# *REPORT TO THE CONGRESS*

# Improvements Needed To Speed Implementation Of Medicaid's Early And Periodic Screening, Diagnosis, And Treatment Program

Social and Rehabilitation Service
Department of Health, Education, and Welfare

*BY THE COMPTROLLER GENERAL OF THE UNITED STATES*

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on improvements needed to speed implementation of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program. Medicaid is administered by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

We made our review at the request of Congressman Ralph H. Metcalfe.

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

# Contents

## ABBREVIATIONS

| | |
|---|---|
| AFDC | aid to families with dependent children |
| EPSDT | early and periodic screening, diagnosis, and treatment |
| GAO | General Accounting Office |
| HEW | Department of Health, Education, and Welfare |
| MSA | Medical Services Administration |
| SRS | Social and Rehabilitation Service |

*COMPTROLLER GENERAL'S REPORT TO THE CONGRESS*

# IMPROVEMENTS NEEDED TO SPEED IMPLEMENTATION OF MEDICAID'S EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

Social and Rehabilitation Service
Department of Health, Education, and Welfare

## D I G E S T

### *WHY THE REVIEW WAS MADE*

Congressman Ralph H. Metcalfe asked GAO to review implementation of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program administered by the Department of Health, Education, and Welfare's (HEW's) Social and Rehabilitation Service (SRS).

An estimated 10 million children under age 21 are eligible for free physical examinations and medical diagnosis and treatment under the EPSDT provisions of the Social Security Act.

GAO examined steps taken to implement EPSDT by SRS and Alabama, Idaho, Illinois, Massachusetts, Oregon, Rhode Island, Washington, and Wisconsin. As of June 30, 1973, about 1.8 million children eligible for Medicaid resided in these States.

### *FINDINGS AND CONCLUSIONS*

States are required to provide EPSDT under their Medicaid programs. This requirement is to get States more actively involved in preventive health care by identifying and treating medical problems early. In the long run the EPSDT approach has great potential for reducing the incidence of long-term, costly medical care.

HEW was slow in developing regulations. Also, HEW has not aggressively tried to make States comply with the law and Federal regulations. Both HEW and the States have been concerned also with the potential cost of providing EPSDT. As a result, only a small percentage of eligible children have been screened.

As of June 30, 1973, 3 of the 8 States had not started EPSDT screening and EPSDT screenings had been provided to only 58,000 of the 1.8 million eligible children in the 8 States. EPSDT screenings that have been performed appear to effectively identify health problems. (See p. 11.)

More children could be screened if emphasis were placed on informing families about EPSDT and if allied health professionals were used more in areas with a shortage of physicians.

In addition, EPSDT would be more effective if States insured that screenings were updated and that conditions found during the examinations were treated.

#### *HEW enforcement of compliance issues*

The Social Security Amendments of 1967 (Public Law 90-248), which added the EPSDT requirements to Medicaid, required implementation of EPSDT by July 1, 1969.

From 1968 to 1971 SRS officials developed program regulations. Final regulations became effective on February 7, 1972--about 2-1/2 years after the law stipulated that the program be fully implemented.

Results of several demonstration projects experimenting with various approaches to implement EPSDT will not be available until fiscal years 1975 and 1976.

SRS regional commissioners and their staffs were responsible for insuring that State plans and actions complied with Federal requirements. Regions reported problems with State implementation for all eight States but HEW has not held compliance hearings.

As of June 30, 1973, 4 years after the Congress required EPSDT to be implemented, none of the eight States had fully implemented it for all eligible children. One of the States was in compliance with HEW regulations. The States' slow implementation of EPSDT was due, in part, to HEW's slow action on compliance issues. (See pp. 8 and 9.)

*Increased outreach efforts needed*

Outreach is an important part of EPSDT. SRS Medicaid guidelines recommend that each State actively seek out eligible children by

--informing parents that EPSDT is available and when and where services are provided,

--helping parents understand the nature and purpose of the program,

--enlisting the help of community agencies in locating eligible children, and

--helping families receive EPSDT and providing necessary transportation.

GAO found that the States, and areas within them, were using a wide variety of outreach methods. Some were making more extensive outreach efforts than others and, as a result, had much higher screening rates.

Social Security Amendments of 1972 (Public Law 92-603) require HEW, effective July 1, 1974, to impose a monetary penalty on States that do not

--inform eligible persons of available EPSDT and

--provide these services.

On August 2, 1974, SRS issued regulations to implement this provision. The regulations require that written materials explaining the services available under EPSDT be provided annually to all families receiving public assistance payments under Aid to Families With Dependent Children (AFDC). (See p. 15.)

*Increased use of allied health professionals needed*

The mixture of physicians, nurses, technicians, volunteers, and paraprofessionals used to perform separate segments of EPSDT screening varied among areas. Some areas had a shortage of physicians participating in EPSDT.

Those shortage areas that extensively used allied health professionals to perform EPSDT screened more children than areas that used only physicians. (See pp. 17 and 18.)

*States are not meeting their targeted screening schedules*

The primary objective of EPSDT is to provide preventive health care to children in low-income families. Emphasis on preventing diseases and other crippling conditions requires periodic medical examinations.

The eight States GAO visited had established schedules for performing periodic screenings. However, on the basis of States' screening rates before June 30, 1973, none of the States will meet their schedules. (See pp. 18 and 19.)

*States need to insure that conditions are treated*

A large number of children who have had EPSDT screenings have been referred for further diagnosis and treatment. Although potential health problems were being identified, most States did not have an effective statewide record system indicating whether the children were being treated. (See ch. 4.)

*RECOMMENDATIONS*

The Secretary of HEW should direct the Administrator, SRS, to take more aggressive action, including formal compliance hearings, to make States comply with the law and SRS regulations.

The Secretary also should direct the Administrator to:

--Develop criteria for determining which children do not need EPSDT screening because they are receiving regular, adequate medical care equivalent to screening and disseminate the criteria to all States so that screening efforts are directed toward children who need it.

--Encourage States to use outreach techniques, such as personal contacts in addition to the required annual written notification.

--Enclourage and help States to use allied health professionals for screening, especially in those areas that have a shortage of physicians.

--Enclourage and help States to increase their screening efforts to insure that all eligible children are screened.

--Encourage and help States to establish procedures to insure that screenings are periodically updated.

--Monitor States' progress in meeting their screening schedules.

--Require States to establish procedures to follow up on children with problems identified during the screening process to insure that needed treatment is provided.

*AGENCY ACTIONS AND UNRESOLVED ISSUES*

HEW concurred with GAO's recommendations and described actions that had been or will be taken. HEW said these plans are necessarily tentative and contingent upon the availability of staff.

Regulations were issued on August 2, 1974, implementing section 299F of the Social Security Amendments of

1972 which impose a 1-percent reduction of Federal AFDC payments to States which (1) fail to inform in writing, at least annually, all AFDC families of the availability of screening, (2) assist eligibles in obtaining screenings after they request them, or (3) arrange for treatment of conditions uncovered by screening.

HEW will also require the States to have the same procedures for non-AFDC families. While written notification to eligible families of the availability of EPSDT is important, GAO's review showed that use of additional outreach techniques, such as personal contacts, could increase participation in EPSDT.

HEW said it will continue to encourage and assist States to use allied health professionals for screenings and it is beginning to assist the States to refine their programs to insure screenings are periodically updated.

SRS is developing plans for monitoring each State's performance in meeting screening schedules as a part of a comprehensive plan of work with States on improving EPSDT implementation.

HEW is supporting efforts by various States to identify children under comprehensive care to enable States to concentrate on screening those children not under such care.

Children under regular medical care do not need to be screened if the care they receive includes all the elements of the screening program. Several States also commented that many children were under the regular medical care of a physician and may not need to be screened.

HEW should develop criteria for determining which children do not need EPSDT screening because they are receiving regular, adequate medical care equivalent to screening and disseminate the criteria to all States so that screening efforts are directed toward children who need it.

Finally, the Secretary of HEW sponsored regional conferences with the States during August 1974, at which it was emphasized that HEW will impose fiscal sanctions on those States not meeting Federal EPSDT requirements.

If effectively implemented with adequate resources, actions taken and planned by HEW should help alleviate problems discussed in this report. The eight States reviewed also commented on GAO's findings. Supplemental information provided by the States is included in Chapter 5. (See pp. 20 to 22.)

## *MATTERS FOR CONSIDERATION BY THE CONGRESS*

This report contains no recommendations requiring legislative action by the Congress. It does contain information on the slow implementation by HEW and the States of a congressionally mandated program.

# CHAPTER 1

## INTRODUCTION

Congressman Ralph H. Metcalfe requested that we review the implementation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program under Medicaid.

## DESCRIPTION AND ADMINISTRATION OF MEDICAID

Medicaid--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government reimburses costs incurred by the States in providing medical care to persons who cannot afford it. The Government pays from 50 to 81 percent (depending on the per capita income in the States) of the costs incurred by the States in providing medical services under their Medicaid programs. As of June 30, 1974, 49 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had Medicaid programs.

Medicaid recipients include persons and families receiving or entitled to receive cash assistance payments under the Social Security Act. In addition, States may elect to pay for medical care provided to medically needy persons and families (individuals whose income equals or exceeds the State's standards under the appropriate financial assistance plan but is insufficient to meet their medical costs).

The Secretary of the Department of Health, Education, and Welfare (HEW) has delegated the responsibility for administering Medicaid to the Administrator of the Social and Rehabilitation Service (SRS). Authority to approve grants for State Medicaid programs has been delegated to the SRS regional commissioners, who administer the field activities of the program through HEW's 10 regional offices. The commissioners are responsible for determining whether State programs are administered in accordance with the Federal requirements and the provisions of approved State plans.

Under the Social Security Act, States have the primary responsibility for initiating and administering their Medicaid programs. The services provided to Medicaid

recipients vary among States but, as a minimum, all States must provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing home services, EPSDT to individuals under 21 years of age, physicians' services, home health care services, and family planning services.

## IMPORTANCE OF EPSDT TO HEALTH OF CHILDREN

Medicaid is the largest Federal program providing health care to children. An estimated 10 million children are eligible for Medicaid services. In the past, Medicaid services have been limited largely to providing services when people requested medical assistance.

The EPSDT amendment to Medicaid was added by the Social Security Amendments of 1967 (Public Law 90-248). The reports of the Senate Finance Committee and the House Committee on Ways and Means[1] pointed out that States should take agressive steps to identify and treat children's health problems. These reports indicated that the Congress was concerned about differences among States in providing medical services to children with handicapping and potentially handicapping health problems that could lead to chronic illness, disability, and death. Further, the reports indicated a concern for (1) extending outreach efforts to make eligible families aware of the availability of free health services, (2) stimulating the use of these services, and (3) making health services available to children so they can receive medical help before their problems become chronic and irreversible damage occurs.

EPSDT requires States to get actively involved in preventive health care for children by identifying and treating medical problems early. As a part of EPSDT, a State must provide eyeglasses, hearing aides, other treatment for visual and hearing defects, and some dental care. EPSDT has great potential for reducing the incidence of long-term costly medical care.

[1]Senate Report No. 90-744 and House Report No. 90-544.

HEW does not have information on the actual costs of EPSDT because they are not reported separately from other Medicaid costs.

## SCOPE OF REVIEW

We made our review at HEW headquarters, Washington, D.C.; HEW regional offices in Boston, Chicago, and Seattle; and State agencies administering the Medicaid program in eight States--Alabama, Idaho, Illinois, Massachusetts, Oregon, Rhode Island, Washington, and Wisconsin. As of June 30, 1973, these States had about 1.8 million children eligible for Medicaid. We visited public health offices, private clinics, and public welfare offices; observed medical examination procedures used by EPSDT providers; and discussed EPSDT with selected families of eligible children. Our fieldwork was conducted from June to December 1973.

## CHAPTER 2

## HEW PROGRAM DIRECTION NEEDS IMPROVEMENT

HEW was slow in developing EPSDT regulations. Although HEW has awarded five contracts to national medical provider groups to design and develop ways to help States and localities carry out EPSDT, the results of these studies will not be available until 5 to 6 years after EPSDT's required implementation date. In addition, HEW has not taken effective action to insure that States fully implement EPSDT. As a result of this and the States' concern about the cost of providing EPSDT, States have been slowly implementing EPSDT and only a small percentage of the eligible children have been screened.

### HEW'S SLOWNESS IN DEVELOPING REGULATIONS

The Social Security Amendments of 1967 required EPSDT to be implemented by July 1, 1969, in every State that had a Medicaid program.

From 1968 to 1971 SRS officials developed program regulations after consulting with (1) experts in the field of health care for young people, (2) other HEW agencies, (3) the Office of Management and Budget, and (4) the States. The Secretary of HEW referred to this period of time as

> "* * * an embarrassingly long period of delay and debate, occasioned mainly by a concern over the impact on Federal and State budgets and on States' medical resources * * *."

On December 11, 1970, the Administrator of SRS published proposed regulations in the Federal Register for implementing EPSDT. The proposed regulations stipulated that the States would provide whatever treatment a child needed regardless of the limits the States had placed on other Medicaid services. About half the States were concerned about the potential cost of unlimited care. This led HEW to consider alternative regulations.

Growing congressional concern and a court suit against the Secretary encouraged HEW to issue final implementing

regulations. The final regulations, published in the Federal Register on November 9, 1971, allowed States to limit treatment to those services normally provided under States' Medicaid plans, except that the States must also provide eyeglasses, hearing aids, other visual and hearing treatment, and some dental care.

These regulations became effective on February 7, 1972, about 2-1/2 years after the law stipulated that the program be fully implemented and 4 years after EPSDT was authorized by law. The regulations required States to start implementing EPSDT, at least for children under age 6, but allowed States until July 1, 1973--4 years after the July 1, 1969, required starting date--to fully implement services for all children under age 21. The States were allowed to phase in their programs because of the concern over the estimated fiscal impact of EPSDT on State budgets.

In October 1972, the President signed the Social Security Amendments of 1972. Title II of the amendments requires the Secretary of HEW to reduce Federal Aid to Families with Dependent Children (AFDC) payments to the States by 1 percent starting in fiscal year 1975 if a State fails to:

--Inform AFDC families of the availability of child health screening services.

--Actually provide or arrange for such services.

--Arrange for or refer to appropriate personnel for corrective treatment, those children disclosed by such screening as suffering illness or impairment.

In its report on the Social Security Amendments of 1972,[1] the Senate Finance Committee stated that many States had failed to implement EPSDT or had only partially implemented it because of their contention that the screening, diagnosis, and treatment of all eligible children under age 21 was not possible because of limited State financial and health care resources. The Committee believed that a

[1]Senate Report No. 92-1230

penalty provision would underline the Committee's intent that the States fully implement health screening programs.

SRS published regulations to implement this penalty provision on August 2, 1974.

The regulations require the States to:

--Inform in writing, at least annually, all eligible AFDC families of the availability of screenings and where and how screenings can be obtained.

--Assist those AFDC eligibles who request screenings in obtaining them, normally within 60 days of the request.

--Arrange for treatment of conditions uncovered during screening, normally within 60 days of the screening.

States which do not fulfill these requirements can be assessed a 1 percent penalty in Federal AFDC payments.

## LIMITED MONITORING AND TECHNICAL ASSISTANCE

In implementing EPSDT, HEW established a monthly reporting requirement for total numbers screened and potential problems identified by the screening for each State, starting in October 1972. It designated EPSDT as a priority project in July 1973. In addition, HEW funded four demonstration projects, five development projects, and one evaluation project. Eight of these projects were funded during fiscal years 1973 and 1974, from 3 to 4 years after EPSDT's required implementation date. These projects were planned to be completed from 8 months to 3 years after their starting dates.

The demonstration projects were being used to test various approaches in implementing EPSDT at the local level and were considered expedient in helping the States to implement their EPSDT. The results of these projects will not be available until fiscal years 1975 and 1976--6 to 7 years after the required implementation date.

In implementing EPSDT and designing and developing ways of assisting States and localities in carrying out EPSDT, HEW has contracted with several national medical provider groups. Under these contracts the American Medical Association is to develop a guide for health provider participation in EPSDT. The American Society of Dentistry for Children is to prepare a manual on developing dental components of EPSDT. The American Academy of Pediatrics is to prepare guidelines for early identification of health problems and guides for treatment and diagnosis. The Health Facilities Foundation is to develop a manual for training health professionals.

HEW awarded a grant on June 1, 1972, to the Regional Health Services Research Institute for evaluating EPSDT. The organization started work on the project in July 1972. A phase I report was published in October 1972 and a phase II report was published in September 1973. The principal criticisms in the first report included the following:

--An absence of effective outreach and followup services.

--Many children undergoing screening appeared to have regular contact with physicians but the physicians had not given the children a vision, an audiometer, or a developmental test.

--State information systems did not adequately insure systematic followup.

--Data systems did not contain data necessary for adequate economic analyses of EPSDT programs.

The second report emphasized the activities of successful State and local organizations, including examples of effective outreach methods, screening procedures, and tracking systems for effective followup. SRS' Medical Services Administration (MSA) distributed a summary of these findings to the States.

In December 1973, the Acting Director of the HEW Office of Child Development and the Commissioner of MSA announced steps to use local Head Start programs in getting EPSDT to

children. The Administrator of SRS approved this plan in February 1974 with the provision that each State's title XIX Director and Governor must approve all outreach. In June 1974, the Office of Child Development funded 200 Head Start demonstration projects to carry out this effort.

SRS regional office personnel are responsible for (1) reviewing EPSDT's progress in the States to detect problem areas, (2) providing technical assistance requested by the States, and (3) determining the status of implementation. The size of the SRS regional office staffs working on EPSDT varied considerably among regions during fiscal year 1974. As of April 1974, regional commissioners estimated that between .2 and 3 professional man-years of effort would be spent in their regions on EPSDT in fiscal year 1974. Accordingly, SRS' ability to determine the status of the States' implementation of EPSDT and to provide needed assistance varied between regions.

## COMPLIANCE HEARINGS NOT HELD

Under title XIX of the Social Security Act, as amended, the Secretary of HEW has the authority to withhold Medicaid payments if a State's plan for administering its Medicaid program does not meet mandatory Federal requirements or if an approved plan is not carried out. One of the primary goals of SRS is to insure that people receive the benefits intended by laws and implementing regulations.

SRS regional commissioners and their staffs are responsible for insuring that State plans are in accordance with Federal requirements and that States are operating in conformity with approved plans. Although regional representatives have monitored and assisted States in implementing EPSDT, State programs need further improvement. As of June 30, 1973, 4 years after the Congress required EPSDT to be fully implemented, none of the eight States had done so for all eligible children under 21 years old. However, Rhode Island was in compliance with SRS regulations in force in June 30, 1973, which required providing EPSDT to children under 6.

SRS regulations require that, when an issue cannot be informally resolved through negotiations with a State, the

SRS regional commissioner will recommend that the Administrator, SRS, hold formal hearings to determine the State's compliance with Federal requirements. These hearings serve as the basis for deciding whether to withhold Medicaid payments to the State for noncompliance.

As of June 30, 1973, Illinois had not informed the families of all eligible children about EPSDT, and Alabama had not provided transportation to and from medical services. Idaho and Washington had not provided statewide services, and Wisconsin, Oregon, and Massachusetts had not begun implementation. Regional staffs had reported these problems which, in two cases, had also been noted in several quarterly reports, but HEW has not held formal compliance hearings involving these seven States.

The States have been slow in implementing EPSDT as a result of HEW's slow action on compliance issues. For example, as of July 1, 1973, 4 years after the implementation date, Oregon had not implemented EPSDT services. Oregon officials told us that they would do only what HEW required in providing EPSDT. The SRS regional commissioner recommended, in May 1973, to the Administrator of SRS that formal compliance action be taken against Oregon, but, as of May 1974, hearings had not been held.

In December 1973, the Director of the Division of Program Monitoring, MSA, reported to the Commissioner that MSA had discontinued analysis of the quarterly compliance reports and did not plan to follow up on compliance issues with the States. An SRS representative told us that SRS had not pursued compliance issues because of the difficulty of documenting the problems and going through compliance hearings.

## CONCLUSIONS

Some States have been slow in implementing EPSDT because of HEW's slow efforts and an apparent reluctance to use formal compliance procedures. HEW needs to take more aggressive action to bring the States into compliance with the law and HEW regulations.

## RECOMMENDATION

In those cases where the States are not complying with the law or SRS regulations, we recommend that the Secretary require the Administrator, SRS, to take more aggressive action, including formal compliance hearings, to bring these States into compliance.

## AGENCY COMMENTS AND OUR EVALUATION

By letter dated September 9, 1974, HEW furnished us with its comments on our findings and recommendations. (See app. II.) HEW stated that in regional conferences held with representatives of the States on August 9, 13, and 16, 1974, it was made very clear that HEW plans to move aggressively against those States which continue to be out of compliance with program requirements. HEW said it would initiate formal compliance action in such cases.

Judicious use of the penalty provision and compliance hearings should help insure that States comply with the EPSDT requirements.

## CHAPTER 3

## NEED TO PROVIDE SCREENING TO MORE CHILDREN

States have tried to inform low-income families of the increased preventive health services available to their children as a result of EPSDT. However, only a small percentage of the eligible children had received EPSDT screenings as of June 30, 1973, and this percentage varied considerably among States and among areas within States. At that time three of the eight States visited had not started screening.

The number of children screened could be increased if HEW would encourage States to place greater emphasis on informing families about EPSDT and if the number of allied health professionals providing the services were increased in those areas that have a shortage of physicians. In addition, EPSDT's preventive health benefits could be increased if HEW required States to establish procedures to insure that screening examinations are periodically updated in accordance with screening schedules.

### PREVENTIVE SERVICES INCREASED

Following are examples of how EPSDT has increased preventive health care to more children.

Idaho's Maternal and Child Health Clinics were screening children only through age 5 before EPSDT, and only upon the parents' request. EPSDT has expanded screening to include all children under age 21 and has introduced considerable outreach efforts (see p. 15.) through letters and personal visits.

County Health Department employees in Alabama told us EPSDT has been beneficial for children and has detected health problems that the public health nurses' routine work would not have found. For example, some individuals were treated for potential tuberculosis detected by EPSDT.

Washington State officials told us that, before EPSDT was implemented, Washington had no preventive health care program available to all low-income children.

Preventive health care was and is available to some low-income children under programs other than EPSDT, including school health programs, maternal and child health clinics, and neighborhood health centers. Because of the limited statistics on preventive health care provided by these programs, we could not determine the number of children receiving screenings. EPSDT has emphasized preventive care rather than crisis treatment which had been the emphasis in the past.

## LIMITED NUMBERS SCREENED

Only a small portion of the eligible children had been screened as of June 30, 1973. Overall about 58,000, or 3 percent, of the 1.8 million eligible children in the 8 States had been screened. This rate varied from zero for three states that had not started screening to 16 percent in Alabama.

One reason for the different screening rates is that some States began screening earlier than others and as a result screened more children than those States that were slow in implementing the service. For example, Alabama started screening in October 1971 and had a higher rate than Oregon which started screening in August 1973. Slow implementation by some States is also reflected in the low national screening rate--7 percent as of June 30, 1973.

Other reasons which contributed to the different rates include different outreach approaches and different types of medical providers doing the screening. Also, Massachusetts officials informed us that their Medicaid program had provided EPSDT services since 1968, but the State is having difficulty documenting it. In addition Rhode Island officials indicated that most eligible children were under the regular care of a doctor and many have been given unrecorded screenings.

The following table shows EPSDT screening data for the States reviewed.

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | Screening started | | Estimated number of eligible children under 21 | Children screened (note a) | |
|---|---|---|---|---|---|
| | Age | Date | | Number | Percent |
| Alabama | 0 to 5 | Oct. 1971 | 240,000 | 39,015 | 16 |
| | 6 to 11 | Dec. 1972 | - | - | - |
| | 12 to 20 | Apr. 1973 | - | - | - |
| Idaho | 0 to 5 | Jan. 1973 | - | - | - |
| | 6 to 20 | July 1973 | 13,558 | 1,594 | 12 |
| Illinois | 0 to 5 | Feb. 1972 | 583,349 | [b]12,888 | 2 |
| | 6 to 20 | Aug. 1973 | - | -- | - |
| Massachusetts | 0 to 20 | July 1973 | 415,800 | (c) | - |
| Oregon | 0 to 20 | Aug. 1973 | 73,521 | 0 | 0 |
| Rhode Island | 0 to 5 | Jan. 1973 | 37,000 | 202 | 1 |
| | 6 to 20 | July 1973 | - | - | - |
| Washington | 0 to 20 | Nov. 1972 | 240,000 | 4,473 | 2 |
| Wisconsin | 0 to 20 | July 1973 | 148,025 | 0 | 0 |
| Total | | | 1,751,253 | 58,172 | 3 |

[a] Appendix I shows a breakdown, by fiscal year, of the number of children receiving EPSDT screenings. States also are providing screenings under other health programs.

[b] Data only through March 30, 1973.

[c] Massachusetts officials informed us that EPSDT type services have been provided since 1968, but they were not able to provide documentation to this effect.

## SCREENING PROCEDURES AND PAYMENTS

SRS screening guidelines recommend that a State's screening include at least:

> "* * * a health and developmental history (physical and mental); an assessment of physical growth; developmental assessment; inspection for obvious physical defects; ear, nose, mouth, and throat inspection (including inspection of teeth and gums); screening tests for cardiac abnormalities, anemia, sickle cell trait, lead poisoning, tuberculosis, diabetes, infections and other urinary tract conditions; and assessment of nutritional status and immunization status * * *."

The States appeared to be including most of these tests in their EPSDT physical examinations. In a few cases States were conducting other tests considered optional in the guidelines.

An Alabama health official told us the State was not testing all children for lead poisoning because of the historically low incidence of such cases. The State was, however, making optional lab tests for parasites because of their high incidence in some areas of the State.

The amount paid to providers for each EPSDT examination varied from State to State. Washington providers were paid $12.60 for initial screenings and $6.30 for subsequent screenings. The costs of urine and anemia laboratory tests were included in these fees, while other laboratory costs were paid separately. Rhode Island paid $20 for the screening and an additional $7.50 for laboratory tests.

Dental screeners in Illinois received $8, and other screening providers received from $11 to $22 for each examination, depending on the age of the child screened. Massachusetts allowed $17 for the screening and $9 for followup visits. In Alabama, doctors received $10 for each screening and could send specimens to the State laboratory for analysis. Some physicans believed that these rates are too low; this could affect their participation in EPSDT.

## IMPROVED OUTREACH NEEDED

Outreach is an important part of EPSDT. SRS guidelines recommend that each State actively seek out children eligible for EPSDT by (1) informing parents that EPSDT is available and when and where it is provided, (2) helping parents understand the nature and purpose of the screening program, (3) enlisting the help of community agencies in locating eligible children, and (4) helping families receive EPSDT--including necessary transportation.

SRS guidelines recommend a number of ways to publicize the availability of EPSDT services to eligible and potentially eligible individuals, including posters, flyers, pamphlets, and radio, television, and newspaper announcements.

States were using a wide variety of outreach methods. Some of the States and areas within States using more extensive outreach efforts than others had higher screening rates than those with less extensive outreach efforts. For example, most of the areas in Idaho and Alabama were using a variety of outreach methods and had higher screening rates than Illinois and Washington which had done little more than mail EPSDT inserts to families with eligible children.

Each of Idaho's seven regions planned and executed its own outreach efforts through the local offices of the State Department of Environmental and Community Services. In addition to informational bulletins mailed by the State to persons eligible for Medicaid, some regional offices also mailed their own brochures, telephoned eligible families, and made personal visits to encourage parents to make screening appointments for their children. Three of the four Idaho regions we visited were making extensive personal contacts and had screening rates of 16 to 35 percent at June 30, 1973. The region with the 35-percent screening rate used personal service aides--mothers who had been receiving assistance under the AFDC program--to help provide outreach services to eligible families. The aides were hired with 90 percent matching funds from the federally assisted Work Incentive Program. In contrast to the three regions making extensive personal contacts, the fourth region was doing little in the way of personal outreach and had only a 3-percent screening rate for the same time.

In Alabama, individual counties were responsible for their outreach efforts. The public health nurses in each county made personal contacts with families of eligible children. In one of the two counties we visited, public health nurses were following up on some of the children who did not show up for their scheduled screening examinations. In the other county, screening appointment letters were being mailed to families but there was no followup on children who missed their appointments. The first county had screened 62 percent of its eligible children and the other county had screened 37 percent.

In Illinois, interim EPSDT procedures which were issued in February 1972 provided that public aid caseworkers encourage eligible families to use EPSDT. However, 15 of 26 caseworkers we talked to told us they were not informing eligible families about EPSDT. Some of these caseworkers said they had not been instructed to do so. The State had experimental projects which used personal outreach, but, as of September 1973, it had not used this approach statewide. As of June 30, 1973, Illinois had screened 2 percent of its eligible children.

Each local public assistance office was responsible for outreach in the State of Washington. In addition, the State mailed inserts with a Medicaid card or warrant to notify recipients that EPSDT was available and how to arrange to have children screened. Public assistance officials told us that caseworkers informed new public assistance recipients of EPSDT when they first became eligible. When caseworkers made their regularly scheduled visits, they also told recipients about EPSDT. However, some caseworkers said they were not actively disseminating EPSDT information because of heavy workloads. Numerous public assistance recipients were not assigned to caseworkers and were not contacted unless they requested help. These recipients were notified about EPSDT only through the mailed inserts. As of June 30, 1973, Washington had screened 2 percent of the eligible children.

The Regional Health Services Research Institute at the University of Texas Medical School conducted an EPSDT impact and evaluation study in 1973 in selected localities of eight States other than the ones we visited. The study showed that the average rate of children who appeared for screening was highest in those localities where families were personally contacted.

The Social Security Amendments of 1972 (Public Law 92-603) added a penalty effective July 1, 1974, for States that do not inform and provide EPSDT. (See pp. 5 and 6.) On August 2, 1974, SRS published regulations to implement this provision. The regulations require States to inform AFDC families annually in writing of EPSDT. However, States which used a variety of outreach methods had higher screening rates than those States which primarily relied on mailing EPSDT inserts to eligible families.

## ALLIED HEALTH PROFESSIONALS SHOULD BE USED MORE

SRS expected all levels of professional expertise to be involved in EPSDT. Its guidelines provide that screening should be performed under the supervision of, or with consultation from, physicians, dentists, optometrists, audiologists, or other health care specialists. Parts of the screening, such as interviews, observations, and tests, can be conducted by nurses, trained health aides, laboratory technicians, and trained volunteers.

All the States we visited were using several types of personnel to do the screening. Physicians, nurses, technicians, volunteers, and paraprofessionals were being used to do different segments of the screenings. For example, some regions in Idaho were using physicians to perform the physicals and nurses and specially trained personal service aides to do other parts of the screening, such as immunizations, developmental tests, hearing and vision tests, dental examinations, and children's medical histories. In Illinois, physicans were conducting most of the screening examinations with the assistance of nurses and laboratory technicians. Private physicians and physicians at neighborhood health centers performed screenings in Rhode Island.

Some areas of States we visited had a shortage of physicians participating in EPSDT. Those shortage areas that extensively used allied health professionals to perform EPSDT screened more children than shortage areas that used only physicians. For example, in one area in Washington, few children were being screened because only two doctors were providing EPSDT, and allied health professionals were not being used. In contrast, in many areas in Alabama, doctors were not available so public health nurses were doing the screening. The percentages of children screened in these areas were as high as 62 percent. The Wisconsin comments pointed out that allied health professionals are now used almost exclusively in its EPSDT program.

In a booklet entitled "Standards of Child Health Care," the American Academy of Pediatrics stated:

> "* * * a physician may delegate the responsibility of providing appropriate portions of health examinations and health care for infants and children to a properly trained individual working under his supervision."

The Academy believes that:

> "* * * such personnel, who are working as members of a health team headed by a physician, can provide better child health care to more children than the physician who is working alone."

The number of children screened could be greatly increased nationwide if HEW would encourage States to use more allied health professionals in the screening process.

PERIODIC SCREENING NOT INSURED

EPSDT's primary objective is to provide preventive health care to children of low-income families. The emphasis on preventing diseases and other crippling conditions necessitates periodic medical examinations. Each State is responsible for developing its own schedule for screening children. The eight States we visited had established schedules for performing periodic screenings.

Idaho plans to screen children annually, with some tests of the screen left out. Alabama plans to screen all eligible children every 3 years. In Rhode Island, after a child is given an initial screening examination, he is considered to be under the care of the provider who is supposed to schedule followup examinations in accordance with customary medical practice. Most of the States, however, have not instituted procedures to insure that screenings are periodically updated.

On the basis of past screening rates, none of the States will meet their targeted schedules. Fiscal year 1973 rates varied from a high of 13 percent for Alabama to zero for three States which had not started screening. (See app. I.)

SRS does not require States to report data showing their compilance with screening schedules. It requires only that each State report statistics which show the gross number of screening examinations performed. This data does not show whether the children were screened for the first time or whether the screenings were periodic updates of previous examinations. SRS should monitor States' progress in meeting their EPSDT schedules.

## CONCLUSIONS

The number of children being screened could be increased if additional emphasis were placed on informing eligible families about EPSDT. Also, more screenings could be performed if the number of allied health professionals providing the services was increased in those areas having a shortage of physicians. Finally, EPSDT preventive health benefits could be increased if States made sure that screenings were periodically updated.

## RECOMMENDATIONS

To insure that eligible children receive EPSDT benefits, we recommend that the Secretary of HEW direct the Administrator, SRS, to:

--Develop criteria for determining which children do not need EPSDT screening because they are receiving regular, adequate medical care equivalent to screening and disseminate the criteria to all States so that screening efforts are directed toward children who need it.

--Encourage States to use outreach techniques, such as personal contacts, in addition to the required annual written notification.

--Encourage and help States to use allied health professionals for screening, especially in those areas that have a shortage of physicians.

--Encourage and help States to increase their screening efforts to insure that all eligible children are screened.

--Encourage and help States to establish procedures to insure that screenings are periodically updated.

--Monitor States' progress in meeting their screening schedules.

## AGENCY COMMENTS AND OUR EVALUATION

HEW stated that States are now required, as a result of regulations issued on August 2, 1974, to inform AFDC families in writing, at least annually, of EPSDT services available and where and how the services can be obtained. States must also have arrangements to provide such information to persons for whom printed material is inappropriate. If a State does not meet these requirements, it is subject to a 1-percent reduction of Federal AFDC funds. SRS is now developing criteria for applying the penalty. Although the 1-percent penalty applies only to AFDC families, the basic EPSDT regulation requires that all eligibles be informed, and HEW will stipulate that non-AFDC families be informed in the same manner as AFDC families. The sanction for not informing non-AFDC families would be a conformity hearing.

HEW also commented that it had supplied television and radio spot announcements on EPSDT to the States for use as they saw fit.

We agree that written notification of the availability of EPSDT is important. However, our review showed that the use of additional outreach techniques, such as personal contacts, increased participation in EPSDT. We believe HEW should encourage the States to use other outreach techniques in addition to annual written notifications to help insure that families of children who need to be screened are made aware of EPSDT.

Regarding our recommendation that HEW encourage and assist States to use allied health professionals for screening, HEW said that MSA will continue to emphasize this alternative in technical assistance activities with States. Also, a manual for training allied health professionals for work in EPSDT is being developed by the Health Facilities Foundation of San Francisco. The manual is currently scheduled for distribution early in 1975.

We noted that the EPSDT screening guide developed by HEW and distributed in August 1974 to providers points out that screening can be accomplished by properly trained allied health professionals but does not emphasize this alternative.

Regarding our recommendation to encourage and assist the States to increase their screening efforts, HEW commented that it has encouraged (through the August 2 regulations) States to make efforts that will insure that screening is available to all eligible children. States must take an active role in assisting eligibles requesting screening services or be subject to a 1-percent reduction in Federal AFDC funds. The States must (1) explain what services are available, (2) tell how and where services can be obtained, (3) insure that an adequate number of providers are available to deliver services within 60 days of the request, and (4) have a monitoring system to insure that requested services are provided. In addition, in August 1974 HEW made available to providers a manual on how to perform screening.

HEW also commented that many eligible children are under comprehensive care of physicians so screening efforts should be directed toward those not under care.

Several States also commented that many children were under regular medical care but they did not know the comprehensiveness of screening under this care. We agree that children under regular medical care may not need to be screened if the care they receive includes all the elements of the screening program. HEW should continue to develop criteria for determining which children do not need EPSDT screening and, when completed, disseminate the criteria to all States so that screening efforts are directed toward children who need it.

In commenting on our recommendation to encourage and assist the States to establish procedures to insure that screenings are periodically updated, HEW said it was beginning to encourage and assist States to refine their EPSDT programs, especially in the area of case management. We agree that a good case management system would be an effective method for insuring that screenings are periodically updated and we believe HEW should continue assisting States in devising such systems.

Regarding our recommendation that SRS monitor the States' progress in meeting their screening schedules, HEW said SRS is developing plans for encouraging, assisting, and monitoring States' performance in meeting screening schedules as a part of a comprehensive plan of work with States on improved EPSDT implementation. States will be assisted in identifying causes of delays in meeting schedules and developing solutions drawn in many instances from HEW's knowledge of successful practices. HEW said some of these plans are necessarily tentative, contingent upon the number and distribution of available staff for EPSDT.

If effectively implemented with adequate resources, the actions taken and planned by HEW should help alleviate the problems discussed in this chapter.

## CHAPTER 4

## NEED TO INSURE TREATMENT IS PROVIDED

The Social Security Act requires States receiving Medicaid funds to arrange for treating children's medical problems identified by screening. A large number of children who had received EPSDT screening were referred for further diagnosis and treatment, but the States generally did not know whether these children were being treated. The treatment effort could be improved if HEW would require State agencies to develop and use statewide followup systems to identify those children who have not received treatment and assist them in getting to the appropriate medical care providers.

SRS guidelines state that each State should seek to develop

> "* * * records which will establish a health care history for each child which details screening tests provided, conditions uncovered, results of diagnosis, and services rendered (by condition) so that costly and unnecessary repetition of screening and diagnostic procedures will not occur, and appropriate medical treatment will be facilitated * * *."

The screenings that have been performed appear to be effective in identifying health problems, as shown in appendix I and in the following table.

## CONDITIONS FOUND DURING SCREENING (note a)

| | Alabama | Washington |
|---|---|---|
| Number of children screened | 39,015 | 4,473 |
| Types of conditions found (note b): | | |
| Visual | 1,627 | 190 |
| Hearing | 593 | 306 |
| Dental | 11,956 | 599 |
| Lead poisoning | 0 | 2 |
| Other (note c) | 25,851 | 1,635 |
| Total | 40,027 | 2,732 |

a
As of June 30, 1973.

b
May be referred for treatment for more than one illness or impairment.

c
Includes intestinal parasites, anemic conditions, heart conditions, and any other physical or mental conditions.

Although health problems were being identified, none of the States we visited were effectively using a statewide record system for determining whether the children were being treated. Several States had plans for computerized systems which could monitor the health care children received, but at the time of our fieldwork only Alabama had an automated followup system which could be used statewide. The State sends each county a monthly list of all children whose medical treatments have been paid. The counties could have used these printouts to determine whether children were being treated, but neither of the two counties we visited had done so.

In Alabama the effectiveness of followup efforts varied from county to county. One county we visited was effectively using referral forms. When a child was referred for treatment, the county health department kept a copy of the referral form. The health department attached the form to a health record which was not filed until the treatment provider informed the county the child had been treated. Treatment providers were called periodically to determine the status of the child's treatment. If an appointment was not kept, the family was called. When the number of untreated referrals became large, screening was discontinued and the public health nurses concentrated on following up on those untreated children.

In contrast, the health officials in another Alabama county we visited were preparing and attaching referral slips to each child's health record but were filing these records without following up to determine whether the children received treatment. We reviewed treatment computer reports of 3 counties in Alabama and found that of 508 medical conditions detected, only 139, or 27 percent, had been treated within 1 year of the date of detection.

One child received an EPSDT examination in early 1973 and was referred to a physician for treatment for intestinal parasites. The child did not visit a physician for more than 4 months after the first examination and was admitted to a hospital. A physician at the hospital diagnosed the problem as gastroenteritis. The child then underwent a series of X-ray and urological tests until the problem was again diagnosed as intestinal parasites. The child was then

given drugs to alleviate the problem. A State official told us that, because of poor followup, this child suffered several months of discomfort, and the State paid an estimated $200 of unnecessary medical expense to find intestinal parasites which EPSDT had previously noted.

In Idaho each of seven regional offices determined its own methods of achieving program goals and was responsible for administering EPSDT and establishing appropriate procedures for followup. In one region, an aide was employed to handle outreach efforts which included calling or visiting families to make screening appointments. Two other aides, assigned to take care of treatment followup, were trained to perform outreach and followup and to assist in giving parts of the vision and hearing tests at EPSDT clinics.

One of the Idaho aides had devised a filing and cross-reference system that she used to monitor the services received by eligible families. However, these methods were not used statewide, and the extent of followup in Idaho, as in other States, seemed to depend on the innovation of officials in individual counties or regions. In another region in Idaho very little followup information was available because outreach had been emphasized instead. The program coordinator stated that he lacked the manpower for effective followup.

Rhode Island had a followup system to determine whether children received treatment for conditions identified during EPSDT. All examination forms were reviewed by one official. When a child was referred for treatment, this official sent a letter requesting a caseworker supervisor to contact the family, determine whether treatment was received, and report back to him.

From January through June 1973, the first 6 months of the program, 28 followup letters were sent to caseworker supervisors. As of September 1973, 21 followup reports had been returned. Of the 21 reports returned, 16 reported that children had received treatment, 3 reported that children were scheduled for treatment, 1 report did not specifically mention treatment, and 1 reported no treatment had been sought because the child's symptoms disappeared.

Although this followup system seems effective, it was characterized by timelags between the screening, the notice to social workers, and the report to the State EPSDT official. The entire process often took 3 to 4 months. The average timelag on the seven outstanding reports was about 6 months.

## CONCLUSIONS

The States were identifying large numbers of medical problems for those children screened, but many children were not being treated. The States need to improve their systems to insure that children with problems identified during the screenings are receiving the necessary medical care.

## RECOMMENDATION

We recommend that the Secretary of HEW direct the Administrator, SRS, to require States to establish procedures to followup on children with problems identified during the screening process to insure that needed treatment is provided.

## AGENCY COMMENTS AND OUR EVALUATION

HEW commented that, under the penalty provision of EPSDT regulations, States are required to take steps to assist recipients needing diagnostic and treatment services so that those services will be provided within a reasonable time. HEW will require that States have procedures to insure that needed treatment is provided. HEW will aid the States in this effort by making materials and funds available for training caseworkers in health-related support services. The University of Michigan is under contract to develop these materials.

These actions should help overcome the problems discussed in this chapter.

## CHAPTER 5

## SUPPLEMENTAL INFORMATION PROVIDED BY THE STATES

We gave the eight States included in our review an opportunity to comment on the results of our fieldwork. Each of the States responded and generally agreed that our report was accurate as of the time of our fieldwork. However, they said that much had been done since that time to implement EPSDT.

Several States replied that as of June 30, 1973, HEW regulations required that only children through age 5 be screened and, therefore, the percentage of children that had been screened was higher than reflected in our report.

Several States also indicated concern that the EPSDT statistics did not reflect the number of children receiving screening under other health programs and that EPSDT might duplicate these screenings. However, in most cases, the States could not provide specific statistics on how many children had been screened under other programs or the scope of such screenings. We agree that EPSDT should be coordinated with other programs and that EPSDT efforts should be directed at providing screening and/or treatment to eligible children not receiving these services under other programs. Until the States determine what services children eligible for EPSDT are receiving under other programs, the States cannot effectively direct their EPSDT efforts. Following are summaries of the States' comments.

### ALABAMA

The Director of the Medical Services Administration, Alabama Department of Public Health, agreed that the cost of the EPSDT program concerns all the States but he said that the major problem in Alabama's EPSDT program implementation is the incapacity of available providers to screen, diagnose, and treat the large number of eligible persons on a timely basis, even though Alabama makes optimum use of allied health professionals. He also commented that neither compliance hearings nor fiscal penalties will in any way aid Alabama in solving its problems of trying to provide screening, diagnosis, and treatment for its eligible children.

IDAHO

The Administrator of the Division of Health Services, Idaho Department of Health and Welfare, stated that Idaho's EPSDT program has been expanded since the time of our fieldwork and many of the problems cited in the report have been solved. He commented that Idaho

--is now providing services statewide and has a coordinator at the State level who is working with individual regions to give the program overall unity,

--has developed a "tracking system" to insure that children with problems identified during screening are receiving necessary care, and

--has intensified the outreach portion of the program for informing eligible families.

Because of a shortage of physicians, Idaho is using allied health professionals when possible and, through the Bureau of Child Health, is providing financial assistance to local health departments for training staff members as nurse practitioners.

ILLINOIS

The Director of the Illinois Department of Public Aid commented that many of the children in Illinois were receiving adequate medical attention under the State's Medicaid program and that there was no need to screen these children. He commented that during fiscal year 1972 about 62 percent of the eligible children received one or more types of service identifiable in the medical, dental, or eye care program and that preliminary estimates for fiscal year 1973 indicate that this percentage has increased to 86.2 percent.

He provided statistics which indicated that 19,158 babies received newborn care from 1971 through 1973 and 178,136 children to age 12 received dental prophylaxis during this period.

We talked to Illinois officials to determine how many children received EPSDT-type physicals under programs other than EPSDT. However, these officials were not able to provide us with this information for programs other than the newborn baby program.

MASSACHUSETTS

The Commissioner and Assistant Commissioner of the Massachusetts Department of Public Welfare and the Program Director for EPSDT commented that since the time of our fieldwork Massachusetts has engaged in activities responsive to our recommendations. The following activities have taken place:

--Bilingual notifications were mailed out to all AFDC families with their March 1, 1974, AFDC checks.

--A series of new computer service codes has been developed to enable complete recipient profiles to be established which could be searched for children not receiving proper periodical care or indicated followup.

--Computer printouts, by area, have been obtained.

--Medicaid is currently reimbursing more than 40 neighborhood health centers for outreach, which is one of the services included in the overhead operational cost of the centers.

They also commented that since March 1974 the number of pediatricians with whom Massachusetts has arranged special EPSDT contracts has risen from 50 to over 150. They further mentioned that other EPSDT activities are being researched and/or developed, such as:

--EPSDT outreach policy material for social workers is being developed.

--A system for integrating the Department of Public Welfare's intake process with EPSDT outreach and referrals is being considered.

OREGON

The Director of the Oregon Department of Human Resources agreed that Oregon did not have an EPSDT program in effect at the time of our fieldwork. He pointed out that there was no statutory or regulatory requirement for outreach or follow-up until July 1, 1974, the effective date of Public Law 92-603.

RHODE ISLAND

The Director of the Rhode Island Department of Social and Rehabilitation Services said that for fiscal year 1973, in addition to the 202 EPSDT screenings, there were 1,368 pediatric examinations of newborn babies, 7,022 physical examinations given to children enrolled in various health centers, and 6,500 children were to receive physical examinations required by Rhode Island State law upon entering the 4th, 7th, and 10th grades.

We contacted Rhode Island officials to determine whether these physicals contained all the elements of an EPSDT screening. State officials did not know whether these programs provided screenings as comprehensive as those under EPSDT.

WASHINGTON

The Director of the Washington Department of Social and Health Services commented that Washington now has 146 providers of EPSDT services and has achieved statewide coverage. The total number of children screened through fiscal year 1974 was 20,668 and the total number referred for diagnosis and treatment was 7,999. Local offices are giving high priority to publicizing the program and finding cases for referral. A statewide news release was issued by the State on January 30, 1974, preceded by distribution of television and radio public service announcements provided by HEW.

Providers are invited to contract for providing EPSDT by personal letter, by the department's pediatric consultant, and through county medical societies. Allied health professionals are providing screening services in some rural areas of the State but in other areas no screening services are available.

WISCONSIN

The Secretary of the Wisconsin Department of Health and Social Services commented that the report generally reflects the situation as it was at the time of our fieldwork but that a great deal had been accomplished since then. He reported that:

--By March 1974 screening was underway in seven counties, and nearly all the rest of the counties had begun screening services by the end of April 1974.

--By the end of June 1974 about 5,000 out of the 148,025 eligible children had been screened.

--By the end of June 1974, 100 percent notification of eligible individuals of the availability of EPSDT services was achieved. Newly eligible persons will be informed routinely as part of the initial contact, and personal contacts will be made in selected cases when there is no response to mailed information.

--In 67 counties the public health nurses provide the screening services and are reimbursed for actual costs, and 1 county is served by a nonprofit, community-based health center which is also reimbursed for screening costs. These counties refer patients to other providers for diagnosis and treatment services. In four other counties medical clinics or private physicians provide the screening services and are paid the usual fees for the test administered.

The Secretary also commented that Wisconsin has provided for computerized tracking capability to help insure that referral, diagnosis, and treatment are provided. Claims for payment of appropriate services are indications that services have been rendered. If no claim for payment is made, the local agency will automatically receive notice and be asked to followup to find out why treatment has not been provided.

He noted that many eligible children receive regular, adequate medical care and are not in need of screening. An Interdepartmental Committee on Screening has been formed to consider ways of coordinating the development of EPSDT with screening required by State law on school entry to determine whether a child might have a disability requiring special education services.

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# EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Alabama State Board of Health |
| NUMBER OF ELIGIBLE CHILDREN | 240,000 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED: | | |
| Fiscal year: | | |
| 1970 | 0 | 0 |
| 1971 | 0 | 0 |
| 1972 | 8,032 | 3 |
| 1973 | 30,983 | 13 |
| Total | 39,015 | 16 |
| TYPE OF CONDITIONS FOUND (note a): | | |
| Visual | 1,627 | |
| Hearing | 593 | |
| Dental | 11,596 | |
| Lead poisoning | 0 | |
| Other (note b) | 25,851 | |
| Total | 40,027 | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 29 | |
| Clinics | 0 | |
| Public health departments | 66 | |
| Others | 0 | |
| Total | 95 | |

[a] More than one illness or impairment can be identified for a child.

[b] Includes intestinal parasites, anemic conditions, heart conditions, and any other physical or mental conditions found.

APPENDIX I

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | | |
|---|---|---|
| NAME OF STATE ORGANIZATION | Idaho Department of Environmental and Community Service | |
| NUMBER OF ELIGIBLE CHILDREN | 13,558 | |
| | Number | Percent |
| NUMBER AND PERCENT SCREENED: | | |
| Fiscal year: | | |
| 1970 | 0 | 0 |
| 1971 | 0 | 0 |
| 1972 | 0 | 0 |
| 1973 | 1,594 | 12 |
| Total | 1,594 | 12 |
| TYPE OF CONDITIONS FOUND (note a): | | |
| Visual | 83 | |
| Hearing | 45 | |
| Dental | 420 | |
| Lead poisoning | 0 | |
| Other | 849 | |
| Total | 1,397 | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 0 | |
| Clinics | 0 | |
| Public health departments | 4 | |
| Others | 3 | |
| Total | 7 | |

[a] More than one illness or impairment can be identified for a child.

# EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Illinois Department of Public Aid and Department of Public Health |
| NUMBER OF ELIGIBLE CHILDREN | 583,349 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED (note a): | | |
| Fiscal year: | | |
| 1970 | 0 | 0 |
| 1971 | 0 | 0 |
| 1972 | 1,548 | 0 |
| 1973 | 11,340 | 2 |
| Total | 12,888 | 2 |
| TYPE OF CONDITIONS FOUND (note b): | | |
| Visual | - | |
| Hearing | - | |
| Dental | - | |
| Lead poisoning | - | |
| Other | - | |
| TYPES OF SCREENING PROVIDERS (note c): | | |
| Private physicians | - | |
| Clinics | - | |
| Public health department | - | |
| Others | - | |

[a] These figures represent the number of examinations billed to the State during these years. Screening statistics were available for only 9 months of fiscal year 1973. Illinois commented that children are receiving screening under other programs. (See pp. 29 and 30.)

[b] As of June 30, 1973, this information was not being reported.

[c] Specific numbers of providers are not shown because any medical provider could bill the State for EPSDT services; providers did not have to sign special EPSDT provider agreements as they did in other States.

APPENDIX I

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Massachusetts Department of Public Welfare |
| NUMBER OF ELIGIBLE CHILDREN | 415,800 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED (notes a and b): | | |
| Fiscal year: | | |
| 1970 | - | - |
| 1971 | - | - |
| 1972 | - | - |
| 1973 | - | - |
| Total | - | - |
| TYPES OF CONDITIONS FOUND (note c): | | |
| Visual | - | |
| Hearing | - | |
| Dental | - | |
| Lead poisoning | - | |
| Other | - | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 0 | |
| Clinics | 2 | |
| Public health departments | 0 | |
| Others | 0 | |
| Total | 2 | |

[a] Massachusetts officials informed us that their Medicaid program has provided EPSDT type services since 1968, but the State is having difficulty documenting the screening being performed and the providers.

[b] The Massachusetts Commission for the Blind screened 75 blind children, but this is a separate organization from the Massachusetts Department of Public Welfare so these statistics were not included in the above totals.

[c] As of June 30, 1973, this information was not being reported.

APPENDIX I

EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Oregon Public Welfare Division |
| NUMBER OF ELIGIBLE CHILDREN | 73,521 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED (note a): | | |
| Fiscal year: | | |
| 1970 | - | - |
| 1971 | - | - |
| 1972 | - | - |
| 1973 | - | - |
| Total | - | - |
| TYPE OF CONDITIONS FOUND (note a): | | |
| Visual | - | |
| Hearing | - | |
| Dental | - | |
| Lead poisoning | - | |
| Other | - | |
| TYPES OF SCREENING PROVIDERS (note b): | | |
| Private physicians | - | |
| Clinics | - | |
| Public health departments | - | |
| Others | - | |

[a] Screening had not started as of June 30, 1973.

[b] Provider agreements had not been signed as of June 30, 1973.

APPENDIX I

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Rhode Island Department of Social and Rehabilitative Service |
| NUMBER OF ELIGIBLE CHILDREN | 37,000 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED (note a): | | |
| Fiscal year: | | |
| 1970 | 0 | 0 |
| 1971 | 0 | 0 |
| 1972 | 0 | 0 |
| 1973 | 202 | 1 |
| Total | 202 | 1 |
| TYPES OF CONDITIONS FOUND (note b): | | |
| Visual | 4 | |
| Hearing | 5 | |
| Dental | 0 | |
| Lead poisoning | 0 | |
| Other | 21 | |
| Total | 30 | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 23 | |
| Clinics | 3 | |
| Public health departments | 0 | |
| Others | 0 | |
| Total | 23 | |

[a] Rhode Island commented that it had provided additional screening through other programs to about 15,000 children in fiscal year 1973. (See p. 31.)

[b] More than one illness or impairment can be identified for a child.

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Washington Department of Social and Health Services |
| NUMBER OF ELIGIBLE CHILDREN | 240,000 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED: | | |
| Fiscal Year: | | |
| 1970 | 0 | 0 |
| 1971 | 0 | 0 |
| 1972 | 0 | 0 |
| 1973 | 4,473 | 2 |
| Total | 4,473 | 2 |
| TYPES OF CONDITIONS FOUND (note a): | | |
| Visual | 190 | |
| Hearing | 306 | |
| Dental | 599 | |
| Lead poisoning | 2 | |
| Other | 1,635 | |
| Total | 2,732 | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 48 | |
| Clinics | 13 | |
| Public health departments | 17 | |
| Others | 8 | |
| Total | 86 | |

[a] More than one illness or impairment can be identified for a child.

APPENDIX I

## EPSDT SCREENING STATISTICS AS OF JUNE 30, 1973

| | |
|---|---|
| NAME OF STATE ORGANIZATION | Wisconsin Department of Health and Social Services |
| NUMBER OF ELIGIBLE CHILDREN | 148,025 |

| | Number | Percent |
|---|---|---|
| NUMBER AND PERCENT SCREENED (note a): | | |
| Fiscal year: | | |
| 1970 | - | - |
| 1971 | - | - |
| 1972 | - | - |
| 1973 | - | - |
| Total | - | - |
| TYPES OF CONDITIONS FOUND (note b): | | |
| Visual | - | |
| Hearing | - | |
| Dental | - | |
| Lead poisoning | - | |
| Other | - | |
| TYPES OF SCREENING PROVIDERS: | | |
| Private physicians | 0 | |
| Clinics | 0 | |
| Public health departments | 2 | |
| Others | 0 | |
| Total | 2 | |

[a] One county screened 110 children in March 1973, but the State did not officially start a screening program until July 1973 so these statistics were not included in the above total.

[b] As of June 30, 1973, this information was not being reported.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

SEP 9 1974

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D. C 20548

Dear Mr. Ahart:

The Secretary has asked that I reply to your [July 11, 1974] letter, in which you asked for our comments on a draft report entitled, "Improvements Needed in Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program".

We appreciate the opportunity to review and comment on this report in draft form.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
RESPONSE TO THE GAO AUDIT REPORT ENTITLED

"IMPROVEMENTS NEEDED IN MEDICAID
EARLY AND PERIODIC SCREENING, DIAGNOSIS,
AND TREATMENT PROGRAM"

PREFACE

An item which speaks to all of the report's recommendations is the series of conferences held by the Secretary to reemphasize HEW's commitment to EPSDT. The conferences were held August 9 in Washington, D. C., August 13 in Atlanta, and August 16 in San Francisco. Representatives from the Governors offices were invited as well as State personnel that are responsible for EPSDT. HEW Central Office and Regional Office staff also attended. The Secretary chaired the first conference and his representatives chaired subsequent conferences. It is expected that the primary impact of the conferences would be to emphasize to the States the Federal bureaucracy and the public how strongly the Secretary and HEW are committed to the EPSDT effort.

The Secretary expressed HEW's willingness to impose fiscal sanctions against those States which do not meet Federal requirements. A substantial portion of the conferences were devoted to explaining EPSDT program requirements.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to require the States to improve their methods of informing all eligible families of the availability of EPSDT.

RESPONSE

States are now required to inform AFDC families in writing at least once a year about the EPSDT program; what the program encompasses and how and where services can be obtained. If a State's written notice does not adequately satisfy the above items then the State must provide that information through the use of caseworkers, or other parties designated as responsible for the information function. States that do not adequately inform AFDC families will have their AFDC monies reduced by 1%

per annum assessed quarterly. SRS is currently developing criteria for the application of the 1% penalty which includes the information function. While the 1% penalty applies only to AFDC families the basic program regulation requires that all eligibles must be informed about the EPSDT program. HEW will stipulate that non-AFDC eligibles must be informed in the same manner as the AFDC eligibles. The sanction here for non-compliance would be a conformity hearing. HEW has supplied TV and radio spots to States to use as they see fit.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to encourage and assist the States to use allied health professionals for screening especially in those areas that have a shortage of physicians.

RESPONSE

The GAO report recognizes that HEW guidelines encourage the use of allied health professionals. The Medical Services Administration will continue to emphasize this alternative in technical assistance activities with States. Further, the Health Facilities Foundation of San Francisco is under contract with HEW to develop a manual to be used in the training of allied health professionals that will be working in EPSDT. The manual is scheduled to be available for distribution in October.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to encourage and assist the States to increase their screening efforts in order to insure that all eligible children are screened.

RESPONSE

HEW has encouraged States to make efforts that will insure that screening is available to all eligible children. The program requirements associated with the 1% penalty provision require the States to take an active role in assisting eligibles requesting screening services. This role includes: an explanation of what services are available, where and how services can be obtained, assuring that adequate number of providers are available to provide services normally within 60 days of request and a system to assure that once requested screening services are received.

HEW will make available to providers in August 1974 a "how to" manual on screening.

The recommendation states that HEW should "...insure that all eligible children are screened." It should be noted that many eligible children are under comprehensive care. To screen these children would be a duplication of effort. HEW is supporting efforts by various States to identify children under comprehensive care and concentrate on screening those children not under care.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to encourage and assist the States to establish procedures to insure that screenings are periodically updated.

RESPONSE

All States participating in title XIX now have some type of EPSDT program. Some of the States have taken steps to assure that screenings are periodically updated. HEW is beginning to encourage and assist States to refine their programs, especially in the area of case management. An efficient case management system should assure that screenings are periodically updated.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to monitor the States progress in meeting their screening schedules.

RESPONSE

SRS is developing plans for encouraging, assisting and monitoring States' performance in meeting screening schedules as part of a comprehensive plan of work with States on improved EPSDT implementation. We will be assisting States in identifying causes of delay in meeting schedules and in developing solutions drawn in many instances from our knowledge of successful practices. Some of these plans are necessarily tentative, contingent upon the number and distribution of available staff for EPSDT.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to require the States to establish procedures to follow-up on children with problems identified during the screening process to insure that needed treatment is provided.

RESPONSE

Under the penalty provision, CFR 45, Section 205.146(c)(iii)(b), States are required to take steps to assist recipients needing diagnostic and treatment services so that those services will be provided within a reasonable time period. HEW will require that States have procedures to assure that needed treatment is provided. HEW will aid the States in this effort by making materials and funds available for training caseworkers in health-related support services. The University of Michigan is under contract to develop these materials.

RECOMMENDATION

The Secretary of HEW should direct the Administrator, SRS, to take more aggressive action, including formal compliance hearings, to bring the States into compliance with the law and SRS regulations.

RESPONSE

The Secretary's conference on EPSDT made it very clear that HEW plans to move aggressively against those States which do not meet the 1% penalty criteria. In addition, for those States which continue to be out of compliance with the basic program requirements, or continually refuse to come into compliance with the penalty regulation, HEW will initiate formal compliance action.

APPENDIX III

## PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTERING THE ACTIVITIES DISCUSSED IN THIS REPORT

| | Tenure of office | |
|---|---|---|
| | From | To |
| SECRETARY OF HEALTH, EDUCATION, AND WELFARE: | | |
| Caspar W. Weinberger | Feb. 1973 | Present |
| Frank C. Carlucci (acting) | Jan. 1973 | Feb. 1973 |
| Elliot L. Richardson | June 1970 | Jan. 1973 |
| Robert H. Finch | Jan. 1969 | June 1970 |
| Wilbur J. Cohen | Mar. 1968 | Jan. 1969 |
| John W. Gardner | Aug. 1965 | Mar. 1968 |
| ASSISTANT SECRETARY FOR HEALTH: | | |
| Dr. Charles C. Edwards | Apr. 1973 | Present |
| ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE: | | |
| James S. Dwight, Jr. | June 1973 | Present |
| Francis D. DeGeorge (acting) | May 1973 | June 1973 |
| Philip J. Rutledge (acting) | Feb. 1973 | May 1973 |
| John D. Twiname | Mar. 1970 | Feb. 1973 |
| Mary E. Switzer | Aug. 1967 | Mar. 1970 |
| COMMISSIONER, MEDICAL SERVICES ADMINISTRATION: | | |
| Dr. Keith Weikel (acting) | July 1974 | Present |
| Howard N. Newman | Feb. 1970 | July 1974 |
| Thomas Laughlin, Jr. (acting) | Aug. 1969 | Feb. 1970 |
| Dr. Francis L. Land | Nov. 1966 | Aug. 1969 |

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