracts, it cannot be ascertained without further research whether either the state or the contractor has policies in place to ensure adherence to a preventive pediatric standard or whether either the state or contractor has ever developed a process for evaluating pediatric medical necessity cases. In the absence of specific standards and evaluation procedures, the extent to which children receive greater levels of covered benefits than adults cannot be ascertained without a great deal of additional research into actual coverage determination practices.

Policy Implications and Conclusions

The EPSDT program can result in additional expenditures for states compared to that for adults in one of two basic ways:

- a state is obligated to cover *classes or amounts* of services for children that are not covered for adults (e.g., unlimited medically necessary mental health visits versus a defined limit);
- with respect to covered services, the pediatric medical necessity standard that governs EPSDT requires a state to grant coverage under circumstances when coverage would be denied in the case of an adult. One example would be an obligation to commence physical therapy in a child in order to prevent a disability rather than treating it in an adult in order to restore some level of functioning. Another would be an obligation in the case of a disabled child to continue therapy indefinitely in order to prevent deterioration, while being allowed to limit therapy in the case of an adult.

One step in determining the cost estimates of additional expenditures for states is to identify entire classes of services that a state would cover for children but not for adults as a result of the EPSDT requirements. Similarly, it is also necessary to identify overt amount, duration and scope limits that apply to adults but not children.¹⁵ In theory, once these classes and limits are identified, their possible cost can be estimated. However, their true cost cannot be known until one is able to know the frequency with which these services are actually furnished *as medically necessary*. Unfortunately, the medical necessity question is an extremely difficult issue to analyze for cost estimation purposes. The analysis depends on the application of finely drawn definitions to medical facts. Furthermore, from the definitions shown on Table 2, it is evident that no two states define medical necessity (or even pediatric medical necessity) in quite the same way. If the federal standard (prevent or ameliorate) is used to prepare the cost estimate, it is not clear that this is the standard that is being routinely applied in every state.

The question of the extra costs for State Medicaid programs due to the preventive pediatric coverage standard in EPSDT remains unclear. Fourteen states have a formal statutory or regulatory definition as part of their own Medicaid programs that do incorporate a preventive pediatric standard. Furthermore, very few states actually incorporate a pediatric medical necessity standard into their contracts. As a result, it is difficult to know whether an expansive coverage standard is

¹⁵ For a discussion of these issues and findings from the reviews of State Medicaid Plans, see Chapter 1. This memo found that because every State Plan is so distinct, the exact impact of the EPSDT rules will vary dramatically.

routinely applied or else is applied only infrequently (e.g., for selected types of health needs or only when a coverage denial is challenged). Several recent articles suggest that states may actually pursue rather aggressive coverage of children¹⁶ and that coverage to the extent needed to prevent or deter the onset of a physical or mental condition is the norm. If so, the question of cost estimation still remains, since it is not clear how to estimate the cost of a preventive rather than a treatment/restorative standard, particularly where, as here, one can see the wide variation in preventive standards.

One approach might be to compare the New York Medicaid statutory definition, which is a standard insurance-style definition and which would be legal if applied to adult Medicaid beneficiaries with that used in Arizona or Vermont, whose definitions are preventive in nature.

New York

Consistent with quality care and generally accepted professional standards.

Arizona

***Medically Necessary means a covered service provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to (a) prevent disease, disability, and other adverse health conditions or their progression, or (b) prolong life. ***

Vermont

Health care services including diagnostic testing, preventive services and aftercare appropriate, in terms and type, amount, frequency level, setting and duration to the member's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or managed the diagnosis or condition, and (1) help restore or maintain the member's health; or (2) prevent deterioration of or palliate the member's condition; or (3) prevent the reasonable likely onset of a health problem or detect and incipient problem.

¹⁶ Finkelstein, BS, Silvers, JB, Marrero, U, Neuhauser, D, Cuttler, L. Insurance Coverage, Physician Recommendations, and Access to Emerging Treatments, *JAMA* 1998; 279:663-8.