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# Coverage of Vision Services under the State Children's Health Insurance Program (SCHIP)

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## Summary

A small but significant proportion of children have visual impairments. When detected early, many childhood vision abnormalities are treatable, but the potential for correction and normal visual development diminishes with age. Under SCHIP, states may provide coverage by expanding Medicaid or creating a separate SCHIP program or both. Medicaid and SCHIP provide access to an array of vision-related services, including vision screening services that can help children in low- to moderate-income families overcome these difficulties.

Medicaid's mandatory Early, and Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit ensures access to vision screening services for children. However, there are several other Medicaid benefit categories where vision screening services may be delivered. Often such services are billed as a part of a well-child visit. Under SCHIP, state-specific benefit packages must provide well-baby and well-child care, which includes a vision screening component. As with Medicaid, the well-child coverage requirement is not the only service category where children could receive vision screening under SCHIP. Children may also receive vision screening services under other SCHIP-covered services such as physician services.

A June 2000 CRS benefits survey provides some clues as to access to vision services under SCHIP Medicaid expansion and separate state programs. At that time, nearly all Medicaid and SCHIP programs covered vision services for children, and most also covered eye glasses. The survey data indicates that the breadth of vision-related benefits available under these two programs likely differs within and across states.

Coverage policies and benefit limits for the lowest-income children as described in state Medicaid plans are seldom absolute because of EPSDT. For nearly all Medicaid children, states are required to provide all federally allowed treatment to correct identified problems, even if the specific treatment needed is not otherwise covered under a state's Medicaid plan. As a result, when a Medicaid agency reports that a specific benefit is not covered for children, that means the service is available only when delivery of that service meets the EPSDT requirement.

Services for higher-income children under SCHIP are sometimes more restrictive. Unlike Medicaid, but consistent with federal statute, separate SCHIP programs are modeled after private sector, commercial insurance products. The requirement to use benchmark plans (or actuarial equivalents of those plans), most of which are state employee health plans or commercial HMO plans, provides the framework for defining benefit limits. Under commercial insurance products, benefits are always limited by medical necessity, but other limits may apply and will vary by insurance product, as do procedures to monitor for medical need and appropriateness. Payments to providers participating in these plans may be altered based on the outcome of such service utilization reviews, which can in turn affect access to care. This report will not be updated.

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# Coverage of Vision Services under the State Children's Health Insurance Program (SCHIP)

## Background

According to the American Academy of Pediatrics, in 2002, vision disorders were the fourth most common disability among children in the United States, and the leading cause of impaired conditions among children ages 0 through 18. Among preschool-aged children, as many as 2 to 5% were estimated to have impaired vision. However, of the estimated 21% of preschool aged children that received vision screening (i.e., services to detect poor vision or risk factors that interfere with vision and normal visual development), 14% received a comprehensive vision exam provided by an optometrist, or ophthalmologist appropriately trained to treat pediatric patients.[1]

Young children are particularly vulnerable to conditions that interfere with vision and visual development. When detected early, many childhood vision abnormalities are treatable, but the potential for correction that will lead to normal visual development diminishes with age. Thus, early detection and treatment are necessary to ensure the best possible outcome. Common vision disorders or abnormalities in visual development among children include the following:[2]

- *Amblyopia.* Amblyopia, or lazy eye, is diminished vision in one eye resulting from altered visual development where the part of the brain that controls vision favors one eye over the other. If the weaker eye is untreated, eyesight will progressively worsen. This disorder is the most common cause of vision loss in children in the United States, affecting approximately 5% of the child population.[3] Treatment for amblyopia includes corrective lenses; eye surgery; miotic eye drops; or other therapies including occlusion (i.e., covering) of the opposite eye; or optical blurring. Amblyopia is often caused by:

  — *Strabismus.* A misalignment of the eyes resulting in one eye being used less than the other;

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[1] *Pediatrics,* vol. 109, no. 3, Mar. 2002, pp. 524-525.

[2] Monte D. Mills, "The Eye in Childhood," *American Academy of Family Physician,* Sept. 1, 1999.

[3] [http://www.visionchannel.net/amblyopia/]

— *Anisometropia.* Unequal refractive components of the eye (e.g., one eye may be nearsighted and the other farsighted). This disorder results in images that are not focused simultaneously, so the brain favors the stronger eye;
— *Deprivation.* Includes vision problems where something (e.g., cataracts, ptosis, and corneal scars) interferes with equal visual development in both eyes;
— *Accommodating estropia.* Excessive reflexive convergence or cross eyes;
— *Nystagmus.* Involuntary, rhythmic oscillation of the eyes caused by bilateral poor vision or abnormal motor input;
— *Retinopathy of prematurity (ROP).* ROP is a vision disorder of developing blood vessels that occurs in premature newborns (i.e., those born at less than 32 weeks);

- *Refractive errors.* Nearsightedness (myopia), farsightedness (hyperopia), and astigmatism;
- *Ocular Diseases.* Such as optic nerve disorders and ocular motility disorders; and
- *Color Vision Defects.* Defects in color vision where a person has difficulty distinguishing between colors that are on the "confusion lines" (e.g., yellow and blue, or yellow and violet).

Children's vision screening services to detect such eye problems have long been a mandated part of several federal health programs including the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) under Medicaid,[4] Head Start,[5] and some of the children's programs under the Maternal and Child Health (MCH) block grant.[6] Medicaid regulations require state Medicaid agencies to coordinate child health initiatives (including health screening services) with Title V (Maternal and Child Health) programs, and with other related programs such as Head Start. In addition, the Education of the Handicapped Act[7] mandates vision screening for children with disabilities and/or developmental delays that enter early intervention programs. Early intervention programs provide an array of services and supports for children with special needs, and for their families.

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[4] Section 1905(r) of the Social Security Act.

[5] U.S. Department of Health and Human Services, *Head Start: A Child Development Program.* Washington, DC, Department of Health and Human Services, 1981, DHHS Publications No. (OHDS) 81-30192.

[6] U.S. Department of Health and Human Services, *Legislative Base Maternal Child Health Programs,* Washington, DC, Department of Health and Human Services, 1980, DHHS Publication Number (HSA) 80-5221.

[7] 20 U.S.C. § 1400.

## What Are Vision Services and What Types of Providers Deliver Vision Services?

To provide context for the discussion that follows, this section describes various vision services, and the types of providers that generally offer such services.

**Vision Screening Services.** Vision screening services include procedures to detect poor vision or risk factors that interfere with vision and normal visual development. Such services may be provided in a variety of settings (e.g., schools, health clinics, child care settings, optometrist's office, etc.), and may be conducted by a variety of qualified health service providers (e.g., school nurses, parent volunteers, medical practitioners, optometrists, etc.).

**Primary Vision Care and Related Services.** Optometrists provide most primary vision care. Primary vision care includes eye exams to diagnose vision problems and eye diseases, and to test patients' visual acuity, depth and color perception, and ability to focus and coordinate the eyes. In general an optometrist's role is to analyze test results and develop a treatment plan. Optometrists prescribe eyeglasses and contact lenses and provide vision therapy and low-vision rehabilitation. They are qualified to administer drugs to patients to aid in the diagnosis of vision problems and to prescribe drugs to treat some eye diseases. Optometrists often provide preoperative and postoperative care to patients who have vision correction or other eye surgery. They also diagnose conditions due to systemic diseases such as diabetes and high blood pressure, referring patients to other health practitioners as needed.

Ophthalmologists are physicians who specialize in eye care. Like optometrists, they provide primary vision care services like those listed above; however, in addition, they diagnose and treat eye diseases, deformities, and injuries that require surgery.

**Eye Surgery.** Eye surgery includes procedures performed by ophthalmologists to correct physical deformities, or to repair tissue after injuries, or preventive surgeries on patients with debilitating diseases or disorders.

**Eye Glasses and Corrective Contact Lenses.** Eyeglasses and contact lenses are aids to vision prescribed by a physician skilled in diseases of the eye or by an optometrist. Opticians fit eye glasses and, in some states, may fit contact lenses according to prescriptions written by ophthalmologists or optometrists. Some opticians specialize in fitting contacts, artificial eyes, or cosmetic shells to cover blemished eyes.

## Screening of Vision Disorders among Children

Despite the prevalence of vision disorders among children, vision screening programs to detect poor vision or risk factors that interfere with vision and normal

visual development vary by state and by geographic region.[8] A 1999 vision screening policies and procedures survey among the 50 states and the District of Columbia showed that 34 states had guidelines for pre-school age vision screening, even though consensus among vision care experts recommends that eye screenings occur as early as childbirth. Two additional states (i.e., Virginia, and Washington) had preschool vision screening guidelines, but only for children with disabilities. Further, in most states, mandatory vision screening did not occur until the children entered kindergarten. The survey also indicated that there was little consensus across states on the ages at which children should be screened, the areas of vision that should be evaluated, the appropriate tests to administer, or the types of personnel that should administer the screening (e.g., school nurses, aides, teachers, volunteer parent assistants, medical practitioners, trained technicians, etc.). The authors concluded that even among states with well-established vision screening policies, there is no guarantee that the procedures in place would effectively identify children who require further examination by a trained eye care specialist (i.e., optometrist, or ophthalmologist).[9]

In April 2003, four professional organizations[10] concerned with children's eye care developed guidelines to be used by physicians, nurses, educational institutions, public health departments, and other professionals who perform vision screening services for infants, children, and young adults. The guidelines establish that eye examinations and vision screening should be performed on newborns at birth, and at all well-child visits. In addition, visual acuity measurement tests (e.g., picture tests, Snellen numbers, or the tumbling E test) should be performed as early as possible, usually at 3 years of age. The guidelines also establish criteria for appropriate number, timing, and age-appropriate procedures for each eye evaluation. Finally, the guidelines recommend that children found to have an ocular abnormality or who fail vision screening should be referred to a pediatric ophthalmologist or an eye care specialist appropriately trained to treat pediatric patients.[11]

Many of the public health programs listed above (e.g., Head Start, Medicaid's EPSDT program, and MCH) with mandatory vision screening requirements rely instead on the *Recommendations for Preventive Pediatric Health Care* periodicity schedules developed by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics (AAP) to establish vision screening guidelines for their program enrollees.[12] As compared to the 2003 vision screening standards

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[8] [http://www.medicalhomeinfo.org/screening/Screen%20Materials/PUPVS_%7E2.DOC].

[9] Johanna Seddon and Donald Fong, eds. *Public Health and the Eye: A Survey of Vision Screening Policy of Preschool Children in the United States,* Survey of Ophthalmology, vol., no. 5, Mar.-Apr. 1999.

[10] The four eye care professional organizations include (1) the American Academy of Pediatrics (AAP), (2) the American Association of Certified Orthoptists, (3) the American Association for Pediatric Ophthalmology and Strabismus, and (4) the American Academy of Ophthalmology.

[11] *Pediatrics,* vol. 111, no. 4, Apr. 2003.

[12] Centers for Medicare and Medicaid Services (CMS), *State Medicaid Manual,* Part 5,

(continued...)

mentioned above, the AAP's recommendations are far less detailed in that they do not identify specific age-appropriate procedures for each eye evaluation, or the level of training required by individuals who perform the screenings. Instead, they indicate ages for which vision screening should be performed either subjectively based on the child's medical history, or objectively based on a standard testing method.

# The SCHIP Program

## Background

SCHIP was established in 1997 under a new Title XXI of the Social Security Act, and provides health insurance to certain uninsured children in families with modest income. A total of $39.7 billion has been appropriated for SCHIP for FY1998 through FY2007. Approximately, 5.8 million children were enrolled in SCHIP during FY2003. Nationally, through FY2003, $13.7 billion in federal dollars had been spent under the program.

In general, Title XXI defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States may set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL),[13] or if the applicable Medicaid income level for children is at or above 200% FPL prior to SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. As of FY2002, the upper income eligibility limit under SCHIP had reached 350% FPL (in New Jersey). Nearly one-half (24) of the states and the District of Columbia had established upper income limits at 200% FPL. Another 13 states exceeded 200% FPL. The remaining 13 states set maximum income limits below 200% FPL.

Within these general rules, states may provide child health assistance to qualifying children in two basic ways. They may cover children under their Medicaid programs, and/or they may create a separate SCHIP program. (More details on available benefits under each approach are described in the next section.) When states provide Medicaid coverage to targeted low-income children, Medicaid rules typically apply. When states provide coverage to targeted low-income children through separate SCHIP programs, Title XXI rules typically apply. In both cases, the federal share of program costs comes from federal SCHIP appropriations. As of July 2004, 17 states had Medicaid expansions, 18 had separate state programs, and 21 used a combination approach.[14]

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[12] (...continued)
Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, Section 5360, pp. 5-57. Available on CMS's website at [http://www.cms.hhs.gov/manuals/pub45/pub_45.asp].

[13] In 2002, the poverty guideline in the 48 contiguous states and D.C. was $18,850 for a family of four. Information available at [http://aspe.hhs.gov/poverty/04poverty.shtml].

[14] Some states classified as "separate state program states" have more than one such program. Program totals include the outlying areas.

Title XXI does not establish an *individual* entitlement to benefits. Instead, Title XXI entitles *states* with approved state plans for Medicaid coverage or separate SCHIP programs to predetermined federal allotments based on a distribution formula set in the law. However, targeted low-income children covered under Medicaid are entitled to the benefits offered under that program as dictated by Medicaid law. No such individual entitlement exists for targeted low-income children covered in separate SCHIP programs.

## Vision-Related Benefits under SCHIP Medicaid Expansion Programs

Under Medicaid (including SCHIP Medicaid expansion programs), some benefits are mandatory and others may be covered at state option. States that choose to expand Medicaid to new eligibles under SCHIP authority must provide the full range of mandatory Medicaid benefits for the categorically needy, as well as all optional services covered.[15]

Some categories of service have an obvious connection to vision screening, while others do not. This is in part due to the fact that many of the benefit categories listed in statute identify a type of provider or care setting rather than a type of service. For example, as discussed above, a wide variety of qualified providers may deliver vision screening services under Medicaid, including physicians, optometrists, and other qualified providers, and enrollees may access vision-related services in a variety of settings such as a hospital or a rural health clinic. The Medicaid *mandatory* categories of service that all states must offer to their categorically needy groups, and that are likely to include vision-related benefits such as vision screenings, eye exams, and treatment of eye diseases or visual impairments (e.g., eye surgery or eye glasses), are:

- inpatient hospital services;
- outpatient hospital services;

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[15] The two broad eligibility categories described in Medicaid statute include categorically needy and medically needy. Categorically needy refers to low-income families and children, aged, or individuals who are blind or have a disability, and certain pregnant women who are eligible for Medicaid. Medically needy individuals are persons who fall into one of the categorically needy groups but whose income and resources are too high to qualify as categorically needy. (42 C.F.R. §435.4).

Special benefits rules apply if states choose to cover medically needy populations. States may offer a more restricted benefit package for those enrollees but are required, at a minimum, to offer the following: prenatal and delivery services for pregnant women; ambulatory services for individuals under 18 and those entitled to institutional services; and home health services for individuals entitled to nursing facility services. Broader requirements apply if a state has chosen to provide coverage for medically needy persons in institutions for mental disease and intermediate care facilities for the mentally retarded. If so, the state is required to cover either all of the mandatory services, or alternatively, the optional services listed in any seven of the categories of care and services in Medicaid law defining covered benefits.

- physician services (e.g., including optometrists);[16]
- rural health clinic services;
- federally qualified health center services;
- other laboratory and X-ray services (e.g., opthalmoscopy to view and analyze diseases of the optic nerve);
- certified pediatric and family nurse practitioners; and
- early and periodic screening, diagnosis and treatment (EPSDT) for persons under age 21 years (more on this benefit below).

Categories of *optional* benefits that can include vision care are:

- eye glasses;
- clinic services;
- certain diagnostic, screening, preventive, and rehabilitative services;
- certain nurse practitioner services;
- certain targeted case management services; and
- prescription drugs.

Finally, under Medicaid, states can apply for waivers to modify virtually all aspects of their programs without congressional review. Under the Section 1115 waiver authority, states may test a major restructuring of their Medicaid program. States have the flexibility to experiment with different approaches for the delivery of health care services, or to adapt their programs to the special needs of particular geographic areas or groups of recipients. As of the fall of 2003, there were 53 operational Medicaid Section 1115 waiver programs in 32 states and the District of Columbia. While none of these waivers specifically focus on vision-related benefits, some provide access to such services through redefined benefit packages, and/or provide vision-related services for population groups that would not otherwise be covered such as parents and childless adults.

**Medicaid's EPSDT Service Category.** Coverage policies and benefit limits for children under Medicaid are seldom absolute in part because of special provisions in the law requiring that children receive all medically necessary services authorized in federal statute through the EPSDT program. The EPSDT program provides screening and preventive care to nearly all groups of Medicaid beneficiaries under 21 years of age.[17] Furthermore, under EPSDT, *states are required to provide all federally-allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a state's Medicaid plan*.[18] Thus, states may be required to cover some services for children that would be optional or not covered at all for adults. This guarantee does not exist in SCHIP. Instead, SCHIP children have access to benefit packages modeled after

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[16] A doctor of optometry, though not an M.D., is considered a "physician" for all the covered vision care services he/she is legally authorized to perform in the state in which he/she performs them. (Social Security Act §1861(r), and 42 C.F.R. § 410.20(b)).

[17] EPSDT is not a mandatory benefit for the medically needy, although states that choose to extend EPSDT to their medically needy population must make the benefit available to all individuals under age 21.

[18] Social Security Act §1905(r).

private sector, commercial insurance products. Under commercial insurance products, benefits are always limited by medical necessity, but other limits defining coverage may exist as well.

At a minimum, vision screening services under EPSDT must include diagnosis and treatment for defects in vision and must cover eyeglasses. States set distinct standards and protocols for each component of the EPSDT services, including vision screenings.[19] State-specific periodicity schedules to determine the type of procedure to use, and the criteria for determining when a child should be referred for further diagnostic examination must meet reasonable standards of medical practice established by the state after consultation with recognized pediatric medical organizations. Unlike state periodicity schedules for general medical screening services, the Centers for Medicare and Medicaid Services (CMS) *does not* require states to submit their vision care periodicity schedules as a part of their Medicaid state plan for approval by CMS. However, most states' vision care periodicity schedules are in accordance with the recommendations of the American Academy of Pediatrics (AAP).[20]

The *State Medicaid Manual* explains that EPSDT exams must be performed by, or under the supervision of, a certified Medicaid physician, dentist, or other provider qualified under state law to furnish primary medical and health services. EPSDT screening services may be provided in several settings including state and local health departments; school health programs; programs for children with special health needs; Maternity and Infant Care projects; children and youth programs; Head Start programs; community health centers; well-child and rural health clinics; medical/dental schools; prepaid health care plans; developmental disability agencies; university-affiliated facilities; day care centers; rehabilitation agencies and voluntary health organizations. EPSDT qualified providers may include nurse practitioners, nurse midwives, registered nurses, physician assistants, private practitioners, and/or any other licensed practitioners. With such a broad range of service delivery settings and qualified provider arrangements, tracking operational vision screening practices under the EPSDT requirement within a state is complex.

***EPSDT Program Data.*** States must submit an annual EPSDT report (i.e., CMS Form 416) to CMS with basic program participation information. The current CMS Form 416 records the number of children by age group (i.e., less than 1 year old, 1-2 years of age, 3-5 years of age, 6-9 years of age, 10-14 years of age, 15-18 years of age, and 19-20 years of age) and by basis of Medicaid eligibility (i.e., categorically needy, or medically needy) who:

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[19] Section 1905(r) of the Social Security Act specifies that each state must develop its own periodicity schedule for screening, vision, hearing and dental services after appropriate consultation with medical and dental organizations involved in child health care. By law, the CMS may not require states to use any particular periodicity schedule for the delivery of EPSDT services under Medicaid. (For more details, see CMS, *State Medicaid Manual:* Part 5: *Early and Periodic Screening Diagnostic and Treatment Services,* Section 5124, pp. 5-19.)

[20] Personal communication with Cindy Ross, CMS, May 3, 2004.

- are eligible for EPSDT services;
- have received child health screening services;
- are referred for corrective treatment;
- have received dental services;
- are enrolled in managed care; and/or
- are screened for blood lead tests.

For purposes of reporting on this form, child health screening services are defined as initial or periodic screens according to a state's screening periodicity schedule. States are instructed to report children who received a full medical screen including a comprehensive health and developmental history; a comprehensive unclothed physical exam; immunizations, when appropriate; laboratory tests, including lead testing, when appropriate; and health education and anticipatory guidance. On the current CMS Form 416, children receiving only vision screening services and/or hearing screening services are not counted as having received a medical screen.

Prior to FY1999, the CMS Form 416 also tracked the number of children who received vision screens, and/or hearing screens. FY1998 was the last year vision screening data were available from the CMS Form 416, and the last year for which CMS 416 data are available for all 50 states and the District of Columbia. In FY1998, 21.7 million children were eligible for the EPSDT program. Of those eligible children, 3.1 million (14.2%) received a vision screen. In that year, children age 6 through 14 were among those most likely to receive a vision screen.[21] These data should be interpreted with caution, however, because as discussed above there are several other Medicaid benefit categories (e.g., rural health clinic services and physician services) where vision screening services may have been rendered.

## Vision-Related Benefits under SCHIP Separate State Plans

The SCHIP statute defines child health assistance to include a wide range of coverable benefits. As with Medicaid, some categories of service have an obvious connection to vision-related benefits while others do not. The categories of service that may include vision screening and corrective eye treatment are:

- inpatient hospital services;
- outpatient hospital services;
- physician services;
- surgical services;
- clinic services (including health center services) and other ambulatory health care services;
- prescription drugs and biologicals and the administration of such drugs and biologicals;
- over-the-counter medications;
- laboratory and radiological services;

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[21] CMS Form 416, *Annual EPSDT Participation Report, All States, FY1998,* available at [http://www.cms.hhs.gov/medicaid/epsdt/ep1998n.pdf]

- durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eye glasses, and adaptive devices);
- nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting;
- any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (if recognized by state law, and prescribed, furnished or supervised by a physician or other licensed practitioner or state- or local-government operated health care facility); and
- any other health care services or items specified by the Secretary and not excluded under this section.

Under SCHIP separate state programs, states do not simply select among these benefits in establishing what is and is not covered. Rather, states choose from any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to beneficiaries. The option chosen determines the set of covered benefits under separate SCHIP programs.

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program (FEHBP); (2) the health coverage that is offered and generally available to state employees in the state involved; and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care (more discussion on this requirement below), including age-appropriate immunizations.[22] Benchmark equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services.[23]

SCHIP regulations define well-baby and well-child services as: (1) healthy newborn inpatient physician visits, including routine screening including vision screenings (whether provided on an inpatient or on an outpatient basis); (2) routine physical examinations; (3) laboratory tests relating to their visits; (4) immunizations, and related office visits; and (5) when covered under the state plan (at the state's

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[22] Social Security Act § 2103(c)(1).

[23] Social Security Act § 2103(a)(2)(C).

option) routine preventive and diagnostic dental services.[24] As with Medicaid, CMS *does not* require states to submit their well-baby and well-child or vision screening periodicity schedules as a part of their SCHIP state plan, nor (except in the case of immunizations) has CMS endorsed a specific professional standard (i.e., periodicity schedule) for well-baby and well-child care coverage under SCHIP plans. Apart from immunizations and dental services, CMS allows states to define well-baby and well-child care for coverage purposes.

Finally, as with Medicaid, states may apply for Section 1115 waivers to modify program rules that establish special programs or demonstration projects to accommodate unique needs. Currently, 12 states have such waivers under SCHIP. While none of these waivers specifically focus on vision-related services, like some of the Medicaid Section 1115 waiver programs, they may provide access to such services through redefined benefit packages, and/or provide vision-related services for population groups that would not otherwise be covered.

# Scope of Vision-Related Benefits for Children: A Snapshot of Selected Medicaid and SCHIP Coverage Policies in FY2000

## Survey Design and Data Caveats

In 2000, the Congressional Research Service (CRS) contracted with the National Academy for State Health Policy (NASHP) to collect data from Medicaid and SCHIP state agencies on limits placed on selected benefits for children under each program. Two parallel survey instruments[25] were developed with extensive input from state officials; one for Medicaid programs and one for separate state SCHIP programs. The benefits data collected from these surveys represent general program policies as of June 2000.

For each benefit category listed on the survey, respondents indicated the amount of each service children could receive without special permission, that is, before prior authorization[26] was required. If there was no point at which prior authorization for

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[24] 42 C.F.R. § 457.520.

[25] These surveys covered other topics in addition to benefits for children. In the Medicaid survey, detailed data were also collected on eligibility rules and the extent and scope of managed care activities for all Medicaid populations. The SCHIP survey covered many other major aspects of program policy (e.g., eligibility rules, administrative services, outreach activities, employer-sponsored insurance, healthcare marketplace, public input methods, coordination with other state agencies, managed care policies, cost-sharing, and crowd-out prevention). For information on results from these other survey components, go to [http://www.nashp.org].

[26] Prior authorization, also referred to as precertification or preadmission screening, means that an entity other than a provider (e.g., state Medicaid agency, fiscal agent, or other contractor) must approve the delivery of a specific service to a specific beneficiary or the

(continued...)

continued services was necessary, the benefit was identified as unlimited. State officials could also indicate that limits for a specific benefit were absolute, meaning that children could not receive more than the specified amounts even with prior authorization.

For Medicaid, including Medicaid expansion programs under SCHIP, survey results were reported for all 50 states and the District of Columbia. For SCHIP, survey results were reported for a total of 41 separate programs in 33 states, representing the universe of such states and programs in June 2000. Two states (California and New Jersey) had two SCHIP programs with different benefit plans, and three states (Connecticut, Florida, and Massachusetts) each had three SCHIP programs with different benefit plans.

Four service categories, all of which could include vision-related benefits such as vision screenings, eye exams, treatment of eye diseases or visual impairments (e.g., eye surgery or eye glasses) were included. These were well-child care (non-EPSDT), physician services (SCHIP survey only),[27] vision services, and eye glasses.

There is no direct one-to-one correspondence between any one of the four service categories included on the surveys and a single coverable benefit listed in Medicaid statute. Vision screening services for children under Medicaid typically occur as a part of a well-child visit under the category of service called "diagnostic, screening, preventive, and rehabilitative services," or under the EPSDT benefit.[28] In addition, vision screening services rendered to a child are not always identifiable in Medicaid claims-level data as they are often billed as a part of other well-care screening service visits.[29] Comprehensive vision exams (i.e., exams provided by an ophthalmologist or an eye care specialist appropriately trained to treat pediatric patients) are generally covered under the physician services category, but may also be covered under other service categories such as EPSDT, or under the optional benefit listed above called diagnostic, screening, preventive, and rehabilitative services. Eye surgery and prescription drugs to treat eye diseases may be covered under physician services, pharmacy, or outpatient hospital services. Finally,

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[26] (...continued)
Medicaid agency will not reimburse the provider for that service. Examples of other common utilization controls include (1) concurrent review, which means an authorized entity (e.g., state Medicaid agency, or a contractor) reviews services while they are being provided to a given beneficiary; for example, hospital stays may be subject to concurrent review when they exceed a specified length of stay, and (2) utilization review, which is a generic term encompassing all reviews of service provision — whether they happen prospectively, concurrently, or retrospectively.

[27] The amount, duration, and scope of physician services was not captured on the Medicaid portion of the benefits survey because coverage of physician services is mandatory under Medicaid. When medically necessary for children, *all* benefits (mandatory or optional) are essentially unlimited due to EPSDT.

[28] Personal communication with Cindy Ruff, CMS, May 4, 2004.

[29] The state Medicaid manual does not require states to break out vision services from other screening services under EPSDT. Also as discussed above, the CMS Form 416 no longer captures vision screening services separately from other screening services.

eyeglasses, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist are often covered under Medicaid's eye glasses service category or EPSDT, but may be covered under a different benefit category depending on the state.

Like Medicaid, SCHIP has more than one benefit category listed in statute that would encompass vision screening services. Several could apply here (e.g., physician services, clinic services and other ambulatory health care services, and any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services).

In sum, each of the four categories of service used in the surveys likely corresponds to multiple benefits listed in both Medicaid and SCHIP statute. This is an important problem for the survey design because very different limits may apply to "vision screening services," as included on the surveys, when delivered as a "physician service" versus a "medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative service," for example. For this reason, the survey data are imprecise.

To further complicate the picture, both Medicaid and SCHIP programs rely on managed care organizations (MCOs) to deliver services to most beneficiaries, especially for children without disabilities.[30] There are likely to be variations in coverage of, and limits placed on, specific benefits across Medicaid and/or SCHIP managed care plans in a given state. Detailed data on variations in benefit limits specific to individual managed care contracts under each state program, which can differ from the general criteria delineated in SCHIP state plans as reported here, were *not* captured.

Also, these data date from 2000. While these survey data serve as a baseline documenting general coverage policies in place during a strong economic period when many states were expanding their Medicaid and SCHIP programs, states may have changed coverage policies since that time.[31] The results from the two surveys represent general, statewide benefit limit policies for broad classifications of vision-related services for children under each program. The importance of these survey

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[30] Under SCHIP, managed care is the predominant service delivery system. At the time of the CRS-sponsored survey (June 2000), all but five SCHIP programs (AL, NC, ND, WV, and WY) contracted with one or more managed care plans to deliver care to SCHIP children. CA, for example, contracted with 23 comprehensive health plans.

[31] Faced with declining state revenues and increasing medical care expenses, states implemented a number of cost containment strategies for fiscal years 2003 and 2004. According to the National Association of State Budget Officers, *Medicaid and Other State Healthcare Issues: Current Trends,* June 2003, a majority of the Medicaid cutbacks focused on containing prescription drug costs, reducing provider reimbursement rates, and eliminating or reducing optional services and populations (e.g., eliminating coverage for certain qualified alien children, and eliminating optional services such as dental, optometry, and podiatry services). Under SCHIP, about one third of states implemented cost containment measures in FY2003 or planned to do so in FY2004. Examples of such containment strategies include capping program enrollment, increasing beneficiary cost-sharing requirements, and reducing provider payment rates.

results lies in the identification of the different *methods* states use in their Medicaid versus SCHIP programs to define the breadth of these services for children.

## General Coverage Policies and Methods for Limiting Benefits

For each of the four vision-related benefit categories included in the CRS-sponsored surveys, **Tables 1 through 4** provide a summary of whether the service is covered, and general information about service limits and monitoring activities for Medicaid and separate SCHIP programs across states. The general coverage policies and methods for limiting benefits are summarized below. **Appendices A through D** provide information on the specific limits and monitoring activities identified by states for their Medicaid and SCHIP programs (when applicable) as of June 2000.

**Well-Child (non-EPSDT) Services.** As of June 2000, 11 out of 51 Medicaid programs did *not* cover well-child services *outside of EPSDT*. By contrast, all 33 states covered well-child services for children in at least one of their SCHIP programs (only Connecticut-B and Connecticut-C did *not* cover this benefit under SCHIP).[32] This difference is likely due to the fact that under Medicaid, states cover well-child care and screening services under the mandatory EPSDT benefit instead. Under Medicaid, and SCHIP, approximately two-thirds of the programs reported that well-child care services for children were unlimited (see **Table 1**).

Under SCHIP, of the eight programs with specified limits and/or monitoring of well-child services, three programs (Arizona, California-A, and California-B) reported that the amount, duration, and scope of those services varies by MCO. Four of the five remaining programs (Alabama, North Carolina, North Dakota, and West Virginia) reported that the well-child visits follow AAP guidelines, and/or the state-specific periodicity schedule. Under four SCHIP programs (Connecticut-A, Indiana, Mississippi, and New York), well-child quantity limits were not specified (see **Appendix A**).

[32] The state's separate child health program (CT-B) covers uninsured children whose family income is at or below 300 % of the federal poverty level. Children with special needs who are eligible for the wrap-around services offered in (CT-C) receive medically necessary services under (CT-A).

## Table 1. Coverage of, and Limits for Monitoring of Well-Child (Non-EPSDT) for Children under Medicaid and SCHIP (as of June 2000)

| Program classifications | Medicaid (51 programs in 50 states and DC) | | SCHIP (41 programs in 33 states) |
|---|---|---|---|
| | CN only | CN + MN | |
| Programs that do *not* cover well-child (non-EPSDT) services | *NOTE: Under Medicaid, all states cover well-child care and screening services under the mandatory EPSDT benefit. The states listed below chose not to cover well-child care and screening services outside of EPSDT as well.* | | 2 — CT-B, and CT-C |
| | *3 — AL, MS, and WY* | *8 — FL, LA, MA, NC, OK, TX, VA, and WA* | |
| Programs with *unlimited* well-child (non-EPSDT) services | 10 — AK, CO, DE, IN, MO, NM, NV, OR, SC, and SD | 24 — AR, CA, CT, DC, GA, HI, IA, KS, KY, MD, ME, MI, MN, MT, ND, NE, NH, NJ, NY, PA, RI, VT, WI, and WV | 27 — CO, DE, FL-A, FL-B, FL-C, IA, IL, KS, KY, MA-A, MA-B, MA-C, ME, MI, MT, NH, NJ-A, NJ-B, NV, OR, PA, TX, UT, VA, VT, WA, and WY |
| Programs *with* specified limits and/or monitoring of well-child (non-EPSDT) services | 3 — AZ, ID, and OH | 3 — IL, TN, and UT | 8 — AL, AZ, CA-A, CA-B, GA, NC, ND, and WV |
| Programs for which limits were *not* specified | 0 | 0 | 4 — CT-A, IN, MS, and NY |

**Source:** Congressional Research Service (CRS) analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** State abbreviations are used in this table. In the Medicaid column, the subcolumn labeled "CN only"means that coverage, limitations and monitoring of vision services apply only to beneficiaries classified as categorically needy, and the subcolumn labeled "CN+MN" means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the "CN only" or the "CN+MN" subcolumns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states without medically needy programs were Arkansas, Alabama, Arizona, Colorado, Delaware, Idaho, Indiana, Missouri, Mississippi, New Mexico, Nevada, Ohio, South Carolina, South Dakota, and Wyoming. These 15 states are always listed in the "CN only" subcolumn. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with

different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., California-A, California-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., Connecticut-A, Connecticut-B, Connecticut-C).

**Physician Services.** States were not required to report the amount, duration, and scope of physician services on the Medicaid benefits survey because coverage of physician services is mandatory under Medicaid. When medically necessary for children, *all* benefits (mandatory or optional) are essentially unlimited due to EPSDT. Under SCHIP, most programs (40 of 41 programs) covered physician services for children (see **Table 2**).[33] States were not required to report quantity limits for physician services as the types of physicians covered under this benefit are diverse (e.g., dentists, ophthalmologists, and various physician specialists), and SCHIP programs generally allow for coverage that is within the scope of practice within each given discipline (see **Appendix B**).

### Table 2. Coverage of, and Limits for Monitoring of Physician Services for Children under Medicaid and SCHIP (as of June 2000)

| Program classifications | Medicaid (51 programs in 50 states and DC) | SCHIP (41 programs in 33 states) |
|---|---|---|
| Programs that do *not* cover physician services | Service not included in the Medicaid survey (see note) | 1 — CT-C* |
| Programs with *unlimited* physician services | | 0 |
| Programs *with* specified limits and/or monitoring of physician services | | 0 |
| Programs for which limits were *not* specified | | States were not required to report quantity limits for physician services (see note)<br>*40 — AL, AZ, CA-A, CA-B, CO, CT-A, CT-B, DE, FL-A, FL-B, FL-C, GA, IA, IL, IN, KS, KY, MA-A, MA-B, MA-C, ME, MI, MS, MT, NC, ND, NJ-A, NJ-B**, NH, NV, NY, OR, PA, TX, UT, VA, VT, WA, WV, and WY* |

[33] The survey data indicated that NJ-B's separate state program *did not* cover physician services, however conversations with individuals responsible for administering the CRS-sponsored benefit survey at the National Academy for State Health Policy agreed that this survey response was likely a result of reporting error. NJ's separate state program, NJ-B, offers FEHBP-equivalent coverage, and physician services are included in the FEHBP benefit package.

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** The amount, duration, and scope of physician services was not captured on the Medicaid benefits survey because coverage of physician services is mandatory under Medicaid. When medically necessary for children, *all* benefits (mandatory or optional) are essentially unlimited due to EPSDT.

On the SCHIP benefits survey, states were only asked to report covered/not covered for their coverage of physician services. States were not required to report quantity limits for physician services as the types of physicians covered under this benefit are diverse (e.g., dentists, ophthalmologists, and general practitioners), and the programs generally allow for coverage that is within the scope of practice within each given discipline. In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., California-A, California-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., Connecticut-A, Connecticut-B, Connecticut-C).

* The Connecticut-C benefit package provides additional "wrap around" services for children with special health care needs. Children who are eligible for (Connecticut-C) receive medically necessary services under (Connecticut-A).

** See footnote number 33.

**Vision Services.** As of June 2000, all Medicaid programs covered vision services for children as did nearly all SCHIP programs (except California-B, Connecticut-B, Connecticut-C, and Michigan). More Medicaid than SCHIP programs reported that vision services for children were unlimited (39% as compared to 32%). Fifty-one percent of Medicaid programs reported specified limits and/or monitoring of their vision services coverage, compared to 46% of SCHIP programs. Under both Medicaid and SCHIP, there were five programs where vision services limits existed, but were not specified (see **Table 3**).

For this survey item, states reported quantity limits for all types of vision-related services including eye glasses, frames, and contact lenses; vision screenings; eye exams; and orthopic training. With respect to specified limits on vision services under Medicaid, four programs (Maine, Minnesota, New Jersey, and Wisconsin) reported using prior authorization as their only method of limiting access to service use. One additional program (New York) specified further quantity limits (i.e., one visit every two years) in addition to their prior authorization requirement. A majority of the Medicaid programs (26 of 51 programs) reported a specific quantity limit such as: "one exam every two years," or "two exams plus follow up without prior authorization." In some cases quantity limits were specified for more than one type of vision-related service (e.g., eye exams and prescription lenses). Four Medicaid programs (Hawaii, New Mexico, Oklahoma, and Pennsylvania) referred to a vision screening periodicity schedule — in three cases their EPSDT periodicity schedule — to identify limits on their vision-related benefits. Finally, in three Medicaid programs (Arizona, Delaware, and Tennessee), the states reported provider limitations for their vision-related benefits (i.e., the service coverage varies by MCO).

Under SCHIP, many states reported quantity limits in their separate state programs for all types of vision-related services including eye glasses, frames, and contact lenses; vision screenings; and eye exams. In general, the types of quantity limits placed on vision-related services under SCHIP were similar to those under Medicaid. In almost half the programs, (19 of 41 programs), states reported a specific quantity limit such as "one exam per calendar year," or "refractions limited to one per year." Several programs (California-A, Iowa, and Massachusetts-B) reported that their coverage of vision-related services varies by MCO. In one program (Utah), the state limited its vision-related benefit to a dollar-based limit, and in one program (Maine) prior authorization was required to access services. Unlike under Medicaid, states did not report vision-related periodicity schedules as limits for their vision service coverage (see **Appendix C**).

## Table 3. Coverage of, and Limits for Monitoring of, Vision Services for Children under Medicaid and SCHIP (as of June 2000)

| Program classifications | Medicaid (51 programs in 50 states and DC) | | SCHIP (41 programs in 33 states) |
|---|---|---|---|
| | CN only | CN + MN | |
| Programs that do *not* cover vision services | 0 | 0 | 4 — CA-B, CT-B, CT-C, and MI |
| Programs with *unlimited* vision services | 7 — AK, CO, NV, OR, RI, SD, and WY | 13 — CA, CT, DC, FL, IL, KS, LA, MI, TX, UT, VT, WA, and WV | 13 — CO, DE, FL-A, FL-B, FL-C, IL, KS, KY, MA-A, MA-C, MT, NV, and WY |
| Programs *with* specified limits and/or monitoring of vision services | 9 — AL, DE, ID, IN, MO, MS, NM, OH, and SC | 17 — AR, GA, HI, IA, KY, MD, ME, MT, NC, ND, NE, NH, NY, OK, PA, VA, and WI | 19 — AL, AZ, CA-A, GA, IA, ME, NC, ND, NH, NJ-A, NJ-B, OR, PA, TX, UT, VA, VT, WA, and WV |
| Programs for which limits were *not* specified | 1 — AZ | 4 — MA, MN, NJ, and TN | 5 — CT-A, IN, MA-B, MS, and NY |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** State abbreviations are used in this table. In the Medicaid column, the subcolumn labeled "CN only" means that coverage, limitations, and monitoring of vision services apply only to beneficiaries classified as categorically needy, and the subcolumn labeled "CN+MN" means that coverage, limitations, and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the "CN Only" or the "CN + MN" subcolumns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states *without* medically needy programs were Alaska, Alabama, Arizona,

Colorado, Delaware, Idaho, Indiana, Missouri, Mississippi, New Mexico, Nevada, Ohio, South Carolina, South Dakota, and Wyoming. These 15 states are always listed in the "CN Only" subcolumn.

In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., California-A, California-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., Connecticut-A, Connecticut-B, Connecticut-C).

**Eye Glasses.** As of June 2000, only one Medicaid program (Delaware) did not cover eye glasses for their beneficiaries; however, this program is required to provide coverage of eye glasses under their EPSDT benefit. By contrast, six SCHIP programs (Calfornia-B, Connecticut-B, Connecticut-C, Florida-B, New York, and Utah) did not cover eye glasses. Roughly 26% of Medicaid and 22% of SCHIP programs indicated that their eye glasses benefit was unlimited. An additional 69% of Medicaid programs identified limitations on this benefit, compared to approximately 56% of SCHIP programs (see **Table 4**).

Under Medicaid, 68% (35 programs) of all programs set a single overall quantity limit, usually expressed in terms of pair(s) of eye glasses per year(s). Of these programs, several indicated that they would provide an initial pair of eye glasses, but subsequent repairs/replacements would require prior authorization. In eight of the 35 programs with specified quantity limits on eye glasses, additional corrective lenses were available only based upon beneficiary diagnosis and/or condition (e.g., one pair per year unless prescription changes 0.75 diopters,[34] or axis changes of 15 degrees). Some programs also indicated that eye glasses could be replaced if lost or broken. In four programs (Georgia, New Mexico, Oklahoma, and Tennessee) prior authorization was required to access eye glasses.

Under SCHIP, the specified benefit limits were similar to those under Medicaid. A majority of the programs set a single overall quantity limit, usually expressed in terms of pair(s) of eye glasses per year(s). As under Medicaid, several programs indicated that they would provide an initial pair of corrective lenses, but repairs or replacement would require prior authorization. One major difference between the Medicaid and SCHIP coverage limitations was the use of dollar-based limitations under SCHIP. In five programs (Colorado, Connecticut-A, Iowa, North Dakota, and West Virginia) the states set a dollar-based maximum limit for eyeglasses during a given benefit period (see **Appendix D**).

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[34] A diopter is a unit of measure used by eye care specialists to measure the refractive power of a lense whose focal length is one meter.

## Table 4. Coverage of, and Limits for Monitoring of, Eye Glasses for Children under Medicaid and SCHIP (as of June 2000)

| Program classifications | Medicaid (51 programs in 50 states and DC) | | SCHIP (41 programs in 33 states) |
|---|---|---|---|
| | CN only | CN + MN | |
| Programs that do *not* cover eye glasses | 1 — DE | 0 | 6 — CA-B, CT-B, CT-C, FL-B, NY, and UT |
| Programs with *unlimited* eye glasses coverage | 6 — AK, CO, NV, OR, RI, and SD | 7 — IL, KS, MA, MN, PA, TX, and WV | 9 — DE, FL-C, IL, MA-A, MA-C, NJ-A, NV, OR, and WY |
| Programs *with* specified limits and/or monitoring of eye glasses | 8 — AL, ID, IN, MO, MS, OH, SC, and WY | 27 — AR, CA, DC, FL, GA, HI, IA, KY, LA, MD, ME, MI, MT, NC, ND, NE, NH, NJ, NM, NY, OK, TN, UT, VA, VT, WA, and WI | 23 — AL, AZ, CA-A, CO, CT-A, FL-A, GA, IA, KY, ME, MI, MS, MT, NC, ND, NH, NJ-B, PA, TX, VA, VT, WA, and WV |
| Programs for which limits on eye glasses were *not* specified | 1 — AZ | 1 — CT | 3 — IN, KS, and MA-B |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** State abbreviations are used in this table. In the Medicaid column, the subcolumn labeled "CN only" means that coverage, limitations and monitoring of vision services apply only to beneficiaries classified as categorically needy, and the subcolumn labeled "CN + MN" means that coverage, limitations and monitoring of such services apply to both categorically needy and medically needy beneficiaries.

As of Oct. 2000, 36 states had medically needy programs that covered at least some groups under Medicaid. These 36 states may be shown in either the "CN Only" or the "CN + MN" subcolumns, depending on benefit coverage policies for categorically needy versus medically needy beneficiaries. Those states WITHOUT medically needy programs were Alaska, Alabama, Arizona, Colorado, Delaware, Idaho, Indiana, Missouri, Mississippi, New Mexico, Nevada, Ohio, South Carolina, South Dakota, and Wyoming. These 15 states are always listed in the "CN Only" subcolumn.

In the SCHIP column, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had more than one such program with different benefit plans. Two states (California and New Jersey) each had two separate SCHIP programs. In this case, an A or B extension was added to the state abbreviation to distinguish these programs (e.g., California-A, California-B). Three states (Connecticut, Florida, and Massachusetts) each had three separate SCHIP programs. In this case, an A, B, or C extension was added to the state abbreviation to distinguish these multiple programs (e.g., Connecticut-A, Connecticut-B, Connecticut-C).

**The Nature of Benefit Limits for Children under Medicaid and SCHIP.** It is important to note that comparing quantity limits under Medicaid and SCHIP must be done with care because the term "limits" does not have the same

meaning across these two programs. For example, state Medicaid plans may indicate that children are limited to one eye exam per year. But children who need more than one such visit in a year can obtain additional visits, as long as the provider of care demonstrates the medical necessity for more visits. Stated limits on benefits under Medicaid reflect what providers can generally expect to be paid for in the absence of official clearance for more services, rather than absolute limits on what beneficiaries may receive, although additional conditions governing provider reimbursement (e.g., prior authorization) may effectively alter receipt of services. In addition, as noted above, when medically necessary for children, *all* benefits (mandatory or optional) are essentially unlimited due to EPSDT. By contrast, separate SCHIP programs are modeled after private sector, commercial insurance products. Under commercial insurance products, benefits are always limited by medical necessity, but other limits may apply as well. For this reason, under SCHIP quality limits are sometimes more restrictive.

## Conclusion

A small but significant proportion of children have visual impairments. When detected early, many childhood vision abnormalities are treatable, but the potential for correction and normal visual development diminishes with age. Medicaid and SCHIP provide access to an array of vision-related services including screening that can help children in low- to moderate-income families overcome these difficulties.

Medicaid's mandatory EPSDT benefit ensures access to vision screening services for children. Under EPSDT, state-specific periodicity schedules for vision screening services are often in accordance with the AAP recommendations. However, CMS does not require states to summit such schedules as a part of their state plans for approval. In addition, in FY1998, the last year in which data on vision screening services under EPSDT were collected, just over 14% of EPSDT-eligible children received a vision screen. This measure is somewhat misleading, however, because there are several other Medicaid benefit categories (e.g., well-child care, and physician services) where vision screening services may be delivered. Often such services are billed as a part of a well-child visit.

Under SCHIP, state-specific benefit packages must provide well-baby and well-child care, which includes a vision screening component. Like Medicaid, CMS *does not* require states to submit their well-baby and well-child or vision screening periodicity schedules as a part of their SCHIP state plan, nor (except in the case of immunizations) has CMS endorsed a specific professional standard (i.e., periodicity schedules) for well-baby and well-child care coverage under SCHIP plans. As with Medicaid, the well-child coverage requirement is not the only service category where children could receive vision screening under SCHIP. Children may also receive vision screening services under other SCHIP covered services such as physician services and other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.

A June 2000 CRS benefits survey gives us some clues about access to vision screening services under SCHIP Medicaid expansion programs and separate state

programs. At that time, nearly all Medicaid and SCHIP programs covered vision services (e.g., vision screenings, eye exams, treatment of eye diseases or visual impairments such as eye surgery or eye glasses) for children, and most also covered eye glasses, either as a part of their eye glass coverage or as a part of their vision services. Except in a few states where vision-benefit limits under SCHIP were defined in terms of the AAP or state-specific periodicity schedule, these survey data do not answer the question "how many screenings are covered and at what ages do the screenings occur?" However, the survey data do indicate that the breadth of vision-related benefits available under these two programs likely differs within and across states.

Coverage policies and benefit limits for the lowest-income children as described in state Medicaid plans are seldom absolute because of EPSDT. For nearly all Medicaid children, states are required to provide all federally-allowed treatment to correct identified problems, even if the specific treatment needed is not otherwise covered under a state's Medicaid plan. As a result, when a Medicaid agency reports that a specific benefit is not covered for children, that means the service is available only when delivery of that service meets the EPSDT requirement. In these circumstances, providers typically go through a prior authorization process to receive payment for what are sometimes called "EPSDT extended benefits."

Services for higher-income children under SCHIP are sometimes more restrictive. Unlike Medicaid, but consistent with federal statute, separate SCHIP programs are modeled after private sector, commercial insurance products. The requirement to use benchmark plans (or actuarial equivalents of those plans), most of which are state employee health plans or commercial HMO plans, provides the framework for defining benefit limits. Under commercial insurance products, benefits are always limited by medical necessity, but other limits may apply and will vary by insurance product, as do procedures to monitor for medical need and appropriateness. Payments to providers participating in these plans may be altered based on the outcome of such service utilization reviews, which can in turn affect access to care.

## Appendix A. Specified Limits and/or Monitoring of Well-Child (Non-EPSDT) Services for Children under Medicaid and SCHIP (as of June 2000)

| | Medicaid | | | | SCHIP | |
|---|---|---|---|---|---|---|
| Programs | Covered groups | General quantity limits | Provider, service, or condition limits | Programs | General quantity limits | Provider, service or condition limits |
| AK | CN only | UNLIMITED | | AK | N/A | |
| AL | NOT COVERED OUTSIDE OF EPSDT* | | | AL | Follow AAP guidelines | |
| AR | CN + MN | UNLIMITED | | AR | N/A | |
| AZ | CN only | | Varies by MCO; no FFS | AZ | NOT REPORTED | Varies by MCO |
| CA | CN + MN | UNLIMITED | | CA-A | NOT REPORTED | Varies by MCO |
| | | | | CA-B | NOT REPORTED | Varies by MCO |
| CO | CN only | UNLIMITED | | CO | UNLIMITED | |
| CT | CN + MN | UNLIMITED | | CT-A | NOT REPORTED | |
| | | | | CT-B | NOT COVERED | |
| | | | | CT-C | NOT COVERED | |
| DC | CN + MN | UNLIMITED | | DC | N/A | |

| | Medicaid | | | | SCHIP | |
|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **General quantity limits** | **Provider, service or condition limits** |
| DE | CN only | UNLIMITED | | DE | UNLIMITED | |
| FL | NOT COVERED OUTSIDE OF EPSDT* | | | FL-A | UNLIMITED | |
| | | | | FL-B | UNLIMITED | |
| | | | | FL-C | UNLIMITED | |
| GA | CN + MN | UNLIMITED | | GA | Some services covered, some limitations. | |
| HI | CN + MN | UNLIMITED | | HI | N/A | |
| IA | CN + MN | UNLIMITED | | IA | UNLIMITED | |
| ID | CN only | AAP recommended periodicity | | ID | N/A | |
| IL | CN + MN | All well-child visits are considered EPSDT | | IL | UNLIMITED | |
| IN | CN only | UNLIMITED | | IN | NOT REPORTED | |
| KS | CN + MN | UNLIMITED | | KS | UNLIMITED | |
| KY | CN + MN | UNLIMITED | | KY | UNLIMITED | |
| LA | NOT COVERED OUTSIDE OF EPSDT* | | | LA | N/A | |
| MA | NOT COVERED OUTSIDE OF EPSDT* | | | MA-A | UNLIMITED | |
| | | | | MA-B | UNLIMITED | |
| | | | | MA-C | UNLIMITED | |

| | Medicaid | | | | SCHIP | |
|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **General quantity limits** | **Provider, service or condition limits** |
| MD | CN + MN | UNLIMITED | | MD | N/A | |
| ME | CN + MN | UNLIMITED | | ME | UNLIMITED | |
| MI | CN + MN | UNLIMITED | | MI | UNLIMITED | |
| MN | CN + MN | UNLIMITED | | MN | N/A | |
| MO | CN only | UNLIMITED | | MO | N/A | |
| MS | NOT COVERED OUTSIDE OF EPSDT* | | | MS | NOT REPORTED | |
| MT | CN + MN | UNLIMITED | | MT | UNLIMITED | |
| NC | NOT COVERED OUTSIDE OF EPSDT* | | | NC | three visits per year for children ages 1-3, one visit per year ages 4-7. one visit every three years ages 7-19 | |
| ND | CN + MN | UNLIMITED | | ND | 0-12 months-seven visits, 13-24 months-three visits, 25 months-18 years-one per benefit period | |
| NE | CN + MN | UNLIMITED | | NE | N/A | |
| NH | CN + MN | UNLIMITED | | NH | UNLIMITED | |
| NJ | UNLIMITED | | | NJ-A | UNLIMITED | |
| | | | | NJ-B | UNLIMITED | |
| NM | CN only | UNLIMITED | | NM | N/A | |

| | Medicaid | | | | SCHIP | |
|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **General quantity limits** | **Provider, service or condition limits** |
| NV | CN only | UNLIMITED | | NV | UNLIMITED | |
| NY | CN + MN | UNLIMITED | | NY | NOT REPORTED | |
| OH | CN only | 24 physician visits per year | | OH | N/A | |
| OK | NOT COVERED OUTSIDE OF EPSDT* | | | OK | N/A | |
| OR | CN only | UNLIMITED | | OR | UNLIMITED | |
| PA | CN + MN | UNLIMITED | | PA | UNLIMITED | |
| RI | CN + MN | UNLIMITED | | RI | N/A | |
| SC | CN only | UNLIMITED | | SC | N/A | |
| SD | CN only | UNLIMITED | | SD | N/A | |
| TN | CN + MN | per EPSDT guidelines | subject to MCO approval | TN | N/A | |
| TX | NOT COVERED OUTSIDE OF EPSDT* | | | TX | UNLIMITED | |
| UT | CN + MN | not more than one/day | | UT | UNLIMITED | |
| VA | NOT COVERED OUTSIDE OF EPSDT* | | | VA | UNLIMITED | |
| VT | CN + MN | UNLIMITED | | VT | UNLIMITED | |
| WA | NOT COVERED OUTSIDE OF EPSDT* | | | WA | UNLIMITED | |
| WI | CN + MN | UNLIMITED | | WI | N/A | |
| WV | CN + MN | UNLIMITED | | WV | Follow AAP schedule | |

| | Medicaid | | | | SCHIP | |
|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **General quantity limits** | **Provider, service or condition limits** |
| WY | NOT COVERED OUTSIDE OF EPSDT* | | | WY | UNLIMITED | |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** In the two "Programs" columns (one for Medicaid and one for SCHIP), state abbreviations are used. For SCHIP, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had two or three such programs with different benefit plans. In this case, an A, B, or C extension was added to the state abbreviation (e.g., Connecticut-A, Connecticut-B, Connecticut-C) to distinguish multiple programs as needed.

In the "Covered groups" column for Medicaid, "CN only" means this benefit is covered for categorically needy beneficiaries only, and "CN + MN " means this benefit is covered for both categorically needy and medically needy beneficiaries.

Under the SCHIP columns, N/A means that the state had no separate SCHIP program at the time of the survey, and thus, coverage of this benefit is not applicable.

* Under Medicaid, all states cover well-child care and screening services under the mandatory EPSDT benefit. These states chose not to cover well-child care and screening services outside of EPSDT as well.

Definition of other terms (in alphabetical order):
AAP — American Academy of Pediatrics
EPSDT — Early Periodic Screening Diagnosis and Treatment Program
FFS — Fee-for-service
MCO — managed care organization

## Appendix B. Specified Limits and/or Monitoring of Physician Services for Children under Medicaid and SCHIP (as of June 2000)

| | Medicaid | | SCHIP |
|---|---|---|---|
| **Programs** | **Service not included in the Medicaid survey (see note)** | **Programs** | **General quantity limits** |
| AK | | AK | N/A |
| AL | | AL | NOT REPORTED* |
| AR | | AR | N/A |
| AZ | | AZ | NOT REPORTED* |
| CA | | CA-A | NOT REPORTED* |
| | | CA-B | NOT REPORTED* |
| CO | | CO | NOT REPORTED* |
| CT | | CT-A | NOT REPORTED* |
| | | CT-B | NOT REPORTED* |
| | | CT-C | NOT COVERED* |
| DC | | DC | N/A |
| DE | | DE | NOT REPORTED* |
| FL | | FL-A | NOT REPORTED* |
| | | FL-B | NOT REPORTED* |
| | | FL-C | NOT REPORTED* |
| GA | | GA | NOT REPORTED* |
| HI | | HI | N/A |
| IA | | IA | NOT REPORTED* |
| ID | | ID | N/A |
| IL | | IL | NOT REPORTED* |
| IN | | IN | NOT REPORTED* |
| KS | | KS | NOT REPORTED* |
| KY | | KY | NOT REPORTED* |
| LA | | LA | N/A |
| MA | | MA-A | NOT REPORTED* |
| | | MA-B | NOT REPORTED* |
| | | MA-C | NOT REPORTED* |

| | **Medicaid** | | **SCHIP** |
|---|---|---|---|
| **Programs** | **Service not included in the Medicaid survey (see note)** | **Programs** | **General quantity limits** |
| MD | | MD | N/A |
| ME | | ME | NOT REPORTED* |
| MI | | MI | NOT REPORTED* |
| MN | | MN | N/A |
| MO | | MO | NOT COVERED |
| MS | | MS | NOT REPORTED* |
| MT | | MT | NOT REPORTED* |
| NC | | NC | NOT REPORTED* |
| ND | | ND | NOT REPORTED* |
| NE | | NE | N/A |
| NH | | NH | NOT REPORTED* |
| NJ | | NJ-A | NOT REPORTED* |
| | | NJ-B | NOT REPORTED*, ** |
| NM | | NM | N/A |
| NV | | NV | NOT REPORTED* |
| NY | | NY | NOT REPORTED* |
| OH | | OH | N/A |
| OK | | OK | N/A |
| OR | | OR | NOT REPORTED* |
| PA | | PA | NOT REPORTED* |
| RI | | RI | N/A |
| SC | | SC | N/A |
| SD | | SD | N/A |
| TN | | TN | N/A |
| TX | | TX | NOT REPORTED* |
| UT | | UT | NOT REPORTED* |
| VA | | VA | NOT REPORTED* |
| VT | | VT | NOT REPORTED* |
| WA | | WA | NOT REPORTED* |
| WI | | WI | N/A |

| | Medicaid | | SCHIP |
|---|---|---|---|
| **Programs** | **Service not included in the Medicaid survey (see note)** | **Programs** | **General quantity limits** |
| WV | | WV | NOT REPORTED* |
| WY | | WY | NOT REPORTED* |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** In the two "Programs" columns (one for Medicaid and one for SCHIP), state abbreviations are used. For SCHIP, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had two or three such programs with different benefit plans. In this case, an A, B, or C extension was added to the state abbreviation (e.g., Connecticut-A, Connecticut-B, Connecticut-C) to distinguish multiple programs as needed.

The amount, duration, and scope of physician services was not captured on the Medicaid benefits survey because coverage of physician services is mandatory under Medicaid. When medically necessary for children, all benefits (mandatory or optional) are essentially unlimited due to EPSDT.

* On the SCHIP benefits survey, states were only asked to report covered/not covered for their coverage of physician services. States were not required to report quantity limits for physician services as the types of physicians covered under this benefit are diverse (e.g., dentists, ophthalmologists, and general practitioners), and the programs generally allow for coverage that is within the scope of practice within each given discipline.

Under the SCHIP columns, N/A means that the state had no separate SCHIP program at the time of the survey, and thus, coverage of this benefit is not applicable.

** The survey data indicated that NJ-B's separate state program did not cover physician services, however conversations with individuals responsible for administering the CRS-sponsored benefit survey at the National Academy for State Health Policy agreed that this survey response was likely a result of reporting error. New Jersey's separate state program, NJ-B, offers FEHBP-equivalent coverage, and physician services are included in the FEHBP benefit package.

## Appendix C. Specified Limits and/or Monitoring of Vision Services for Children under Medicaid and SCHIP (as of June 2000)

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| AK | CN only | UNLIMITED | | | AK | N/A | | |
| AL | CN only | | one eye exam every two years — more if medically necessary | | AL | | one exam each calendar year | |
| AR | CN + MN | | one exam per 12 months | | AR | N/A | | |
| AZ | CN only | | | Varies by MCO; no FFS | AZ | | Exams for prescription lenses limited to one visit per year | |
| CA | CN + MN | UNLIMITED | | | CA-A | | one exam and pair of eye glasses per year | Varies by MCO |
| | | | | | CA-B | NOT COVERED | | |
| CO | CN only | UNLIMITED | | | CO | UNLIMITED | | |
| CT | CN + MN | UNLIMITED | | | CT-A | NOT REPORTED | | |
| | | | | | CT-B | NOT COVERED | | |
| | | | | | CT-C | NOT COVERED | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| DC | CN + MN | UNLIMITED | | | DC | N/A | | |
| DE | CN only | | one per year | Covered in MC only | DE | UNLIMITED | | |
| FL | CN + MN | UNLIMITED | | | FL-A | UNLIMITED | | |
| | | | | | FL-B | UNLIMITED | | |
| | | | | | FL-C | UNLIMITED | | |
| GA | CN + MN | | one per year | | GA | | one visit per year | |
| HI | CN + MN | | one refraction per year — screens per EPSDT periodicity schedule | | HI | N/A | | |
| IA | CN + MN | | one pair per two years | | IA | | refractions limited to one per year | Varies by MCO |
| ID | CN only | | one vision check per year | | ID | N/A | | |
| IL | CN + MN | UNLIMITED | | | IL | UNLIMITED | | |
| IN | CN only | | one exam per year | | IN | NOT REPORTED | | |
| KS | CN + MN | UNLIMITED | | | KS | UNLIMITED | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| KY | CN + MN | | two exams plus follow up without PA | | KY | UNLIMITED | | |
| LA | CN + MN | UNLIMITED | | | LA | N/A | | |
| MA | CN + MN | NOT REPORTED | | | MA-A | UNLIMITED | | |
| | | | | | MA-B | | | varies by MCO |
| | | | | | MA-C | UNLIMITED | | |
| MD | CN + MN | | one per year | | MD | N/A | | |
| ME | CN + MN | x | PA required for some services like low vision aids | | ME | x | PA required for some services like low vision aids | |
| MI | CN + MN | UNLIMITED | | | MI | | not covered | |
| MN | CN + MN | x | | | MN | N/A | | |
| MO | CN only | | one eye exam per year | | MO | N/A | | |
| MS | CN only | | one eye exam per year | | MS | NOT REPORTED | | |
| MT | CN + MN | | one eye exam per year | | MT | UNLIMITED | | |
| NC | CN + MN | | one refraction per year without PA | | NC | | one exam per 12 months | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| ND | CN + MN | | < age 21, one exam per year | | ND | | one exam every 12 months | |
| NE | CN + MN | | one exam per year; more if need to determine presence suspected condition | | NE | N/A | | |
| NH | CN + MN | | one refraction per state fiscal year | | NH | | one routine exam every 24 months | |
| NJ | CN + MN | x | | | NJ-A | | one eye exam per year | |
| | | | | | NJ-B | | one eye exam per year | |
| NM | CN only | | exams per EPSDT guidelines | | NM | N/A | | |
| NV | CN only | UNLIMITED | | | NV | UNLIMITED | | |
| NY | CN + MN | x | one visit per two years (refraction)<br><br>contacts, tinted lenses, and orthopic training require PA | | NY | | not specified | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| OH | CN only | | one exam, frame, and lenses per 12-month period | | OH | N/A | | |
| OK | CN + MN | | per EPSDT guidelines | | OK | N/A | | |
| OR | CN only | UNLIMITED | | | OR | | one per year | |
| PA | CN + MN | | Children ages 3-6 are eligible for one eye exam per year. Children over age 6 are eligible for eye exam during their 8th, 10th, 12th, 14th, 16th, 18th, and 20th year.<br><br>Unlimited eyeglass repair or replacement of lost or stolen glasses | | PA | | one exam per year | |
| RI | CN only | UNLIMITED | | | RI | N/A | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| SC | CN only | | one exam per year, one additional visit if one-half diopter change during year | | SC | N/A | | |
| SD | CN only | UNLIMITED | | | SD | N/A | | |
| TN | CN + MN | varies by MCO | | No FFS | TN | N/A | | |
| TX | CN + MN | UNLIMITED | | | TX | | one exam per 12 months for corrective lenses.<br><br>One pair non-prosthetic eye wear per 12 months. | |
| UT | CN + MN | UNLIMITED | | | UT | | $30 maximum limit | |
| VA | CN + MN | | one visit per year without PA | | VA | | one exam every two years | |
| VT | CN + MN | UNLIMITED | | | VT | | one comprehensive and interim exam every 12 months | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| WA | CN + MN | UNLIMITED | | | WA | x | one exam per year, more frequently if problem | |
| WI | CN + MN | x — all contacts, special lenses frames must have PA | | | WI | N/A | | |
| WV | CN + MN | UNLIMITED | | | WV | | annual exam | |
| WY | CN only | UNLIMITED | | | WY | UNLIMITED | | |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** In the two "Programs" columns (one for Medicaid and one for SCHIP), state abbreviations are used. For SCHIP, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had two or three such programs with different benefit plans. In this case, an A, B, or C extension was added to the state abbreviation (e.g., CT-A, CT-B, CT-C) to distinguish multiple programs as needed. In the "Covered groups" column for Medicaid, "CN only" means this benefit is covered for categorically needy beneficiaries only, and "CN + MN " means this benefit is covered for both categorically needy and medically needy beneficiaries.

Under the SCHIP columns, N/A means that the state had no separate SCHIP program at the time of the survey, and thus, coverage of this benefit is not applicable.

Definition of other terms (in alphabetical order):

EPSDT — Early Periodic Screening Diagnosis and Treatment Program
FFS — Fee-for-service
MC — managed care
MCO — managed care organization
PA — prior authorization

## Appendix D. Specified Limits and/or Monitoring of Eye Glasses for Children under Medicaid and SCHIP (as of June 2000)

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| AK | CN only | UNLIMITED | | | AK | N/A | | |
| AL | CN only | | one every two years — more if medically necessary | | AL | | one pair per year | |
| AR | CN + MN | | one pair per 12 months | | AR | N/A | | |
| AZ | CN only | | | Varies by MCO; no FFS | AZ | | one pair per contract year | |
| CA | CN + MN | | one pair per year without PA | | CA-A | | one pair per year | Varies by MCO |
| | | | | | CA-B | NOT COVERED | | |
| CO | CN only | UNLIMITED | | | CO | | $50 credit towards purchase per benefit period | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| CT | CN + MN | | some limits on re-placements | | CT-A | | Allowance of $100 every two consecutive continuous eligibility periods. In some certain situations, optical hardware is not limited benefit, and the allowance limitations do not apply. | Varies by MCO |
| | | | | | CT-B | NOT COVERED | | |
| | | | | | CT-C | NOT COVERED | | |
| DC | CN + MN | | all contact lenses and special glasses require PA; will replace and repair glasses | | DC | N/A | | |
| DE | | | not covered | | DE | UNLIMITED | | |
| FL | CN + MN | | two pair per year | | FL-A | | one pair/two yrs. Unless size/RX changes | |
| | | | | | FL-B | NOT COVERED | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| | | | | | FL-C | UNLIMITED | | |
| GA | CN + MN | x | PA required for contact lenses; new glasses unless prescription change meets Medicaid requirements | | GA | x | PA required for contact lenses, trifocal lenses, oversized frames, hi-index and poly-carbonate lenses. | |
| HI | CN + MN | | one pair every two years w/out PA | | HI | N/A | | |
| IA | CN + MN | | one pair per two years | | IA | | Max $100 to include one pair of frames every two years and one set of prescribed corrective lenses per calendar year | Varies by MCO |
| ID | CN only | | one every four years | | ID | N/A | | |
| IL | CN + MN | UNLIMITED | | | IL | UNLIMITED | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| IN | CN only | | one pair per year unless prescription changes .75 diopters or axis changes 15 degrees; replaced if lost or broken | | IN | NOT REPORTED | | |
| KS | CN + MN | UNLIMITED | | | KS | | NOT REPORTED | varies by MCO |
| KY | CN + MN | | two pair per year w/out PA | | KY | x | two pair of glasses per 12 months | |
| LA | CN + MN | | one pair per year; all repairs/ replacements require PA | | LA | N/A | | |
| MA | CN + MN | UNLIMITED | | | MA-A | UNLIMITED | | |
| | | | | | MA-B | | | varies by MCO |
| | | | | | MA-C | UNLIMITED | | |
| MD | CN + MN | | one pair per year unless prescription changes, or lost, stolen, or broken | | MD | N/A | | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| ME | CN + MN | | two pair per year w/out prior authorization | | ME | x | PA required for over two pair per year | |
| MI | CN + MN | | under age 21, two replacements per year | | MI | | Once per 24 months, or once per 12 months if change in prescription is needed. | |
| MN | CN + MN | UNLIMITED | | | MN | N/A | | |
| MO | CN only | | one pair every two years | | MO | N/A | | |
| MS | CN only | | two eyeglasses per year, four lenses per year | | MS | | one pair per year | |
| MT | CN + MN | | one pair per year | | MT | | One pair per child per benefit year; contacts not covered | Varies by MCO |
| NC | CN + MN | | one pair per year | | NC | | one set lenses per year, one set of frames every two years | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| ND | CN + MN | | < age 21, one pair per year | | ND | | Frames-once every two years, $80 max. benefit for prescribed lenses once every 12 months. | |
| NE | CN + MN | | First pair replacement of lenses and frames when no longer useable, replacement of lenses when prescription change is significant enough | | NE | N/A | | |
| NH | CN + MN | | one pair per year if diopter change is more than + or - 0.5. | | NH | | one pair per year w/limited frame selection | |
| NJ | CN + MN | | one pair per year | | NJ-A | UNLIMITED | | |
| | | | | | NJ-B | | one pair in a 24 month period or as medically necessary | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| NM | CN only | x | one pair and prescribed replacement w/out prior authorization, all contacts require prior authorization | | NM | N/A | | |
| NV | CN only | UNLIMITED | | | NV | UNLIMITED | | |
| NY | CN + MN | | one pair every two years | | NY | NOT COVERED | | |
| OH | CN only | | one frame, and lenses per 12 month period | | OH | N/A | | |
| OK | CN + MN | x | As prescribed to correct visual defects or protect children with monocular vision; some require PA | | OK | N/A | | |
| OR | CN only | UNLIMITED | | | OR | | one pair per year | |
| PA | CN + MN | | Unlimited eyeglass repair or replacement of lost or stolen glasses | | PA | | two pair per year | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| RI | CN only | UNLIMITED | | | RI | N/A | | |
| SC | CN only | | one pair per year + additional lenses if one-half diopter change | | SC | N/A | | |
| SD | CN only | UNLIMITED | | | SD | N/A | | |
| TN | CN + MN | x | covered upon justified need for replacement | | TN | N/A | | |
| TX | CN + MN | UNLIMITED | | | TX | | one pair non-prosthetic eye wear per 12 months. | |
| UT | CN + MN | | one pair per two years | | UT | NOT COVERED | | |
| VA | CN + MN | | one pair per two years | | VA | | one pair per two years | |
| VT | CN + MN | | no replacement within 24 months if not broken or lost and change is less than one-half diopter | | VT | | One pair every two years unless one-half diopter change | |

| | Medicaid | | | | | SCHIP | | |
|---|---|---|---|---|---|---|---|---|
| **Programs** | **Covered groups** | **Requires PA or other review** | **General quantity limits** | **Provider, service, or condition limits** | **Programs** | **Requires PA or other review** | **General quantity limits** | **Provider, service or condition limits** |
| WA | CN + MN | | one per two years | | WA | | one pair every two years | |
| WI | CN + MN | | two pair per year | | WI | N/A | | |
| WV | CN + MN | UNLIMITED | | | WV | | Contacts and eyeglasses limited to $100 per 12 months | |
| WY | CN only | | initial pair and periodic replacement | | WY | UNLIMITED | | |

**Source:** CRS analysis of benefits data collected in two 2000 surveys, one for state Medicaid programs and the other for separate state SCHIP programs, conducted by the National Academy for State Health Policy under contract to CRS.

**Notes:** In the two "Programs" columns (one for Medicaid and one for SCHIP), state abbreviations are used. For SCHIP, 28 states had a single separate SCHIP program represented by the state abbreviation. The remaining five states with separate SCHIP programs each had two or three such programs with different benefit plans. In this case, an A, B, or C extension was added to the state abbreviation (e.g., CT-A, CT-B, CT-C) to distinguish multiple programs as needed.

In the "Covered groups" column for Medicaid, "CN only" means this benefit is covered for categorically needy beneficiaries only, and "CN + MN " means this benefit is covered for both categorically needy and medically needy beneficiaries.

Under the SCHIP columns, N/A means that the state had no separate SCHIP program at the time of the survey, and thus, coverage of this benefit is not applicable.

Definition of other terms (in alphabetical order):
FFS — fee for service
MCO — managed care organization
PA — prior authorization

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