THE EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) BENEFIT UNDER THE MEDICAID PROGRAM

DRAFT

PRELIMINARY FINDINGS OF A 1997 BALANCED BUDGET ACT-MANDATED STUDY

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EXECUTIVE SUMMARY

Background

This report provides preliminary findings from a study of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) conducted by the Office of Strategic Planning, Division of Beneficiary Research, Health Care Financing Administration (HCFA). HCFA is currently preparing a Report to Congress on the EPSDT benefit, which responds to the Section 4744 of the Balanced Budget Act (BBA), requiring the Secretary of the Department of Health and Human Services to conduct a study of the provision of the Early and Periodic Screening, Diagnostic and Treatment services under the Medicaid Program under Title XIX of the Social Security Act and report to Congress on the actuarial value of EPSDT services. Specifically, the study was required to include "an examination of the actuarial value of the provision of EPSDT services and an examination of the actuarial value attributable to the non-screening portions of EPSDT services."[1]

Approaches

HCFA developed a multi-dimensional framework to address Section 4744 of the BBA to study and report on the EPSDT benefit. To estimate the actuarial value of EPSDT services, State Medicaid data from the State Medicaid Resource File (SMRF) were analyzed. 1995 was the most current year of available SMRF data, containing information on 28 States.[2] Specifically, the study examined EPSDT services provided to Medicaid-eligible children under 21 years of age. In this study, HCFA applied a uniform definition of the EPSDT benefit to include a variety of screening and treatment services, including:

- comprehensive health screening services including immunizations;
- vision screening and treatment services;
- dental screening and treatment services;
- hearing screening and treatment services; and
- other types of identified EPSDT services.

Taken together, these services provide a broad set of indicators for the EPSDT benefit. HCFA's uniform definition of EPSDT services includes State-based claims for EPSDT services and a subset of non-EPSDT claims based on nationally recognized procedure and diagnosis codes. Appendix A contains a list of national HCFA Common Procedure Coding System (HCPCs) and

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[1] Balanced Budget Act of 1997, Conference Report to Accompany H.R. 2015, July 30, 1997, p. 891.

[2] Due to data limitations discussed in the methods section, only 26 States were used in the analysis.

diagnosis codes used to identify EPSDT-related services. Additionally, this study examined State-specific procedure codes to identify EPSDT services. The research design and methodology used in this study is fully described in a later chapter.

Key Issues Addressed

This study attempted to address three key issues:

- What is the actuarial value of EPSDT services?
- What is the actuarial value of medically-necessary services, whether or not they are covered under the State plan?
- What is the portion of the actuarial value of EPSDT services that are attributable to partial providers of EPSDT services?

Key Findings

- The nationally weighted average for EPSDT services in 26 States, representing 11 million Medicaid-eligible children, was $170 per child in 1995.
- Approximately 55 percent of all Medicaid-eligible children, under 21 years of age, in 26 States received at least one or more EPSDT services.
- Individual States varied greatly in average per-capita expenditures for EPSDT services, ranging from $76 in California to $540 in Delaware. Eighteen States had average per-capita expenditures for EPSDT services that ranged from $100-$300. Seven States had average per-capita expenditures that were more than $300. Only one State had average per-capita expenditures less than $100.
- Among all Medicaid-eligible children, 36 percent received preventive care, 9 percent received immunizations, 16 received dental screening and treatment services, 8 percent received vision screening and treatment services, and 1 percent received hearing screening and treatment services.
- The average payment for providing selected EPSDT services varied according to the type of service. For instance, average payments for preventive care services totaled $38; dental screening and treatment services averaged $33 per Medicaid-eligible child.
- EPSDT payments accounted for 13.6 percent of total Medicaid dollars in the 26 States in the study sample. There was great variation across States in the percent of State Medicaid expenditures attributable to EPSDT services, ranging from a low of 7 percent in Colorado to a high of 26 percent in Pennsylvania. However, this was not as great as the

variation in per-capita expenditures (*see above*). On average, States with greater total per-capita expenditures had greater EPSDT per-capita expenditures.

CHAPTER 1

BACKGROUND

The Medicaid Program is mandated to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to all enrolled children under 21 years of age. In 1967, Congress established the EPSDT benefit to increase the number of Medicaid-eligible children receiving preventive and comprehensive health services. During the past thirty years, the EPSDT benefit has grown from a narrowly-defined health screening benefit toward a more comprehensive health program for Medicaid-eligible children. In the late 1980s, there was concern that the EPSDT program was failing to meet its full potential to provide screening and treatment services to all Medicaid-eligible children. There is evidence that access to EPSDT services is improving. According to HCFA-416 data, more than half (57 percent) of Medicaid-eligible children received EPSDT screening services in 1995 and 47 percent received services in 1992. In comparison, less than one third (30 percent) of Medicaid-eligible children in 1988 received screening services (HCFA-420 Quarterly Report data).

A. The Omnibus Budget Reconciliation Act of 1989

Congress included several provisions in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) (Public Law 101-239, section 6403, enacted on December 19, 1989) to increase children's access to EPSDT services. EPSDT comprehensive benefits include periodic well-child examinations, immunizations, laboratory tests, counseling and health education, vision services, dental services, and hearing services. The changes made by section 6403 include:

- Defining screening services to include blood lead level assessment appropriate for age and risk factors, and health education including anticipatory guidance;

- Requiring distinct periodicity schedules for screening, dental, vision, and hearing services and requiring medically necessary interperiodic screening services;

- Adding newly required service component of "other necessary health care, diagnostic services, treatment and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"; and

- Clarifying that nothing in the Medicaid law permits limiting program participation for EPSDT providers to those that can furnish all required EPSDT diagnostic or treatment services or prohibiting the participation of qualified providers that can

furnish only one such service."[3]

These amendments were intended to increase the number of Medicaid-eligible children being screened and receiving needed medical treatment.

B. The Balanced Budget Act of 1997

The enactment of the Balanced Budget Act (BBA) of 1997 required the Department of Health and Human Services to conduct a study of the EPSDT benefit, which should include actuarial analyses of the cost of EPSDT services and those services related to medical necessity (see Appendix B for the statutory language and the conference agreement reports). Another required component of the study was to examine the portion of the actuarial value of services attributable to partial providers of EPSDT services.

The BBA statutory language states that under Section 4744 of the Balanced Budget Act, the Department, "in consultation with Governors, directors of State Medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the Medicaid program under title XIX of the Social Security Act in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)). The study conducted ... shall include examination of the actuarial value of the provision of such services under the Medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act [i.e., the Social Security Act] and to the second sentence of such section." Section 1905(r)(5) states:

> "Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [the list of Medicaid services] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.
>
> Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and

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[3] The Federal Register, Vol. 58, No. 189, Friday, October 1, 1993, p. 51289.

periodic screening, diagnostic, and treatment services."[4]

C. HCFA's Research Activities on the EPSDT Benefit

Currently, HCFA's Office of Strategic Planning is conducting a study of the EPSDT benefit, focusing its research efforts on addressing the key components of the study, as stated above in the BBA mandate. Consultation has been made with HCFA's Center for Medicaid and State Operations (CMSO) staff about the operational issues involved in EPSDT services. Additionally, the study has been guided by feedback from members of the Medicaid/Maternal and Child Health Technical Advisory Group (MCH-TAG) regarding key issues involved in the EPSDT study. Members of the MCH-TAG were asked to provide information on expenditure estimates of EPSDT services, definitions of medically-necessary services and their associated expenditures, and State Medicaid plans regarding EPSDT services. The purpose of this report on HCFA's study of EPSDT services is to serve as background material for a meeting with representatives from several provider and beneficiary groups, scheduled for April 6, 1999. This report reflects preliminary findings of the expenditures and use of EPSDT services nationally. The study on the EPSDT benefit is on-going and is not yet completed.

In 1993, HCFA funded a study of children's preventive and EPSDT services before and after enactment of OBRA-89, which expanded benefits to more low-income children. The MEDSTAT Group conducted the study and relied on 1989 and 1992 Medicaid Tape-to-Tape data from California, Georgia, Michigan, and Tennessee. They examined provider supply issues and found that there was substantial growth in enrollment in all four states and higher child/provider ratios after the OBRA-89 expansions. The MEDSTAT Group also reported an increase in Medicaid enrollment and modest increases in the use of preventive care services. The use of dental services increased significantly in Georgia, but not in the other three States. The MEDSTAT Group's study findings will be discussed in the context of issues to be addressed in this report of preliminary findings from HCFA's study of the EPSDT benefit.

Appendix A contains a copy of MEDSTAT's 1997 Final Project Synthesis Report, entitled "Comparative Study of the Use of EPSDT and Other Preventive and Curative Health Care Services Enrolled in Medicaid" and an article written by researchers with the MEDSTAT Group entitled "Medicaid Providers of Children's Preventive and EPSDT Services, 1989 and 1992."

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[4] Balanced Budget Act of 1997, Conference Report to Accompany H.R. 2015, House of Representatives Report 105-217, July 30, 1997. Compilation of the Social Security Laws.

CHAPTER 2

THE EPSDT BENEFIT

A. Introduction

As the child health component of Medicaid, EPSDT provides a comprehensive set of preventive and health care services to Medicaid-eligible children under age 21. The term EPSDT describes the program's goals and gives information on the services it covers:

Early: assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic: assessing a child's health at key points in her/his life to assure continued health and development;

Screening: using tests and procedures to determine if children being examined have conditions requiring closer medical (including mental health) or dental attention;

Diagnostic: determining the nature and cause of conditions identified by screenings and those that require further attention; and

Treatment: providing services needed to control, correct, or reduce physical and mental health problems.

States are required to offer a broad range of health services and conduct activities to inform Medicaid-eligible individuals about the EPSDT benefit and encourage their participation in the Medicaid program. For instance, States are required to provide Medicaid-eligible children and families with transportation, assistance in scheduling medical appointments, and locating EPSDT health care providers.

State Medicaid agencies also are required to develop eligibility criteria and develop State plans that list covered services. States are responsible for paying for medical services that are covered under the State plan for Medicaid beneficiaries. In addition, the OBRA-89 EPSDT amendments require that Medicaid-eligible children receive health services that may not be covered under the State plan for adults but which may be considered medically necessary. In a later section, the issue of medical necessity is addressed.

State Medicaid expenditures are matched by the federal government for a share of the expenditures they spend for Medicaid services. The Federal share varies from one State to another. Expenditures for medical services, including screening, diagnosis, and treatment, are

reimbursed by the Federal government at State-specific rates. This rate varies from 50 to 83 percent with poorer States receiving a higher rate for the expenditures of Medicaid medical services and wealthier States receiving a lower rate. Administrative expenses for activities such as outreach, eligibility determinations, provider relations, some transportation activities, and follow-up are usually matched by the Federal government to the State Medicaid agency at a rate of 50 percent.

B. The Scope of EPSDT Services

Under Federal statute, States are required to provide medical check-ups, vision, hearing, and dental services to Medicaid-eligible children. Additionally, States are required to provide medically-necessary diagnostic and treatment services to all Medicaid-eligible children. Moreover, States are responsible for providing case management, and transportation services to Medicaid-eligible children. States are required to cover the following services:

- comprehensive health screening services, including:
    - comprehensive health and developmental history;
    - a comprehensive unclothed physical examination;
    - laboratory tests (including blood lead level assessment); and
    - health education (including anticipatory guidance);
- appropriate immunizations;
- vision assessment and treatment services;
- dental assessment and treatment services;
- hearing assessment and treatment services; and
- any other necessary diagnostic or treatment service to correct or ameliorate illnesses and conditions detected, whether or not the service is covered under a State's Medicaid plan.

C. Medically Necessary Services

Prior to the OBRA-89 amendments, children with health problems detected during a health screen were referred for treatment, as long as the treatment services were covered by the State's Medicaid plan. Under OBRA-89, States were required to provide any medically necessary service, whether or not the services were included in the State Medicaid plan. In effect, States could not restrict access to medically necessary services.

Because the EPSDT benefit requires States to provide any service or item that is medically necessary to correct or ameliorate a defect, physical and/or mental illness, or a condition, it is nearly impossible for States to establish limits on any specific type of services. States are required to provide services that physicians deem medically necessary. It is generally believed that this has been one of the fiscal challenges of the EPSDT program. Accordingly, States have responded differently to the medically necessary provision of the law. Some States may require prior-authorization of services that are considered medically necessary and fall outside the scope of State Medicaid plan for adults, ages 21 and over. Appendix C contains definitions of medically necessary services in Alabama and Delaware. Additionally, Appendix C provides a brief description of California's experience with medically necessary services.

There is concern about expensive medically necessary services that States must provide to Medicaid-eligible children under the EPSDT program. Appendix C also contains examples of high-cost expenditures from three States: Alabama, California, and Kentucky. Other examples of high-cost medically necessary services may include organ transplantation, psychiatric care, private duty nursing, home health care, and physical therapy. The cost of organ transplantation services will be discussed in Chapter 4.

One of the challenges of identifying medically necessary services was by determining which specific services were outside the scope of a State Medicaid plan. This study relies on utilization and payment data from the State Medicaid Resource File (SMRF), which is available through calendar year 1995. In order to analyze the SMRF data to examine medically necessary services that fall beyond the scope of the State plans, it was necessary to obtain copies of State Medicaid plans for 1995. During an early phase of this study, it became known that it was not possible to obtain retrospective information on covered services from 1995 State Medicaid plans. Thus, this study was unable to identify medically necessary services using available HCFA data because of limited information from States about how they implement the medical necessity provision. Given this, the approach has been to examine changes in per-capita expenditures since the OBRA 1989 provisions. To the extent that expenditures for children have increased at a different rate than that for adults, it could be evidence of a programmatic effect due to the medical necessity provision.

D. Periodicity Schedules

The OBRA-89 amendments required each State to establish periodicity schedules for EPSDT screening services according to reasonable standards of medical and dental practice. States determine age-appropriate periodicity schedules in consultation with recognized medical organizations, such as the American Academy of Pediatrics (AAP). Appendix D contains AAP's recommendations for preventive pediatric health care and HCFA's State Medicaid Manual (Part 5, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), dated September 1998), which requires that childhood immunization be provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP). EPSDT screening services must be provided in accordance with a State's periodicity schedule.

Under the EPSDT benefit, interperiodic screening services are available to Medicaid-eligible children if there is reason to suspect illness or condition that did not exist or was not identified at the regular periodic screening. Such screenings may be medically necessary to diagnose and treat suspected physical or mental conditions.

Specific treatment services may require prior authorization and may be limited to medically necessary services, as defined by the State Medicaid Agency. However, States may not set arbitrary limits such as 14 inpatient hospital days, 3 prescriptions per month, or 12 patient sessions per year. Generally, EPSDT treatment services include all mandatory and optional services available under the Medicaid program. Examples of optional services include case management, physical therapy, rehabilitative services, and private duty nursing.

CHAPTER 3

RESEARCH METHODOLOGY

A. Data Sources

Information on EPSDT services is reported to HCFA from State Medicaid agencies in various forms. Participation in the EPSDT program is available through the HCFA-416 Form (an aggregate annual report), which contains the number of children who receive EPSDT services by age group and basis of Medicaid eligibility. Information on the HCFA-416 contains participant ratios, which are defined as the number of Medicaid-eligible children who received at least one general health screening service compared to the number of eligible children expected to receive a screening service. The HCFA-416 also provides screening ratios, which are defined as the number of screening services received by eligible children as a percentage of the number of screening services expected to be received, as adjusted by the proportion of the year they are Medicaid eligible. For each federal fiscal year, States must report annual EPSDT data on the HCFA-416 Form. For purposes of this study, one of the limitations of the HCFA-416 data is that it does not contain information on the costs of EPSDT services. In addition, the use rates can be suspect. For example, some State reports show EPSDT use exceeding 100 percent of children.

States are also required to submit annual Medicaid program statistics on the HCFA Form 2082, "Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services," which contains summary counts for Medicaid recipients, services, expenditures during the Federal fiscal year. The information in the HCFA-2082 database contains total payments for Medicaid-covered services and the total number of patients receiving services. It is an aggregated database that does not allow for person-level or claims-level analyses. However, the information in the HCFA-2082 allows HCFA to examine State and national trends in Medicaid enrollment and utilization of services. The advantage of HCFA-2082 data is that it contains information from all States (e.g., 56 Medicaid jurisdictions) and lists Medicaid expenditures for EPSDT services separately from other Medicaid-covered services.

The HCFA-2082 Form includes information on Medicaid eligibles, recipients, services, and payments. The State Medicaid Manual instructs States to report information on EPSDT services that relate to periodic and interperiodic screenings, which include some -- but not all -- EPSDT services. According to the State Medicaid Manual, information on dental, hearing, and vision services are not reported within the EPSDT type of service (TOS-17) category; such services are listed under other areas. For instance, dental services are reported in TOS-9 and vision and hearing services are reported under TOS-10 ("other practitioners' services"). One of the limitations of the HCFA-2082 data is that it does not provide all required information to analyze program expenditures at the individual level and States' definitions of EPSDT are not uniform.

Prior to the Balanced Budget Act of 1997, States have had the option of reporting patient-level data directly to HCFA in lieu of the hard-copy HCFA-2082. For these States, HCFA prepares the 2082 reports directly. The patient-level data is known as the Medicaid Statistical Information System (MSIS). Before 1999, States were not required to participate in the MSIS project. As of December 1995, 28 States were participating in the MSIS project, which has allowed HCFA an opportunity to build a significant data source for analysis of Medicaid utilization patterns.

MSIS is used to create the State Medicaid Research Files (SMRF). The primary data for the analyses presented in this report are derived from this data system. The SMRF database contains information on Medicaid eligibles, claims, and utilization of services during the calendar year. This study also relied on HCFA's Tape-to-Tape database (the precursor to the SMRF data base), which includes all claims, enrollment, and provider data, beginning in 1989 for four States (California, Georgia, Michigan, and Tennessee).

B. Study Sample

This study relies on 1995 calendar year data, which is the most current available SMRF data. There were 25 States for which HCFA was able to get State specific procedure codes. The three States excluded from the analysis due to lack of procedure codes were Alabama, Florida, and Maine. In addition, Tennessee was included because State specific codes were available, even though the most recent SMRF data was 1993.

The need for EPSDT services varies greatly by age. For example, infants are most in need of immunizations, while family planning services are appropriate for adolescents. For this reason, this study conducted analyses on the use and expenditures of EPSDT services for specific age groups. The age groups used in this study are largely consistent with age groupings used by the HCFA-416 Form. The age groupings for this study are: less than one year of age, 1-5 years of age, 6-14 years of age, 15-18 years of age, and 19-20 years of age. While the HCFA-416 includes an age category for 15-20 year olds, this study separates 15-18 year olds from 19-20 year olds because of differences in health care utilization.

C. Research Design

The first phase of this study included an analysis of EPSDT services as reported on the HCFA-2082. EPSDT is a specific type of service category on the HCFA-2082. Preliminary analyses of the 2082 data revealed that not all States followed the same coding logic to identify EPSDT services. The data reflected great variability in how States reported EPSDT use and expenditure rates. Two States, Kansas and North Dakota, reported no EPSDT expenditures at all in 1995. In Utah, per-capita expenditures for EPSDT totaled only 9 cents per child. Three other States had rates of less than $10 per child. At the other extreme were Delaware ($325 per child) and Pennsylvania ($243 per child). The extremely large range of values, particularly the low values for many States clearly indicates that the data reported in the aggregate 2082 reports are not valid for actuarial estimates because there is no standard definition of EPSDT services. Figures 1 and 2

show the range of average expenditures across all 26 SMRF States.

These findings indicated that the research design of this study required definitions of EPSDT services based on uniform categories of EPSDT services. Consequently, this study adopted an approach that relied on identifying EPSDT services through nationally representative procedure and diagnosis codes (HCPCs), as well as State-specific codes for EPSDT services.[5]

Another part of the mandate was to estimate the actuarial costs of services provided due to the "medically necessary" provision of OBRA 1989. This has proven to be an almost insoluble problem. Medical necessity is defined only as those services outside the State plan. Thus, it has not been possible to define these services in such a manner that they can be measured directly. Consequently, an analysis was designed to estimate OBRA impacts in this area indirectly. This was addressed in a trend analysis of the Tape-to-Tape States (California, Georgia, Michigan, and Tennessee) from 1989-1995 (with the exception of Tennessee, which is only current through 1993). The purpose of this analysis was to estimate the extent of EPSDT services that were attributable to medical necessity. One of the assumptions in examining trend data of the four Tape-to-Tape States is that differences in utilization and expenditure rates between Medicaid-eligible children and adults would be an indirect measure to examine the impact of medically necessity.

D. Definition of EPSDT Services

Although EPSDT services are defined in Federal statute, in practice, there is little consistency in how these definitions are implemented and translated into procedure codes at the State level. Consequently, a major task of this project was to define EPSDT services in such a way that they could be measured consistently nationwide. This study relies on a uniform definition of EPSDT services that includes nationally recognized HCFA Common Procedure Coding System (HCPCs) and diagnosis codes, as well as State-specific procedure codes. The study incorporated comments from HCFA's CMSO division regarding diagnosis and procedure codes that apply to EPSDT screening and treatment services. Appendix C contains the information on the uniform definition of EPSDT services, including a listing of all HCPCs and diagnosis codes used in the analyses.

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[5] This study included State-specific procedure codes for EPSDT services because it was understood that many State Medicaid agencies relied on State-specific codes, rather than nationally-representative codes, to identify EPSDT-related services. According to staff within HCFA's Center on Medicaid and State Operations, a significant percent of codes for EPSDT-related services are based on State-specific procedure codes, rather than nationally representative codes (HCPCs and diagnosis codes). Individual State-specific procedure codes identified as EPSDT services are not included in this report; such information may be requested by contacting HCFA staff.

For purposes of this study, EPSDT services include the following categories of services:

- preventive care services (including comprehensive health screenings, health history, measurements for height/weight, blood pressure, head circumference, lead screening, hematocrit/hemoglobin, urinalysis, as well as at-risk procedures such as TB test, cholesterol, STD screening, pelvic exam, counseling, health education and guidance, and screening lab tests);
- immunizations;
- vision screening and treatment services;
- hearing screening and treatment services;
- dental screening and treatment services; and
- other identified EPSDT services (including family planning, nursing services, mental health services, and physical and occupational therapy, among other services).

The original research design approach of this study was to categorize selected EPSDT services (e.g., vision, hearing, and dental) into screening and treatment groups separately. However, preliminary analyses revealed that such screening and treatment services were not clearly distinguishable, as listed by State-specific procedure codes. Thus, it was decided not to attempt to distinguish between screening and treatment services for vision, hearing, and dental services.

E. Weighted Estimates

Because of the nature of Medicaid eligibility, persons often are covered for only part of a year. Thus, use of services for periods of time not under Medicaid entitlement are missing. In order to remove this "missing observation" bias, rates were adjusted to reflect a full-year's entitlement. Analyses of expenditures for EPSDT services are based on person-year equivalents. Months of managed care enrollment were excluded because MSIS data do not capture utilization information from prepaid plans for Medicaid-eligible enrollees. Person-year equivalents are calculated as the total months of non-managed care enrollment divided by 12. Calculating months of non-managed care enrollment was based on subtracting the number of months for managed care enrollment from the number of months eligible for Medicaid.

Use rates (percent children receiving an EPSDT service) are calculated on gross enrollment (minus prepaid plan enrollment). Conceivably, all children could receive an EPSDT service, no

matter how short their Medicaid coverage period. If so, a use rate based on person year equivalents could exceed 100%, a non-sensical results. Therefore, utilization rates for EPSDT services were calculated on the unadjusted total number of Medicaid-eligible children within each State.

F. Representativeness of the Study Population

The 28 States in the SMRF database are a self-selected group of States and may not be representative of the nation. In 1995, there were several States with large Medicaid programs that were not included in MSIS including New York, which accounted for 14.8 percent (or $2.66 billion) of total Medicaid expenditures nationally. In 1995, six States -- Texas, Ohio, Illinois, Florida, Massachusetts, and New York -- represented 31.8 percent of total Medicaid child enrollees. Because these States did not participate in the 1995 MSIS, they were not included in the study sample.

While it is not possible to determine whether this would have an effect on utilization of EPSDT services, it is worthwhile to compare the 26 SMRF States with the non-SMRF States. Table 1 presents data on number of Medicaid-eligible children, total expenditures, and average expenditures per child.

Table 1
Comparison of Average Expenditures per Medicaid-Eligible Child
for SMRF and Non-SMRF States, 1995

	Number of Medicaid-eligible children	Total Expenditures (in $ millions)	Average Expenditures per Medicaid-Eligible Child
All States	23,395,606	$27,388	$1,171
Non-SMRF States	11,979,185	16,488	1,376
SMRF States	11,416,421	10,899	955
SMRF States (except CA)	7,620,317	8,670	1,138

In 1995, there were over 23.4 million children nationwide who had Medicaid eligibility. Total Medicaid expenditures for these children were approximately $27.4 billion, or an average of $1,171 per Medicaid-eligible child. The 26 SMRF States accounted for 49 percent of Medicaid-eligible children, but only 40 percent of total Medicaid expenditures. This is due, in part, to California's large population of Medicaid-eligible children, which accounts for 16 percent of all Medicaid-eligible children nationwide. California also has a low per-capita expenditure rate for children ($587 per child in 1995), which is about half of the national average. California's

utilization patterns heavily weight the overall averages in the study sample. Removing California from the SMRF calculations reduces -- but does not eliminate -- the difference between SMRF and non-SMRF States. Medicaid per-capita expenditures for children are lower in SMRF States ($948 with California or $1,145 excluding California) than in the rest of the country ($1,171). Thus, it may be that average EPSDT expenditures in the SMRF States are lower than the national average.

G. Data Limitations and Caveats

The accuracy of the data is largely determined by the quality of the State Medicaid agency's reporting mechanism. Not all States have specific procedure codes for EPSDT services. Among the 26 States included in this study, the level of detail in coding EPSDT services ranged greatly. For instance, Utah had at least 350 codes for EPSDT services, while other States had as few as ten codes for EPSDT services.

Coding for EPSDT services was made as uniform as possible for all States, but because the descriptions of individual State Medicaid procedure codes varied greatly in the level of detail for each procedure code, there may be a small margin of error in categorizing all possible EPSDT services. Nonetheless, a concerted effort was made to include all EPSDT-related codes in HCFA's uniform definition of EPSDT. HCFA's uniform EPSDT coding scheme provides a mechanism to analyze EPSDT services across States.

Under fee-for-service Medicaid, all data on potential EPSDT services are captured by billing claims submitted by health care providers. Because capitated plans do not bill separately for individual services, expenditures cannot be analyzed by type of service. Thus, the current study excludes children who were enrolled in Medicaid managed care plans. Under the BBA, States will be required to submit encounter data for Medicaid beneficiaries in managed care. However, such a system is not currently available.

It is important to note that perhaps more children are receiving EPSDT services than are reflected in the available data sources. First, States and, more specifically, providers do not bill all encounters with Medicaid-eligible children as EPSDT services. In some States, the public health department may provide preventive health care such as blood lead screening tests for which . Medicaid is not billed. Second, it is not always possible to detect preventive care provided as part of a sick child visit, if those services were not specifically coded as EPSDT services. Thus, it is likely that estimates of use and expenditures reported here represent conservative estimates of actual utilization patterns.

CHAPTER 4

MAJOR FINDINGS

Among the study population of 26 SMRF States, there were 11,135,053 Medicaid-eligible children, of which 7 percent were under 1 year of age, 35 percent were children 1-5 years of age, 39 percent were children 6-14 years of age, 13 percent were children 15-18 years of age, and 6 percent were 19-20 years of age. As shown in Table 2, the 26 SMRF States had a range of Medicaid-eligible children, ranging from a low of 33,482 in Wyoming to a high of 3,747,209 in California (representing 34 percent of the total Medicaid population of the 26 SMRF States).

Total Medicaid expenditures for the study sample of 26 States totaled $9.75 billion, of which $1.327 million (13.6 percent) were for EPSDT services, according to HCFA's uniform EPSDT definition. As shown in Table 3, the percent of State Medicaid expenditures attributable to EPSDT services varied from approximately 7 percent in Colorado to 26 percent in Pennsylvania. EPSDT accounted for over 20 percent of Medicaid expenditures for children in three States; Pennsylvania (26 percent), Utah (23 percent), and Washington (25 percent). Conversely, there were three States in which less than 10 percent of expenditures were accounted for by EPSDT; Alaska (9 percent), Colorado (7 percent), and North Dakota (7 percent).

Despite federal participation goals that 80% of Medicaid-eligible children should receive EPSDT services, these analyses of fee-for-service claims from 26 SMRF States found that 55 percent of Medicaid-eligible children received one or more EPSDT services. A comparative analysis of HCFA's uniform definition of EPSDT services with data from the HCFA-416 Form for the 26 SMRF States show similar overall utilization rates in which Medicaid-eligible children receive EPSDT services (*see* Appendix F). Differences in utilization rates may relate to the fact the HCFA-416 is based on the 1995 fiscal year data and the SMRF is based on 1995 calendar year data.[6] Overall, there were 11 million Medicaid-eligible children in the 26 States in the study population. National weighted averages of the HCFA-416 data indicate that 53 percent of Medicaid-eligible children received one or more EPSDT services compared with 56 percent utilization rate for HCFA's uniform definition of EPSDT services.

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[6] An additional difference may be based on the fact that HCFA-416 data relies on payment date information, whereas the SMRF data relies on service date information.

Table 2
Percentage of Medicaid-Eligible Children Under Age 21
as a Percent of the Total Sample Population

STATE	Number of Medicaid-eligible children	Percent of total sample population	Person-year equivalents of Medicaid children
TOTAL	11,135,053	100%	7,794,129
Alaska	49,038	0.4	35,369
Arkansas	192,266	1.7	133,037
California	3,747,209	33.7	2,946,051
Colorado	207,995	2.8	124,515
Delaware	54,593	0.5	34,112
Georgia	756,199	6.8	589,070
Iowa	165,961	1.5	106,600
Indiana	382,590	3.4	299,641
Kansas	157,793	1.4	112,152
Kentucky	280,676	2.5	198,916
Michigan	817,146	7.3	451,350
Minnesota	347,054	4.2	128,643
Missouri	466,267	3.1	350,827
Mississippi	317,788	2.9	242,631
Montana	57,790	0.5	41,049
North Dakota	34,306	0.3	23,852
New Hampshire	58,811	0.5	40,826
New Jersey	481,673	4.3	312,762
Pennsylvania	929,626	8.3	557,748
Rhode Island	76,156	0.7	29,677
Tennessee	501,879	4.5	359,856
Utah	126,366	1.1	85,696
Vermont	57,341	0.5	44,191
Washington	493,640	4.4	373,612
Wisconsin	341,408	3.1	149,902
Wyoming	33,482	0.3	22,540

Table 3
EPSDT Payments as a Percentage of Total Medicaid Payments for Children in 1995

State	Medicaid Total Payments	Total EPSDT Payments	EPSDT Payments as a Percent of Total Medicaid Payments
AK	$90,074,765	$7,996,035	8.88%
AR	334,386,303	42,327,307	12.66
CA	2,222,299,326	225,103,878	10.13
CO	241,910,060	16,718,725	6.91
DE	102,844,563	18,417,294	17.91
GA	927,524,023	108,562,488	11.70
IA	232,230,905	38,474,215	16.57
IN	381,281,712	49,657,593	13.02
KS	191,230,287	19,855,390	10.38
KY	269,267,050	37,606,651	13.97
MI	675,616,102	72,109,214	10.67
MN	340,091,838	44,621,930	13.12
MO	457,786,331	73,080,943	15.96
MS	358,247,308	40,826,488	11.40
MT	75,433,524	9,217,815	12.22
ND	44,137,077	3,138,054	7.11
NH	76,572,870	11,925,401	15.57
NJ	580,916,875	63,889,890	11.00
PA	887,877,294	231,754,651	26.10
RI	71,164,791	13,311,206	18.70
TN*	468,995,848	56,432,663	12.03
UT	128,328,117	28,981,360	22.58
VT	62,968,162	11,696,454	18.58
WA	260,804,042	64,199,539	24.62
WI	225,950,640	32,583,323	14.42
WY	41,057,056	4,915,762	11.97
TOTAL	9,748,996,869	1,327,404,269	13.62%

A. Estimated Screening and Treatment Rates for Children Under 21

Table 4 shows the estimated EPSDT utilization rates and per-capita expenditure rates by State. Across all States, it is estimated that 55 percent of children received at least one EPSDT service. Use rates were fairly consistent across States. Only two States had use rates lower than 50 percent; California (49 percent) and Wisconsin (43 percent). Use rates exceeded 70 percent in three States: Delaware (75 percent), New Hampshire (71 percent), and Washington (78 percent).

In 1995, 55 percent of Medicaid-eligible children received one or more EPSDT services: 36 percent received preventive care services; 9 percent received immunizations; 8 percent of children received vision services, 16 percent received dental services, 1 percent received hearing services, and 23% received other types of EPSDT services. Table 5 shows use rates by age groups. The percent of Medicaid-eligible children who received at least one EPSDT service ranged from a low of 51% among children 6-14 years of age to a high of 68 percent for children under the age of one.

Table 5
Percent of Medicaid-Eligible Children Under 21 Who Received One or More EPSDT Services

Age Groups	Percent who received EPSDT services
All Medicaid-eligible children	55%
Under 1 year of age	68%
1 - 5 years of age	59%
6 - 14 years of age	51%
15 - 18 years of age	52%
19 - 20 years of age	58%

B. Estimated EPSDT Payment Rates for Children Under 21

Per-capita expenditures for EPSDT were not as consistent across States as were use rates. One State had per-capita total EPSDT expenditures of less than $100 (California at $76) and one State with per-capita expenditures more than $500 (Delaware $540). Twenty States had per-capita expenditures that ranged between $100 - $300. Six States had per-capita expenditures more than $300 (e.g., Delaware $540, Rhode Island $449, Pennsylvania $416, Iowa $361, Minnesota $347, Utah $338, and Arkansas $318). Table 4 also shows the impact of California on the overall average. Eliminating California from the calculations increases the overall estimate of per-capita EPSDT expenditures by 34 percent, from $170 to $227. Table 4 also shows the effect of using

individual procedure codes as opposed to the type of service code found in the HCFA-2082. Kansas and North Dakota, which had no EPSDT expenditures on the HCFA-2082 had per-capita expenditures of $177 and $132, respectively, based on State and National coding. Utah, with only 9 cents per child from the HCFA-2082, had one of the highest EPSDT expenditure rates of $338.

Table 6 shows age specific estimates of EPSDT per-capita expenditures. The highest rate of expenditures was shown for 19 and 20 year olds at $338 while the lowest rate of expenditures was shown for children 1 to 5 years of age at $136.

Table 6
National Average Payments for EPSDT Services for Children Under 21 Years of Age

Age Groups	**Average Mean Payments for EPSDT services**
All Medicaid-eligible children	$170
Under 1 year of age	$242
1 - 5 years of age	$136
6 - 14 years of age	$148
15 - 18 years of age	$253
19 - 20 years of age	$338

Table 7 presents data on average payments per-person year enrollees (e.g., weighted estimates) for categories of EPSDT services. The data are displayed in two ways: including and excluding data for California. Dental care and preventive care account for 22 percent and 19 percent, respectively, of average EPSDT expenditures. "Other" EPSDT accounts for 49 percent of EPSDT expenditures. Included in "other" EPSDT services include services from "other practitioners" such as vision and hearing specialists, private duty nurses, physical or occupational therapists, social workers. Other EPSDT services also include (but are not limited to) family planning services, physical therapy, occupational therapy, psychological assessment and rehabilitation services, the medical portion of early intervention multi-disciplinary assessment, and transportation services, among other services. The exclusion of California has a particularly marked effect on use and costs of dental care. Use rates increase from 16 percent to 24 percent and expenditures increase from $33 to $52. California is particularly low in dental use because of a State wide dental capitation plan.

Table 7
National Average Payments for EPSDT Services:
Preventive Care, Immunizations, Vision, Hearing, and Dental Services

	26 SMRF States (including CA)		25 SMRF States (excluding CA)	
EPSDT services	Percent of children who received care	Average Payments (weighted estimates)	Percent of children	Average Payments (weighted estimates)
All EPSDT services	55%	$170	59%	$227
Preventive care	36%	$38	38%	$49
Immunizations	9%	$4	13%	$6
Vision	8%	$9	9%	$12
Hearing	1%	$2	2%	$3
Dental	16%	$33	24%	$52
Other	23%	$84	20%	$105

Table 8 shows age specific per-capita expenditure rates by State. Most States follow a U-shaped pattern with higher expenditures in the youngest and the oldest age groups.

Table 9 shows the State specific average Medicaid cost for the following EPSDT services: preventive care, immunizations, vision screening and treatment, hearing screening and treatment, dental screening and treatment, and other types of EPSDT services. There were a few unusual exceptions to the general patterns. Expenditures for vision services in Washington were about 10 times the overall average payment rate. Washington accounted for 26 percent of all EPSDT expenditures in these States, but only 4 percent of the child population. Pennsylvania and Wyoming were particularly high in hearing costs and Iowa was very high in dental expenditures.

Tables 10-15 present the average Medicaid payments (e.g., weighted estimates) for each type of EPSDT service by age group and by State. For each type of EPSDT service, payment and utilization rates are discussed separately below.

Preventive Care Services

In 1995, 51 percent of children under age 1, 43 percent of children 1-5 years of age, 28 percent of children 6-14 years of age, 34 percent of children 15-18 years of age, and 45 percent of 19-20 year olds received preventive care services in the 26 SMRF States. Table 10 shows variations across States in the average payment levels for preventive care services. The national average payment for preventive care services was $38. For children under age 1, the average payment for preventive care services amounted to $133. Average payments were $44 for children 1-5 years of age, $22 for children 6-14 years of age, $34 for children 15-18 years of age, and $53 for children 19-20 years of age.

Immunizations

In 1995, 26 percent of children under age 1, 15 percent of children 1-5 years of age, 4 percent of children 6-14 years of age, and 4 percent of children 15-18 years of age. Table 11 shows the State specific expenditures rates. The national average payment for immunizations for all Medicaid-eligible children totaled $4. Average payments for immunizations for children under age 1 totaled $24, and $7 for children 1-5 years of age.

The low immunization rates in Table 11 may relate to the Vaccine for Children (VFC) program, a program for the distribution of pediatric vaccines, administered by the Centers for Disease Control and funded by Title 19. State Medicaid agencies may not submit billing claims for immunizations because of the VFC program. Therefore, Table 11 may undercount the number of Medicaid-eligible children who receive childhood immunizations.

Vision Screening and Treatment Services

Approximately 8 percent of all Medicaid-eligible children received vision screening and treatment services, averaging $9 for all Medicaid-eligible children. In 1995, 1 percent of children under age 1, 3 percent of children 1-5 years of age, 11 percent of children 6-14 years of age, 12 percent of children 15-18 years of age, and 9 percent of 19-20 year olds received vision screening and treatment services (e.g, glasses, contact lens). Average payments for vision care services were highest for pre-teenage to teenage children, averaging approximately $12 to $14 per Medicaid-eligible child, aged 6 and older (Table 12).

Dental Screening and Treatment Services

In 1995, 16 percent of all Medicaid-eligible children received dental screening and treatment services. Twelve percent of children 1-5 years of age, 23 percent of children 6-14 years of age, 18 percent of children 15-18 years of age, and 13 percent of 19-20 year olds received dental screening and treatment services. Average payments for dental care services was $33 per Medicaid-eligible child. Payments were highest for pre-teenage to teenage children, averaging approximately $42 for children 6-14 years of age, $56 for 15-18 year olds, and $36 for 19-20 year olds. In contrast, average payments for children ages 1-5 years of age totaled only $19. Four States had average dental expenditures that totaled $100 or more (Iowa $231; Rhode Island $100; New Hampshire $112; and Alaska $156).

Hearing Screening and Treatment Services

In 1995, few Medicaid-eligible children received hearing screening and treatment services. Only 1 percent of children under age 1, 1 percent of children 1-5 years of age, 2 percent of children 6-14 years of age, 1 percent of children 15-18 years of age, and 1 percent of 19-20 year olds received hearing screening and treatment services. Three States had higher than average hearing screening and treatment rates (Arkansas -- 13 percent; Delaware -- 11 percent; Rhode Island -- 11 percent). Table 14 presents average payments across States for hearing screening and treatment services. The national average payment for hearing services was approximately $2. Average payments were about $1 to $2 in most States, except higher than average payments were in Wyoming and Pennsylvania with per-capita expenditures of $12 and $16, respectively.

Other Types of EPSDT Services

As mentioned previously, this study categorized all State-specific codes as "Other" if State EPSDT codes were not included in the following categories of services – preventive care, immunizations, vision care, dental care, and hearing services. Specific examples of such "other" EPSDT services may include physical therapy, occupational therapy, family planning services, and mental health services. Such services may be provided by a variety of practitioners including (but not limited to) nurses, nurse practitioners, psychologists, and specialists such as podiatrists and chiropractors.

In 1995, the national average payment for other types of EPSDT services totaled $84. On average, 23 percent of all Medicaid-eligible children received some type of "other" EPSDT services. The data in Table 15 show variation in the average payment levels for specific age group: $80 for children under 1 year of age, $61 for children 1-5 years of age, $68 for children 6-14 years of age, $147 for children 15-18 years of age, and $235 for 19-20 year olds.

In some cases, "other" services may be considered medically necessary, such as with organ transplantation. This study included an analysis of the hospital costs of organ transplantation for Medicaid-eligible children under 21 years of age. Appendix E contains the ICD9 or HCPC codes for transplantation services. The following types of transplants were evaluated: bone marrow, heart, kidney, liver, lung, and pancreas.

Medical Necessity - Organ Transplantation

Organ transplants are procedures that are mandated to be covered under the provisions of medical necessity in the EPSDT regulation.[7] Although organ transplantation is expensive on an individual basis, the frequency of transplantation is fairly low.

Table 16 presents findings of the cost of organ transplantation to State Medicaid programs in the 28 SMRF States. In 1995, there were a total of 2.6 million Medicaid hospitalizations in the 28 States. Of these, there were a total of 283 transplants in 22 States. Six States had no recorded transplants. Over one-half of the transplants were bone marrow (N=145). The majority of the remaining transplants were kidney (N=69) and heart (N=56). Overall, the average Medicaid reimbursement per transplant stay was $58,681. Total reimbursements for all of the transplant procedures was $16.6 million. Of that amount, about two-thirds ($10.7 million) were for bone marrow transplants. Heart and kidney transplants accounted for most of the additional expenditures (26 percent and 6 percent, respectively).

California (N=62) and Florida (N=44) had the most Medicaid transplants and expenditures for transplantation: $3 million in California and $2 million in Florida. Other States with at least $1 million in transplant expenditures were Indiana, Minnesota, New Jersey, Pennsylvania, and Wisconsin.

The figures in Table 16 reflect only the inpatient costs of transplantation. Missing from these costs are physician/surgeon fees, immunosuppressive costs, and the costs of related hospitalizations such as rejection episodes. Experience with Medicare kidney transplantation shows that about one-half of the first year's costs for transplant recipients are accounted for by these other factors. If a similar pattern is true for Medicaid transplant patients, then total expenditures for transplantation in these States are likely to be in the range of $30 million. Total expenditures for all services for children in these 22 States in 1995 were $7.6 billion. Therefore, even if the entire cost of transplantation could be attributed to the medical necessity provision of EPSDT, it would only have increased gross expenditures by 0.04 percent.

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[7] Federal Register, Vol. 58, No. 189.

Table 16
Medicaid Expenditures for Organ Transplantation in 1995 for Children Under Age 21
by Type of Transplantation and by Individual States

Type of Transplant	Number	Average Reimbursement	Total Reimbursement
TOTAL	283	$58,681	$16,602,677
Bone Marrow	145	74,022	10,733,190
Heart	56	75,892	4,249,952
Kidney	69	15,151	1,045,419
Liver	5	18,044	90,220
Lung	7	69,120	483,840
Pancreas	1	4,058	4,058
STATES			
Alaska	1	58,630	58,630
Alabama	10	2,555	25,550
Arkansas	7	67,157	470,099
California	62	48,534	3,009,108
Colorado	8	72,933	583,464
Florida	44	46,255	2,035,220
Georgia	12	12,343	148,116
Iowa	5	126,429	632,145
Indiana	23	53,237	1,224,451
Kansas	1	66,634	66,634
Kentucky	10	59,647	596,470
Maine	5	53,005	530,005
Michigan	15	52,525	787,875
Minnesota	16	115,781	1,852,496
Mississippi	15	32,320	484,400
New Hampshire	1	48,739	48,739
New Jersey	14	90,388	1,265,432
Pennsylvania	21	57,005	1,197,105
Rhode Island	2	126,538	253,076
Utah	6	105,705	634,230
Washington	1	4,401	4,401
Wisconsin	14	91,887	1,286,418

C. Provider Participation in the EPSDT Program

The OBRA-89 amendments created incentives to increase provider participation in the EPSDT program. In 1993, HCFA funded a MEDSTAT study to examine changes in utilization of EPSDT services and provider participation before and after enactment of OBRA-89. MEDSTAT analyzed the HCFA Tape-to-Tape data for four States (California, Georgia, Michigan, and Tennessee) for 1989 and 1992. These four States were included in the analyses because of the availability of Medicaid claims, enrollment, and provider data from the MMIS. MEDSTAT found that provider participation increased significantly after enactment of OBRA-89 in the area of office-based and clinic-based providers. In particular, Michigan had a significant increase in the number of Medicaid providers. Appendix A contains a copy of MEDSTAT's 1997 Final Project Synthesis Report, entitled "Comparative Study of the Use of EPSDT and Other Preventive and Curative Health Care Services Enrolled in Medicaid" and an article written by researchers with the MEDSTAT Group entitled "Medicaid Providers of Children's Preventive and EPSDT Services, 1989 and 1992."

Under the BBA mandate, one of the required components of HCFA's study of the EPSDT benefit was to examine the portion of the actuarial value of EPSDT services that are attributable to partial providers of EPSDT services. Analyses of this part of the mandate are in preparation.

D. Trend Analyses of EPSDT Payment and Utilization Rates, 1989-1995

This study included an analysis of trends from 1989-1995 of Medicaid utilization and payment rates for EPSDT services using the HCFA Tape-to-Tape States (California, Georgia, Michigan, and Tennessee). Because preliminary investigations showed that it was not possible to identify "medically necessary" services directly through SMRF data or State Medicaid agencies, it was assumed that the 1989-1995 trend data may indicate differences in utilization and payment rates between Medicaid-eligible children and adults as an indirect measure of the impact of medically necessity.[8]

The data presented in Table 17 for the four Tape-to-Tape States suggest that there was not a

[8] An important caveat to this study is that it does not elaborate on Medicaid eligibility issues. OBRA-89 established Medicaid coverage for pregnant women and children (up to age 6) with incomes less than 133% of the federal poverty level. OBRA-90 expanded Medicaid coverage for children under 19 years of age, born after September 30, 1983 and less than 100% of the federal poverty level. In the current analysis of the EPSDT benefit, HCFA did not measure the effect of Medicaid eligibility on the use and payment of EPSDT services.

significant difference in the annual rate of change between Medicaid adults and children enrollees between 1989 and 1995. Three States (Georgia, Michigan, and Tennessee) exhibited similar patterns in rates of increase in the number of Medicaid-eligible children and mean Medicaid payments.

Table 18 presents data on the four Tape-to-Tape States for 1989-1995 on the average payments for selected EPSDT services including preventive care, immunizations, vision screening and treatment services, hearing screening and treatment services, and dental screening and treatment services. As these data show, there were significant increases in all States in the number of Medicaid-eligible children who received EPSDT services and steady increases in average payment rates for EPSDT services in Georgia Michigan, and Tennessee. For instance, there was an 85 percent increase in the average payment for EPSDT services in Michigan from 1989 to 1995. The average payments for EPSDT services increased 38 percent from 1989 to 1993 in Tennessee. Average payments from 1989 to 1995 increased 74 percent in Georgia. The exception to the trend in increased EPSDT per-capita expenditures was California. Expenditures declined, due to the exclusion of dental services. As discussed above, dental care in California was capitated, beginning in 1993.

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FAX TRANSMITTAL

TO:	Chris Jennings & Jeanne Lambrew	
ORGANIZATION:	White House	
Telephone Number: 456-5560 456-5585	Fax Number: 456-5557	# of Pages (including cover sheet) 4
FROM:	Gregg Haifley	
	CHILDREN'S DEFENSE FUND HEALTH DIVISION	
Telephone Number: (202) 662-3541 FAX Number: (202) 662-3560		Date: 4/20/99 Time: AM PM
Comments: Attached is letter of concern regarding HCFA EPSDT Study.		

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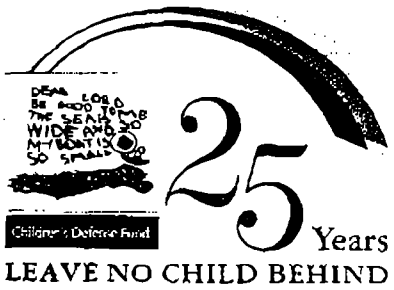

April 20, 1999

Ms. Nancy-Ann DeParle
Administrator, Health Care Financing Administration
Department of Health and Human Services
314G Hubert H. Humphrey Building
Washington, DC 20201

Dear Ms. DeParle:

As part of the Balanced Budget Act of 1997 (P.L. 105-33), Congress included Section 4744 requiring the Secretary of Health and Human Services to conduct a study on the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services through the Medicaid Program. The EPSDT benefits for children include the most basic of services such as immunizations, as well as screening for, and treatment of, vision, dental, and hearing problems. EPSDT also provides for the very comprehensive needs of children with disabilities and special health care needs through services that states may otherwise exclude limit under their state plans.

I am writing to express several deep concerns regarding the current status of the study underway through the HCFA Office of Strategic Planning – a study that has profound implications for these vital services for children through Medicaid.

First, the law mandating the EPSDT study requires that it be conducted "in consultation with ... representatives of appropriate provider and beneficiary organizations...." It appears that the first contact HCFA had with beneficiary or provider groups such as Children's Defense Fund, Families USA, the American Academy of Pediatrics, the National Association of Children's Hospitals, the Center on Budget and Policy Priorities, the March of Dimes, and several other provider and beneficiary organizations occurred on April 6, 1999. At that April 6, 1999 meeting there was a notable absence of beneficiary groups representing children with disabilities and special needs, such as Family Voices and the ARC, to name two very prominent organizations. The lack of consultation with beneficiary and provider groups is particularly disturbing since it is evident from the course of the discussions on April 6th and the materials distributed prior to the meeting that HCFA has been consulting to some degree with the states and their Medicaid directors for nearly a year regarding this study.

Second, the meeting on April 6, 1999 did not reflect the law's requirement of consultation on conducting a study. Rather, the meeting consisted of the presentation of the design, methodology, and outcomes of the study. Barbara Cooper, Paul Eggers, and

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Linda Greenberg were certainly receptive to our comments regarding deficiencies in the data needed to conduct the study. They were also very solicitous of caveats we offered on the data issues. However, many of us felt frustrated by what we perceived as a lack of receptivity to suggestions on the study design and methodology.

Third, the parameters of the HCFA study are limited to the cost of EPSDT services, while the intent of Congress, as expressed in the legislation, included an examination of the provision of EPSDT services.

Fourth, while the law requires the Department to examine the actuarial value of EPSDT services, the data available to HCFA makes this mandate virtually impossible for several reasons. A few of the more significant data limitations include:

- **Claims data reflect encounters for fee-for-service Medicaid beneficiaries but not for those beneficiaries enrolled in and receiving all services through managed care.** Thus, the available claims data are over-representative of children with disabilities and special needs because many states exempt these children from managed care. The costs of care for these children naturally are higher than those who are enrolled in managed care, who tend to be healthier. In sum, because healthier children are under-represented in the fee-for-service claims data, there is a selection bias in using claims data.

- **The claims data available to HCFA do not reflect the scope of services and therefore the actual costs of EPSDT.** HCFA plans to use claims data as furnished by the states, but states are so inconsistent in their use of claims coding and identification of services as EPSDT that it will be difficult to reflect the true level and cost of EPSDT services. For example, certain states, according to HCFA, have identified family planning services and prenatal care as EPSDT services despite the fact that these are services available through Medicaid under provisions of the law separate and distinct from EPSDT. Thus, in addition to EPSDT definitions varying across states, data within states may not be based on the services actually provided above and beyond those provided for adults.

- **EPSDT services and costs are those beyond what state Medicaid plans cover for adults, and the HCFA study methodology does not back these initial levels (adult levels) of services out of the costs being attributed to EPSDT.**

While the HCFA staff have attempted to extrapolate certain conclusions from these data sources, it is clear that the data needed to conduct a sound study are not available. This assessment of the data limitations and usefulness is in no way intended as a criticism of the integrity of the HCFA staff conducting the study. They are quite simply hampered by not having available to them what is necessary to give Congress the actuarial cost information Congress requested.

I am requesting that your office review the current status of the EPSDT study and assess the wisdom of pressing forward with the current design and methodology given the deficiencies in the data. The importance of the EPSDT benefit to the millions of children who rely upon EPSDT services makes it imperative that any study released by HCFA be sound in its design, methodology, and findings. Anything less would pose great peril to the health of the children who rely Medicaid as the source of their health care.

Sincerely,

Gregg Haifley
Deputy Director Health Division

cc: The Honorable Donna Shalala
Chris Jennings
Jeanne Lambrew
Barbara Cooper
Paul Eggers
Linda Greenberg