Chapter 3
Medicaid and the EPSDT Programs

Although dental care may be provided as an optional service to Medicaid beneficiaries (and many States do provide limited dental benefits to their entire Medicaid population), all States must provide dental services to Medicaid-eligible children under 21, as specified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provisions (see the section below and table 3, which outlines the Health Care Financing Administration (HCFA) regulations regarding EPSDT and highlights sections specifically related to dental services). Most publicly funded dental care for low-income children under 21 is provided through Medicaid or the EPSDT programs. Other federally funded programs (such as Head Start, Community/ Migrant Health Centers, the Indian Health Service, and the National Health Service Corps) and State and local programs contribute to the oral health of some of these children, but even these programs bill Medicaid for services they provide directly to eligible children (8). Out of the entire Medicaid program's payments, dental care accounted for only 1 percent (see table 2). Although Federal data do describe the percentage that Medicaid spends on dental care, the information is not routinely broken down by age-i.e., it is unclear how much Medicaid spends on dental care for children.[1]

This section briefly describes Medicaid and EPSDT, focusing on components of those programs particarly relevant to this study. There are other, more detailed, descriptions of both programs elsewhere in the literature (e.g., 9,10,11).

Medicaid

The Medicaid program was authorized in 1965 by the Social Security Act to provide medical assistance to low-income people.[2] The Federal Government shares the cost of the program with States[3] (see table 2), but each State designs and administers its program within broad Federal guidelines (10). Interpretation of the guidelines and specific State needs result in significant variations between programs, particularly in terms of eligibility requirements, covered services and limitations, and reimbursement policies.

Eligibility

Some groups must be covered by Medicaid according to Federal mandate, and others may be covered at the State's option. States must offer Medicaid services to those receiving benefits from two cash assistance programs-Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI)-and to certain target groups. States extend AFDC benefits based on family income, family structure, and parent's employment status and SSI benefits to elderly, blind, and disabled people. Pregnant women and children younger than age 6 (born after Oct. 1, 1983) whose family incomes fall below 133 percent of the Federal poverty level, and children younger than 7 whose family incomes fall within AFDC limits but who do not otherwise qualify for AFDC support are also automatically eligible for Medicaid. This group of people are termed *categorically* needy.

States may classify other groups as categorically needy at their option; children up to age 18 (or 19, 20, or 21) with family incomes within AFDC limits but who do not otherwise qualify, children younger than age 8 with family incomes within the Federal poverty level, and pregnant women and children up to age 1 with family incomes within 185 percent of the Federal poverty level (9). State Medicaid programs may also include people who are *medically* needy; i.e., those who qualify as a result of high medical expenses that reduce their family incomes to a level below the AFDC limits in that State.

Each State may set AFDC limits at their discretion. Table 2 illustrates the AFDC eligibility thresholds of the sample States in this study. The variability in AFDC limits means that children of similar circumstances but living in different States are not equally eligible for Medicaid services.

[1]Data is available about the percentage spent on dental care under the EPSDT program, but this information is confusing since dental care to children is not provided only under EPSDT and some States do not distinguish between payments under Medicaid and payments under EPSDT.

[2]In FY89, there will be an estimated 25 million low-income people, of them over 11 million are children under age 21 (11).

[3]The Federal Government paid 56 percent of total expenditures in fiscal year 1989, providing at least a 50-percent match for each State. The State's share of the match is based on the square of the State per capita income x the square of the National per capita income x 45 percent.

Table 3—HCFA State Medicaid Manual: Part 5-Early and Periodic Screening, Diagnosis, and Treatment; April 1988

"This transmittal introduces Part 5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). It contains EPSDT program guidelines and implements Sections 2(a)(43) and 1905(a)(4)(B) of the Act, including revisions enacted by P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, and P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982."

Sections particularly relevant to dental care:

Introduction

Sec. 5010. OVERVIEW
- A. A Comprehensive Child Health Program.
- B. Administration.

Program Requirements and Methods

Sec. 5110. BASIC REQUIREMENTS

Sec. 5121. REQUIRED SERVICES--INFORMING FAMILIES OF EPSDT SERVICES
- A. General Information.
- B. Individuals to be Informed.
- C. Content and Methods.

Sec. 5122. COMPREHENSIVE INITIAL AND PERIODIC EXAMINATIONS
- A. General Information.
- B. Recommended Standards.
  - 6. Dental Screening Services. **Although an oral examination may be part of a physical exam, it does not substitute for examination through direct referral to dentist. The judgement that dental treatment is or is not necessary can only be made by a dentist. It is the intent of the regulation not to disrupt continuous, comprehensive dental care situations, but rather to encourage and develop them.**
    - **A dental referral required for every child beginning at age 3.[1]**
    - **The initial referral regardless of periodicity schedule; thereafter dental referrals should conform to periodicity schedule(s)...[2]**
    - **The requirement of a direct referral to a dentist can be met in settings other than a dentist's office...**
    - **Determine whether the screening provider of the agency does the direct referral to a dentist. You are ultimately responsible for assuring that the direct referral is made and that the child gets to the dentist's office in a timely manner.**

Sec. 5123. DIAGNOSIS AND TREATMENT
- A. Diagnosis.
- B. Treatment.
  - 1. General. You must provide to eligible EPSDT recipients treatment services included in the plan if a need is indicated by screen ing...

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1 An except ion (only to age 5) wi l l be granted only i f shortage of dentists. [Note: The Omnibus Budget Reconcili at ion Act of 1989 el imi nated this except i on.]

2 [Note: The Omnibus Budget Reconci liation Act of 1989 specifically noted that, among older children, dental examinations should occur with greater frequency than is the case with physical examinat ions.]

Limit prior authorization to treatment services of high cost, or those to be provided over extended periods of time.

2. Required Vision and Hearing Treatment. Dental Care. and Immunizations. Provide the following services, even if they are not included in the State plan:

- Dental care, at as early an age as necessary, needed for relief of pain, infections, restoration of teeth, and maintenance of dental health. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. For further information, consult HCFA's Guide to Dental Care. EPSDT--Medicaid, prepared in cooperation with the American Society of Dentistry for Children and the American Academy of Pedodontics (HCFA Pub. No. 24515).

a. Emergency Services are those necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth); and palliative therapy for periocoronitis associated with impacted teeth. Routine restorative procedures and root canal are not emergency services.

b. Preventive Services, provided either individually or in groups, include:

Instruction in self-care oral hygiene procedures;

- Oral prophylaxis (cleaning of teeth), both necessary as a precursor to the application of dental caries preventives where indicated, or independent of the application of caries preventives for patients 10 years of age or older;
- Professional application of dental sealants when appropriate to prevent pit and fissure caries.

c. Therapeutic Services include:

- Pulp therapy for permanent and primary teeth;
- Restoration 'of carious (decayed) permanent and primary teeth with silver amalgam, silicate cement, plastic materials, and stainless steel crowns;
- Scaling and curettage;
- Maintenance of space for posterior primary teeth lost permanently;
- Provision of removable prosthesis when masticator function is impaired, or when existing prosthesis is unserviceable. It may include services when the condition interferes with employment training or social development; and

Orthodontic treatment when medically necessary to correct handicapping malocclusion.

Sec. 5130. DISCRETIONARY SERVICES

Sec. 5140. PERIODICITY SCHEDULE

Sec. 5150. TRANSPORTATION AND SCHEDULING ASSISTANCE

Utilization of Providers and Cordination With Related Programs

Sec. 5210. REFERRAL FOR SERVICES NOT IN THE STATE PLAN

Continued on next page

Table 3-HCFA State Medicaid Manual: Part 5-Early and Periodic Screening, Diagnosis, and Treatment; April 1988-Continued

Sec. 5220. UTILIZATION OF PROVIDERS
A. General.
B. Broad Base of Qualified Providers.

Sec. **5230.** COORDINATION WITH RELATED AGENCIES AND PROGRAMS
A. General.
B. Relations With State Maternal and Child Health (MCH) Programs.
C. Relations With State or Local Education Agencies.
D. Relations With Head Start.
E. Relations With Special Supplemental Food Program for Women, Infants, and Children, Food and Nutrition Service, U.S. Department of Agriculture (WIC).
F. Relations With Housing Programs.
G. Relations With Social Service (Title XX) Programs.

&C. 5240. CONTINUING CARE
A. General.
B. Requirements.

Administration

sec. **5310.** PROGRAM MONITORING, PLANNING, AND EVALUATION
A. General.
B. Providing for EPSDT Services.
C. Reasonable Standards of Medical and Dental Practice.
D. Case Management.

Sec. **5320.** INFORMATION NEEDS AND REPORTING
A. Information Collection.
B. Requirements.

Sec. **5330.** TIMELINESS

Sec. **5340.** REIMBURSEMENT
A. General Information.
B. Services.
C. Transportation.

Sec. **5350.** CONFIDENTIALITY
A. General.
B. Confidentiality Requirements.

SOURCE: U.S. Department of Health and Human services, Health Care Financing Administration, ***State Medicaid*** *Manual, Part* ***5—Early*** *and* ***Periodic*** *Screening, Diagnosis, and Treatment* ***(EPSDT),*** **April 1988.**

Nationally, less than half the children under age 13 living in poverty were covered by Medicaid for any medical or dental services in 1986 (12).

Services

States are required to provide certain services[4] to categorically needy people and are allowed to provide certain optional Services[5] under the Medicaid program. Although they are not required to do so, most States who cover medically needy people provide them with the same range of benefits offered to categorically needy people in their State. States may also impose limitations on any of the services offered, generally to reduce unnecessary use and control Medicaid outlays. See chapter 4 for further discussion on the relevance of service limitations to this study.

Reimbursement Policies

Except for a few instances,[6] States generally design their own payment methodologies and develop payment levels for covered services. The only two universal reimbursement rules are that Medicaid providers must accept payment in full and that Medicaid is the 'payer of last resort' (i.e., Medicaid pays only after any other payment source has been exhausted).

Institutions, such as hospitals and long-term care facilities, are paid differently than individual practitioners. Payments to institutions are usually based on either retrospective or prospective methodology. Individual practitioners are usually paid in one of two ways: the lesser of their usual charge and the State-allowed maximum, or based on a fixed fee schedule. Reimbursement policies affect the access of low-income children to dental care, as discussed in chapter 4.

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

The EPSDT program was legislated in 1967, and implemented in 1972.[9] The program is unique in that it provides for comprehensive health care, including preventive services, to children under Medicaid. The five basic components of the program ensure its comprehensiveness: informing, screening, diagnosis and treatment, accountability, and timeliness. EPSDT is jointly administered and funded by Federal and State Governments primarily through the Medicaid program, although some States administer the programs separately.

The EPSDT program is structured on a case management approach, to ensure comprehensiveness and continuity of care, though specific combinations of services and providers vary by State. In addition, since 1985 States have been allowed to pay a' 'continuing care provider' to manage the care of EPSDT children. This means that this provider or provider group is responsible for ensuring that each child receives his or her entitled services. These entitled services include notifying the child about periodic screens and performing, or referring, appropriate services, as well as maintaining the child's medical records.

Informing

States must inform all Medicaid eligibles, generally within 60 days of eligibility determination, of the EPSDT program and its benefits, particularly:

- about the benefits of preventive health care;
- about the services available under EPSDT, where and how to obtain them;
- that the services are without cost to those under age 18 (or up to 21, agency choice) except for any enrollment fee, premium, or other charge imposed on medically needy recipients; and

[4]States are required to provide: inpatient and outpatient hospital services, physician services, EPSDT for children under age 21, family planning services and supplies, laboratory and x-ray procedures, skilled nursing facilities for persons over 21, home health care services for those entitled to skilled nursing care, rural health clinic services, and nurse midwife services (12). The EPSDT program includes dental services for children under 21.

[5]States have the Option of also providing these services: clinic services, including dental care; drugs; intermediate care facilities; eyeglasses; skilled nursing facilities for those under age 21; rehabilitative services; prosthetic devices; private duty nursing; inpatient psychiatric care for children or the elderly; and physical, occupational, and speech therapies (12).

[6]Payment rules and limits are established by law for rural health clinics, hospices, and laboratories.

[7]A retrospective system is based on the actual cost of providing the services rendered, after they are provided.

[8]A prospective system is based on a predetermined rate for defined units of service, regardless of the actual cost of providing the service.

[9]The Social Security Amendments of 1967 (Public Law 90-248) added the EPSDT benefit and required implementation by July 1, 1969. Final regulations became effective on Feb. 7, 1972.

that transportation and scheduling assistance are available on request.

Most States provide the information at the time of application for welfare, though some States employ additional outreach methods.

Screening

The program also requires that all eligible children who request EPSDT services receive an initial health assessment. Generally, the screening should be performed within 6 months of the request for EPSDT services. This screening service should include:

- a health and development history screening, including immunizations;
- unclothed physical examination;
- vision testing;
- hearing testing;
- laboratory tests, such as an anemia test, sickle cell test, tuberculin test, and lead toxicity screening; and
- direct referral to a dentist for a dental screening.

Periodic medical examinations are based on the periodicity schedule recommended by the American Academy of Pediatrics. The recent Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) specified that, among older children, dental examinations should occur with greater frequency than is the case with physical examinations.

Diagnosis and Treatment

Further diagnosis of conditions indicated in exams and their treatment are also components of the EPSDT program. Specific diagnostic and treatment services should be part of a State's benefit package, though States may provide a range of services to children enrolled in EPSDT that go beyond the scope of benefits for other Medicaid beneficiaries.

Accountability

States are required to prepare quarterly reports which must contain utilization data by two age groups, O to 6 and 6 to 21:

- number eligible for EPSDT;
- number of eligibles enrolled in continuing care arrangements (and of these, the number receiving services and the number not receiving services);
- number of initial and periodic examinations; and
- number of examinations where at least one referable condition was identified.

Initially, the Federal Government enforced the EPSDT provisions by imposing a monetary penalty, a l-percent reduction in AFDC payments, on States not informing or providing care to eligible children (see the Social Security Amendments of 1972 (Public Law 92-603)). This penalty was eliminated in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and, instead, the adherence to the EPSDT provisions became a condition of Federal finding for Medicaid. OTA was unable to find any evidence that any State was penalized before 1981 or that any State has lost Medicaid Federal funding since that time as a result of not complying with the EPSDT provisions.