DEPARTMENT OF HEALTH & HUMAN SERVICES

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SHO # 24-005

RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements

September 26, 2024

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is committed to improving health outcomes for children and youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP) by working with states as they comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.[1] This letter, along with regular technical assistance webinars and planned future guidance for states, is intended to provide states with the information they need to meet EPSDT requirements.[2] CMS will be working with all states to ensure adherence to these requirements.

Executive Summary

The EPSDT requirements are a cornerstone of the Medicaid program and ensure robust health coverage for children. Children enrolled in Medicaid and eligible for EPSDT are entitled to services that can be covered under EPSDT rules. The goal of EPSDT is to ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting. Section 1905(a)(4)(B) and (r) of the Social Security Act (the Act) entitles eligible children under the age of 21 to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are

[1] Children eligible for EPSDT generally include beneficiaries under the age of 21 enrolled: in Medicaid through a categorically needy group; in Medicaid through a medically needy group in a state that has elected to include EPSDT in the medically needy benefit package; in a Medicaid-expansion CHIP program; or in a separate CHIP program that has elected to cover EPSDT. This includes beneficiaries with an institutional level of care who are eligible for Medicaid by virtue of their enrollment in a home and community-based services (HCBS) waiver under section 1915(c) of the Social Security Act. EPSDT is not available to beneficiaries without satisfactory immigration status who are eligible only for treatment of an emergency medical condition and other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility, such as, for example, family planning services.

[2] This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

covered under the state plan.[3] States will not be able to comply with the EPSDT requirements unless their Medicaid policies and procedures, including medical necessity criteria, prior authorization requirements, and Medicaid fair hearings, reflect consideration of this EPSDT obligation, which creates a higher standard of coverage for eligible children than for adults.[4] States are also required to perform specific administrative duties, such as informing eligible beneficiaries of the availability of EPSDT, submitting annual reports to CMS, and ensuring the availability of providers who are qualified and willing to deliver services under EPSDT.[5]

CMS and the states have a unique partnership in operating Medicaid and CHIP: CMS ensures that states meet federal requirements, but federal law also gives states options for implementing their Medicaid and CHIP programs in a manner tailored to their communities' needs. As of May 2024, 38 million children were enrolled in Medicaid and CHIP.[6] Additionally, as of the date of this letter, 16 states with a separate CHIP have elected to cover a package of services that adhere to Medicaid EPSDT requirements for beneficiaries who are enrolled in a separate CHIP.[7] Children covered through a Medicaid expansion CHIP are entitled to EPSDT.[8]

Section 11004 of title I of division A of the Bipartisan Safer Communities Act (BSCA) requires the Secretary of Health and Human Services (HHS) to issue guidance to states on EPSDT Medicaid coverage requirements "that includes best practices for ensuring that children have

[3] While babies, children, adolescents, and youth may have distinct health care needs, throughout this document, CMS uses "child" and "children" to describe all EPSDT-eligible beneficiaries under the age of 21. In those instances where a policy, strategy, or best practice is specific to a subset of EPSDT-eligible individuals under the age of 21, we specifically identify and define those individuals. Additionally, for minor beneficiaries, the involvement of parents, legal guardians, and other caregivers is often necessary to ensure access to benefits. When we refer to a child's family, that term is meant broadly to include all persons who would be considered a child's family under applicable law.

[4] Medicaid "fair hearings" are also sometimes colloquially called appeals. In this document, we will use the term "fair hearing" to refer to the request that individuals can make when they disagree with an action taken by the state. See 42 C.F.R. part 431, subpart E and more detail below at subsection "*iv. Ensuring Consideration of EPSDT in States' Medicaid Policies and Procedures*" in "I. Promoting EPSDT Awareness and Accessibility."

[5] Section 1902(a)(43)(A) and (D) of the Act, and 42 C.F.R. §§ 441.56(a) and 441.61(b).

[6] According to the CMS May 2024 Enrollment Trends Snapshot, approximately 38 million children were enrolled in Medicaid and CHIP. For the purposes of these data, "children" represents the number of children enrolled in the Medicaid program and the total enrollment for separate CHIP programs as of the last day of the reporting period. The data are limited to only those individuals who are eligible for comprehensive benefits (e.g., emergency Medicaid, family planning-only coverage, and limited benefit dual eligible individuals are excluded). States use the definition of "child" as included in the state's Medicaid state plan in reporting performance indicator data to CMS, and these definitions vary from state to state. See: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2024-medicaid-chip-enrollment-trend-snapshot.pdfand https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[7] Optional coverage of EPSDT services in separate CHIPs reflects all Medicaid EPSDT requirements, including coverage of all section 1905(a) services. As of the date of this letter, 16 states elect the option to provide EPSDT in a separate CHIP. Of these 16 states, 10 states cover EPSDT for all separate CHIP-enrolled individuals: Arizona, Georgia, Idaho, Kansas, Louisiana, Maine, Oklahoma, Rhode Island, South Dakota, and Wisconsin. The other 6 states cover EPSDT for some but not all separate CHIP-enrolled populations: California, Massachusetts, Minnesota, Missouri, New Jersey, and Washington.

[8] 42 C.F.R. § 457.70(c)(2).

access to comprehensive health care services, including children without a mental health or substance use disorder (SUD) diagnosis."[9]

To meet this directive, CMS completed an extensive document review of state EPSDT beneficiary-informing materials, state provider manuals, and managed care contracts, including looking for examples of optimal EPSDT implementation. CMS also considered internal and external EPSDT subject matter expertise, the relevant academic literature, data from and evaluations of CMS programs, and feedback from parents and other caregivers of EPSDT-eligible children, as well as other interested parties.

This guidance is intended to provide an overview of EPSDT requirements and how states can meet the goal of EPSDT: the right care, to the right child, at the right time, in the right setting. The guidance discusses policies, strategies, and best practices to maximize health care access and utilization for EPSDT-eligible children. It is divided into three broad topics:

- **Promoting EPSDT awareness and accessibility** to ensure eligible beneficiaries have comprehensive coverage, are aware of their coverage, know how to access Medicaid benefits, and have supports like transportation and care coordination to facilitate getting the care that they need.
- **Expanding and using the child-focused (EPSDT) workforce** by broadening provider qualifications, using telehealth, encouraging the use of interprofessional consultation, and using payment methodologies to address provider shortages and to help assure that there are an adequate number of health care providers available to meet the needs of beneficiaries.
- **Improving care for EPSDT-eligible children with specialized needs**, with a particular focus on how EPSDT requirements relate to the unique needs of children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs.[10]

Each section of the guidance summarizes federal requirements, followed by strategies and best practices to support states' implementation of those requirements. CMS recognizes that what works in one state may not be feasible in another; we are not requiring states to adopt best practice examples, nor are the best practice examples exhaustive. However, these best practices have proven to be effective avenues utilized by states to comply with EPSDT requirements and we encourage states to consider adopting, as appropriate, the strategies and best practices in this guidance to help improve care and health outcomes for children. For comprehensive information about EPSDT requirements, please refer to *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*.[11]

[9] Pub. L. 117-159.
[10] Throughout the letter, we use the term "behavioral health conditions" to encompass mental health conditions and substance use disorders.
[11] See: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

States have the option of delivering some or all section 1905(a) services through managed care plans (MCP), a state-administered fee-for-service system, or a combination of delivery systems.[12] Regardless of how significant the MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.

Many children enrolled in Medicaid and CHIP also receive services through other federally funded programs, and state Medicaid agencies may partner with other state agencies to ensure that children's needs are met. States utilizing such an approach must follow federal administrative claiming rules regarding claiming Federal Financial Participation (FFP) for administrative expenditures subject to section 1903(a) of the Act.[13] States must also adhere to appropriate cost allocation requirements and coordination of benefits requirements.[14, 15]

CMS is committed to supporting states as they work to ensure they meet EPSDT requirements. CMS will continue to host regular technical assistance webinars for states, and we encourage states to reach out with questions or tailored assistance requests by emailing the EPSDT mailbox at EPSDT@cms.hhs.gov.

[12] The term "managed care plan," when utilized in this document, refers to Medicaid-participating Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).
[13] See: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf.
[14] Subpart E of 45 C.F.R. Part 95.
[15] Section 1902(a)(25)(A) of the Act.

Table of Contents

Overview of EPSDT Requirements

EPSDT requirements were added to the Act in 1967 and have been strengthened and amended since first enacted. Sections 1902(a)(43) and 1905(r) of the Act and the implementing regulations require states to inform eligible beneficiaries or their families about the availability of EPSDT; cover screening, diagnostic, and treatment services; and report to CMS a variety of information about the services provided each year.[16] Section 1905(r) of the Act entitles eligible children to a comprehensive array of prevention, diagnostic, and treatment services. Well-child visits, referred to in statute as screening services, are the foundation of EPSDT coverage and are a crucial entry point for identifying concerns and conditions that require follow-up care. These visits are intended to be comprehensive and include age-appropriate screenings, referrals to diagnostic and specialty services, and referrals to establish ongoing dental, vision, and hearing care. States are required to develop or adopt a schedule of recommended screenings; most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics (AAP) or a modified version thereof.[17] All states are required to provide coverage of appropriate immunizations to EPSDT-eligible children according to the pediatric vaccine schedule established by the Centers for Disease Control and Prevention (CDC).[18] Each state is also required to develop or adopt a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

EPSDT-eligible children may require diagnosis and treatment of an illness or condition that was not present during, or was identified outside of, a well-child visit. States are required to cover comprehensive services, including all services that could be covered under section 1905(a) of the Act that are needed to correct or ameliorate health conditions for EPSDT-eligible children. For example, if an EPSDT-eligible child has an ear infection, a broken arm, a vision change, or a mental health episode, the state must cover medically necessary section 1905(a) services from a qualified provider to correct or ameliorate the condition, regardless of whether the condition was present and identified during a well-child visit.

Furthermore, CMS interprets the "correct or ameliorate" requirement to mean that a service need not cure a condition in order to be covered under EPSDT as a medically necessary service. Services that maintain or improve a child's current health condition are also covered under

[16] See 42 C.F.R. § 441.56.

[17] The Bright Futures program is funded by the Health Resources and Services Administration (HRSA) through a five-year cooperative agreement with the AAP and creates and shares clinical national guidelines for pediatric well-child visits for children birth through the age of 21. See: https://mchb.hrsa.gov/programs-impact/bright-futures.

[18] Under section 1905(r)(1)(B)(iii) of the Act, states must cover, for beneficiaries under age 21 who are eligible for EPSDT services (including beneficiaries enrolled in Medicaid-expansion CHIPs who are eligible for EPSDT), appropriate immunizations (according to age and health history) on the CDC Advisory Committee on Immunization Practices (CDC/ACIP) pediatric immunization schedule (which identifies CDC/ACIP recommended vaccines for those through age 18). Consistent with section 1905(r)(5) of the Act, other vaccinations recommended by ACIP and non-ACIP-recommended vaccines and vaccine administration are covered for beneficiaries eligible for EPSDT, if the service is determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria. For more information, including on Inflation Reduction Act mandated Medicaid coverage of vaccinations for EPSDT-eligible beneficiaries ages 19 and 20, see the *Coverage and Payment of Vaccines and Vaccine Administration under Medicaid, the Children's Health Insurance Program, and Basic Health Program* toolkit, available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/vacines-coverage-payment.pdf.

EPSDT because they "ameliorate" a condition; they prevent a condition from worsening or prevent development of additional health problems. Thus, services such as physical and occupational therapy, for example, are covered when they have an ameliorative, maintenance purpose.

States have the option of delivering some or all section 1905(a) services through MCPs, a state-administered fee-for-service (FFS) system, or a combination of delivery systems. No one delivery system is favored over another, but states must ensure they adhere to EPSDT requirements regardless of the delivery system(s) being utilized. When states use MCPs to deliver some or all EPSDT benefits, states must clearly delineate the MCPs' responsibilities in the managed care contract to help ensure that the MCPs understand the full scope of their obligations under EPSDT. States must monitor and oversee MCPs and must have mechanisms in place to hold MCPs accountable for fulfilling all contracted responsibilities. Regardless of how significant an MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.[19]

EPSDT requires that states cover services described in section 1905(a) of the Act when they are medically necessary for an EPSDT-eligible child. These services must be covered "whether or not such services are covered under the state plan."[20] CMS interprets this to mean that, if an optional 1905(a) service is not covered for adults, the 1905(a) service must still be made available to EPSDT-eligible children when it is medically necessary. Section 1905(a) of the Act describes a variety of mandatory services (e.g., physician, hospital, and laboratory and x-ray services) and optional services (e.g., prescription drugs, personal care services, and rehabilitative services).[21] States must ensure EPSDT-eligible children have access to the full range of coverable services enumerated in section 1905(a) regardless of whether they are mandatory or optional and assure that the children's families and caregivers are aware of and have access to those services to meet an individual child's needs.

A comprehensive array of services has long been statutorily required under EPSDT, which ensures that eligible children can access a child health benefit package that meets their individual needs. Available services for EPSDT-eligible children must not be limited to those that are convenient for the state to cover simply because they are aligned with services typically available for adults. For example, states must cover a range of behavioral health services that meet the assessed needs of an EPSDT-eligible child and not rely solely on inpatient and counseling services as sufficient to meet the requirements of EPSDT. States must adhere to EPSDT requirements, which create a higher standard of coverage for eligible children than adults, when administering their Medicaid programs.

[19] See e.g., section 1932(e)(1)(a) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. §§ 438.66 (requiring states to have monitoring systems for their managed care programs), 438.206 (requiring states to ensure that all services covered under the state plan are available and accessible to MCP enrollees), 438.210 (requiring managed care contracts to identify, define and specify the benefits to be covered by the plan) and 438.700 (sanctions for noncompliance).

[20] Section 1905(r)(5) of the Act.

[21] Section 1902(a)(10) of the Act identifies whether services listed in 1905(a) are mandatory or optional.

States will not be able to comply with EPSDT requirements unless they consider these requirements when establishing medical necessity criteria, setting prior authorization requirements, and conducting Medicaid fair hearings. Furthermore, states cannot ensure compliance with EPSDT requirements unless they have processes in place to oversee, verify, and enforce these requirements, regardless of whether services are delivered through FFS or managed care.

EPSDT Policies, Strategies, and Best Practices to Maximize Health Care Access and Improve Health Outcomes

States implement EPSDT in varying ways due to different Medicaid program designs, payment methodologies, delivery systems, and state licensure laws and regulations. To better understand how states are operationalizing EPSDT requirements, CMS conducted a thorough review of states' EPSDT beneficiary-informing materials, provider materials, and state managed care contracts; held listening sessions with interested parties, including state Medicaid agencies, parents and other caregivers of EPSDT-eligible children, and advocates; and reviewed various states' coverage and provision of specific EPSDT services.

In this letter, we have assembled EPSDT strategies and best practices that we identified during our research. Specifically, within various EPSDT topics and subtopics, we outline first what states are required to do under applicable federal statutes, regulations, and CMS's interpretation of the applicable statutes and regulations (collectively referred to as "policies" in this SHO); highlight strategies that states currently use to meet the federal requirements; and then describe one or more best practices (i.e., model strategies). These best practices may not apply to all states but serve to highlight parts of state programs that are notable or high performing. In many cases, a strategy or best practice is included only once in this letter (i.e., under only one topic or subtopic) but is applicable across many EPSDT topics and subtopics. Similarly, while some of the strategies and best practices we include focus on a particular type of Medicaid delivery system—either FFS or managed care—many of the strategies and best practices could be implemented by states under a FFS delivery system or by an MCP with proper state oversight. In many cases, aligning policies across delivery systems could be a best practice to promote streamlined access to care. States are encouraged to identify and implement the strategies and best practices that will have the most impact on the EPSDT-eligible children in their state.

I. Promoting EPSDT Awareness and Accessibility

Helping families and caregivers understand how their children's Medicaid coverage works and how to use their children's benefits is an important step to ensuring that children get the care they need. During listening sessions with state Medicaid agencies, parents, other caregivers of EPSDT-eligible children, and advocates, CMS heard repeatedly that some families do not fully understand the breadth of and how to access the services available to EPSDT-eligible children.[22] During listening sessions, many interested parties reported that families may be asking for help for their children but may not understand what type of services or specialists to request, or where to go for help.

[22] Throughout March and April of 2023, CMS held a series of listening sessions with advocates from 24 states, parents and caregivers from 18 states, and 26 state agency representatives.

States are responsible for ensuring that EPSDT-eligible children or their families are informed about EPSDT requirements, have necessary assistance with transportation and scheduling appointments when needed, receive screening and diagnostic services at appropriate intervals, and receive follow-up treatment as needed.[23] Additionally, states must ensure that their policies and procedures, such as determining medical necessity, consider EPSDT requirements and, likewise, must ensure that all EPSDT-eligible children in the state have access to the full EPSDT scope of coverage and services, even if the state contracts with an MCP to deliver some or all of the services available under EPSDT. To that end, this section describes: i. EPSDT informing requirements; ii. EPSDT requirements regarding scheduling assistance and transportation; iii. improving health care accessibility using care coordination and case management for EPSDT-eligible children; iv. considering EPSDT in states' Medicaid policies and procedures; and v. meeting requirements related to EPSDT and managed care.

i. Improving Awareness of Available Services through EPSDT Informing Requirements

Table 1: EPSDT Informing Policies, Strategies, and Best Practices

Policies	States are required to use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible children "generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter."[24] States must effectively make this information available to individuals who are blind or deaf, or who cannot read or understand the English language.[25] Many states that utilize a managed care delivery system satisfy EPSDT informing obligations by including this responsibility in their contracts with MCPs. If a state delegates informing enrollees of the EPSDT requirements to an MCP, the state's contract with the MCP should include the specific timelines and standards required under EPSDT.[26] MCPs must use a state-developed model enrollee handbook to define which benefits are covered under the MCP and how to access these benefits.[27] In addition, the handbook must also provide information on how and where to access benefits covered by the state, including how transportation is provided to these benefits.[28] This required information must be provided in an accessible format, in prevalent non-English languages, and be available in alternative formats

[23] Sections 1902(a)(43) and 1905(r) of the Act and 42 C.F.R. §§ 431.53, 441.56, and 441.62.
[24] Section 1902(a)(43) of the Act and 42 C.F.R. § 441.56(a)(4).
[25] 42 C.F.R. § 441.56(a)(3).
[26] The Center for Medicaid & CHIP Services (CMCS) also issued a CMCS Informational Bulletin (CIB) regarding EPSDT coverage requirements for children and youth in managed care and it includes more information about informing requirements. This CIB is available at: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib010517.pdf.
[27] 42 C.F.R. § 438.10(c)(4).
[28] 42 C.F.R. § 438.10(g)(2)(ii).

Policies (cont.)	upon request and at no cost to the enrollee.[29,30] The MCP may provide this information by mail or electronically when the accessibility requirements defined in regulations are met.[31]
Strategies	Write EPSDT materials in easy-to-understand language. Some states mail printed materials directly from the state Medicaid agency and post these materials on the state's Medicaid website. This information is written in easy-to-understand language and includes an explanation of EPSDT's "correct or ameliorate" standard in materials describing well-child, behavioral health, vision, and dental services. States are encouraged to use plain language at an easy-to-understand grade-level to communicate the breadth and depth of the EPSDT requirements, including how to access services. For example, instead of using the statutory "correct or ameliorate" language, states could use "treat or improve" or "prevent a child's condition from getting worse." Additionally, states are encouraged to review their practices as they relate to the national standards for culturally and linguistically appropriate services (CLAS), and states must inform families of the availability of language assistance services and offer this assistance to individuals who have limited English proficiency or other communication needs.[32,33]
Best Practices	***Use clear language in provider and family handbooks to describe the breadth of available services.***[34] States should use clear language in both their provider and family handbooks to ensure EPSDT-eligible children understand the entirety of services available under EPSDT, and that use of the EPSDT acronym is not required to request these services. For example, our review found provider handbooks that included statements such as "services are covered even if the services are not covered for adults" or "child beneficiaries are entitled to a broader scope of services than adults." Additionally, some beneficiary-facing materials describe EPSDT as "more robust than the benefit for adults and…designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible." ***Supplement a beneficiary handbook with web-based information, social media platforms, and electronic communication.*** In addition to mailing a

[29] 42 C.F.R. § 438.10(a) defines a prevalent non-English language as one determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.
[30] 42 C.F.R. § 438.10(c)-(d).
[31] 42 C.F.R. § 438.10(a) and (c)(6).
[32] 42 CFR § 435.905(b).
[33] See: https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf.
[34] While states are not required to use handbooks for Medicaid FFS delivery systems, states are required to use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible children, as noted above. As a result, some states have implemented this requirement by developing handbooks or fliers on services delivered via FFS.

Best Practices (cont.)	beneficiary handbook, social media platforms and electronic communications can be important tools to disseminate information about services available under EPSDT requirements and to engage with community members. Educational videos and targeted communications can reach Medicaid-eligible families in the community. Some states reported seeing a noticeable increase of beneficiaries responding to state-initiated social media campaigns. States and MCPs can provide text reminders to a child's family to bring the child in for a check-up and keep contact information up to date with the state.[35, 36]

ii. Providing Required EPSDT Support Services: Scheduling Assistance and Transportation

EPSDT requires that states provide supports to beneficiaries in addition to covering clinical services. For example, federal regulations require that state Medicaid agencies offer, and provide if requested, necessary assistance with scheduling appointments for, and transportation to, services, as well as coordination with related programs, which is discussed in "*iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children*" subsection below.[37]

Table 2: EPSDT Scheduling Assistance Policies, Strategies, and Best Practices

Policies	Federal regulations require that state Medicaid agencies offer necessary assistance with scheduling appointments for services.[38]
Strategies	Incentivize MCPs to assist with appointment scheduling. The health care system can be difficult to navigate and extra support with scheduling appointments may assist with children getting access to the care they need. In some states that use MCPs to deliver medically necessary services to EPSDT-eligible children, the contract language itemizes in specific, measurable ways the state's requirements for the MCPs to contact and send

[35] Phone calls and text messages, initiated either directly by the state agency or through a state contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act. For more information, see: https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-coverage-calls.

[36] The *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes* final rule (89 FR 22836) requires state Medicaid agencies to keep beneficiary contact information up to date by obtaining regular updates from reliable sources, including managed care plans and the U.S. Postal Service National Change of Address database. When beneficiary mail is returned to a state Medicaid agency with no forwarding address, the state must check its Medicaid Enterprise System, as well as information from reliable sources, for updated contact information. If the state is still unable to determine the beneficiary's address, the state must make a reasonable effort to contact the beneficiary, which includes making at least two attempts to contact the beneficiary through two or more modalities to obtain updated address information. While the final rule is effective June 3, 2024, states have 18 months after the effective date of the rule to comply with these requirements. See: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

[37] 42 C.F.R. §§ 441.62, 431.53, 441.61.

[38] 42 C.F.R. § 441.62.

Strategies (cont.)	reminders to families and to provide scheduling assistance. This can be included at the MCP or provider/clinic level. For this strategy to be effective, states should have a process in place to oversee and continually evaluate how the MCP is operationalizing the contract language in practice.
Best Practices	Regardless of delivery system, some states or their MCPs perform initial telephonic outreach and scheduling support to families. Specific best practices for conducting this outreach and scheduling support are described below. ***Offer a beneficiary services contact line.*** Some states offer a "beneficiary services" contact line staffed by the Medicaid agency to help with finding appropriate providers that are accepting new patients. ***Maintain practice-level dashboards.*** One state with high utilization rates of well-child visits maintains a dashboard to create summary and detailed (i.e., member-level) reports on high-risk beneficiaries, utilization, and quality measure performance. The state makes these reports available to clinics so that, in addition to generally tracking their performance, the clinics can use the reports to target outreach and reminders, in particular for children with missing or late well-child visits. ***Require MCPs to provide proactive outreach and assistance to members.*** Some high-performing states require MCPs to reach out to their members and inform them about services available under EPSDT requirements, in addition to the minimum requirement that services covered under the state plan are available and accessible to enrollees in a timely manner and providing a member handbook.[39] In some cases, these MCPs are contractually required to use information from the Medicaid agency's monthly data retrieval to identify all enrollees who are due or overdue for a well-child visit. These enrollees are then contacted by their respective MCP and assisted with scheduling the service as soon as possible. While this best practice was identified in a managed care delivery system, proactive outreach and scheduling assistance has been implemented in FFS and could be modified for use by states with Primary Care Case Management (PCCM). ***Establish Children's Resource Centers.*** One state established Children's Resource Centers to help families navigate programs that span multiple agencies, drawing on funding for children with special needs available to state maternal and child health agencies through the Title V Maternal and Child Health Services Block Grant Program. To increase the number of families utilizing Children's Resource Centers, Medicaid administrative funds have been used with other funding to establish a statewide telephone and web-based hotline. The state has extensively promoted this new hotline,

[39] 42 C.F.R. § 438.206(a) establishes the minimum coverage requirement.

Best Practices (cont.)	which parents can call to speak with staff (trained as resource guides) to receive guidance on identifying and accessing programs.

Table 3: EPSDT Transportation Policies, Strategies, and Best Practices

Policies	Non-Emergency Medical Transportation (NEMT) plays an essential role in enabling access to medically necessary services, and states are required to assure that beneficiaries have access to necessary transportation.[40] The assurance of transportation is not a requirement for states to pay for a ride, but rather a requirement to make certain that every Medicaid beneficiary who has no other means of transportation has access to transportation needed to receive covered care. To comply with EPSDT requirements, states must inform EPSDT-eligible children and their families in clear and nontechnical language that this necessary assistance with transportation is available.[41] Beyond the general transportation assurance requirement, Medicaid EPSDT regulations at 42 C.F.R. § 441.62 require that states offer and provide EPSDT-eligible beneficiaries with "necessary assistance with transportation as required under § 431.53[.]"[42] In determining what constitutes necessary transportation for eligible children under age 21, the state should consider the needs and best interests of the child when providing additional assistance with transportation to covered services. CMS interprets the references in 42 C.F.R. §§ 441.53 and 441.62 to "necessary" transportation and "necessary" assistance with transportation to mean that states must also cover the cost of transportation for any person who needs to accompany an eligible child to their medical service(s). Transportation for the person accompanying the child includes coverage for trips to and from the service (e.g., roundtrip for admission, roundtrip for discharge), including in cases of out-of-state trips. Additionally, if a child is receiving residential or facility-based care (e.g., inpatient, neonatal intensive care unit (NICU), psychiatric residential treatment facility (PRTF), etc.) and the presence of the parent, family member, or other caregiver is necessary so that they can actively participate in the treatment/intervention for the direct benefit of the child, then the state may pay for transportation for the parent, family member, or caregiver without the child present in order to ensure the child's medically necessary services are provided (e.g., to provide breast milk or breastfeed, participate in family therapy, medical decision making, and consent for surgery, etc.). Alternatively, the cost of a parent, caregiver, or other family member's transportation for the direct benefit of the child could be considered part of the cost of the medical service (e.g., inpatient hospital benefit, etc.) and

[40] Section 1902(a)(4) of the Act and 42 C.F.R. § 431.53.
[41] 42 C.F.R. §§ 441.56, 441.62.
[42] 42 C.F.R. § 441.62.

Policies (cont.)	included in another service payment, rather than paid separately as a distinct service.[43]
Strategies	Take advantage of the flexibilities to design and operate the assurance of transportation. States have considerable flexibility in the design and operation of the assurance of transportation, if they otherwise meet the requirements noted above and described in the Medicaid Transportation Coverage Guide.[44] Generally, states may assure transportation as an administrative activity, as an optional medical service, or a combination of these. When provided pursuant to 42 C.F.R. § 431.53, transportation is covered as an administrative activity under the state plan and is matched at the standard 50 percent FFP rate provided under section 1903(a)(7) of the Act for administrative expenditures. Transportation can be assured as an optional medical service if included in the state's approved state plan, but only when provided by a provider to whom a direct vendor payment can be made by the Medicaid agency.[45] States can claim FFP at the state's regular Federal Medical Assistance Percentage (FMAP) for NEMT and emergency medical transportation when furnished as an optional medical service under an approved state plan, which may be higher than the administrative federal match rate. Additionally, states may cover transportation as an optional medical service delivered through managed care authorities, such as a section 1932(a) state plan amendment, section 1915(b) waiver, or section 1115 demonstration authority under the Act.[46] Many states utilize a broker model, in which a state competitively procures an independent entity to assess need and manage transportation in a designated area. States have the option under state plan authority to establish an NEMT brokerage program and receive the state's regular FMAP for medical assistance.[47] It should be noted that expenditures for broker-arranged NEMT can also be claimed as an administrative activity.
Best Practices	***Use a fixed risk-based payment under transportation broker models and require the broker to develop a beneficiary app to schedule trips.*** We interviewed one state about its high-performing transportation broker model, which aimed to increase oversight of the transportation benefit and simplify the process for beneficiaries. Initially, the new system caused significant disruption due to increased demand, but ultimately led to improved access

[43] See: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf.
[44] Ibid.
[45] 42 C.F.R. § 440.170(a)(2).
[46] Managed care programs can include NEMT as part of the benefits coverage for MCOs and PAHPs or by NEMT-only managed care plans. See 42 C.F.R. § 438.9 addressing regulatory requirements for MCPs that cover only NEMT.
[47] Section 1902(a)(70) of the Act and 42 C.F.R. § 440.170(a)(4).

Best Practices (cont.)	and dramatically reduced costs per trip. The broker is paid a fixed, monthly risk-based payment for all eligible beneficiaries. The contract includes a performance withhold of 3%, contingent on the broker's service delivery performance scorecard. This state also uses its broker contract to improve data and reduce the beneficiary burden to access services. In the state's broker contract, the broker is required to provide data dashboards that allow the state to review near real-time trip details and to develop an app for beneficiaries to use to schedule trips.

iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children

Care coordination and case management are used to describe a range of activities that link individuals to services and can vary in intensity depending on a child and family's needs.[48] Medicaid defines case management as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, and other services.[49] Care coordination is the organization of a patient's care across multiple providers and may focus on a specific service or condition, such as referring and connecting individuals to other programs that support mental health recovery. Care coordination is not defined in section 1905(a) as a service but can be covered in certain circumstances. MCPs are required to provide medically necessary care coordination to enrollees.[50]

For children, especially young children, care coordination and case management are typically provided to the child through the parent or other caregiver. For families, care coordination and case management can ease the process of receiving services by helping to manage the care of the child, reducing duplication of effort, and limiting gaps between service providers. For older youth, families may not be as closely involved but the youth and/or family may still require extra assistance coordinating care in a complex delivery system.

For older children who will soon be transitioning out of coverage that is subject to EPSDT requirements, care coordination and case management can facilitate the development of a comprehensive care plan that outlines the transition process, including referrals to appropriate providers and services. Planning should begin well in advance of a beneficiary's transition and can be facilitated by transition coordinators or care managers who can help coordinate appointments, transfer medical records, and connect families with new health care providers.

The level of care coordination and case management must be appropriate for the complexity of the beneficiary's situation and one approach may not be sufficient to meet varied needs. Every state offers one or more approaches to care coordination and case management; however, it may be to the state's advantage to assess its care delivery program to determine if additional approaches may be useful. Additionally, when a state has multiple approaches for care

[48] See: https://www.medicaid.gov/sites/default/files/2019-12/epsdt-care-coordination-strategy-guide.pdf.
[49] 42 C.F.R. § 440.169(a).
[50] 42 C.F.R. § 438.208.

coordination and case management or is considering adding another approach, the state should ensure that these approaches are streamlined to minimize the risk that an EPSDT-eligible child will experience a duplication of services.

Table 4: EPSDT Care Coordination and Case Management Policies, Strategies, and Best Practices

Policies	Medicaid regulations do not define "care coordination," nor is it a specific section 1905(a) service, but it can be covered if it meets the definitions and requirements of existing Medicaid authorities. For example, states can cover care coordination under the rehabilitative services benefit in section 1905(a) of the Act.[51] Case management is a section 1905(a) service in Medicaid. Like many other components of the EPSDT mandate, not every child needs case management, but every child must have case management available to them when it is medically necessary. When children are assessed to need section 1905(a) services, EPSDT obligations require states to ensure that the children receive these services. Like other services covered under EPSDT, case management covered under EPSDT must address a child's specific needs.[52] One child may need care coordination between two providers (e.g., between a primary care provider and an orthopedic specialist for a child with a broken bone), whereas another child with co-occurring medical, developmental, and/or behavioral health conditions may need more complex case management to support the child's access to services and supports provided by a wide range of providers, state agencies, and the education system. Given the role of the education system in the lives of children, states are encouraged to include collaboration with Local Educational Agencies as an accepted practice within Medicaid case management and care coordination to reduce service fragmentation and enhance comprehensive coordination of Medicaid services across settings.[53, 54] More detailed information about the delivery of Medicaid services in schools can be found in the 2022 CMCS Informational Bulletin *Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services* and subsequent 2023 guidance

[51] Section 1905(a)(13) of the Act and 42 C.F.R. § 440.130(d).
[52] Section 1905(r)(5) of the Act.
[53] See: https://www.medicaid.gov/faq/index.html?search_api_fulltext=ID:166416.
[54] Local Educational Agencies are public boards of education or other public authorities legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state. 34 C.F.R. § 300.28.

Policies (cont.)	*Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*.[55, 56] For older children (youth), transitioning from pediatric to adult care is generally a smooth process. However, in some circumstances, particularly for youth with complex medical, developmental, or behavioral health conditions and youth in foster care, approaching the age limit for EPSDT eligibility is a critical time. Any youth no longer entitled to EPSDT who maintains Medicaid eligibility would transition to the Medicaid benefit package(s) available to adults in their respective state; the services included in their adult benefits might be subject to amount, duration, or scope limitations that did not apply under EPSDT.[57] Because states are not required to cover optional section 1905(a) benefits for adults, some services may no longer be available and, if possible, case managers and care coordinators should identify alternatives during this critical time. Depending on the state, some youth may no longer be eligible for Medicaid and would need to transition into other coverage.
Strategies	There are multiple Medicaid authorities under which states can deliver care coordination and case management. Some, but not all, of these authorities are included in the scope of services covered under EPSDT. Below are the various vehicles for care coordination and case management. - PCCM: According to the Act, "primary care case management services," an optional section 1905(a) benefit, means case management-related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a PCCM contract.[58] If a state is delivering care in a PCCM delivery system, individual services are paid FFS and each beneficiary is assigned a primary care provider who acts as case manager in the sense that the provider makes sure well-child services are received as recommended, referrals are provided and followed up, and ongoing health issues are monitored for each child assigned to the practice. The provider receives a small monthly amount to perform these activities. - MCPs: Medicaid MCOs, PIHPs, and PAHPs are required by regulation to coordinate health care services for each of their enrollees and to designate a person or entity, such as a primary care practice or other ongoing source of care appropriate to the child's needs, to provide an

[55] See: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf.
[56] See https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.
[57] For more information about amount, duration, or scope limits that can and cannot apply under EPSDT requirements, see the Policies section of "Table 6: EPSDT and Managed Care Policies, Strategies, and Best Practices," which is located in the "*v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*" subsection of this section.
[58] Sections 1905(a)(25) and (t)(1) of the Act, 42 C.F.R. § 440.168.

Strategies (cont.)	ongoing source of care and coordinate services accessed by the enrollee.[59] Coordinating health care services for their enrollees is also a critical MCP function inherent to a managed care delivery system at the plan level. Care must be coordinated across settings of care and delivery systems when a child receives Medicaid services through an MCP, and an MCP must also coordinate care furnished to its enrollees through the state's FFS program, other MCPs, and community support providers.[60] - Community Health Workers (CHW): CHWs are individuals who have strong ties to the communities they serve and who provide a range of services addressing the health and social needs of beneficiaries, including EPSDT-eligible children and their families. They may be members of communities who are typically underrepresented in health care settings or may be specifically qualified to provide culturally competent care. CHWs may conduct activities such as health promotion and education, patient outreach and follow-up, assistance in navigating the health care system, translation and interpretation of medical information, and care coordination. Certain services provided by CHWs can be covered under the preventive services or rehabilitative services benefits in section 1905(a) of the Act, so long as those services meet regulatory requirements, including that they are recommended by a physician or other licensed provider.[61] - Case Management/Targeted Case Management: Case management services are established in 1905(a) of the Act and defined in regulation as "services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services."[62] Therefore, case management services must be available to EPSDT-eligible children who meet medical necessity criteria for this service. States have additional flexibility under section 1915(g) to target these case management services to a subgroup of Medicaid beneficiaries, such as Medicaid beneficiaries in foster care. In these instances, case management is referred to as "Targeted Case Management" (TCM). Using TCM authority, states do not need to comply with federal requirements for statewideness and comparability of services, enabling them to target case management to an area within the state and/or to defined subgroups of Medicaid beneficiaries (the targeted population).[63] Because the TCM flexibility is defined in section 1915 (and not 1905(a)), it does not fall under EPSDT requirements. As a result, while every EPSDT-eligible child must have access to section

[59] 42 C.F.R. § 438.208(b).
[60] Ibid.
[61] Section 1905(a)(13) of the Act and 42 C.F.R. § 440.130(c) and (d).
[62] Section 1905(a)(19) of the Act and 42 C.F.R. § 440.169(a). See also section 1915(g)(2)(A) of the Act.
[63] Section 1915(g)(1) of the Act and 42 C.F.R. § 440.169(b).

Strategies (cont.)

1905(a) case management services when medically necessary, states are not required to ensure availability of TCM for EPSDT-eligible children.

Case management includes the following four components:[64]

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services.
2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment.
3. Referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.
4. Monitoring and follow up activities.

- Health Homes: Health Homes and Health Homes for Children with Medically Complex Conditions, while not covered as part of the EPSDT requirements, are optional Medicaid state plan benefits that support care coordination for eligible people, including children, with chronic conditions, and for children with medically complex conditions.[65, 66, 67] Health Home services include comprehensive care management; care coordination; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services.
- Administrative Case Management: Case management as an administrative activity (rather than as a covered Medicaid service) involves the facilitation of access to and coordination of services covered under the state's Medicaid program.[68] These activities can include, for example, facilitating access to specialty care and coordinating appointments with multiple providers. A state may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.[69]

[64] 42 C.F.R. § 440.169(d).
[65] Sections 1945 and 1945A of the Act.
[66] Section 1905(r)(5) of the Act requires states to cover health care, diagnostic services, treatment, and other measures described in section 1905(a). Health Homes are described in sections 1945 and 1945A of the Act and are, therefore, not included under the EPSDT mandate.
[67] For more information about section 1945A health home services, including care management and care coordination, that are provided by out-of-state providers for Medicaid-eligible children with medically complex conditions, see CMCS's CIB: https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.
[68] These activities are commonly referred to as "administrative case management," although statute and regulation do not include such terminology. See section 1903(a)(7) of the Act and 42 C.F.R. § 433.15.
[69] See: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf.

Best Practices	***Use community-based care management entities (CME) to coordinate care for children who need moderate or intensive care coordination.*** One state provides care coordination on a tiered basis depending on a child's level of need. Limited care coordination is delivered by MCPs for children with typical care coordination needs. For children who need moderate or intensive care coordination, the state utilizes community-based CMEs whose care coordinators develop a care plan that is guided and driven by the child and their family. This level of care coordination is more extensive and frequent, and involves links to services and resources, and coordination with providers. In this state, CMEs are community-based organizations that serve as the locus of accountability for children and families by providing moderate- to intensive-care coordination and building community resources. CMEs are charged with identifying the formal and informal resources in their geographic area so they can be incorporated into care coordination plans, gathering children and family or caregiver feedback about how effectively they were able to use these resources, and working with local leaders and other interested parties to expand informal resources that children and families need. These services can help prevent family involvement in the child welfare system by supporting families in their own homes and communities.

iv. Ensuring Consideration of EPSDT in States' Medicaid Policies and Procedures

States will not be able to comply with the EPSDT requirements unless their Medicaid policies and procedures, including medical necessity criteria, prior authorization requirements, and Medicaid fair hearings, reflect consideration of the EPSDT requirement to cover section 1905(a) services necessary to correct or ameliorate identified medical needs for EPSDT-eligible children. Medical necessity criteria cannot have the effect of imposing a limit on the amount, duration, or scope of services that can never be exceeded for EPSDT-eligible children, nor can they be arbitrary or result in inappropriate limits on access to a service.[70] States must ensure their policies and procedures are consistent with EPSDT's "correct or ameliorate" standard and do not default to the criteria used for adult beneficiaries.

Table 5: Policies, Strategies, and Best Practices for Ensuring Consideration of EPSDT in States' Medicaid Policies and Procedures

Policies	Regardless of delivery system, children entitled to EPSDT must have access to services that can be covered under section 1905(a) of the Act when those

[70] Section 1905(r)(5) of the Act; per 42 C.F.R. § 438.210(a)(5)(i), each contract between a state and an MCP must specify what constitutes medically necessary services in a manner that is no more restrictive than that used in the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedure.

Policies (cont.)

services are necessary to correct or ameliorate an identified medical need. Thus, while services available to adults may include limits on the amount, duration, and scope of services that can never be exceeded (i.e., a "hard limit"), states are not permitted to apply these kinds of limits to any service covered under EPSDT in either a FFS or managed care delivery system. Similarly, if an optional section 1905(a) service is not covered for adults, that section 1905(a) service must still be made available to EPSDT-eligible children when it is medically necessary. States are ultimately responsible for ensuring EPSDT-eligible children receive the coverage required by the Medicaid statute and regulations, even if some or all of that care is covered through an MCP.[71]

That said, states may impose—and may permit MCPs to impose—utilization controls to safeguard against unnecessary use of care and services in a manner that is consistent with the EPSDT requirements.[72] For example, a state may establish limits on the amount, duration, or scope of services that may be exceeded with prior authorization and/or a medical necessity review (i.e., a "soft limit"). Importantly, under CMS's interpretation of section 1905(r)(5), prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually, and it must not delay the delivery of needed treatment services. Additionally, under CMS's interpretation of section 1905(r), states may not impose prior authorization requirements for EPSDT screening services. In sum, CMS expects states to align prior authorization or other utilization controls broadly for services covered under EPSDT with what Congress has described as the "preventive thrust" of the EPSDT benefit.[73] Note that new requirements regarding timing of prior authorization decisions and reporting state data about prior authorizations will apply to Medicaid FFS and managed care delivery systems beginning in 2026.[74]

Whenever a state Medicaid agency takes an adverse action (which includes a termination, suspension, or reduction in eligibility or services/benefits), it must provide at least 10 days' advance notice and information on fair hearing rights.[75] Medicaid agencies must provide notice and fair hearing rights for a denial of a request for a benefit or service, including a prior authorization request denied in whole or in part, as this action would cause a "denial or change in benefits and services."[76] Adverse action and denial notices must contain a statement of the intended action, the specific reasons and legal support for the action, an explanation of the individual's fair hearing rights (including the right to request an expedited fair hearing, right to

[71] 42 C.F.R. § 438.210(a).
[72] 42 C.F.R. §§ 440.230(d), 438.210.
[73] See also H.R. Rep. No. 101-247 at 399-400, reprinted in U.S.C.C.A.N. 1906, 2125-26; https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf. See also 42 C.F.R. § 438.210(b)-(e).
[74] 42 C.F.R. §§ 440.230(e)(1) and (3), 438.210(d) and 438.210(f).
[75] 42 C.F.R. Part 431, Subpart E.
[76] 42 C.F.R. § 435.917(a) and (b)(2).

Policies (cont.)	representation, and when continued benefits will be provided), and how to request a fair hearing.[77] Notice of denials, including prior authorization decisions, or of adverse actions must be provided in writing, written in plain language, accessible to persons with limited English proficiency and individuals with disabilities, and, if provided in an electronic format, compliant with rules relating to electronic notices and information.[78] State Medicaid agencies must exercise appropriate oversight of their Medicaid fair hearing system to ensure fair hearing decisions correctly apply all relevant federal and state law, regulations, and policies, including the EPSDT "correct or ameliorate" standard.[79] Fair hearing officials must have access to agency information necessary to issue a proper hearing decision, including information concerning state policies and regulations.[80] For example, a hearing officer who conducts a hearing challenging the termination, suspension of, or reduction in covered benefits or services for an EPSDT-eligible child must have access to the state's policies and procedures that implement the EPSDT's "correct or ameliorate" standard and have sufficient training in such policies.[81] The hearing decision must identify the evidence and laws or regulations supporting the decision, including consideration of EPSDT requirements, as applicable.[82] To contest an adverse benefit determination from a managed care plan, beneficiaries must file an appeal or grievance with the plan before requesting a state fair hearing for Medicaid or a state external review for separate CHIP.[83] More detail on requirements for managed care adverse determinations is provided below in the "*v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*" subsection.
Strategies	<u>Ensure EPSDT subject matter expertise across the state Medicaid agency.</u> As EPSDT requirements impact most aspects of Medicaid—including services that vary widely, from dental to pediatric subspecialty care, and may involve FFS and managed care delivery systems—states should disseminate EPSDT expertise across the agency. States should employ personnel with EPSDT expertise to inform policy development, programmatic implementation, and oversight. EPSDT subject matter experts can work with other agency personnel, informing coverage decisions and applications of medical necessity, to ensure that EPSDT-related state policies are consistent with

[77] 42 C.F.R. §§ 435.917(b)(2)) and 431.206-210.
[78] 42 C.F.R. §§ 440.230(e)(2), 435.917, 435.918, 438.10, and 438.210.
[79] 42 C.F.R. §§ 431.10(c)(3)(i)-(ii) and 431.205(a).
[80] 42 C.F.R. § 431.240(c).
[81] 42 C.F.R. §§ 431.240(c) and 432.30.
[82] 42 C.F.R. Part 431 Subpart E. See also: https://www.medicaid.gov/resources-for-states/downloads/mdcid-fair-hrings-prtnr-rsurce.pdf.
[83] 42 C.F.R. §§ 438.402 and 457.1260(b)(2).

Strategies (cont.)	federal requirements. In cases where a state is unable to hire personnel who already have expertise in EPSDT, the state could partner with external organizations to support the training of existing personnel in EPSDT requirements. When appropriate, staff could be supported by employing pediatric Skilled Professional Medical Personnel (SPMP); states can access an increased matching rate of 75% FFP to support those activities.[84] Require managed care plans and Medicaid fair hearing officials to document consideration of EPSDT, when applicable. States can require that managed care appeal resolutions and Medicaid fair hearing decisions, already required to be provided to beneficiaries in writing, include clear evidence that EPSDT requirements were considered during the appeal or fair hearing process. Collect and analyze prior authorization and fair hearing data related to children. As noted above, the new requirements regarding reporting of aggregate information on prior authorization approvals, denials, and timeliness are not yet in effect. However, in advance of those requirements, states can analyze their own information on prior authorizations and appeals by age, service category, and health plan to identify any issues related to authorizations for EPSDT-eligible children. Offer EPSDT-specific provider training. Providers are often the primary source of information for beneficiaries; therefore, it is essential they do not assume that hard limits on adult services apply to children. They should understand and be able to convey the beneficiary's right to timely diagnostic and treatment services. Because Medicaid providers request authorization of medical services for EPSDT-eligible beneficiaries, they should clearly understand how to request additional medical services. States can also work with health care professionals' organizations to provide training on EPSDT policy to the organizations' membership and can structure trainings to qualify for continuing education credit.
Best Practices	***Regularly review decisions for prior authorization requests, managed care appeals, and/or state fair hearing requests for services provided to EPSDT-eligible children, by MCP or service type, for clinical appropriateness.*** One state, upon evaluating data on decisions for prior authorization requests, decided to eliminate the requirement for prior authorization for certain services, while keeping the prior authorization process intact for other services. States can perform the same type of review to ensure prior authorization processes are appropriate across MCPs. States have a variety of oversight mechanisms, including state audits, post-payment reviews, and reviews by an External Quality Review Organization (EQRO), that they can

[84] For more information on SPMP, see the "*i. Improving Care for Children with Behavioral Health Needs*" subsection in "III. Improving Care for Children with Specialized Needs."

Best Practices (cont.)	use to ensure prior authorization requests and claims denials are clinically appropriate. ***Create and require EPSDT-specific web-based provider training***. One state created an EPSDT-specific provider training website and portal to ensure that its providers understand all aspects of EPSDT. The training website is easy to navigate, and providers have flexibility to access the training when they are available and are therefore not dependent on availability of agency or MCP staff. The state monitors provider training through login and completion of a post-training test. ***Prioritize EPSDT-specific expertise***. Some states prioritize having EPSDT leadership and staff-level expertise to provide agency-wide input and guidance. These staff act as expert consultants across the state agency to ensure that EPSDT requirements are considered and included in decision-making. Further, some states require MCPs to have an EPSDT point of contact who is responsible for EPSDT at the plan-level. ***Extend EPSDT technical assistance to MCPs***. One state provides its MCPs with the opportunity for EPSDT-specific review by state staff of the MCPs' member-facing materials as a means of ensuring consistency in EPSDT implementation.

v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT

The majority of states deliver care through a managed care delivery system, and an overwhelming majority of children receive some or all care through managed care. Medicaid managed care provides for the delivery of Medicaid state plan benefits through MCPs that contract with the Medicaid agency. States can structure their managed care programs to require voluntary or mandatory enrollment of Medicaid beneficiaries through Medicaid managed care authorities (e.g., 1932(a) state plan authority, 1915(b) waiver authority, 1915(a) contract authority, etc.). MCPs are typically paid by the state through a risk-based payment such as a capitation rate and negotiate their own payment rates with providers, unless otherwise directed by the state (e.g., a state directed payment). Enrollees select from among an MCP's network of providers. States must also have an enrollment system for all Medicaid managed care programs, which must include when and how often enrollees may select a different MCP.[85]

When states use MCPs to deliver some or all EPSDT benefits, states must clearly delineate the MCPs' responsibilities in the managed care contract to help ensure that the MCPs understand the full scope of their obligations under EPSDT.[86] States must monitor and oversee MCPs and must have mechanisms in place to hold MCPs accountable for fulfilling all contracted

[85] 42 C.F.R. § 438.54(b).
[86] See 42 C.F.R. §§ 438.210(a)(1)-(3), 438.66, 438.206.

responsibilities.[87] Regardless of how significant the MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.

States utilize the requirements in the 42 C.F.R. Part 438 regulations to help ensure that enrollees are aware of, and have access to, medically necessary services in accordance with EPSDT requirements. For example, regulations require that states develop and enforce network adequacy requirements and that states use their managed care contracts to mandate MCP compliance with regulatory requirements and enable enforcement as indicated. The 2024 *Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality* rule (2024 Managed Care Rule) introduced important new requirements for timely access to care, including pediatric-specific timely access requirements, and managed care network adequacy.[88] These requirements will become applicable over the next several years, and states should maintain a focus on EPSDT requirements and children's access to services as they implement these new provisions.[89]

Table 6: EPSDT and Managed Care Policies, Strategies, and Best Practices

Policies	As noted above, the 2024 Managed Care Rule introduced new requirements that will become applicable over the next several years. As such, we have separated the EPSDT managed care policy information into two sections: 1) Current statutory and regulatory requirements (which are relevant today); and 2) Upcoming changes related to the 2024 Managed Care Rule. *Current statutory and regulatory requirements* When a managed care delivery system is used to deliver some or all services required under EPSDT, states must identify, define, and specify the specific EPSDT services that the MCP is required to cover in the MCP's contract.[90] Depending upon the type of MCP and contractual arrangement, the MCP may be responsible for all medically necessary covered services for EPSDT-eligible children while other MCPs or a state's FFS program covers other services; for example dental services may be covered outside of the MCP. When states include some services covered under EPSDT in their managed care contracts but exclude specific section 1905(a) services from such managed care contracts, the contract must be explicit that the MCP is required to cover all medically necessary section 1905(a) services except those that are explicitly excluded. The state maintains the obligation under EPSDT requirements to ensure a child receives coverage of those explicitly excluded medically necessary services to correct or ameliorate identified medical needs. If an MCP is contractually responsible for *all* medically necessary services for EPSDT-eligible children, the MCP is obligated to

[87] Section 1932(e)(1)(a) of the Act; 42 C.F.R. §§ 438.66 and 438.700.
[88] See: https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.
[89] For a full list of applicability dates for Final Rule provisions, see https://www.medicaid.gov/medicaid/managed-care/downloads/applicability-date-chart-mc.pdf.
[90] 42 C.F.R. § 438.210(a).

Policies (cont.)

ensure access to those services, including access to services that may not otherwise be listed as a covered service in its contract.[91]

Outside the scope of section 1905(a), states may also choose to give MCPs the contractual authority to provide in lieu of services and settings (ILOS) for certain services and settings. An ILOS offered by an MCP must be approvable as a service or setting through a waiver under section 1915(c) of the Act or a state plan authority, including section 1905(a), 1915(i), or 1915(k) of the Act.[92] For EPSDT-eligible children, 1905(a) services must be provided when medically necessary and thus cannot be included in an MCP's contract as an ILOS. ILOS are provided at the option of an MCP and an EPSDT-eligible child, when the ILOS can be expected to reduce or eliminate the future need to utilize section 1905(a) services or settings.[93, 94] As an example, a few states are using ILOSs for youth with serious emotional disturbance to provide supports for caregivers, including respite care.

MCPs can also voluntarily provide services that are in addition to those covered under the state plan. These services, often called value-added services, are optional and need not be strictly medical in nature but must improve health care quality. States and their actuaries cannot include the cost of these voluntary services when determining capitation rates.[95]

Medicaid services delivered to EPSDT-eligible children through a managed care delivery system must be determined by an MCP to be medically necessary services in a manner that is no more restrictive than that used in the state's Medicaid program in accordance with the EPSDT standard, not the standard that might be otherwise utilized for adults.[96] States' and MCPs' determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.[97] The state or MCP should consider the child's long-term needs, not just what is required to address the immediate situation. Given the obligation under EPSDT requirements to ensure a child receives coverage of medically necessary section 1905(a) services to correct or ameliorate identified medical needs, medical necessity reviews cannot have the effect of imposing a hard limit for EPSDT-eligible children, nor can they result in inappropriate limits on access to a service.[98]

MCPs must ensure that utilization management adheres to EPSDT principles and takes into consideration a particular child's needs.[99] While states and

[91] 42 C.F.R. § 438.210(a)(2), citing subpart B of 42 C.F.R. Part 441.
[92] 42 C.F.R. §§ 438.3(e)(2) and 438.16.
[93] 42 C.F.R. § 438.16(b).
[94] 42 C.F.R. § 438.3(e)(2).
[95] 42 C.F.R. § 438.3(e)(1)(i), 45 C.F.R. § 158.150.
[96] 42 C.F.R. § 438.210(a).
[97] Section 1905(r)(5) of the Act and 42 C.F.R. §§ 438.210(a)(2) and (a)(5).
[98] Section 1905(r)(5) of the Act and 42 C.F.R. § 438.210(a).
[99] 42 C.F.R. §§ 438.210(a)(4)-(5).

Policies (cont.) MCPs may use prior authorization and other utilization management strategies to ensure that care is being used appropriately, utilization management should not create excessive administrative burden that results in the delay or denial of medically necessary services. Our listening sessions revealed concerns about states and MCPs using commercially available utilization management software to review prior authorization requests. While many states and MCPs rely on this software to streamline the process of authorizing care, states must ensure that any software used by MCPs in this process is consistent with the EPSDT requirement to cover medically necessary care that can be covered under section 1905(a), as well as regulatory requirements for coverage and authorizations of services.[100] States and MCPs should also ensure that the managed care appeals process is operationalized consistent with EPSDT principles and that the staff making appeal decisions understand and adhere to these principles.

States and MCPs should help to ensure the availability and accessibility of services for children by educating providers on EPSDT requirements. It is particularly important for providers to understand that the adult section 1905(a) benefits packages are a subset of services that should be available for an EPSDT-eligible child and hard service limits for adults do not apply to an EPSDT-eligible child's medically necessary care. Lacking this knowledge, it is possible a provider may not request a service for an EPSDT-eligible child because they think the service is not covered.

Services under EPSDT, like all Medicaid services, must be provided with "reasonable promptness."[101] MCPs must maintain a sufficient network of providers with pediatric expertise who can be accessed in a timely manner.[102] If an EPSDT-eligible child does not have timely access to a network provider for medically necessary care, the MCP must arrange for and cover medically necessary covered services out-of-network, including out-of-state if necessary, for as long as the MCP's provider network is unable to provide the medically necessary services.[103] This includes cases in which an enrollee cannot access a medically necessary service within a timeframe contractually imposed on the MCP. In situations where a provider indicates, or the MCP determines, the standard timeframe for a service authorization "could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function," the MCP must make an expedited decision. Specifically, the MCP must make an authorization decision and provide notice to the provider and enrollee as expeditiously as the enrollee's

[100] 42 C.F.R. § 438.210.
[101] Section 1902(a)(8) of the Act.
[102] See Section 1932(b)(5) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. § 438.206(a) and (b)(1).
[103] 42 C.F.R. § 438.206(b)(4).

Policies (cont.) health condition requires and no later than 72 hours after receiving the request for the service.[104]

Upcoming changes related to the 2024 Managed Care Rule

Under the 2024 Managed Care Rule, for rating periods beginning on or after July 9, 2027, states are required to develop and enforce appointment wait time standards for routine appointments for several different service categories, including pediatric primary care services, pediatric outpatient mental health and SUD services, obstetric/gynecological services, and a service of the state's choice. These standards must adhere to maximum appointment wait time standards of 15 business days for primary care and obstetric/gynecological services, and 10 business days for outpatient mental health and SUD. The wait time standards for outpatient mental health and SUD services and primary care are measured separately for pediatric and adult populations. States, however, may choose to establish shorter maximum appointment wait times.[105]

The 2024 Managed Care Rule also includes important provisions to ensure that each MCP is meeting appointment wait time standards and to strengthen states' ability to monitor and address MCPs' access to care issues. The 2024 Managed Care Rule requires states to collect a variety of information on MCP performance, including a provider payment analysis demonstrating each MCP's level of payment for certain services, an enrollee experience survey, secret shopper surveys for appointment wait time standard compliance, and evaluations of the accuracy of electronic provider directories.[106, 107] These provisions become applicable for rating periods beginning on or after July 9, 2026, July 9, 2027, and July 10, 2028, respectively.[108]

These provisions will give states significantly more information about managed care enrollees' access to care that they can use to better understand and address barriers to care. Secret shopper surveys will give states evaluative data on MCPs' compliance with appointment wait time standards; provider payment analyses will give states more information to evaluate the effect of payment rates on provider networks; and the enrollee experience survey can examine factors affecting utilization of services beyond numbers of network providers. This may include the degree to which written materials, transportation, quality of care, and other factors may be discouraging or preventing enrollees from accessing necessary care.

[104] 42 C.F.R. § 438.210(d)(2)(i).
[105] 42 C.F.R. § 438.68(e).
[106] 42 C.F.R. §§ 438.68(f), 438.66(b)(4) and (c)(5), 438.207(b).
[107] These provisions in the 2024 Managed Care Rule requires these for MCOs, PIHPs, and PAHPs. They do not apply to PCCM entities and PCCMs except for the enrollee experience surveys at state option.
[108] For a full list of applicability dates for Final Rule provisions, see https://www.medicaid.gov/medicaid/managed-care/downloads/applicability-date-chart-mc.pdf.

Policies (cont.)	However, the survey must be thoughtfully developed in order to produce meaningful results. States may want to consider validating the survey through an EQRO as part of the annual external quality review (EQR) conducted for MCPs. For Medicaid programs, EQR and EQR-related activities performed on MCPs are eligible for up to a 75% enhanced federal match when conducted by a qualified EQRO and when the EQR-related activities are completed using methodologies consistent with the updated EQR protocols.[109]
Strategies	Incentivize performance improvement for services covered by MCPs. States may use state directed payments (SDP) to direct MCPs' payments to providers to achieve goals related to performance improvement, fee schedules, and delivery system reform.[110] Several states have implemented pediatric-specific SDPs to improve quality and access by offering enhanced rates or a minimum fee schedule for eligible pediatric providers.[111, 112] Utilize ILOSs to enhance and expand access to health care services and settings. ILOSs allow states and MCPs to enhance 1905(a) services and settings.[113] For example, states and MCPs can minimize the risk of EPSDT-eligible children being placed in out-of-home settings by providing ILOSs, including home and community-based services (HCBS), to EPSDT-eligible children.[114] Additionally, ILOSs can be used to expand the breadth of available behavioral health care settings, thereby helping to ensure EPSDT-eligible children receive care in the most medically appropriate setting for their needs. Focus on pediatric provider networks. States are required to ensure that Medicaid MCPs maintain provider networks that are sufficient to provide accessible and timely care to enrollees, including EPSDT-eligible children.[115] This may include the state evaluating the ratio of children to MCP providers, including children with disabilities, as an oversight function and determining whether the number of pediatric subspecialists is sufficient

[109] FFP at the 75% rate is available in expenditures for EQR, (including the production of EQR results) and the EQR-related activities set forth in § 438.358 when performed on MCOs and conducted by EQROs and their subcontractors. In comparison, for PIHPs, PAHPs, or PCCM entities, FFP at the 50% rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO, and for EQR (including the production of EQR results) and EQR-related activities performed by an EQRO on entities other than MCOs. See: 42 C.F.R. § 438.370.

[110] All SDPs must comply with applicable federal requirements, including those at 42 C.F.R. § 438.6.

[111] 42 C.F.R. § 438.6.

[112] See: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html.

[113] 42 C.F.R. §§ 438.3(e)(2), 438.16.

[114] Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 require that services for individuals with disabilities be provided in the most integrated setting appropriate to the needs of qualified individuals with disabilities. These statutes may prohibit child welfare agencies from encouraging out-of-home placements to receive services, where out-of-home placements are not the most integrated setting appropriate, and such placement would be unnecessary under the statutes and the Supreme Court's decision in *Olmstead*.

[115] Section 1932(b)(5) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. §§ 438.68(a)-(b), 438.206(a).

Strategies (cont.)	to address the needs of the population enrolled. States may then utilize the flexibility they have to develop or revise a specific quantitative network adequacy standard or appointment wait time standard beyond those already required to target an area under the EPSDT mandate where there is a suspected or confirmed gap in network adequacy. For example, the needs of a specific population of an MCP's enrollees may require specific types of subspecialty providers. Monitor and improve MCPs' performance in ensuring access to care for children. As states implement the 2024 Managed Care Rule provisions related to secret shopper surveys, payment analyses, and enrollee surveys, states can gain insight on their MCPs' performance in assuring access to services per EPSDT requirements by keeping a focus on findings related to children.
Best Practices	***Use and enforce managed care contract language to require MCPs to use best practices.*** To improve awareness of, and access to, services for which coverage is required under the EPSDT mandate when some or all of those services are delivered in a managed care delivery system, states can include managed care contract language to implement a variety of practices, such as: - Contacting parents to assist with scheduling a well-child visit unless the parent declines. - Tracking whether children are due or overdue for well-child visits, as well as whether they received dental check-ups in line with timeframes identified in the managed care contracts. - Issuing sanctions or financial incentives (such as incentive arrangements) based on the MCP's annual reports on pediatric metrics.[116] - Tracking primary care providers' referrals to dentists. - Including in enrollee handbooks the availability of and how to obtain specific specialty care, such as private duty nursing, personal care, and medical equipment. - Providing clinics and primary care providers with a monthly list of children due and overdue for a well-child visit for that clinic to perform outreach and ensure the member has access to prompt services, while ensuring that these efforts to reach members are coordinated with MCP outreach to the same families. - Training providers on how members access NEMT, along with missed appointment assistance provided by the MCP, to encourage a shared understanding of how to use Medicaid benefits.

[116] States can use a variety of strategies for incentive arrangements, including those described at 42 C.F.R. §§ 438.6(b)(2), 438.6(b)(3), and 438.700.

Best Practices (cont.)

Convene MCPs around shared quality goals. Convening MCPs as a group to work toward specific, measurable improvement goals in pediatric performance measures has been effective in increasing children's utilization of well-child care. States can set performance targets and expectations for MCPs to serve as the basis for quality improvement and convene MCPs to strategize and work toward those targets to improve the care that children receive. Ideally, states take a leadership role in guiding MCPs to work on a set of initiatives, benchmarking performance, and cataloging and disseminating statewide any MCPs' improvement strategies that have been particularly effective.

Implement a non-clinical Performance Improvement Project (PIP) to ensure occurrence of well-child visits. MCPs are required to engage in PIPs in clinical and non-clinical areas each year to objectively measure performance, implement interventions, evaluate the effectiveness of these interventions, and initiate activities to sustain improvement.[117] One state with particularly high well-child visit utilization implemented a non-clinical PIP to help ensure data accuracy and to ensure that when well-child visits occur, the associated data are captured and reported correctly.

Include children with disabilities or other complex medical needs in managed care quality strategies. States with managed care programs must develop and maintain a managed care quality strategy to set measurable targets and improve the quality of care within the state's Medicaid program.[118]

- States that serve children with disabilities or complex medical needs in managed care are encouraged to include pediatric subspecialty care measures in their quality strategy to ensure this small population remains a focus.[119]

Improve quality and utilization for children through optional focus studies in annual EQR. States with MCPs also must ensure that a qualified EQRO conducts an annual EQR for each contracted MCP. EQR is the analysis and evaluation by an EQRO of aggregated information on the quality, timeliness, and access to the health services that an MCP or its contractors provide to beneficiaries. The mandatory and optional EQR-related activities provide opportunities to assess specific areas of MCP performance and provide information that can be used to improve health care access for children.[120]

- States with managed care programs may include optional focus studies within their annual EQR, including a focus study to investigate an area

[117] 42 C.F.R. § 438.330(d).
[118] 42 C.F.R. § 438.340.
[119] For more information about policies, strategies, and best practices related to children with disabilities or other complex health needs, see the "*iii. Improving Care for Children with Disabilities or Other Complex Health Needs*" subsection in the "III. Improving Care for Children with Specialized Needs" section.
[120] 42 C.F.R. §§ 438.350, 438.358.

Best Practices (cont.)	of concern or establish a baseline for current utilization.[121] This offers a broad opportunity to improve quality and utilization for children through analysis of well-child visit utilization variations by age, geography, and MCP, as well as rates of prior authorization approvals and denials. States' expenditures for EQR of MCOs may be eligible for FFP at a 75% match rate, including the production of the EQR technical report for MCOs and EQR-related activities performed on MCOs, when conducted by the state's contracted EQRO for managed care organizations that have a contract under section 1903(m) of the Act.[122]

II. Expanding and Using the Children-Focused (EPSDT) Workforce

CMS has heard from states that in some regions and for some services, state Medicaid agencies have difficulty enrolling providers, and research supports these experiences. For example, workforce data collected by the Health Resources and Services Administration (HRSA) indicate that the availability of pediatricians varies, with the number of pediatric physicians per 100,000 individuals ranging from 7.9 to 68.0 across states in 2023.[123] HRSA also projected that, by 2036, metro areas will have 98% supply adequacy for pediatric physicians and nonmetro areas will only have 69% supply adequacy.[124] CMS recognizes that provider availability issues and distribution vary among states. However, states have been working creatively within federal requirements to expand the EPSDT workforce, in particular by: i. broadening provider qualifications, ii. using telehealth, iii. encouraging the use of interprofessional consultation, and iv. using payment methodologies that incentivize EPSDT provider participation.[125]

When implementing any of the strategies or best practices in these areas, states should be mindful of administrative burden, which providers have cited as a barrier to Medicaid participation. If possible, states should consider taking steps to reduce the administrative burden on providers by streamlining provider enrollment, performing cost-benefit analyses of prior authorizations, and/or changing prior authorization for categories of requests that are typically approved. Similarly, states should ensure that provider payment rates are adequate to establish a sufficient network of providers.[126] Although adequate payment rates are not, in and of themselves, enough to ensure a sufficient network, without them, any other steps a state might take to improve the provider workforce likely will be less effective.

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[121] 42 C.F.R. § 438.358(c)(5).
[122] 42 C.F.R. § 438.370(a).
[123] See: https://data.hrsa.gov/topics/health-workforce/ahrf.
[124] See: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf.
[125] By "EPSDT workforce" we mean providers whose medical expertise focuses on health care services for individuals under the age of 21 (e.g., pediatricians, pediatric cardiologists, etc.), as well as any general practitioners who have the relevant training and knowledge to provide care to these children and youth.
[126] See section 1902(a)(30)(A) of the Act, which requires states to assure that payments for Medicaid services are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the Medicaid state plan at least to the extent that such care and services are available to the general population in the geographic area.

i. Broadening Provider Qualifications to Expand the EPSDT Workforce

Table 7: Policies, Strategies, and Best Practices for Broadening Provider Qualifications to Expand the EPSDT Workforce

Policies	Generally, in Medicaid FFS programs, states must ensure that a Medicaid beneficiary may obtain covered services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services to that particular beneficiary.[127] States have broad flexibility to establish reasonable provider qualifications related to the fitness of the provider to perform covered medical services, and states can require that MCPs use network providers that meet these standards.[128] In addition, federal statute and regulations require that many Medicaid benefits be provided by physicians or other licensed practitioners. Where that is not the case, states may expand the range of existing providers of Medicaid-covered services by providing training and support and creating paraprofessional qualifications for other provider types to expand the pool of available providers.
Strategies	Develop non-licensed practitioner types. Many states have added practitioner types that do not require licensure to deliver care where allowable.[129] This includes, for example, allowing peer support practitioners to deliver services to children and to parents/legal guardians when for the direct benefit of the child under a number of different Medicaid authorities, including section 1905(a) services such as rehabilitative services.[130] These practitioners expand the workforce available to serve beneficiaries and allow licensed providers, such as social workers, psychologists, and psychiatrists, to focus on the more complex or clinically intensive services that they alone can provide. Additionally, expanding the use of recovery or other therapeutic groups allows licensed providers to serve more people, while also providing access to elements of peer support. Broaden the role of existing providers. Some states have offered optional provider training, along with rate increases, to expand the ages of individuals the provider will see, thereby reducing referrals to pediatric subspecialists. Other states have expanded access to primary care provider consultation for mild-to-moderate psychiatric conditions, relieving some pressure on participating child psychiatrists. Several examples described below ask more

[127] Section 1902(a)(23)(A) of the Act and 42 C.F.R. § 431.51(b). See also 42 C.F.R. § 441.61(b).
[128] See: 42 C.F.R. §§ 431.51(c)(2), 438.214(a) and (b).
[129] See: https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.
[130] See: https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.

Strategies (cont.)	of primary care providers, and we note that to be successful, these practices need to be adequately paid for and supported.
Best Practices	***Incorporate oral health into children's primary care visits.*** One state model linking oral health with primary care has shown promise by improving oral health care for young children. According to standards of medical practice, young children have primary care visits more frequently than older children, and incorporating oral health into these visits has yielded success. States may train primary care providers and pay them for services including oral evaluations or screenings, risk assessments, parent or caregiver counseling, and fluoride varnish application. States may also establish procedures to support referrals to ongoing dental care.[131] ***Support and incentivize general practitioners to serve younger children.*** A different approach that has yielded an increase in available dental practitioners is to provide training, support, and enhanced payments to general dentists to increase their ability to serve younger children. Children younger than five may require specialized instruments and behavioral support for dental examinations and treatment, and some general dentists may be hesitant to treat them. One state trains general dentists in behavioral techniques and makes enhanced payments for the extra time it may take to serve this population. Partner organizations, funded in part by Medicaid administrative expenditures, provide support to children and families to connect to participating providers. This approach has yielded an increase in the numbers of participating providers willing to serve very young children. This best practice was identified with dentists but could be applied with other providers and services as well.

ii. Using Telehealth to Expand the EPSDT Workforce

Table 8: Telehealth Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	State Medicaid agencies have a great deal of flexibility in developing coverage and payment parameters for Medicaid services delivered via telehealth, including services provided to EPSDT-eligible children.[132] For Medicaid services that states allow to be delivered using telehealth, states must continue to meet any federal requirements related to coverage of the benefits and other applicable federal law, including the requirements of Title XIX of the Act and federal regulations (as interpreted in published CMS

[131] For resources from a 14-state learning collaborative to improve oral health prevention in primary care, please visit CMCS's Oral Health Quality Improvement Resources website, available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/oral-health-quality-improvement-resources/index.html.

[132] See: https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf.

Policies (cont.)	guidance), and the parameters of a state's CMS-approved Medicaid state plan and/or demonstration projects and waivers.
Strategies	Allow providers to deliver services via telehealth. To address EPSDT provider shortages, states have the option to enroll additional individual providers, and/or enable additional provider types, to render services via telehealth.[133] For instance, subject to state enrollment and scope of practice laws and policy, states could potentially enroll and pay out-of-state providers to deliver services to EPSDT-eligible children via telehealth. Address workforce shortages in rural and medically underserved areas by allowing services, including behavioral health services, to be delivered using telehealth. Workforce shortages in rural or medically underserved areas can be mitigated by state Medicaid agencies allowing providers to deliver services, including behavioral health services, using telehealth. To address behavioral health workforce challenges in particular, states may use strategies like optimizing Pediatric Mental Health Care Access (PMHCA) programs and using telehealth as a model of integration.[134] Mental health care access programs are a high-value means of supporting pediatric primary care providers to manage mild to moderate mental health and SUD treatment without the need to refer patients to specialty care.
Best Practices	***Enroll out of state providers.*** While not specific to pediatric providers, one state allows out-of-state providers to deliver services via telehealth under a "Border Status" policy.[135] This policy allows certain providers—such as providers in a state that physically borders the state and all out-of-state independent laboratories, regardless of location—to potentially enroll in the state's Medicaid program. All of these providers are subject to the same provider requirements as in-state providers.

iii. Encouraging the Use of Interprofessional Consultation to Address EPSDT Workforce Shortages

Table 9: Interprofessional Consultation Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	Interprofessional consultation is defined as a situation in which the patient's treating physician or other qualified health care practitioner requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise to assist the treating practitioner with the patient's care without patient face-to-face contact with the

[133] Ibid.
[134] See: https://mchb.hrsa.gov/sites/default/files/mchb/about-us/pmhca-fact-sheet.pdf and https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders.
[135] See: https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf.

Policies (cont.)	consulting practitioner. For the consulting physician to receive direct payment from Medicaid, the services must be directly relevant to the individual patient's diagnosis and treatment, and the consulting practitioner must have specialized expertise in the particular health concerns of the patient. Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care. Interprofessional consultation services may be covered under a variety of Medicaid state plan benefits, such as physician services, services of other licensed practitioners, and rehabilitative services. Both the treating practitioner and the consulting practitioner must be enrolled in Medicaid or CHIP.[136]
Strategies	Mitigate the need for referrals to pediatric subspecialists by connecting primary care providers and child behavioral health providers using a PMHCA program. PMHCA programs exist in 46 states and 8 entities.[137] These programs provide child psychiatry consultation to primary care providers in real time and have been demonstrated to be beneficial both for individual consultation and for disseminating best practices through training to enhance the capacity for diagnosis and treatment provided within primary care. Primary care providers can call a number and be connected to a child psychiatrist who can consult on individual patients. State PMHCA programs provide primary care providers with the support they need to diagnose and treat children with mild to moderate behavioral health conditions, resulting in a reduction in the number of families waiting for referrals to pediatric subspecialists. Subject to section 1903(a) of the Act, many states are able to claim FFP for some of the costs incurred to administer a PMHCA program, subject to Medicaid administrative claiming rules.[138] Additionally, states can partner with their PMHCA lead agency (which may be the Health and Human Services agency, the Behavioral Health Agency, or Title V agency within the state Health and Human Services Department) to ensure funding sustainability through claiming for Medicaid covered services delivered to EPSDT-eligible Medicaid beneficiaries.
Best Practices	***Adopt the Collaborative Care Model (CoCM).*** Interprofessional consultation is one of the components of the CoCM, an evidence-based approach that integrates and improves both behavioral and physical health among individuals of any age, including children.[139] CoCM uses a team-based approach in which a treating practitioner addresses patients' mental health

[136] See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.
[137] See: https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access.
[138] See: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf.
[139] For more information on interprofessional consultation and CoCM, see: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.

Best Practices (cont.)	and SUD conditions while supported by a behavioral health care manager and a psychiatric consultant. CoCM is used by numerous state Medicaid agencies and has demonstrated success in expanding access to and improving outcomes in behavioral health care by integrating a behavioral health care manager with a primary care provider at an office location. These providers then collaboratively manage a caseload of children with behavioral health conditions through weekly consultations with a psychiatrist and other behavioral health practitioners, often through telehealth. The integration of telehealth within the collaborative care model both improves access to psychiatrists for Medicaid beneficiaries and increases the caseload that can successfully be managed by a limited behavioral health workforce.

iv. Using Payment Methodologies that Incentivize EPSDT Provider Participation

Table 10: Payment Methodology Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	States have considerable flexibility under Medicaid authorities to develop Medicaid payment methodologies, including payment incentives for services delivered to EPSDT-eligible children. States are required under a FFS delivery system to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[140] In managed care, states contract with MCPs to provide some or all Medicaid benefits, as specified in the contract, to Medicaid beneficiaries enrolled in the MCP. Generally, states prospectively pay MCPs a risk-based capitation rate (typically a per member per month payment) for providing services to a Medicaid enrollee. Capitation rates are required to be actuarially sound, meaning that the rates are projected to provide for all reasonable, appropriate, and attainable costs for services and populations covered under the contract.[141] Please also note that all federal statutory and regulatory requirements apply to payments made for services covered under EPSDT, regardless of service delivery system, including requirements applicable to the sources of the non-federal share.[142]
Strategies	States may explore options to enhance or structure Medicaid payment rates to reward providers for delivering high quality care to EPSDT-eligible children. Often, states with higher rates of utilization of well-child visits

[140] Section 1902(a)(30)(A) of the Act.
[141] 42 C.F.R. §§ 438.2, 438.4.
[142] See for example, sections 1902(a)(73)(A), 1902(a)(30), 1902(a)(2), 1903(w) of the Act, 42 C.F.R. Part 447 Subpart B, 42 C.F.R. Part 433 Subpart B, and 42 C.F.R. § 440.200, et seq.

Strategies (cont.)	have established a variety of financial enhancements to reward providers for delivering this care. While some states have enhanced rates for primary care services delivered to EPSDT-eligible children, others may withhold a percentage of rates or pay quality incentives based on MCP or practice performance on Child and Adolescent Well-Child Visit quality measures. States may also include adjustments in their FFS rate setting methodologies that increase rates by state-specified amounts or percentages and recognize standards used for rate-setting, such as national health care cost indices. Some states benchmark FFS Medicaid payment rates to specific rates (i.e., releases of published Medicare rates).[143] While this serves as an important data point when considering rate sufficiency, many services that may be medically necessary for EPSDT-eligible children are not covered by Medicare. CMS may also consider for approval Medicaid state plan FFS methodologies in which states benchmark Medicaid rates to other publicly published rates for pediatric services from a non-Medicaid entity. In addition, states may use Medicare or other rates that are publicly published by a payer other than the state Medicaid agency to inform their own state rate development processes to the extent that rates are widely available to the public and updated at a regular interval.[144] In managed care delivery systems, states may also utilize state directed payments to direct MCPs' payments to providers to achieve goals related to performance improvement, fee schedules, and delivery system reform.[145, 146]
Best Practices	***Attract providers to the Medicaid program using differential rates.*** States commonly set different FFS provider rates in different geographical regions to attract providers in regions where care may be scarce, and MCPs may negotiate payment rates with providers based on specific needs.[147] States

[143] Please note that the *Ensuring Access to Medicaid Services* final rule amended 42 C.F.R. § 447.203, effective July 9, 2024, to require payment rate analyses comparing state Medicaid payment rates with Medicare rates for specified categories of service, which may include services delivered to EPSDT-eligible children. See: https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

[144] For more information on state plan amendment payment requirements, see: https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html. For more information on requirements for comprehensive methodology descriptions, see: https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/fed-req-pymt-methodologies.docx.

[145] 42 C.F.R. § 438.6(c).

[146] For more information about state directed payments, see the "*v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*" subsection in the "I. Promoting EPSDT Awareness and Accessibility" section.

[147] We remind states that in accordance with 42 C.F.R. § 438.4, Medicaid managed care capitation rates must be developed in accordance with the standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or

Best Practices (cont.)	that utilize managed care may require MCPs to participate in service payment models intended to recognize value or outcomes over volume of services or performance improvement initiatives.[148] States and MCPs may also consider different provider rates based on the age of the child or the complexity of care, or for pediatric subspecialists or other difficult-to-recruit providers. Higher-performing states, as measured by both the Child Core Set of Quality Measures and the CMS-416, have established a variety of financial incentives targeting well-child visits. Some states have enhanced FFS provider rates for primary care services for EPSDT-eligible children, while others pay quality incentives based on MCP or practice performance on Child and Adolescent Well-Child Visit quality measures.

III. Improving Care for Children with Specialized Needs

Children with specialized needs face unique health care issues that may impact their development. For example, a high percentage of children involved in foster care have been exposed to trauma, which can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, and emotional well-being.[149] Early detection and treatment in these situations is particularly important for achieving optimal health for children with increased or complex health needs. As such, EPSDT can be a crucial tool in addressing the needs of these children, including: i. children with behavioral health needs; ii. children in foster care; and, iii. children with disabilities or other complex health needs.

Additionally, states should carefully consider the transition coordination mentioned in the "*iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children*" subsection of the "I. Promoting EPSDT Awareness and Accessibility" section, particularly for children with specialized needs as they near the age of transitioning out of EPSDT eligibility. It is critical that these individuals have assistance with coordinating appointments, transferring medical records, and connecting with new health care providers to ensure continuity of, and access to, necessary health care.

i. Improving Care for Children with Behavioral Health Needs

"Behavioral health" is not an identified, stand-alone service defined within the Act. States are specifically required under the EPSDT provisions of the statute to include an assessment of both physical and mental health development in EPSDT-required screenings, as well as diagnostic and treatment services to correct or ameliorate illnesses and conditions identified by that screening.[150] However, states have broad discretion to cover behavioral health services and supports (including mental health and SUD treatment, peer supports, and/or other services) under a variety of benefit categories in section 1905(a) of the Act, such as physician and clinic services,

factors used to develop capitation rates must not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

[148] 42 C.F.R. § 438.6(c).

[149] See: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

[150] Section 1905(r)(1)(B) and 1905(r)(5) of the Act.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services, inpatient and outpatient hospital services, and rehabilitative services. Previous guidance issued in 2018, *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance,* includes a detailed table of Medicaid authorities that may apply to specific mental health services discussed below.[151]

Delivering mental health and SUD treatment services poses challenges unlike those in other areas of care. The breadth of behavioral health needs for children throughout their development can be most effectively met by a delivery system that can address a range of needs, beginning with early prevention and including an array of covered treatments. While the demand for behavioral health services has grown, many behavioral health providers do not participate in any health coverage networks, accepting patients who pay out-of-pocket only. This has impacted the availability of these services, resulting in widespread reports of children who are unable to access care. Despite these challenges, some states have reformed their behavioral health delivery system for children and successfully identify and address their behavioral health needs by providing a range of services that are available when and where children need them.

The strategies for improving coverage of and access to behavioral health services below are not exhaustive. As part of technical assistance to states, CMS anticipates publication of a Children's EPSDT Behavioral Health Toolkit.

Table 11: EPSDT Policies, Strategies, and Best Practices for Improving the Delivery of Behavioral Health Services

Policies	Consistent with section 1905(r)(5) of the Act, states must provide coverage for an array of medically necessary mental health and SUD services along the care continuum in order to meet their EPSDT obligation. Within children's mental health, there is not yet a nationally available standard, such as Bright Futures for well-child screening and periodicity schedules, for assessing patient needs and describing the continuum of care using a common language. However, there is a broad range of mental health and SUD service types, providers, and settings that can be covered under section 1905(a). The extent of possible coverage allows states to cover a broad array of behavioral health services necessary to achieve good outcomes for children. A service array of behavioral health care that is consistent with EPSDT requirements includes, but is not limited to: 1) screening and assessment; 2) services to build skills for mental health and/or to address early signs or symptoms of concern with or without a diagnosis; 3) community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health acute and/or chronic conditions, including routine community-based services as well as community-based services to meet more intensive needs; 4) services to

[151] See: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Policies (cont.)

address urgent and crisis needs; and 5) inpatient care only when medically necessary.[152]

States have an obligation to assess the availability of 1905(a) services to meet EPSDT-eligible children's individualized assessed needs, ensure that there are an array of services to meet those needs, and establish and apply medical necessity criteria, but they have flexibility in how they meet that obligation. States are expected to adhere to long-standing EPSDT obligations for eligible individuals from birth to age 21.

As discussed earlier, states are required to develop or adopt a schedule of recommended screenings to determine the existence of physical or mental illnesses or conditions for EPSDT-eligible children.[153] Most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics or a modified version thereof.[154] Periodicity schedules recommend a schedule for screening services, including developmental, mental health, and SUD screenings, and states must ensure children have access to those screenings according to the state-determined schedule. States are required to cover treatment for children's medical needs, per the requirement at section 1905(r)(5) of the Act to cover all section 1905(a) services needed to "correct or ameliorate" health conditions for EPSDT-eligible children.[155]

States should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria. This may be particularly salient when addressing the developmental and behavioral health needs of children under age 5.[156] States may not categorically exclude eligible children who have a disability, including an intellectual or developmental disability, from receiving coverage for and provision of behavioral health services.[157] As with a physical health condition, states must ensure that behavioral health symptoms that are identified through screening are addressed in a timely way, as waiting for an illness to develop rather than addressing symptoms when they arise is not consistent with section 1905(r)(5) of the Act.

As states implement EPSDT, they should be mindful of other federal requirements that intersect with the provision of health care services to

[152] In addition to Medicaid requirements, states are obligated to meet the requirements of the Americans with Disabilities Act and *Olmstead*. Compliance with Medicaid requirements, or receipt of the Secretary's approval of specific Medicaid programs, does not necessarily indicate compliance with civil rights statutes, including the ADA.
[153] Section 1905(r)(1)(A)(i) of the Act. See also section 1905(r)(1)(A)(ii) of the Act, regarding coverage of screening services at intervals outside the state-established schedule, if medically necessary.
[154] Ibid.
[155] Section 1905(r)(5) of the Act.
[156] See: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.
[157] See: Title II of the Americans with Disabilities Act, 42 U.S.C. 12132; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794(a); sections 1902(a)(10)(B) and 1905(r)(5) of the Act; and 42 C.F.R. § 440.240.

Policies (cont.)

children. Consistent with federal disability rights laws and the Supreme Court's decision in *Olmstead* v. L.C., 527 U.S. 581 (1999), states must ensure that services covered under EPSDT are provided in the most integrated setting appropriate for the child, which includes clinics, or in schools, and at home, and must avoid unnecessary placements in segregated treatment settings.[158, 159] As children should be cared for in the most integrated setting appropriate for their needs, inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including for children and youth with severe needs, and should be reserved for children with acute needs on a short-term basis.[160] Lastly, states must ensure compliance with the mental health parity requirements in the Mental Health Parity and Addiction Equity Act (MHPAEA) (Pub. L. 110-343) by ensuring that any financial requirements or treatment limitations imposed on mental health and substance use disorder services in separate CHIPs, in Medicaid Alternative Benefit Plans, and for enrollees in Medicaid managed care organizations (MCO) are no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical services in the same benefit classification.[161, 162]

States should take advantage of the numerous section 1905(a) benefits under which behavioral health services can be covered, as well as the different types of providers who can deliver these services.[163] In addition to licensed providers, states may create qualifications for other practitioners, where CMS regulations defining the applicable benefit allow, to expand access to services.

Medicaid agencies have long employed SPMP to ensure that the administration of the program is informed by, and aligned with, clinical standards on behalf of Medicaid beneficiaries; states can access an increased federal matching rate of 75% to support those activities. In 2024, CMS newly allowed states to claim the increased SPMP matching rate with respect to expenditures for employees who have obtained a master's degree in social work or a master's degree in another behavioral health field, or a higher degree, provided they are licensed as independent practitioners by the state

[158] Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794; 45 C.F.R. § 84.76; Section 1557 of the Affordable Care Act, 42 U.S.C. 18116; 45 C.F.R. § 92.207(b)(6).

[159] See: https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd011400c.pdf.

[160] Ibid.

[161] 42 C.F.R. part 438, subpart K (§§ 438.900 through 438.930), 440.395, and 457.496.

[162] For more information about the mental health and SUD parity requirements for managed care in Medicaid and CHIP, see CMCS's CIB, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06122024.pdf. Parity also applies to Alternative Benefit Plans, section 1937 of the Act and 42 C.F.R. § 440.395.

[163] See: https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd011400c.pdf. See also: https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html..

Policies (cont.)	and all other SPMP requirements are met.[164] This policy will support states to reach the goals set forth in CMCS's *Mental Health and Substance Use Disorder Action Plan*, through hiring and maintaining the specialized expertise needed to administer a robust Medicaid program that can meet beneficiaries' mental health and SUD needs.[165] Certified Community Behavioral Health Center (CCBHC) services were added to section 1905(a) of the Act in 2024; guidance on this state plan service category is forthcoming.[166] Also in 2024, CMS issued guidance to states regarding *Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination*.[167] States can claim enhanced federal Medicaid matching rates for certain expenditures to support the 988 suicide and crisis line and to otherwise improve access to and coordination of treatment and support services for children and youth with mental health and SUD needs. There are special considerations for behavioral health services for separate CHIPs. States that have separate CHIPs must cover behavioral health services needed to screen, diagnose, and treat a broad range of mental health and SUD conditions in a culturally and linguistically appropriate manner.[168] In addition, similar to Medicaid, all states with separate CHIPs must cover medications for addiction treatment and tobacco cessation services.[169] States may demonstrate compliance with mental health parity requirements for separate CHIPs by covering all services under section 1905(r) of the Act (including section 1905(a) services in accordance with section 1905(r)(5)), without excluding coverage for any such services for any particular condition, disorder, or diagnosis, to be deemed compliant.[170]
Strategies	States use a combination of strategies to meet children's behavioral health needs, including creating a children's behavioral health benefit package with a range of section 1905(a) services to adhere to EPSDT requirements, as well as other state plan services (e.g., services authorized under section 1915(i), 1915(j), 1915(k) and/or 1945) and waiver services. Services authorized through 1915 and 1945 authorities can be used to augment section 1905(a)

[164] See: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24001.pdf.
[165] See: https://www.medicaid.gov/medicaid/benefits/downloads/cmcs-mntl-helth-substnce-disrdr-actn-plan.pdf.
[166] Section 209, Title I, Division G, Consolidated Appropriations Act, 2024, Pub. L. 118-122, (enacted March 9, 2024). See: https://www.congress.gov/118/bills/hr4366/BILLS-118hr4366enr.pdf.
[167] See: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf.
[168] Section 2103(c)(5) of the Act; also see SHO# 20-002: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf.
[169] Sections 1905(a)(4)(D) (tobacco cessation for pregnant individuals in Medicaid), 1905(a)(29) (medication-assisted treatment for opioid use disorders in Medicaid), and 2103(c)(5) (mental health and substance use disorder services in CHIP) of the Act.
[170] 42 C.F.R. § 457.496(b).

Strategies (cont.)	services covered under EPSDT. Access can be improved to a broad range of services through structural elements such as a single point of entry. Critical components of a high functioning behavioral health system for children include 1) a single point of entry, 2) supporting the management of children with mild to moderate needs in primary care settings, 3) covering a range of specialty care provided in the community to meet the specific needs of children when and where they arise, and 4) relying on inpatient behavioral health treatment only when medically necessary. Support the management of children with mild to moderate behavioral health needs in primary care settings. Children with mild to moderate behavioral health conditions can benefit from strategies that support the development of integrated pediatric primary care, some components of which can be covered under section 1905(a) benefits, as detailed in previous guidance.[171] Many states have decreased barriers to integration by allowing Medicaid payment for activities performed by integrated behavioral health clinicians, which allow children to continue to be served in primary care settings. Some states have removed prohibitions on same day billing, including allowing different practitioners in the same setting to bill for services provided on the same day as long as they are not duplicative, to enable "warm hand offs" rather than requiring families to seek care elsewhere or return another day. Other states incentivize integration by adding Behavioral Health Integration and psychiatric Collaborative Care Model services and rates to their state plan.[172] All states must cover developmental and behavioral health screening for EPSDT-eligible children as described in section 1905(r)(1) and (5). A few states require that providers use an evidence-based, age-appropriate developmental or behavioral health screening tool during every well-child visit. States have increased developmental and behavioral health screening rates by paying add-on rates to primary care providers for using an evidence-based screening tool during well-child and follow-up visits and by using quality incentive payments to support reaching screening goals. Cover the broad range of specialty care that can be authorized under section 1905(a) to meet EPSDT obligations and consider augmenting that coverage with services authorized under section 1915(c) and 1915(i) of the Act. States have used a range of Medicaid-coverable services to help meet children's behavioral health needs, including crisis services, CCBHC services,

[171] See: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.

[172] For more information about Behavioral Health Integration and the psychiatric Collaborative Care Model, see CMS's MLN Booklet on Behavioral Health Integration Services, available at: https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf. For more information about Collaborative Care Models, see also the "*iii. Encouraging the Use of Interprofessional Consultation to Address EPSDT Workforce Shortages*" subsection in "II. Expanding and Using the Children-Focused (EPSDT) Workforce."

Strategies (cont.)	outpatient mental health and SUD treatment, and intensive home-based services. - Crisis services: Crisis services may be provided in a facility, at home, or in the community. Mobile Crisis Intervention (MCI) services are available 24/7 and may be provided in the home or any setting where a crisis may be occurring and includes rapid response, individual assessment, and crisis resolution by trained mental health and SUD treatment professionals and paraprofessionals. States cover MCI under a range of Medicaid authorities, including 1905(a), as outlined in the 2021 *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services*.[173] Because of states' broad discretion in setting provider qualifications, states can require MCI providers to receive training on the unique issues that arise when working with children and youth, such as ways to engage with parents and/or guardians who are on scene; special consent issues that arise with minors; and specific information on the facilities and providers that are most equipped to work with a child or youth in crisis. - CCBHCs: CCBHC services are a newly established benefit under section 1905(a) as a model for delivering behavioral health care. Several states are addressing the need for specialized behavioral health care through the development of CCBHCs, which are designed to ensure access to coordinated, comprehensive, 24/7 behavioral health care and include staff with expertise in addressing trauma and promoting the recovery of children with serious emotional disturbance.[174] States that include services ranging in intensity that are easily accessible can decrease emergency department utilization and inpatient hospitalization rates and can help avoid unnecessary child welfare system involvement. - Outpatient mental health and SUD treatment: All states are required to cover medically necessary outpatient mental health and SUD treatment for EPSDT-eligible children, as this treatment falls under several section 1905(a) benefit categories. States have broad discretion to license and credential providers of these services; most states cover a range of qualified providers and practitioners, such as peer support practitioners, CHWs, or other professional supports, to augment the professional staff in their network and ensure maximum service availability. - Intensive home-based services: Intensive home-based services may include therapy, care coordination, parent and/or youth peer services,

[173] See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

[174] For more information on CCBHCs and the CCBHC demonstrations authorized under section 223 of the Protecting Access to Medicare Act (PAMA), as expanded under section 11001 of the BSCA of 2022, see the Consolidated Appropriations Act of 2024, Public Law 118-122 and CMS's Section 223 Demonstration Program to Improve Community Mental Health Services website, available at: https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html.

Strategies (cont.)	and behavioral interventions, among others. Many states cover components of intensive home-based services under section 1905(a). Some states identify children with more serious behavioral health needs and develop a section 1915(c) HCBS waiver program to prevent placement in residential care. Intensive care coordination (ICC) is usually provided in accordance with a detailed service plan to provide therapeutic supports to help the child develop skills to successfully function in the community. Many states reported providing ICC through a TCM benefit for children with Serious Emotional Disturbance, where the Intensive Care Coordinator partners with the child and their family to convene a team of cross-sector service providers, community members, friends, and other supports to develop a comprehensive and individualized plan of care.[175, 176] Other services coverable under section 1905(a) may allow children and youth to access intensive treatment without the need for out-of-home placement, including the therapies provided in the context of Partial Hospitalization Programs or Intensive Outpatient Programs. Some state Medicaid programs cover parent peers, whose work is critical to supporting parents to allow children with more intensive needs to remain at home. States may choose from several different federal Medicaid authorities to add coverage of peer support services to their state plans, including the rehabilitative services benefit that has most often been cited by states for this purpose, as well as the preventive services benefit.[177] Some parent-facing services can be paid for through the child's Medicaid benefit if the service is provided for the direct benefit of the child.[178, 179] <u>Rely on behavioral health treatment provided in inpatient and residential settings only when necessary.</u> Inpatient treatment should not be used as a default intensive treatment, including due to a lack of capacity in community-based settings, but should be reserved for children and youth who cannot be safely and effectively treated in those settings. For EPSDT-eligible beneficiaries, states are required to cover medically necessary psychiatric inpatient hospitalization in a general hospital, a freestanding psychiatric hospital, or a psychiatric residential treatment facility under the section 1905(a) "inpatient psychiatric services for individuals under age 21"

[175] See: https://store.samhsa.gov/sites/default/files/intensive-care-youth-coordination-pep19-04-01-001.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.
[176] ICC activities can be covered under the TCM benefit if they meet Medicaid requirements at 42 C.F.R. § 440.169(b).
[177] Section 1905(a)(13) of the Act. See: https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.
[178] See: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clarifying-guidance-support-policy_215.pdf.
[179] See: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.

Strategies (cont.)	benefit.[180, 181] States or their contracted MCPs must have adequate inpatient capacity either in- or out-of-network to meet the service needs of their EPSDT-eligible beneficiaries.[182] Establish a single point of entry for the behavioral health system. A few states have established a behavioral health system with a single point of entry that can be accessed by parents, clinicians, schools, juvenile justice, and foster care agencies, as well as youth themselves. This approach greatly reduces the complexity and delays in accessing and obtaining care. Cover section 1905(a) services in separate CHIP programs to be deemed compliant with mental health parity. One approach states may use in separate CHIPs to demonstrate compliance with mental health parity requirements is to cover the same services as those covered under the Medicaid EPSDT benefit. In order to be deemed compliant with mental health parity requirements through this approach, separate CHIP coverage must align with all Medicaid requirements for EPSDT, including coverage of section 1905(a) services in accordance with section 1905(r)(5) of the Act.[183]
Best Practices	***Create a seamless and comprehensive behavioral health system for children*.** One state approached the delivery of behavioral health services to children and youth by creating a system that provides a seamless and comprehensive array of behavioral health services with a single point of entry. The state Medicaid agency establishes payment and coverage policy, pays for services, and creates and monitors a contract with an administrative services organization (ASO), for which the state claims federal administrative match. The ASO provides streamlined implementation and coordination of the range of youth behavioral health services and acts as a single point of entry to the system through a toll-free number staffed by clinicians who provide assessment and triage, as well as utilization management. The ASO also hosts a statewide electronic health record and out-of-home bed-tracking system. This state uses a range of authorities, including section 1905(a), other Medicaid state plan authorities (e.g., 1915(i)), and section 1115 demonstration opportunities, to cover a care continuum to meet the behavioral health needs of children with mental health, substance use, and/or intellectual and developmental disorders. The array of covered services includes state plan services, such as case management, psychiatry and psychology services, medication management, counseling, intensive in-home services, and TCM, as well as mobile crisis intervention services, which can be covered under a number of different Medicaid authorities, such as

[180] 42 C.F.R. § 440.160.
[181] See section 1905(a)(16)(A) of the Act and 42 C.F.R. § 441.151.
[182] 42 C.F.R. §§ 438.206(b), 441.61(b).
[183] 42 C.F.R. § 457.496(b).

Best Practices (cont.)	sections 1905(a) and 1915(i) of the Act, for example. The state further uses its section 1115 demonstration authority to expand eligibility to youth who are not otherwise Medicaid or CHIP eligible but who are at risk of out-of-home placement so that virtually all youth who are assessed to be at risk of out of home placement are eligible. The section 1115 demonstration also covers services such as enrichment activities to enhance community inclusion, social/emotional learning services, home and vehicle modifications, and respite care. Primary care clinicians make use of the state's PMHCA program to enable children with mild to moderate mental health needs to be managed without entering the specialty care system. The state participates in the Medicaid CCBHC demonstration opportunity, which has increased capacity for child behavioral health specialty care when needed. Since adoption of this model, the state's out-of-home placements have been reduced by 60%, and most children are able to receive care while remaining in their current living situation.

ii. Improving Care for Children in or Formerly in Foster Care

While children in foster care represent less than 2% of all children enrolled in Medicaid, they are an especially vulnerable population whose safety and well-being are the legal responsibility of the state. Children in Title IV-E foster care, children who were in title IV-E foster care but who are now receiving title IV-E kinship guardianship or adoption assistance, and former foster youth up to age 26 are automatically eligible for Medicaid and are entitled to the same range of EPSDT services as other EPSDT-eligible children. Children in or formerly in foster care have higher rates of physical and behavioral health care needs compared with children without a history of foster care involvement. Children in foster care may not live close to their home communities or may move from place to place, disrupting the relationship with primary care, dental, and other providers. State Medicaid agencies can work with the state child welfare agency to identify and address the priority needs for children in or formerly in foster care in their state and to ensure that they have access to the Medicaid covered services to which they are entitled. While receipt of Title IV-E is one eligibility pathway to Medicaid, many children who have contact with the child welfare agency or are otherwise at risk of foster care often have Medicaid eligibility that entitles them to EPSDT unrelated to their entry into foster care.

Table 12: EPSDT Policies, Strategies, and Best Practices for Children in Foster Care

Policies	Within a few days of placement in foster care, or as statutorily obligated, states should ensure that children receive an initial assessment of acute physical and behavioral health needs, followed by a comprehensive visit similar to a well-child visit. Title XIX specifically enumerates receipt of benefits under Title IV-E of the Act as categorically entitling eligible children

Policies (cont.)	to Medicaid and EPSDT.[184] Title IV-B of the Act requires the state child welfare agency to develop a health care coordination and oversight plan for their children involved in foster care with input from the state Medicaid agency, pediatricians, other health care experts, child welfare service experts, and recipients of these services.[185] To address challenges in the transition to adult coverage and care, state Medicaid agencies are required to maintain coverage for former foster youth until age 26, including for those foster youth who were enrolled in another state when they turn age 18.[186, 187] These youth retain EPSDT eligibility until age 21.
Strategies	Develop and maintain a collaborative relationship with the child welfare agency to ensure that children in foster care receive all medically necessary services to which they are entitled under EPSDT requirements. The child welfare agency can provide expertise to the state Medicaid agency in identifying the specific needs of the population of children in foster care or those at risk of out-of-home placement so that the Medicaid agency can develop effective policies to meet those needs. Collaboration between Medicaid and child welfare agencies can support implementation of EPSDT requirements if a child enters foster care. Support youth in foster care by using dedicated MCPs, covering "wraparound" services, paying enhanced provider rates for primary care visits, and/or using an EQR study to examine health care utilization among these youth. States have adapted Medicaid to address the unique health care needs of youth in foster care in different ways. Several states have dedicated MCPs that serve these children and youth exclusively, with rates reflective of their needs, and states monitor performance improvement metrics specific to foster youth. Other states cover "wraparound" services that include caregiver support and are specifically designed for children in or at risk of out-of-home placement. Other states pay enhanced provider rates for primary care visits to reflect the extra time that may be needed when a child enters care or moves to a new family placement and to help ensure an adequate supply of providers to meet the timeliness goals of their programs. A few states have their EQR perform a focus study to examine foster care health care utilization patterns; states serving this population outside of managed care could perform a similar analysis.
Best Practices	***Require MCPs to assign a liaison and trauma-informed care manager to children in foster care.*** One state enrolls children in foster care into the same MCPs as other children but requires each MCP to have a foster care liaison

[184] Section 1902(a)(10)(A)(i)(I) of the Act.
[185] Section 422(b)(15)(A) of the Act.
[186] See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf.
[187] See: https://www.acf.hhs.gov/sites/default/files/documents/cb/im2304.pdf.

Best Practices (cont.)	and trauma-informed case managers assigned to these beneficiaries. These dedicated staff coordinate with the state's child welfare agency, Medicaid agency, and providers. They perform additional outreach to and educate foster parents, who may need extra assistance navigating two complex systems of care. Additionally, these case managers provide transitional assistance as youth age out of foster care, return home, or live with a permanent family. The complex needs of children in foster care may result in higher capitation rates paid to the MCPs.[188] ***Implement an MCP dedicated to children in foster care.*** Other states have implemented an MCP dedicated solely to serving children and youth in foster care. A statewide MCP for children in foster care allows the state Medicaid agency to draft a contract that includes the requirements of both the Medicaid and child welfare agencies and enables the MCP to specialize and focus on the special needs of this population. These MCPs provide foster families with case managers who are trained to understand the foster care landscape, the MCPs' network adequacy requirements are built to reflect the needs of the population enrolled, and the reporting requirements reflect performance measures specific to the needs of the population in foster care and child welfare requirements for timeliness.

iii. Improving Care for Children with Disabilities or Other Complex Health Needs

Children with disabilities or other complex health needs often have a combination of functional limitations, chronic health condition(s), ongoing use of medical technology, and high resource need and use. These children usually require a robust set of section 1905(a) services provided by primary care and pediatric subspecialists, as well as numerous therapists. These children also may have behavioral health conditions or developmental or intellectual disabilities that add complexity to their clinical presentation. Case management, as previously described in this letter, is an essential tool for coordinating across a beneficiary's care team to ensure that these children, when eligible for EPSDT, receive the medically necessary services they are entitled to under EPSDT requirements.

Table 13: EPSDT Policies, Strategies, and Best Practices for Children with Disabilities or Other Complex Health Needs

Policies	Children with disabilities or other complex health needs may qualify for Medicaid or CHIP on the same bases as other children, and, in some cases, may qualify on the basis of their disability or their corresponding needs for long-term services and supports.[189] The policies, strategies, and best

[188] 42 C.F.R. § 438.4.

[189] Section 1902(a)(10) and (e)(3) of the Act, 42 C.F.R. §§ 435.100-300; Section 2102(b)(1)(A) of the Act, 42 C.F.R. § 457.320(a)(6).

Policies (cont.)

practices included herein are not intended to be limited only to children who qualify for Medicaid based on a disability.

EPSDT requirements are critically important for eligible children with disabilities or other complex health needs, who may or may not qualify for Medicaid due to their disability and may or may not meet an institutional level of care or be at risk of requiring institutionalization. The intersection of EPSDT requirements with requirements for other Medicaid authorities, such as managed care and HCBS authorities, as well as for other federal programs, can be complicated. Many children with disabilities or other complex health needs receive health services through multiple federal programs, including the Title V Maternal and Child Health program, with special provisions relating to intersecting entitlements that can be complex for families to navigate.[190] Medicaid agencies are required to have an interagency agreement with their Title V agencies and may choose to develop interagency agreements with other state agencies.[191] Importantly, Title V is a secondary payer after Medicaid—an exception to the general rule of Medicaid being the payer of last resort.[192]

States may not require children determined to be disabled by their state or the Social Security Administration, or children receiving services under Title V, to enroll into certain types of managed care without an approved section 1915(b) waiver or section 1115 demonstration authority.[193] If states seek section 1915(b) waiver authority, they must demonstrate that restricting the beneficiary's freedom of choice of provider does not substantially impair access to medically necessary services of adequate quality.[194]

To meet their EPSDT obligations and the needs of children with disabilities or other complex health needs, states should have an adequate number of enrolled providers, and MCPs should have a sufficient provider network, including pediatric specialists and children's hospitals, wherever possible, to deliver section 1905(a) medically necessary covered services.[195] States must develop and enforce pediatric-specific network adequacy standards for certain provider types in most managed care programs.[196] States can claim the increased SPMP federal matching rate to support employing qualified individuals who have advanced skills and the expertise necessary to ensure that states understand how to meet the needs of children with disabilities or other complex health needs.[197, 198]

[190] See: https://crsreports.congress.gov/product/pdf/IF/IF12685.
[191] 42 C.F.R. § 431.615.
[192] Section 505(a) of the Act.
[193] Sections 1932(a)(2)(A)(i)-(iii), 1915(b), and 1115 of the Act, and 42 C.F.R. § 438.50(a).
[194] Section 1915(b) of the Act.
[195] See section 1902(a)(30)(A) of the Act and 42 C.F.R. §§ 441.61, 438.68.
[196] 42 C.F.R. § 438.68(b) and (e).
[197] 42 C.F.R. § 433.15(b)(5).
[198] 42 C.F.R. § 432.50(d).

Policies (cont.)

Children with disabilities or other complex health needs can often require specialized care not available close to home. To ensure that EPSDT-eligible children receive timely access to providers, including pediatric subspecialists, states and MCPs should have clear procedures on how to access out-of-network and/or out-of-state providers. For EPSDT-eligible children enrolled in Medicaid managed care who need access to out-of-network care, states and their MCPs must ensure mechanisms exist to guarantee timely access to medically necessary services.[199] States are required to pay for EPSDT-eligible children's medically necessary 1905(a) services furnished by out-of-state providers (such as pediatric subspecialists) when the state determines on the basis of medical advice that the services are more readily available in another state.[200]

For children whose medical needs cannot be met by in-state providers and for whom the state has identified an out-of-state provider to deliver medically necessary services, states should screen and enroll out-of-state providers within an abbreviated timeframe to help ensure that children can access care in a timely fashion. Additionally, states should develop standard agreements with other states governing coverage and payment for services furnished to Medicaid-eligible children living in another state by providers screened and enrolled in the other state(s). For example, states could streamline the process of enrolling out of state providers by relying on the enrollment screening conducted by other states based on criteria outlined in agreements between states.[201, 202] Regardless of whether the care is delivered by out-of-network or out-of-state providers, states are required to assure transportation and scheduling assistance for EPSDT-eligible children.[203]

While doing so is not required under EPSDT, states may develop approaches to cover services in addition to those covered under section 1905(a), with the goal of maintaining children with disabilities or other complex health needs in integrated home and community-based settings or helping them return to their community. This may assist states with their community integration obligations under Title II of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).[204] HCBS may be covered under a

[199] 42 C.F.R. § 438.206.
[200] Section 1902(a)(16) of the Act and 42 C.F.R. § 431.52.
[201] 42 C.F.R. § 431.52.
[202] See: https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.
[203] 42 C.F.R. §§ 431.53, 441.62.
[204] For more information on the *Olmstead* decision, see CMS's series of five "*Olmstead* letters," which identify policies and provide technical support, tools, and resources for states to support their efforts to build robust, community-based systems that support community integration and community living: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD011400C.pdf; https://www.medicaid.gov/federal-policy-guidance/downloads/smd072500a.pdf; https://www.medicaid.gov/federal-policy-guidance/downloads/smd072500b.pdf;

Policies (cont.)

number of authorities to help individuals receive care at home and in the community.[205] This includes, for example, HCBS waivers under section 1915(c) of the Act and state plan HCBS under section 1915(i) of the Act. Services that can only be covered under section 1915 of the Act, and that cannot be covered under section 1905(a), are not included under EPSDT.[206]

Under section 1915(c) of the Act, individuals must meet a specified institutional level of care (hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities) and be part of one or more of the following target groups or any subgroups thereof: aged or disabled or both, individuals with intellectual or developmental disabilities or both, or individuals with mental illness. These section 1915(c) waiver programs may be condition-specific, such as for children with Autism Spectrum Disorder (ASD), or may be more general, such as for those who are technology dependent or medically fragile.[207] States may also specify the minimum and maximum age of individuals enrolled in a section 1915(c) waiver program. Under section 1915(i) of the Act, individuals are required to meet state-defined needs-based criteria to access state plan HCBS. A state has the option to establish eligibility criteria for state plan HCBS under section 1915(i) based on age, diagnosis, disability, and/or Medicaid eligibility group.

The section 1915(c) waiver program and state plan 1915(i) HCBS authorities both require states to develop a written person-centered service plan (PCSP) for each beneficiary to identify services and supports needed to function successfully in the community and to assure their health and welfare. The PCSP must reflect the services and supports (both paid and unpaid) that are important to meet an individual's needs identified through an assessment of their functional needs.[208]

As discussed above, under section 1905(r)(5) of the Act, the EPSDT mandate includes coverage of any medically necessary service under section 1905(a) of the Act. States must determine whether any medically necessary services

https://www.medicaid.gov/federal-policy-guidance/downloads/smd011001a.pdf; and https://www.medicaid.gov/federal-policy-guidance/downloads/smd011001b.pdf.

[205] In addition to HCBS waiver programs under section 1915(c) of the Act and state plan HCBS under section 1915(i) of the Act, which are discussed more fully in this SHO, states can also cover HCBS under section 1915(k) of the Act and section 1915(j) of the Act. Section 1915(k) of the Act establishes the optional Community First Choice (CFC) benefit, which allows states to provide eligible Medicaid enrollees with HCBS attendant services and supports under the state plan. Section 1915(j) of the Act establishes an optional service delivery model for HCBS in which states can allow individuals to self-directed personal care services (PAS) as an alternative to traditional agency-delivered services. PAS includes personal care and related services provided under the Medicaid state plan or HCBS provided under a section 1915(c) waiver program.

[206] Section 1905(r)(5) of the Act.

[207] For more information about the Medicaid options, including 1915(c) HCBS waivers, to cover services for children with ASD, see CMCS's CIB and the related FAQ, available at, respectively: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf and https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-09-24-2014.pdf.

[208] 42 C.F.R. §§ 441.301(c)(2), 441.725(b).

Policies (cont.) included on an EPSDT-eligible child's PCSP are coverable as section 1905(a) services under EPSDT obligations before covering them under a 1915(c) HCBS waiver program, or a state plan option under 1915(i) (HCBS), 1915(j) (self-directed personal care services), or 1915(k) (Community First Choice). As a result, any 1915(c) waiver program services and state plan 1915 services that could be covered under a section 1905(a) benefit must be covered first as a section 1905(a) service for EPSDT-eligible children.

While states have the option to include extended section 1905(a) services under section 1915 authorities (i.e., a section 1905(a) service with an extended amount, duration, or frequency compared to what is available for that 1905(a) service under the Medicaid state plan), that does not change the underlying EPSDT requirement at section 1905(r)(5) to cover EPSDT-eligible children's medically necessary section 1905(a) services. For example, a section 1915(c) waiver program may include coverage of extended 1905(a) services (i.e., covering for individuals enrolled in the waiver program a section 1905(a) service in an amount greater than otherwise permitted under the state plan). Even though the section 1915(c) waiver program covers section 1905(a) services beyond what is covered under the state plan, the state would still be required to cover medically necessary section 1905(a) services for EPSDT-eligible children, whether or not they are enrolled in the waiver program, in the amount, duration, or scope that is medically necessary for the individual child, in order to comply with section 1905(r)(5).

However, the state must cover waiver program services for EPSDT-eligible children enrolled in the section 1915(c) waiver program that differ from any coverage required under EPSDT under section 1905(r). Additionally, CMS interprets section 1905(r)(5) to mean that a state's decision to cover a section 1905(a) service under a section 1915 authority cannot be used to deny, delay, or limit access to medically necessary section 1905(a) services for which coverage is required under EPSDT.

An EPSDT-eligible child who is also eligible under a section 1915(c) waiver program or 1915 state plan benefit may need section 1905(a) services above and beyond what is medically necessary, to enable them to live in the community and avoid institutionalization. In this case, the child is entitled to all necessary services: those that are identified in their approved PCSP that assist the child to function in the home and community and avoid institutionalization via a section 1915(c) waiver program or section 1915 state plan authority, as well as any medically necessary section 1905(a) services under EPSDT. It is the responsibility of states to ensure that EPSDT-eligible children receive all services to which they are entitled.

EPSDT-eligible Medicaid-enrolled children who are on a waitlist for a section 1915(c) HCBS waiver program are entitled to all medically necessary

Policies (cont.)	section 1905(a) services under EPSDT while on the waitlist.[209] States cannot limit the number of individuals served by state plan 1915(i) HCBS and, as a result, any EPSDT-eligible child who meets the state's 1915(i) enrollment criteria is entitled to the 1915(i) services and supports identified in their PCSP, as well as any medically necessary section 1905(a) services under the EPSDT obligation.[210]
Strategies	Expand MCP enrollment to include children with disabilities or other complex health needs. An increasing number of states are expanding enrollment in their MCPs to include children with disabilities or other complex health needs and other populations not previously enrolled.[211] Some states have developed specific MCP contracts and enroll these children into specialized MCPs. This strategy has the benefit of focusing on pediatric subspecialty networks, tailored reporting on relevant requirements, and enhanced care coordination. Other states enroll children into existing MCPs with other children, potentially streamlining administration while still allowing for enhanced care coordination. In both cases, including these children in state managed care quality strategies and focused EQRO studies helps demonstrate quality of care for the population. To understand how to meet the needs of these children, states and their MCPs should identify the population of high-need children and adolescents. This may require using diagnosis and/or service utilization data, identification by providers, or entitlement for Supplemental Security Income. States might use a standardized assessment tool to determine an individual child's needs and what services they may need. Provide care coordination. Due to the number of services and providers involved in care for children with disabilities or other complex health needs, quite a few states offer moderate to intensive care coordination for these beneficiaries. Regardless of delivery system, moderate to intensive care coordination helps ensure a single point of contact for families and provides integration among the child's providers. Care coordinators streamline access to services and minimize redundancies or gaps in care by coordinating among the child's Medicaid providers and other child-serving agencies to ensure that families do not have to conduct their own research about which agency or agencies can help them. States can establish an executive level children's cross-agency team to ensure consistency in policy and implementation.

[209] Under a section 1915(c) HCBS waiver program, states may limit the number of individuals who may be served by the waiver. Section 1915(c)(3) of the Act.

[210] 42 C.F.R. § 441.725.

[211] Certain children with special health care needs may not be required to enroll into mandatory managed care without an approved section 1915(b) waiver or section 1115 demonstration authority. See section 1932(a)(2)(A) of the Act.

Best Practices	***Coordinate programs for children and youth with disabilities or other complex health needs, provide them with a broad range of non-medical services, and implement a program to help their families navigate care.*** One state coordinates several programs focused on addressing the needs of children and youth with disabilities or other complex health needs by locating them all in a single administrative unit to create a cohesive system of care. The state also convenes an advisory council made up of parents of these children and youth, state and county agency staff, advocates, and providers to provide insight into the common challenges that families of children and youth with disabilities or other complex health needs encounter. This state operates a statewide section 1915(c) waiver program that provides a broad range of nonmedical services, tailored to the needs of these children, that complements medical services provided under EPSDT. This includes services like parental skills training, respite care, and home modifications. The state has also implemented programs to help families navigate the system of care. The state pays qualifying hospitals for TCM provided by a team that includes a provider, a nurse, and a care coordination assistant. To help improve awareness of these and other programs within and outside of Medicaid, the state has also launched a statewide telephone and web-based hotline for families to receive guidance on identifying and accessing programs.

Conclusion

CMS is committed to ensuring children get the care they need, when and where they need it, and that states adhere to EPSDT requirements. The EPSDT mandate represents a critical part of the Medicaid program that is designed to ensure eligible children have access to essential medical, dental, behavioral health, and developmental services from an early age. As Medicaid has grown more complex, navigating access to these services has become more difficult, with coordination and assistance ever more important to access care. By focusing on the critical importance of health care access and utilizing best practices to provide services to EPSDT-eligible children, states can help children and their families address and overcome barriers they may face in obtaining comprehensive health care services. The collective effort and shared commitment of CMS, state Medicaid agencies, health care providers, and caregivers is essential in advancing the coverage goal of EPSDT—the right care, to the right child, at the right time, in the right setting—to help ensure children in Medicaid have the opportunity to reach their full health potential.

CMS is eager to work with states as they work to ensure that EPSDT requirements are being met for their beneficiaries. We will continue to host periodic technical assistance webinars for states, and we encourage states to reach out with questions or tailored assistance requests by emailing the EPSDT mailbox at EPSDT@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director