Coverage Guide

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Guide for States:

Coverage in the Medicaid Benefit for Children

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Introduction

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements are a cornerstone of the Medicaid program and ensure robust health coverage for children. EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for Medicaid-enrolled infants, children, youth, and adolescents under 21 years of age (collectively referred to in this Guide as "children"), as specified in the Social Security Act (the Act).[1] The EPSDT requirements are more robust than the Medicaid requirements for adults and are designed to ensure that children receive early detection and care, so that health problems are either averted or diagnosed and treated as early as possible. The goal of EPSDT is to ensure that children get the health care they need when and where they need it—the right care to the right child at the right time in the right setting.

> The goal of EPSDT is to ensure that individual children get the health care they need when and where they need it—the right care to the right child at the right time in the right setting.

The states and the Centers for Medicare & Medicaid Services (CMS) share responsibility for implementing the EPSDT requirements. States have affirmative obligations to make sure that Medicaid-eligible children and their families are informed of what they are entitled to under EPSDT, have access to required screenings, and can obtain necessary diagnostic and treatment services to correct or ameliorate identified conditions in a timely way.[2] States have broad flexibility to determine how best to ensure that the EPSDT requirements are met. In general, states either administer EPSDT directly through fee-for-service (FFS) arrangements or contract with entities (e.g., managed care plans[3] [MCPs]) to administer some or all EPSDT benefits. Regardless of the approach taken, the states retain ultimate responsibility for ensuring that all EPSDT-eligible children in the state have access to the full EPSDT scope of coverage and services and that EPSDT requirements are met.

The Act establishes the scope of covered benefits for EPSDT-eligible children. States must ensure coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in Section 1905(a) of the Act, regardless of whether such services are covered under the state plan for adults. This includes physician, nurse practitioner, and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health

[1] SSA §1902(a) and 1905(r).
[2] CMS, State Medicaid Manual §§ 5010, 5121, 5310.
[3] In this document, "managed care plan" includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR § 438.2.

and substance use disorders (SUDs); treatment for vision, hearing, and dental diseases and disorders; and much more.

States need to arrange (directly or through delegations or contracts) for children to receive the physical health, mental health, vision, hearing, and oral health services they need to treat or ameliorate their health problems and conditions. Through the EPSDT requirements, children's health problems should be addressed *early,* before they become advanced and treatment is more difficult and costly. This broad coverage requirement results in a comprehensive, high-quality health benefit for EPSDT-eligible children under 21 years of age who are enrolled in Medicaid.

The Americans with Disabilities Act (ADA) and the *Olmstead* decision require states to ensure that services provided under EPSDT are delivered in the most integrated setting appropriate to a child's needs, such as in the child's home or elsewhere in the community, if doing so does not fundamentally alter the state's program.[4,5,6] Therefore, states should consider developing community-based treatment options wherever possible.

States report certain data about their delivery of EPSDT services to CMS annually[7] using the Form CMS-416 and the Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP) (Child Core Set).[8] CMS and states use these data to monitor EPSDT performance.

Many states with a separate CHIP elect to cover a package of services that adhere to the Medicaid EPSDT requirements for beneficiaries who are enrolled in a separate CHIP.[9] In addition, states with Medicaid Alternative Benefit Plans (ABPs) must ensure that all EPSDT-eligible children who are enrolled in ABPs have access to services available under EPSDT requirements.[10,11]

Children are entitled to the full scope of EPSDT services regardless of delivery system. Thus, the vast majority of EPSDT-eligible children who are enrolled in managed care also are entitled to the full scope of EPSDT services. States should work closely with their MCPs to support proper implementation of EPSDT. Regardless of how significant the MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with the EPSDT requirements.

This Guide is intended to help states understand the scope of services that are covered under EPSDT so that they can realize EPSDT's goals and provide the best possible child health benefits through their Medicaid programs. In addition, the Guide can help build staff knowledge

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[4] 28 CFR § 35.130(d).
[5] CMS, Olmstead Update No. 4 (January 10, 2001).
[6] Department of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the ADA and Olmstead v. L.C. (June 22, 2011).
[7] SSA §1902(a)(43)(D) and 2108(e).
[8] CMS, State Medicaid Manual § 2700.4.
[9] Optional coverage of EPSDT services in separate CHIPs reflects all Medicaid EPSDT requirements, including coverage of all § 1905(a) services.
[10] U.S. Code. Title 42 § 1396u-7.
[11] 42 CFR § 440.345.

and expertise regarding EPSDT to help the state Medicaid agency implement EPSDT requirements across the program. This Guide does not establish new EPSDT policy but rather compiles into a single document various EPSDT policy guidance that CMS has issued over the years.

Program Integrity:

States must comply with all applicable federal Medicaid statutes and regulations, including requirements governing provider screening and enrollment, payment methodologies, utilization controls, and program integrity. States are required to maintain effective systems and safeguards to prevent, detect, and address fraud, waste, and abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate. States should also have robust internal controls and oversight mechanisms in place to identify and remediate vulnerabilities related to FWA and beneficiary access. Failure to meet program integrity obligations may result in compliance actions, including corrective action plans, withholdings, deferrals, disallowances, or other enforcement measures.

Technical Assistance:

Technical assistance is available to help states determine how to implement state intentions under state plan or waiver authorities and remain consistent with EPSDT requirements. CMS encourages states to contact their CMS state lead or the EPSDT mailbox (EPSDT@cms.hhs.gov) when considering changes to benefits.

This Guide outlines:

1. EPSDT's requirements for informing families and children
2. EPSDT's screening requirements, including interperiodic screening
3. The full scope of diagnostic and treatment services under EPSDT, including requirements governing dental, vision, and hearing services
4. Services available under other federal authorities
5. Strategies to ensure appropriate coverage, including ensuring medical necessity
6. Notice and Fair Hearing requirements
7. States' responsibilities to ensure access to EPSDT services and providers
8. Assistance to states as they work with MCPs to provide the best child health benefit possible
9. Quality reporting mechanisms to measure EPSDT performance for states

I. Informing

Federal law requires that states inform all eligible individuals of the availability of EPSDT services in a timely manner—in the case of families whose EPSDT-eligible children are enrolled in Medicaid but have not utilized EPSDT services—annually thereafter.[12,13] States employ a combination of written and oral methods to implement their informing process and ensure that EPSDT-eligible children and their families are aware of the comprehensive coverage available to them and how to access available benefits, and obtain necessary supports to facilitate getting the care they need.[14,15] To this end, states must inform EPSDT-eligible children and their families: 1) about the benefits of preventive care; 2) of the services available through EPSDT and how to obtain them; 3) that services are available without charge, except for premiums that may be charged for medically needy children; and 4) that transportation and appointment scheduling assistance are available upon request.[16] States must offer transportation and scheduling assistance "prior to the due date of a child's periodic examination," and once a request for support services has been made, states should assume that the request applies to any follow-up services as well.[17]

States must inform EPSDT-eligible beneficiaries and their families using clear and non-technical language. States also must provide information in a manner that is accessible to those who cannot read or understand English.[18,19] The ADA requires reasonable accommodations for an individual who may have difficulty receiving information about or accessing EPSDT because of a disability.[20] Therefore, states must provide the required EPSDT information in prevalent non-English languages, and that information must be available in alternative formats upon request and at no cost to the individual.[21]

In addition to informing EPSDT-eligible children and their families about the services available through EPSDT and how to obtain them, states also need to ensure that MCPs and other contractors, as well as participating health care providers, have the information about EPSDT that they need to ensure children receive all services to which they are entitled. This includes how children can obtain services when needed to correct or ameliorate a condition and how to use the grievance and appeal process. If states rely on MCPs to provide eligible children and their families with the required EPSDT information for beneficiaries, they should clearly delineate these responsibilities in the managed care contract, monitor and oversee the plans,

[12] SSA § 1902(a)(43)(A).
[13] CMS, State Medicaid Manual §§ 5121.A, 5121.C.; 42 C.F.R. § 441.56(a)(4).
[14] SSA §1902(a)(43)(A).
[15] CMS, State Medicaid Manual §§ 5121.A, 5121.C.
[16] SSA § 1902(a)(43)(A) and 42 CFR § 441.56.
[17] CMS, State Medicaid Manual § 5150.
[18] 42 CFR § 441.56(a)(3).
[19] CMS, State Medicaid Manual § 5121.C.
[20] 42 CFR § 12131. Definitions.
[21] 42 CFR § 441.56(a)(3) and § 438.10.

and have mechanisms in place to hold plans accountable for fulfilling their contractual responsibilities.[22,23]

II. Periodic and Interperiodic Screenings

EPSDT covers regular screening services (well-child visits) for infants, children, and adolescents that include medical, vision, hearing, and dental assessments. Well-child visits are designed to identify physical and mental health and developmental issues as early as possible. These visits are the foundation of EPSDT coverage and are a crucial entry point for providing preventive care as well as identifying matters that require follow-up. Well-child visits are intended to be comprehensive and include age-appropriate laboratory, developmental, and other screenings; referrals to diagnostic and specialty services; and referrals to establish ongoing dental, vision, and hearing care.

States have the responsibility to ensure that all EPSDT-eligible children and their families are informed of both the availability of screening services and that they are not required to make a formal request for an EPSDT screen.[24] States provide or arrange for screening services both at established intervals, typically referred to as "periodic screenings" or "well-child visits," and on an as-needed or "interperiodic" basis. An EPSDT well-child visit has five components:

1. Comprehensive health and developmental history that assesses both physical and mental health[25]
2. Comprehensive, unclothed physical examination
3. Appropriate immunizations, in accordance with the schedule for child and adolescent vaccines established by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices
4. Laboratory testing (including blood-lead screening appropriate for age and risk factors)[26]

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[22] 42 CFR § 438.210(a).
[23] 42 CFR § 438.10(c)(5).
[24] For minor beneficiaries, the involvement of parents, legal guardians, and other caregivers is often necessary to ensure access to benefits. We intend the term "family" to include all persons considered family members under applicable law.
[25] CMS has issued a number of bulletins to states offering guidance for coverage of behavioral health services for children and youth—e.g., State Health Official, "Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirement," SHO # 24-005, Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth, and Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions.
[26] CMS issued guidance on June 22, 2012, to align blood-lead assessment for Medicaid children with CDC recommendations. After providing data that demonstrated that universal testing is not the most effective approach to identifying childhood exposure to lead, a state may request to implement a targeted lead screening plan rather than continue universal testing of all EPSDT-eligible children ages 1 and 2. Medicaid will also provide reimbursement for lead investigations in the home or primary residence of a child with an elevated blood lead level. See Informational Bulletin.

5. Health education and anticipatory guidance for both the child and the family[27,28]

Under the Act, states establish periodicity schedules for medical, vision, hearing, and dental screenings to set the frequency by which certain covered services should be provided to ensure that EPSDT-eligible children have access to screening services according to that schedule.[29] Although federal law does not prescribe the periodicity schedules, it does require states to establish the schedules based on current standards of pediatric medical, vision, hearing, and dental practice and to consult with recognized medical and dental organizations involved in child health care when developing the schedules.[30] Most states use Bright Futures, developed by the American Academy of Pediatrics (AAP), which includes screenings and assessments for physical, developmental, behavioral, and oral health, as well as vision and hearing. States should review all of their EPSDT periodicity schedules regularly to keep them up to date.[31,32]

States must adopt periodicity schedules for vision and hearing screening that meet reasonable standards of medical practice. For the vision and hearing screenings covered under EPSDT, most states adhere to professional guidelines that recommend these screenings be integrated into well-child visits.

Although professional guidelines (e.g. Bright Futures) recommend that screening professionals include an oral health assessment in the well-child visit at specified ages, states must also cover dental or oral health screening separately under EPSDT. Many states have adopted the American Academy of Pediatric Dentistry's (AAPD) recommended periodicity schedule for dental services for children and adolescents. Screenings for dental and oral health, which may be performed by dental professionals or by medical professionals according to state scope-of-practice rules, can take place in community or group settings, including schools, as well as in clinics or medical and dental offices. Such screenings can be helpful in identifying children with unmet dental care needs so they can be referred to a dental professional for treatment.

States should review all their EPSDT periodicity schedules regularly to keep them up to date.

Under EPSDT, states are required to cover medically necessary interperiodic screening visits when an EPSDT-eligible child requires diagnosis or treatment of an illness or condition that was not present at the well-child visit or to determine if there has been a change that requires

[27] SSA § 1905(r)(1)(B).
[28] CMS has clarified that states may cover maternal depression screening as part of a Medicaid well-child visit under EPSDT, as it is primarily for the benefit of the child. Any diagnostic or treatment services directed solely at the mother can be covered only if the mother is Medicaid-eligible. See Informational Bulletin.
[29] 42 CFR § 441.58.
[30] SSA § 1905(r).
[31] CMS, Vision and Hearing Services for Children and Adolescents.
[32] CMS, State Medicaid Manual § 5123.2.F.

additional services. Interperiodic screening visits may be requested by a beneficiary or their family or by a physician, dentist, or other qualified professional (e.g., a health, developmental, or educational professional) who comes into contact with a child outside of the formal health care system. This includes, for example, personnel working for state early intervention or special education programs, Head Start, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). A state may not limit the number of medically necessary health care visits a child receives or require prior authorization for either periodic or interperiodic screenings.

Screening services need not be conducted by a Medicaid provider in order to trigger EPSDT coverage for follow-up diagnostic services and necessary treatment by a qualified Medicaid provider. Any provider operating within the scope of their practice, as defined by state law, may provide a screening service. For example, a school nurse may provide a vision screening to an EPSDT-eligible child, and that child would be entitled to further screening, diagnostic or treatment services regardless of whether the nurse is an enrolled Medicaid provider. Similarly, a screening service provided before a child enrolls in Medicaid is sufficient to trigger follow-up diagnostic and necessary treatment after enrollment. To receive the benefits of EPSDT, the family or child does not need to formally request an EPSDT screen. Rather, any visit or contact with a qualified medical professional is sufficient to satisfy EPSDT's screening requirement, and states should consider a child who is receiving services to be participating in EPSDT, whether the family or child requested screening services directly from the state or the health care provider.[33,34]

Example of Screenings Beyond Those Required by the Periodicity Schedule

A child receives a regularly scheduled well-child visit at five years of age at which no problem is detected. Before their next annual checkup, the school nurse recommends to the child's parent that the child needs follow-up because a teacher suspects a vision problem. Even though the next scheduled well-child visit is not due until the age of six, the child would be entitled to receive a timely interperiodic screening to determine if there is a vision problem and to receive appropriate treatment as indicated.

The affirmative obligation to connect children with necessary treatment is a crucial component of EPSDT and makes the Medicaid benefits for children more robust than those for adults.[35] Screening services provide the crucial link to necessary covered treatment, as EPSDT requires states to "arrang[e] for … corrective treatment"—either directly or through referral to appropriate providers or licensed practitioners—for any illness or condition detected by a screening.[36]

Establishing Payment for Screening Services

States with a FFS system establish their own fee schedules for screening services. Under the Health Insurance Portability and Accountability Act (HIPAA), CMS has adopted standardized code sets for diagnoses and procedures used in all transactions, and states should use

[33] CMS, State Medicaid Manual § 5310.
[34] HCFA, Title XIX State Agency Letter No. 91-33; April 3, 1991.
[35] CMS, State Medicaid Manual § 5124.B.
[36] SSA § 1902(a)(43)(C).

compliant billing codes.[37] States may develop a bundled payment rate to pay for the medical screening components under one billing code or may recognize each component of the EPSDT screening separately. States may encourage providers to perform all five components of the EPSDT well-child visit but cannot exclude providers who perform only partial screenings from being paid for the parts they do provide.

III. Treatment Services Available under EPSDT

EPSDT-eligible children should have access to a broad scope of treatment services to meet their individual needs. Section 1905(a) of the Act establishes the scope of benefits covered under EPSDT, including but not limited to, physician and hospital services; private-duty nursing; personal care services; home health and medical supplies, equipment, and appliances; rehabilitative services; and vision, hearing, and dental services. This section describes how states can ensure that a full range of treatment services are available to EPSDT-eligible children under section 1905(a) of the Act; this section also includes details on coverage of certain services, including oral health, vision and hearing, mental health, SUD, and personal care.

In addition to the treatment services authorized under Section 1905(a), EPSDT-eligible children may have access to services authorized under other Medicaid federal authorities that are not subject to EPSDT requirements (e.g., 1915(c) Home and Community-Based Services [HCBS] waiver services) and for which they are eligible. Although these other services may supplement an EPSDT-eligible child's care, EPSDT is a legal entitlement, and medically necessary EPSDT-required services must be accessed under the Section 1905(a) authority prior to other Medicaid authorities. For more detailed information, please see the next section, "V. Services Available under Other Federal Medicaid Authorities."

A. Ensuring a Full Range of Treatment Services under EPSDT

States are required to cover under their state plan certain services described in section 1905(a) of the Act. States have the option to cover under their state plan all other section 1905(a) services. However, states are required to cover all section 1905(a) services "to correct or ameliorate defects and physical and mental illnesses and conditions" that EPSDT-eligible children may be experiencing regardless of whether or not the state has elected to cover the service under its state plan. If a section 1905(a) service, supply, or equipment is not listed as covered for adults in the state Medicaid plan, the state nonetheless must provide it to an EPSDT-eligible child if it is medically necessary. The broad range of such services includes, but is not limited to, case

[37] CMS, Code Sets Overview.

management services (including targeted case management);[38] incontinence supplies; organ transplants and any related services; a specially adapted car seat that is needed by a child because of a medical problem or condition; and medical foods. Federal financial participation (FFP) is available at the state's Federal Medical Assistance Percentage (FMAP).

A state may need to take additional steps to ensure that EPSDT-eligible children have access to medically necessary care. For example, if an EPSDT-eligible child needs a medically necessary service that is not covered in the state Medicaid plan for adults, the state would need to develop a payment method for the service and may need to establish a single-service agreement with an in-state or an out-of-state provider who will accept Medicaid payment. Similarly, a state may need to enter into a single-service agreement with a provider if a certain provider type is not participating in Medicaid but is needed for an EPSDT-eligible child's medically necessary care. If an EPSDT-eligible child's physician or other provider uses medical terminology to prescribe a medical service or supply that does not mirror Medicaid terminology, the state must determine if the service or supply could be covered under Section 1905(a). If the service or supply could be covered under section 1905(a) of the Act, the state must ensure that the child has access to that service or supply if it is medically necessary to correct or ameliorate the child's condition.

In addition to services that can "correct" a condition, services that can "ameliorate" a condition (i.e., make a condition more tolerable) must be covered under EPSDT. Services that maintain or support health problems rather than cure or improve them can be ameliorative and are a crucial component of a comprehensive child-focused health benefit. In particular, children with disabilities may benefit from services that can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Less common maintenance services include medical supplies, equipment, and appliances (such as pressure-relieving cushions or bed rails). Ameliorative services are a crucial component of a comprehensive child-focused health benefit. If not available to a child under EPSDT, such services may also be covered under HCBS authorities in order to prevent or delay institutionalization. See Section IV. *Services Available to Children under Other Federal Authorities* of this Guide.

B. Covering Oral Health, Vision and Hearing, Mental Health and SUD, and Personal Care Services

As noted above in Section IV.A of this Guide, *Ensuring a Full Range of Treatment Services under EPSDT*, the scope of services that must be covered under EPSDT provides eligible children with access to a wide range of services. This section goes into detail about certain services available under EPSDT, some of which are explicitly referenced in Section 1905(a) of the Act and some of which can be covered under various Section 1905(a) Medicaid service categories. The services discussed in this section, which include oral health and dental services, vision and hearing services, mental health and SUD services, and personal care

[38] Care coordination is the organization of care across multiple providers and may focus on a specific service or condition and can be covered under the rehabilitative services option. See SSA § 1905(a)(19) and 42 CFR §§ 440.169 and 441.18.

services, are not an exclusive list of all services that must be covered under EPSDT when medically necessary.

a. Oral Health and Dental Services

States must cover medically necessary dental services for EPSDT-eligible children, irrespective of whether the services are covered for adults. Section 1905(r)(1)(A) of the Act requires that states cover oral screenings and dental exams at the intervals identified in the state's selected dental periodicity schedule, which should be developed in consultation with recognized dental organizations involved in child health care.[39,40] Any services necessary to identify and treat an illness or condition identified during an oral screening or dental exam must be covered for EPSDT-eligible children.[41]

Although CMS does not define the specific dental treatment services that states must cover for EPSDT-eligible children, these services may not be limited to emergency situations and should include, at a minimum:[42]

- Dental care needed for relief of pain or infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary);
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures;[43] and
- Orthodontic services for EPSDT-eligible children to the extent necessary to prevent disease, promote oral health, and restore oral structures to health and function.[44] Orthodontic services for cosmetic purposes are not covered.

Dental care that is deemed medically necessary for an individual child is covered even when the frequency is greater than specified in the periodicity schedule.[45,46] For example, for a child determined by a qualified provider to be at moderate or high risk for developing early childhood caries (i.e., tooth decay), a state may need to cover dental exams and preventive treatments more frequently than the twice-yearly periodicity schedule recommended by the AAPD. Risk assessment resources are available for providers, including an assessment tool from AAPD that includes a caries-risk assessment form, clinical guidelines, and treatment protocols.

Primary care medical providers can also offer evidence-based oral preventive care, such as fluoride varnish, risk assessment, and oral health education, and refer children to a dental professional for a complete checkup and any needed treatment. CMS has developed quality-

[39] SSA § 1905(r)(3).
[40] CMS, State Medicaid Manual § 5110.
[41] CMS, State Medicaid Manual § 2700.4.
[42] CMS published an informational bulletin about CMS efforts working with states to improve access to oral health services for children enrolled in Medicaid and a toolkit for improving delivery of dental and oral health services.
[43] CMS, State Medicaid Manual § 5124.B.2.b.
[44] Ibid.
[45] CMS, State Medicaid Manual § 5110.
[46] CMCS, Informational Bulletin (May 4, 2018).

improvement resources related to improving the provision of oral health preventive services in primary care settings.[47]

Depending on the dental practice act in individual states, there is a wide range of dental professionals who can work under the supervision of a dentist to provide oral health services—e.g., dental hygienists, dental therapists, dental assistants, and community dental health coordinators. Dental supervision also can include a wide range of arrangements—e.g., direct, indirect, general, public health, and collaborative practice arrangements. Some state practice acts also permit specified dental professionals to work without dentist supervision in certain circumstances. Utilization of all provider types and arrangements permitted under a state's dental practice act can help ensure access to dental care as well as promote an integrated health care delivery system.

Given the limited supply of pediatric dental specialists, several states have worked to enhance the capacity of general dental practices to treat very young children, including offering enhanced payment rates for dentists who treat this population, reflecting the additional time required, after receiving state-approved training. In addition, the Center for Medicaid & CHIP Services' (CMCS) oral health strategy guide, Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents, provides additional information on oral health and EPSDT.

b. Vision and Hearing Services

Vision and hearing services are a required component of EPSDT. Hearing impairments can lead to other problems, including interference with normal language development in young children, and can delay a child's social, emotional, and academic development. Vision problems can similarly lead to delays in learning and social development and can be evidence of serious, degenerative conditions.

To determine the existence of a suspected illness or condition, sections 1905(r)(2) and (4) of the Act require that vision and hearing services be provided at intervals that meet reasonable standards, as determined in consultation with medical experts, and at other intervals as medically necessary.

At a minimum, vision services must include screening, diagnostic services and treatment for defects in vision, including eyeglasses. Glasses to replace those that are lost, broken, or stolen also must be covered. Hearing services must include, at a minimum, screening, diagnosis and treatment for defects in hearing, including hearing aids, and states must establish a plan to exceed any limits in place for adults.[48]

In addition, if hearing and vision problems are detected through screening, medically necessary diagnostic and treatment services that fit into the categories listed under Section 1905(a) must be covered. This includes not only services provided by physicians, such as ophthalmologists, but also services from licensed professionals such as optometrists. In addition, any medically necessary

[47] Learn more on the Oral Health Quality Improvement Resources page.
[48] SSA § 1905(r).

medical supplies, equipment, and appliances—which may include hearing aids, cochlear implants, and eyeglasses—must be covered by states.

c. Mental Health and Substance Use Services

"Behavioral health" is not an identified, stand-alone service defined within the Act; however, treatment for mental health and substance use symptoms and conditions are available under several Section 1905(a) Medicaid service categories. States commonly use a variety of services to meet children's identified needs, including but not limited to hospital, clinic, and physician services.[49] States may also make use of other categories, including rehabilitative services, preventive services, and other medical or remedial care provided by licensed practitioners, such as psychologists, to ensure that there is an array of services to treat EPSDT-eligible children's behavioral health needs.[50,51] States may expand the range of existing providers of Medicaid-covered services by establishing qualifications for paraprofessional provider types, such as youth and family peer supports and other types of non-licensed providers.

Rehabilitative services, which must be restorative in nature, are often part of states' coverage of mental health and SUD services, and include, "any medical or remedial services provided in a facility, a home, or other setting recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[52] Rehabilitative services provided to children should reflect goals appropriate for the child's developmental stage and level of cognition.

Some services offered in the community, including those that can be provided through Section 1905(a) of the Act, have proven to significantly enhance outcomes for children with serious emotional disturbances. Depending on the interventions that the individual child needs, services that can be covered under the rehabilitative services benefit include but are not limited to:

- Community-based crisis services, such as mobile crisis teams and crisis stabilization services
- Intensive community-based services such as intensive home-based therapy
- Individualized mental health and substance use treatment services provided in outpatient, community-based settings, such as a school, a workplace, or home, including medication management and therapies to eliminate psychological barriers that would impede development of community-living skills
- Peer support, including parent peers

With respect to the provision of any mental health and SUD services covered under the rehabilitative services benefit, including those noted above, CMS requires states to include service definitions and describe provider qualifications, as the rehabilitative services benefit

[49] SSA § 1905(a).
[50] SSA § 1905(a) and 42 CFR § 440.130(d).
[51] CMCS, State Medicaid Director (November 13, 2018).
[52] SSA § 1905(a).

does not specify provider qualifications. As with any EPSDT service, states are not required to include coverage in the state plan, but states would need to include a payment method for each service it provides to EPSDT-eligible children.

CMS has issued detailed guidance encouraging states to include screening, assessments, and treatments focusing on children who have been victims of complex trauma. EPSDT can be a crucial tool in addressing the profound needs of this population, including children who are involved in the child welfare system.

d. Personal Care Services

Medicaid state plan personal care services are optional services for adults, but they must be covered for EPSDT-eligible children when medically necessary to "correct or ameliorate" a condition in any setting in which normal life activities take place. Section 1905(a)(24) of the Act defines personal care services as services that are:

> *furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility …or institution for mental disease, that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State; (B) provided by an individual who is qualified to provide such services and is not a member of the individual's family; and (C) furnished in a home or other location.*[53]

Personal care services provide a range of assistance with performing activities of daily living, such as dressing, eating, bathing, transferring, and toileting, as well as instrumental activities of daily living, such as preparing meals and managing medications.[54] Personal care services cannot be provided in an inpatient setting or to a resident of a hospital, nursing facility, intermediate care facility or institution for mental disease.

The determination of whether a child needs personal care services must be based on the child's individual needs and in accordance with a treatment or service plan. Medicaid payments generally are not available for personal care services provided by the child's legally responsible relatives under the Medicaid state plan unless the state has exercised the option authorizing self-directed care.[55,56]

[53] SSA § 1905(a) and 42 CFR § 440.167.
[54] CMS, State Medicaid Manual § 4480.
[55] 42 CFR § 440.167. States may apply for the state plan option that authorizes self-directed personal care and related services and, through that option, may allow beneficiaries to hire legally responsible relatives.
[56] SSA § 1915(j).

IV. Services Available to Children under Other Federal Authorities

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 needs and use. These children usually require a robust set of Section 1905(a) services provided by primary care and pediatric subspecialists, as well as a variety of 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, 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 to which they are entitled.

EPSDT-eligible children may have access to other Medicaid services that are not subject to EPSDT requirements. When providing children with needed services, Medicaid services described under Section 1905(a) of the Act should always be used before providing services available under other federal authorities. Other services—such as respite authorized through a Section 1915(c) Home- and Community-Based Services waiver or Health Homes authorized through Section 1945 or 1945A of the Act—can supplement services authorized by Section 1905(a) but, unlike EPSDT services, they may be subject to caps on enrollment or dollar limits.

A. Waiver and State Plan Home and Community-Based Services

Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than long-term care in a nursing facility, intermediate-care facility, or hospital. States can implement HCBS programs to serve a variety of targeted groups, such as individuals (including children) with intellectual or developmental disabilities, physical disabilities, or mental health and/or substance use disorders. There are a few avenues states can take to provide HCBS that are not otherwise covered by Medicaid program in accordance with Section 1905(a) of the Act.

a. Home and Community-Based Services Waivers

A state Medicaid program may offer services through HCBS waiver programs authorized under Section 1915(c) of the Act. Waiver programs provide coverage of services that are not otherwise covered by Medicaid (even for children under the EPSDT requirements) because they do not fit into one of the categories of coverable services listed in Section 1905(a) of the Act. Such HCBS includes respite services, supported employment, or other services approved by CMS that can help prevent institutionalization. These programs are sometimes called 1915(c)

waivers after the section of the Social Security Act that authorizes them.[57] For each beneficiary enrolled in an HCBS waiver program, states must develop a written person-centered service plan that identifies the services that the beneficiary needs to function successfully and ensure their health and welfare.

Because HCBS waivers can provide services not otherwise covered under Section 1905(a) of the Act, they can be used to supplement the Section 1905(a) services available to children under EPSDT to provide a more comprehensive benefit package for children with special needs who would otherwise need the level of care provided in an institutional setting, thereby allowing children to remain in their homes or communities.[58] The HCBS waiver services supplement EPSDT services that are coverable under Section 1905(a). The child's needs must be met first with services available under Section 1905(a). A waiver may be employed to provide services that are needed to prevent institutionalization but that are not authorized under, or exceed what is considered medically necessary for purposes of, Section 1905(a).[59]

Further, children who have been determined eligible for Medicaid and are on a waiting list for an HCBS waiver program are entitled to EPSDT and to all medically necessary services that fit into the categories listed in Section 1905(a). States cannot deny Section 1905(a) services because a Medicaid enrolled child is on an HCBS waiver waiting list.[60] Conversely, although states may limit the amount, duration, and scope of HCBS waiver services provided to beneficiaries (including those under age 21) who are enrolled in a waiver, states may not limit the amount, duration or scope of Section 1905(a) services to EPSDT-eligible children under 21 years of age who are enrolled in an HCBS waiver program.[61,62]

Children who are enrolled in an HCBS waiver program are also entitled to all EPSDT services. If a child enrolled in Medicaid is on a waiting list for an HCBS waiver, they are entitled to EPSDT and to medically necessary services that fit into the categories listed in Section 1905(a).

[57] 42 CFR § 440.167. States may apply for the state plan option that authorizes self-directed personal care and related services and, through that option, may allow beneficiaries to hire legally responsible relatives.
[58] SSA § 1915(j).
[59] Ibid.
[60] CMS, Olmstead Update No. 4 (January 10, 2001).
[61] SSA § 1905(d)(r)(5) and § 1915(c)(1).
[62] CMS, State Health Official (September 26, 2024).

b. State Plan Home and Community-Based Services

States may choose to offer HCBS to children through several state plan authorities:1) Section 1915(i), which authorizes coverage of HCBS to individuals who meet certain financial eligibility criteria, needs-based criteria, and any targeting criteria defined by the state[63]; 2) Section 1915(j), which authorizes self-direction of Section 1905(a) state plan personal assistance services and Section 1915(c) HCBS; and 3) Section 1915(k) home- and community-based attendant services and supports. Like services provided pursuant to a Section 1915(c) waiver, these Section 1915 authorities are not subject to EPSDT coverage provisions but can be used by states to supplement EPSDT services. States may also seek approval to offer services through Section 1115, which authorizes innovative programs that HHS finds consistent with the objectives of Medicaid and meet other statutory requirements, including the requirement that a Section 1115 demonstration be determined to be budget neutral as certified by the CMS Chief Actuary beginning January 1, 2027.

B. Health Homes

The Affordable Care Act established a state plan option that allows states to design “health homes” to coordinate care for Medicaid beneficiaries with chronic conditions.[64] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act created an additional enhanced match for new health homes focused on SUD by amending Section 1945 of the Act.[65] The Medicaid Services Investment and Accountability Act created Section 1945A of the Act, establishing a new health home state plan option that provides an opportunity for states to cover care coordination for children with medically complex conditions.[66] Under these health home benefits, providers coordinate the full range of medical, behavioral health, and long-term services and supports that Medicaid beneficiaries with chronic health conditions need. In addition, health homes may be especially useful for children with medically complex conditions, as they cover care coordination services necessary to support family-centered systems of care.

States receive a 90 percent enhanced federal match for the first eight quarters of implementation under Section 1945 of the Act and an additional two quarters for new SUD-focused health home programs under Section 1945(c) of the Act. Under Section 1945A of the Act, states receive up to a 90 percent enhanced federal match for the first two quarters of implementation. Services can include comprehensive care management, care coordination, transitional care, parent and family support, use of health information technology to link services, and referrals to community and social support services.

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[63] CMS and SAMHSA. Joint Informational Bulletin. (May 7, 2013)
[64] SSA § 1945.
[65] SSA § 1945(c)(4).
[66] SSA § 1945A.

C. Interagency Coordination

EPSDT-eligible children often receive services from other federal agencies. Federal rules require state Medicaid agencies to collaborate with their state's Title V[67] Maternal and Child Health (MCH) agencies and grantees to enhance health outcomes for children.[68] To meet this requirement, State Medicaid agencies need to have interagency agreements with their state's MCH program in order to improve access to EPSDT services.[69] Among other things, cooperating MCH agencies can provide outreach, screening, diagnostic or treatment services, health education and counseling, case management, and other assistance to provide comprehensive and effective child health services. MCH programs also can help Medicaid programs to enlist providers who can help deliver a broad array of services. In addition, they can inform potential and actual Medicaid beneficiaries about EPSDT and refer them to necessary services.[70] Ongoing collaboration with other child-focused programs may also contribute to an effective child health program. CMS encourages such collaborations, as these agencies are important partners in creating and delivering a high-quality, well-integrated child health benefit.

D. Enabling Services

When requested, state Medicaid agencies are required to provide assistance with scheduling appointments and transportation to appointments for beneficiaries who need this assistance and to ensure that covered services are appropriately delivered to children.

a. Transportation Services

Transportation is an essential part of making medically necessary health care available to children. To ensure that EPSDT-eligible beneficiaries can access needed preventive, diagnostic, and treatment services, states must offer appointment scheduling assistance and assure necessary emergency and non-emergency transportation to and from medical appointments.[71,72] This includes covering the costs of an ambulance, taxi, bus, or other carrier. It can also include reimbursing for mileage. States must use the least expensive mode of transportation that is appropriate to meet the individual's needs. For example, public transportation can be covered instead of a taxi if the public transportation is appropriate for a particular beneficiary and takes a reasonable amount of time.

In addition, "related travel expenses" are covered if necessary. For example, if the child needs to be accompanied to their medical services, the cost of transportation for the person accompanying the child is a related travel expense. This may include coverage for that person's transportation,

[67] SSA § 509(a)(2).
[68] 42 CFR § 705(a)(5)(F), § 709(a)(2), § 441.61(c).
[69] 42 CFR § 431.615.
[70] CMS, State Medicaid Manual; § 5230.
[71] SSA § 1902(a)(4)(A) and 42 CFR §§ 440.170, 441.62.
[72] CMCS, Informational Bulletin (July 12, 2021).

including meals and lodging.[73,74] In other circumstances, states may cover transportation for a parent or caregiver if necessary for the direct benefit of the child; that is, in order to ensure the child's medically necessary services can be provided.[75]

States can offer assistance with transportation in a variety of methods. Some states offer non-emergency transportation through brokers and other types of administrative managers who coordinate transportation services. Transportation may also be included in managed care contracts. If a state chooses not to include transportation services in their managed care contracts, the state itself will need to administer the service. No matter the type of arrangement, it is important to remember that the state has ultimate responsibility for ensuring the provision of transportation services.

CMS has published a Medicaid Transportation Services Guide to provide states with a one-stop source of guidance on federal requirements and state flexibilities regarding the assurance of transportation.

b. Interpretation and Translation

State Medicaid agencies and Medicaid MCPs, as recipients of federal funds, are required to take "reasonable steps" to ensure that individuals who have limited English proficiency have meaningful access to Medicaid services.[76] States should provide beneficiaries with notice of the availability of language-assistance services and auxiliary aids and services.[77] States must also ensure that directories of Medicaid-participating providers include the languages spoken by those providers.[78]

> Interpreters may not be paid separately, but their services may be included as part of an allowable Medicaid service when reimbursed when billed by a qualified provider rendering a Medicaid-covered service.

States are not required to—but may—pay providers for the cost of language services. States may consider the cost of language services to be included in the regular rate of payment for the

[73] 42 CFR § 440.170(a).
[74] CMS, Medicaid Transportation Coverage Guide (2023).
[75] Ibid.
[76] 42 C.F.R. §§ 435.905, 436.901. State Medicaid agencies and MCPs also are subject to federal civil rights laws that have accessibility requirements. *See, e.g.*, Section 1557 of the Affordable Care Act (42 U.S.C. § 18116); Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), and the Americans with Disabilities Act (42 U.S.C. §§ 12101 et seq.).
[77] 45 CFR § 92.11.
[78] SSA § 1902(a)(83)(A)(ii).

underlying direct service. In those cases, Medicaid providers are obligated to provide language services to those with limited English proficiency and to bear the costs for doing so. Alternatively, states may allow providers to bill specifically for interpreter services. States have the option to make claims for the cost of interpretation services, either as medical-assistance-related expenditures or as administration.[79,80]

Interpreters are not Medicaid qualified providers and may not be paid separately. However, their services may be included as part of an allowable Medicaid service when billed by a qualified provider rendering a Medicaid- covered service. States have options in how they claim federal financial participation (FFP) for interpretation. States may claim standard 50 percent federal matching rate for translation and interpretation activities that are claimed as an administrative expense and may claim 75 percent federal matching for expenses related to the enrollment, retention, and use of services under Medicaid by children of families for whom English is not their primary language.[81] For example, a state may contract for a language telephone line to be used for enrollment as well as by providers when delivering care to beneficiaries as long as interpretation is not included and paid for as part of the payment rate for direct services.[82]

States can also raise payment rates to recognize additional service costs, including interpreter costs, but they must do so for services rendered by all providers in the class. CMS maintains claiming information on a webpage dedicated to Translation and Interpretation Services.

V. Permissible Limitations on Coverage of EPSDT Services

States have many mechanisms to ensure that children get the right service at the right time, including setting parameters for medical necessity, requiring prior authorization for certain services, determining the relative cost-effectiveness of alternatives, and covering experimental treatments at their discretion.

A. Individual Medical Necessity

Services within the Section 1905(a) scope of benefits must be provided to an EPSDT-eligible child only if they are necessary to "correct or ameliorate" the individual child's physical or mental condition, i.e., only if "medically necessary." States are permitted, but not required, to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory EPSDT requirement to cover Section 1905(a) services needed to correct or ameliorate the child's

[79] CMS, State Medicaid Director (July 1, 2010).
[80] CMS, Informational Bulletin (April 26, 2011).
[81] SSA § 1903(a)(2)(E).
[82] CMS, State Medicaid Director (August 31, 2000).

condition. The determination of whether a service is medically necessary for an - EPSDT eligible child must be made on a case-by-case basis, taking into account the child's particular needs. The state—or the MCP as contracted by the state—must apply the "correct or ameliorate" standard and take into account the child's long-term needs, not just what is required to address the immediate situation. If the state or its contractors rely on software to streamline coverage decisions, the state should ensure that any software used in this process is consistent with EPSDT requirements.

Although most of the care and treatment that a child needs will fall within one or more Section 1905(a) categories, not all will. Services that are not listed in Section 1905(a) are not subject to EPSDT requirements. For example, home accessibility modifications and respite care do not fall into a section 1905(a) benefit category and are therefore excluded under EPSDT. A state may choose to cover these services under 1) a 1915(c) HCBS waiver; 2) a 1915(i) state plan HCBS benefit; or 3) other federal authorities authorizing coverage of HCBS.

Determination of whether a service is medically necessary for an EPSDT-eligible child must be made on a case-by-case basis, taking into account the child's particular needs.

As noted, EPSDT medical necessity decisions are individualized. Flat, fixed, hard, or arbitrary limits (e.g., budget or monetary caps, standard deviations from the norm, or hourly maximums) are not consistent with the EPSDT requirements and therefore may not be applied to the coverage of Section 1905(a) services for EPSDT-eligible children.[83,84,85,86] As a utilization control, states may adopt a definition of medical necessity that places "soft" limits on services, pending an individualized determination by the state, or that limits a treating provider's discretion. However, additional services beyond these limits must be provided if determined to be medically necessary to correct or ameliorate the individual child's condition.[87,88] For example, although a state may include in its state plan a limit on the number of physical therapy visits per year for individuals age 21 and older, such a hard limit could not be applied to EPSDT-eligible children. A state could impose a "soft" limit on the number of physical therapy visits, but if it were to be determined through review of an individual child's case that additional physical therapy services were medically necessary to correct or ameliorate the child's condition, those services would have to be covered.

[83] Health Care Finance Administration, Regional Transmittal Notice (Sept. 18, 1990).
[84] Memorandum from Rozann Abato, Acting Director, HCFA, to Associate Regional Administrator (Sept. 5, 1990).
[85] Memorandum from Christine Nye, HCFA Medicaid Director, to Regional Administrator Region VIII (1991).
[86] CMS, Information on School-Based Services in Medicaid (August 18, 2022).
[87] 42 CFR §§ 440.230 and 438.210(a).
[88] CMS, State Health Official (September 26, 2024).

Although the treating health care provider is responsible for determining or recommending that a particular covered service is needed to correct or ameliorate the child's condition,[89] the state also has a role to play in determining whether a service is medically necessary. If there is a disagreement between the treating provider and the state's expert as to whether a service is medically necessary for a particular child, the state is responsible for making a coverage decision for the individual child based on the evidence and application of the EPSDT requirements. That decision may be appealed by the child (or the child's family) under the state's Medicaid fair hearing procedures, as described in "VI. Notice and Fair Hearing Requirements."

B. Utilization Management Strategies

Prior Authorization

States may impose utilization controls to safeguard against unnecessary use of services. For example, a state may establish limits on the amount of a treatment that will be covered for a child and require prior authorization for coverage of medically necessary services above those limits.[90] Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually and under the EPSDT coverage standards. Importantly, prior authorization procedures and other utilization controls may not delay delivery of needed treatment services and must be consistent with what Congress described as the "preventive thrust" of EPSDT.[91,92] Therefore, prior authorization may not be required for any EPSDT screening services.

States need to ensure that their utilization control/prior authorization systems are programmed to apply the EPSDT requirements. Prior authorization decisions also need to be made and communicated to the requesting provider and Medicaid beneficiary promptly.[93] When the authorization request involves outpatient prescription drugs, the state must respond by telephone or other telecommunication device within 24 hours of a request and must provide for dispensing a 24-hour supply of the drug in emergency situations.[94] In addition, utilization management strategies used for mental health and SUDs must comply with the Mental Health Parity and Addiction Equity Act, including being no more restrictive than those strategies used for physical health conditions.

C. Cost Effective Alternatives

A state may not deny medically necessary treatment to a child based on cost alone but may consider the relative cost-effectiveness of alternatives as part of the prior authorization process. A state need not make a service available in every possible setting as long that service is

[89] SSA §§ 1905(a) and (r).
[90] SSA §§ 1905(a) and (r).
[91] H.R. Rep. No. 101-247 at 399, *reprinted in* U.S.C.C.A.N. 1906, 2125.
[92] CMS, State Health Official (September 26, 2024).
[93] For managed care, 42 CFR § 438.210(d).
[94] SSA § 1927.

available when a child needs it. Therefore, states may cover services in the most cost-effective mode as long as the less expensive service is equally effective and available.[95,96] The child's quality of life must also be considered.[97]

A state may not deny medically necessary treatment based on cost alone but may consider the relative cost-effectiveness of alternatives as part of the prior authorization process.

D. Experimental Treatments

EPSDT does not require coverage of treatments, services, or items that are experimental or investigational. Such services and items may, however, be covered at the state's discretion if it is determined that the treatment or item could be effective in addressing the child's condition.[98] Neither the federal Medicaid statute nor the regulations define what constitutes an experimental treatment. Medicare guidance on whether a service is experimental or investigational is not determinative of the issue and may not be relevant to the pediatric population.[99] The state's determination of whether a service is experimental must be reasonable and should be based on the latest scientific information available.[100] In addition, for beneficiaries participating in a qualifying clinical trial, the routine patient costs that are otherwise covered under the state plan must be covered by the state agency.[101]

VI. Notice and Fair Hearing Requirements

A. State Notice and Fair Hearing Requirements

Children, as all beneficiaries, have fair hearing rights whenever the state denies a request for benefits or services (including a prior authorization request denied in whole or in part) and when a state takes action to terminate, suspend, or reduce covered benefits or services, including

[95] CMS, Olmstead Update No. 4 (January 10, 2001).
[96] Letter from Rozann Abato, Acting Director, Medicaid Bureau, to State Medicaid Directors (May 26, 1993).
[97] Ibid.
[98] CMS, State Medicaid Manual §§ 4385.C.1, 5122.F.
[99] Ibid.
[100] Memorandum from S. Richardson to State Medicaid Directors (April 17, 1995).
[101] CMS, State Medicaid Director (April 13, 2022).

those for which there is a current approved prior authorization.[102,103] States must ensure that hearing officers who conduct fair hearings that involve EPSDT are knowledgeable about the state's EPSDT policies and procedures and the higher standard of coverage for EPSDT-eligible children than for adult Medicaid beneficiaries,[104] particularly the EPSDT requirement that states cover all Section 1905(a) services needed to "correct or ameliorate" a child's condition.[105]

States must provide children or their families written notice that includes information regarding the beneficiary's fair hearing rights, when services are being terminated, suspended, or reduced, including those for which a beneficiary has a current approved prior authorization, the notice generally needs to be sent at least 10 days before the effective date of the action ("advance notice").[106] Advance written notice of a denial or action must be: 1) written in plain language; 2) accessible to persons with limited English proficiency and individuals with disabilities; and 3) if provided in an electronic format, compliant with rules relating to electronic notices and information.[107]

Written denial and adverse action notices must contain:

- A statement of the decision or intended action, including the effective date of the action
- A clear statement of the specific reasons supporting the decision or intended action
- The specific regulations or changes in federal or state law supporting the decision or action
- An explanation of the individual's right to a fair hearing (including the right to request an expedited hearing), how to request a fair hearing, who can assist the individual at the hearing, circumstances under which benefits will be provided pending the outcome of the fair hearing, and the time frame in which the agency must take final administrative action on the fair hearing.[108]

Beneficiaries are entitled to a fair hearing before the state Medicaid agency.[109] Regardless of whether the hearing is held by the state Medicaid agency or another entity, the hearing must be conducted at a reasonable time, date, and place by an impartial official or other individual who was not directly involved in the initial decision or action.[110] Beneficiaries have the right to represent themselves or use legal counsel, a relative, a friend, or other spokesperson.[111] Before the hearing, beneficiaries or their representatives have the right to examine the case file and all documents that will be used at the hearing.[112] During the hearing, the beneficiaries have the right to: bring witnesses, establish facts, present their case without undue interference, question or refute the state's case, and ask questions of the state's witnesses (i.e., cross-examine).[113]

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[102] SSA § 1902(a)(3) and 42 CFR §§ 431 and 435.917.
[103] U.S. Supreme Court, Goldberg v. Kelly, 397 U.S. 254 (1970).
[104] CMS, State Health Official (September 26, 2024).
[105] 42 CFR § 431.240.
[106] 42 CFR §§ 431.211 and 431.213.
[107] 42 CFR §§ 435.917, 435.905(b), 435.918, and 431.206(e).
[108] 42 CFR §§ 431.206 and 431.210.
[109] SSA § 1902(a)(3) and 42 CFR § 431.205(b).
[110] Ibid.
[111] 42 CFR § 431.206(b)(3).
[112] 42 CFR § 431.242.
[113] Ibid.

The fair hearing process must be accessible to persons with limited English proficiency and individuals with disabilities.[114]

When a benefit or service is terminated, suspended, or reduced, if the beneficiary requests a hearing before the effective date of action, the beneficiary has the right to continued coverage of the contested benefit or service pending the outcome of the fair hearing.[115] This continued coverage may be referred to as "continued benefits," "benefits pending," or "aid paid pending." If the beneficiary loses the fair hearing, the state may require them to repay the state for the cost of the contested services provided pending the outcome of the fair hearing.[116]

B. Grievances and Appeals Through Managed Care

When benefits or services are provided through a managed care delivery system, MCPs must have a grievance and appeal system in place for enrollees.[117] MCPs must provide enrollees written notice explaining the action taken by an MCP when the decision is adverse to the enrollee (called an "adverse benefit determination"). This notice must include the reason for the determination and an enrollee's right to appeal the MCP's decision, how to access documents and information relevant to the determination, how to file an appeal and request a state fair hearing, how and when an appeal can be expedited, and the enrollee's right to continued benefits in certain circumstances until the appeal is resolved.[118]

MCPs must resolve grievances and appeals in a timely manner.[119] "Timely" includes resolving appeals within a state-established timeframe that is no longer than 30 calendar days after the MCP receives the appeal for standard appeals and 72 hours after the MCP receives the appeal when the MCP determines or provider indicates that delay could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or retain maximum function.[120] The state must require enrollees to exhaust the MCP's appeal process before requesting a state fair hearing.[121] States may choose to provide an option for a no-cost independent external medical review.[122]

Like the state fair hearing process, the MCP grievance and appeal processes must be accessible to persons with limited English proficiency and individuals with disabilities.[123]

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[114] 42 CFR §§ 431.205, 435.917, and 435.905(b).
[115] 42 CFR § 431.230.
[116] Ibid.
[117] 42 CFR § 438.402.
[118] 42 CFR §§ 438.404(b) and 42 CFR § 438.420(c).
[119] 42 CFR § 438.408(b).
[120] 42 CFR §§ 438.408(b) and 438.410.
[121] 42 CFR § 438.402(c).
[122] Ibid.
[123] 42 CFR §§ 438.10 and 431.205(e).

VII. Access to Services

EPSDT-required services, like all Medicaid services, must be provided with "reasonable promptness."[124] States need to set standards for the timely provision of EPSDT services, consistent with medical and dental practice standards. States should have processes in place to ensure that services are initiated within a reasonable time.[125] What constitutes a reasonable time will depend on the nature of the service and the individual child's needs. Because states have an affirmative obligation to arrange screening and corrective treatment, a lack of screening and/or treating providers does not relieve a state of its obligation to ensure that services are provided in a timely manner. For example, as noted above, it may be necessary to cover services provided out-of-state and, in the case of managed care, for MCPs to cover services rendered by providers outside the plan's provider network when that network is unable to provide necessary services covered under the contract.[126]

Because states have an affirmative obligation to arrange screening and corrective treatment, a lack of screening and/or treating providers does not relieve a state of its obligation to ensure that services are provided in a timely manner.

The providers available to treat a child's condition may vary from state to state, depending on state scope of practice requirements (e.g., whether a state allows certain specialized provider types or midlevel providers). Section 1905(a)(6) permits states to cover "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law."[127] Therefore, a state may cover services performed by a class of providers (such as licensed dietitians) when the service is not specified in Section 1905(a), as long as the service is determined necessary to correct or ameliorate the child's condition. Alternatively, a provider's services can be covered as a component of a Section 1905(a) service. For example, in the case of a licensed social worker, the services could be provided through a federally qualified health center (FQHC) or a clinic, both of which are recognized providers under Section 1905(a). The process for covering a provider for a service not specified in Section 1905(a) varies depending on how the state intends to provide the service.

[124] SSA § 1902(a)(8).
[125] 42 CFR §§ 441.56(e) and 438.68.
[126] 42 CFR § 438.206(b)(4).
[127] SSA § 1905(a)(6).

A. Number and Range of Providers

Access to covered services is a critical component of delivering an appropriate health benefit to children. Accordingly, a number of Medicaid and EPSDT requirements are intended to ensure that children have access to an adequate number and range of pediatric providers. Medicaid EPSDT provisions require states to arrange for providing necessary corrective treatment to children, directly or through referrals to appropriate entities or individuals.[128] States should "make available a variety of individual and group providers qualified and willing to provide" services to children.[129] States also need to "take advantage of all resources available" to provide a "broad base" of providers who treat children."[130] To this end, states publish and maintain online directories of providers who accept FFS payments, including by specialty and languages spoken, and ensure that Medicaid-participating MCPs publish similar directories.[131]

Some states may find it necessary to recruit qualified providers not currently enrolled in Medicaid to meet children's needs.[132]

Under FFS, a child is entitled to receive Medicaid services from any provider qualified to provide the service and willing to furnish it. Although MCPs may restrict choice of providers in creating their networks, states must ensure that MCPs have adequate capacity to serve enrollees, including maintaining a sufficient number, mix, and geographic distribution of providers of services.[133]

An appropriate level of Medicaid payment can be critical to ensuring adequate access to providers.[134] Although the statute provides states with broad authority to set FFS provider payment rates, it requires that payments to providers be consistent with efficiency, economy, and quality care and be sufficient to enlist enough providers that care and services are available to Medicaid beneficiaries at least to the extent that they are available to the general population in the same geographic area.[135] For managed care, MCPs determine the payment rates that they pay providers that render covered services to their enrollees. These rates, which may differ from FFS rates, provide a tool for plans to be able to attract a robust network.

Federal regulations require that a Medicaid provider agree to accept, as payment in full, the Medicaid payment for a covered service or item.[136] This means that a provider *may not* bill a Medicaid beneficiary for the difference between the provider's charge and the Medicaid payment (called "balance billing"). The payment in full requirement also prohibits Medicaid providers from billing beneficiaries for missed appointments. States may need to monitor compliance with this requirement.

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[128] SSA § 1902(a)(43)(C).
[129] 42 CFR § 441.61.
[130] CMS, State Medicaid Manual § 5220.
[131] SSA § 1902(a)(83) and 42 CFR § 438.10(h)(1).
[132] CMS, State Medicaid Manual § 5220.
[133] SSA § 1932(b)(5)(B), 42 CFR § 438.207(a), and U.S. Code 1396a(a)(23)(B).
[134] Health Care Finance Administration, State Medicaid Director (Jan 18, 2001).
[135] SSA § 1902(a)(30)(A) and 42 CFR § 447.204.
[136] 42 CFR § 447.15.

B. Services Should be Delivered in a Range of Settings and Locations

EPSDT requires states to treat identified medical conditions and entitles eligible children to medically necessary Section 1905(a) services. Although EPSDT does not directly address settings and locations of services, CMS encourages states to deliver services within a range of settings to remove barriers to early care.

a. Services Provided in Schools

Services provided in schools can play an important role in the health care of adolescents and children. Services may be provided by practitioners employed by the school district, by health clinics located in schools, or by community providers who are contracted to provide services in a school setting. Regardless of delivery model, medical, behavioral, and dental care can be efficiently and effectively delivered in schools, while avoiding a child's extended absence.

School health clinics and community clinicians can function as Medicaid providers who are providing services in a school setting. CMS has published a Comprehensive Guide to Medicaid Services and Administrative Claiming that details the implementation of "School-Based Services" in which providers employed by schools or local education agencies (LEAs) can appropriately submit claims for Medicaid-covered services. In addition, CMS, in collaboration with the US Office of Special Education and Rehabilitation Services, has established a technical assistance center to support state Medicaid agencies, LEAs, and school-based entities seeking to expand their capacity to provide school-based Medicaid services.[137] The intersection of federal education policy and Medicaid policy is complex, and CMS encourages states to take advantage of technical assistance opportunities when considering implementation of Medicaid services in schools.

Services provided in schools can play an important role in the health care of adolescents and children.

b. Telehealth

States have flexibility to cover and pay for Medicaid-covered services delivered via telehealth, including site- and service-specific coverage, school-based services, components of the well-child medical visit, in-home services for children with medically complex conditions, and mental health therapies. States should be aware that there may be limits on when services delivered

[137] CMS, Medicaid & School-Based Services.

through telehealth can be counted in the Child Core Data Set and Form CMS-416 EPSDT reporting form. No federal approval is needed for state Medicaid programs to pay providers for telehealth-delivered services that are provided at the same rate that states pay for face-to-face services. A state plan amendment is needed to implement revisions to payment methods to account for telehealth costs.[138]

CMS has developed a Telehealth Toolkit to support states interested in expanding the use of telehealth to deliver Medicaid and CHIP services.

c. Services Provided Out-of-State

States may need to rely on out-of-state services if medically necessary covered services are not available within the state in a timely way or when a Medicaid beneficiary is out-of-state at the time a need for medical services arises. States are required to pay for services provided in another state to the same extent as they would pay for services furnished in-state for in any of the following circumstances:

- The out-of-state services are required because of a medical emergency
- The beneficiary's health would be endangered if they were required to travel to their home state
- The state determines, on the basis of medical advice, that the needed services are more readily available in the other state
- It is the general practice of the locality to use the services of an out-of-state provider, e.g., in areas that border another state.[139]

Coordination among states will facilitate the provision of services when they are needed. Including out-of-state providers gives states the opportunity to expand the range and accessibility of Medicaid services that are available to their enrollees.[140] This can be particularly beneficial for children with disabilities or other complex health needs.[141]

d. Most Integrated Setting Appropriate

Title II of the Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability in public programs, including Medicaid. In *Olmstead v. L.C.,* the U.S. Supreme Court held that unjustified institutionalization of Medicaid beneficiaries violates the ADA. Accordingly, states must cover services in the community, rather than in an institution, when the need for community services can be reasonably accommodated and providing services in the community will not fundamentally alter the state's Medicaid program.

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[138] CMS, Medicaid & CHIP Telehealth Toolkit (2024).
[139] SSA § 1902(a)(16) and 42 CFR § 431.52.
[140] CMS, Olmstead Update No. 3 (July 25, 2000).
[141] CMS, CMS Informational Bulletin (October 20, 2021).

Community-based care is considered a best practice for supporting children with disabilities or other complex medical needs.

CMS has long encouraged states to provide services in home and community settings, particularly for children, not only because of the *Olmstead* decision, but also because community-based care is considered a best practice for supporting children with disabilities and complex medical needs. In addition, it is generally more cost-effective.[142]

Medicaid provides states with many options for covering physical and mental health services in the community. For example, the EPSDT requirements include coverage of the following Section 1905(a) services when medically necessary to correct or ameliorate a child's condition: case management; personal care; private-duty nursing; medical equipment and supplies; and physical, occupational, and speech-language therapy. In addition, as discussed in section IV of this Guide, optional services provided through HCBS authorities can further advance the state's efforts to provide services in the community for children who qualify for those services.

VIII. Managed Care

EPSDT-eligible children are entitled to the full scope of EPSDT services regardless of delivery system though which they receive services. The vast majority of children receiving Medicaid are enrolled in managed care. Properly implemented and monitored, managed care programs can support EPSDT's goal of ensuring that EPSDT-eligible children get the health care they need, when they need it, in the most appropriate setting.

States are responsible for ensuring the fulfillment of EPSDT requirements for all EPSDT-eligible children in the state, regardless of whether the state contracts with MCPs to deliver some or all services. To ensure accountability and that children get all needed services to which they are entitled, it is critical that the state's contracts with MCPs are drafted with sufficient precision so that MCPs' responsibilities are clearly delineated.[143]

If certain EPSDT-related responsibilities and/or services are excluded from the managed care contract, the contract should be explicit regarding those exclusions, and the state must ensure

[142] More information on services in home and community settings can be found through documents such as: CMS Olmstead Update No. 2 (July 25, 2000); CMS Olmstead Update No. 3 (July 25, 2000); CMS Olmstead Update No. 5 (January 10, 2001); CMS State Medicaid Director (May 20, 2010); and CMS/SAMHSA Joint CMCS and SAMHSA Informational Bulletin (May 7, 2013).
[143] 42 CFR § 438.210(a).

that the excluded services are available to EPSDT-eligible children on a FFS basis or through another MCP. For example, the state may exclude dental services from the contract with a managed care organization, but the state must still ensure that children receive those services through either FFS or a specialized dental plan (e.g., a prepaid ambulatory health plan). Moreover, if a managed care contract excludes benefits above specified limits, the state must ensure provision of medically necessary services above those limits through another mechanism (e.g., on a FFS basis).[144]

Managed care plans may not use a definition of medically necessary services for children that is more restrictive than the state's definition.

Managed care plans may not use a definition of medically necessary services for children that is more restrictive than the state's definition,[145] which in turn cannot be more restrictive than the federal "correct or ameliorate" standard. One way to ensure this is for the state to include the EPSDT "correct or ameliorate" definition in the MCP's contract. States should ensure that MCPs' definitions of medically necessary services meet this requirement.

If MCPs are contractually responsible for informing beneficiaries about EPSDT and its benefits, states must ensure that MCPs inform all enrollees and their families of the services covered under EPSDT requirements and how to access them.[146] Information made available to enrollees, including the enrollee handbook, should clearly explain which EPSDT services the MCP is contracted to provide and how enrollees can access any EPSDT services that are not within the scope of the contract.[147]

Managed care plans are required to have adequate provider capacity to serve enrolled children in accordance with the terms delineated in their contract, including an appropriate range of pediatric and specialty services; access to primary and preventive care; and a sufficient number, mix, and geographic distribution of providers.[148] States must monitor their MCPs to ensure that they meet this requirement.

Monitoring MCPs' compliance with EPSDT requirements is essential; a strong oversight framework ensures that states meet both their responsibilities to children and federal reporting requirements. As outlined below, states use several mechanisms to oversee MCPs.

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[144] CMCS, Informational Bulletin (January 5, 2017).
[145] 42 CFR § 438.210(a)(5)(i).
[146] 42 CFR § 438.10(c)(5).
[147] 42 CFR §§ 438.210(g)(2) and 438.10(e)(2)(v).
[148] 42 CFR §§ 438.207 and 438.68.

States contracting with MCPs are statutorily required to draft, implement, and maintain a managed care quality strategy,[149] the goal of which is to provide a blueprint for states to assess and improve the quality of care provided to managed care enrollees.[150] Through this quality strategy, states identify measurable goals and objectives for continuous quality improvement and can monitor and evaluate MCPs' compliance with quality initiatives; their performance on specified performance measures; and their design, implementation, and results of performance improvement projects. States can leverage their quality strategy to focus some monitoring activities on performance measures or goals related to EPSDT, such as well-child visits and delivery of treatment.

States are also required to ensure that external quality reviews (EQRs) of MCPs are conducted by a qualified external quality review organization (EQRO).[151] In this way, states can determine whether MCPs are reporting accurate performance outcomes data and whether they are in compliance with state contract provisions. States can focus their EQRs on a range of EPSDT items, including informing, screening, and delivery of treatment. In addition, states may direct their EQROs to conduct optional EQR-related activities such as focus studies on a particular aspect of clinical or nonclinical services.[152]

The state's monitoring system must also address MCPs' grievance and appeal systems.[153] States can fulfill this responsibility by engaging in an ongoing direct review of grievances and appeals related to children's services, as well as monitoring complaints filed with the state's enrollee and provider hotlines (if the state operates such hotlines). States could also require MCPs to provide reports on these data and perform data analysis of MCPs' encounter data to detect underutilization of services by children.

IX. State and Federal Quality Reporting and Monitoring of EPSDT

States are statutorily required to annually report the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) to CMS. The Child Core Set is updated annually and includes measures related to access to primary and preventive care, behavioral health care, maternal and perinatal health, care of acute and chronic conditions, dental and oral health, and children's experience of care. In addition, states may use Child Core Set data to inform and drive quality improvement, for example by incorporating Core Set measures into their managed care Quality Strategy, leading to improved access to health care services for Medicaid and CHIP beneficiaries. Annual performance on Child Core Set measures is found on the Core Set Data Dashboard. In addition, all states, including those contracting with MCPs, are

[149] SSA § 1932(c)(1).
[150] 42 CFR § 438.202340(a).
[151] SSA § 1932(c)(2) and 42 CFR § 438.350.
[152] 42 CFR § 438.358(c)(5).
[153] 42 CFR § 438.66(b)(2).

required by statute to complete and file Form CMS-416 each year, on which states report the number of children receiving health screening services, dental and oral health services, and referrals for corrective treatment The data reported on the CMS-416 informs CMS about the extent to which each state is meeting the EPSDT requirements with respect to these services.

Conclusion

More comprehensive and less restrictive than the Medicaid benefit for adults, the EPSDT requirements are designed to ensure that children receive the medically necessary preventive services; early care; acute care; and ongoing, long-term treatment and services they need so that health problems are averted or diagnosed and treated as early as possible. For this reason, EPSDT requires coverage of age-appropriate medical, dental, vision, and hearing screening services at specified times, as well as when health problems arise or are suspected. In addition, EPSDT requires coverage for children not only of medically necessary treatment to correct or ameliorate identified conditions, but also of preventive and maintenance services.

The broad scope of EPSDT provides states with the tools necessary to offer a comprehensive, high-quality health benefit. To fully realize EPSDT's potential, however, families, Medicaid providers and managed care plans must be informed about EPSDT's requirements and states must consider how the intersection of various Medicaid policies can affect access to care for children. CMS is available to help states address these issues to ensure that EPSDT coverage meets the needs of children under 21 years of age who depend on Medicaid for their health care.

Appendix: What You Need to Know about EPSDT

EARLY: Assessing and identifying problems early

Children covered by Medicaid are more likely to be born with low birth weights; have poor health; have developmental delays or learning disorders; have behavioral health conditions; or have medical conditions (e.g., asthma) that require ongoing use of prescription drugs. Medicaid helps these infants, youth, and adolescents receive timely, quality health care.

EPSDT is a key part of Medicaid for children and adolescents. EPSDT emphasizes preventive and comprehensive care. Prevention can help ensure the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. It is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and treatment needed to promote healthy growth and development. States may contract out some EPSDT responsibilities, for example to managed care plans, but the state retains ultimate responsibility for ensuring compliance with the EPSDT requirements.

PERIODIC: Checking children's health at age-appropriate intervals

As they grow, infants, children, and adolescents should see their health care providers regularly. Each state develops its own periodicity schedule showing the well-child visits recommended at each age. In the vast majority of states, these are based on the American Academy of Pediatrics' Bright Futures guidelines, Recommendations for Preventive Pediatric Health Care. Bright Futures helps doctors and families understand the types of care that infants, children, and adolescents should get and when they should get them. The goal of Bright Futures is to help health care providers offer prevention-based, family-focused, and developmentally-oriented care for all children and adolescents. Children and adolescents are also entitled to receive additional checkups when a condition or problem is suspected, regardless of whether such checkups are called for in accordance with the state's periodicity schedule.

SCREENING: Providing physical; mental; developmental; dental, hearing, and vision; and other screening tests to detect potential problems

All infants, children, and adolescents should receive regular well-child checkups of their physical and mental health, growth, development, and nutritional status. A well-child checkup includes:

- A comprehensive health and developmental history, including both physical and mental health development assessments
- Physical exam
- Age-appropriate immunizations

- Laboratory tests, including blood-lead level assessments at certain ages
- Health education, including anticipatory guidance.

In addition to medical screens, children need to receive periodic vision, hearing, and dental screening on an established periodicity schedule. Any encounter with a health care professional acting within their scope of practice qualifies as a screen for purposes of the child's obtaining treatment; a formal request for an EPSDT screen is not needed.

DIAGNOSTIC: Performing diagnostic tests to follow up when a health risk is identified

When a well-child visit or other visit to a health care professional shows that a child or adolescent may have a health problem, follow-up diagnostic testing and evaluation must be provided under EPSDT. Diagnosis of mental health; SUD; vision, hearing, and dental problems is included along with other medical problems. Also included are any necessary referrals so that the child or adolescent can receive all needed treatment. A formal diagnosis is not a precondition for the child to receive treatment through EPSDT.

TREATMENT: Correct, reduce, or control identified health problems

EPSDT covers health care, treatment, and other measures necessary to correct or ameliorate the child's or adolescent's physical or mental conditions found by a screening or a diagnostic procedure. "Ameliorate" means to improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the beneficiary's condition, it must be covered if the service is necessary to support, improve, or sustain the child's overall health. In general, states must ensure the provision of, and pay for, any treatment that falls within one of the services listed in the Social Security Act when it is considered "medically necessary" to "correct or ameliorate" the child's or adolescent's condition. This includes treatment for any vision and hearing problems, including eyeglasses and hearing aids. For children's oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health. Some orthodontics are also covered.

Resources

CMS Resources

CMS, *State Medicaid Manual §§ 2700.4 and 5010-5360*

CMS, *Early and Periodic Screening Diagnostic and Treatment Resources*

CMS, State Medicaid Director, "Medicaid Payment for Services Provided without Charge (Free Care)" (December 15, 2014)

CMS, State Health Official Letter, "Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance" Program (March 2, 2020)

CMS, State Medicaid Director, "Health Homes for Children with Medically Complex Conditions" (August 1, 2022)

CMS, State Health Official, "Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)" (January 7, 2021)

CMS, State Medicaid Director, "Healthy Adult Opportunity" (January 30, 2020)

CMS, CMCS Informational Bulletin, "The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children and youth in managed care" (January 5, 2017)

CMS, CMCS Informational Bulletin, "Process for Amending Alternative Benefit Plans" (September 16, 2014)

CMS, CMCS Informational Bulletin, "Alternative Benefit Plan Conforming Changes" (January 28, 2016)

CMS, CMCS Informational Bulletin, "Information on School-Based Services in Medicaid: Policy Flexibilities and Guide on Coverage, Billing, Reimbursement, Documentation and School-Based Administrative Claiming" (May 18, 2023)

Oral Health

CMS, *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents* (September 2013)

CMS, *Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs,* CMS Oral Health Strategy (April 11, 2011)

CMS, CMCS Informational Bulletin," CMS Oral Health Initiative and Other Dental Related Items" (April 18, 2013)

Medicaid/CHIP, *Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States* (June 2014)

CMS, Dental and Oral Health Services in Medicaid and CHIP (February 2016)

CMS, "Issue Brief: Reducing Early Childhood Tooth Decay: Strategies for State Medicaid and CHIP Dental Program Managers" (May 2015)

CMS, CMCS Informational Bulletin, "Update on CMS Oral Health Initiative and Other Oral Health Related Items" (July 10, 2014)

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CMS, CMCS Informational Bulletin, "CMS Oral Health Initiative and Dental Technical Support Opportunity" (June 25, 2020)

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CMS, CMCS Informational Bulletin, "Prevention and Early Identification of Mental Health and Substance Use Conditions" (March 27, 2013)

CMS, Joint CMCS and SAMHSA Informational Bulletin, "Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions" (May 7, 2013)

CMCS, *Mental Health and Substance Use Disorder Action Plan* (July 2023)

CMS, State Medicaid Director, "New Service Delivery Opportunities for Individuals with a Substance Use Disorder" (July 27, 2015)

CMS, State Health Official Letter, "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services" (December 28, 2021)

CMS, CMCS Informational Bulletin, "Requirements of Section 12005 of the 21st Century Cures Act" (June 20, 2018)

CMS, Joint CMCS and SAMHSA Informational Bulletin, "Coverage of Behavioral Health Services for Youth with Substance Use Disorders" (January 26, 2015)

CMS, CMCS Informational Bulletin, "Clarification of Medicaid Coverage of Services to Children with Autism" (July 7, 2014)

CMS, Joint Informational Bulletin, "Coverage of Early Intervention Services for First Episode Psychosis" (October 16, 2015)

CMS, Joint Informational Bulletin, "Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools" (July 1, 2019)

Screening, Diagnostic, and Treatment Services

CMS, "Guide for States Interested in Transitioning to Targeted Blood Lead Screening for Medicaid-Eligible Children" (May 2012)

CMS, State Health Official Letter, "Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act" (June 27, 2023)

CMS, State Health Official Letter, "Medicaid and CHIP Coverage of Stand-alone Vaccine Counseling" (May 12, 2022)

CMS, CMCS Informational Bulletin, "Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children" (May 11, 2016)

CMS, CMCS Informational Bulletin, "Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children's Health Insurance Program" (November 30, 2016)

CMS, CMCS Informational Bulletin, "Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants" (June 11, 2018)

CMS, CMCS Informational Bulletin, "Medicaid Strategies for Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management" (February 22, 2019)

Accessibility

CMS, CMCS Informational Bulletin, "Recent Developments in Medicaid" (April 26, 2011)

CMS, State Medicaid Director, "Policy Guidance on Medicaid for Persons with Limited English Proficiency" (Aug. 31, 2000)

CMS, State Medicaid Director, "Olmstead Update No. 4," Att. 4-B EPSDT (Jan. 10, 2001)

CMS, *Medicaid School-Based Administrative Claiming Guide* (May 2003)

CMS, Joint Informational Bulletin, "Coverage of Maternal, Infant, and Early Childhood Home Visiting Services" (March 2, 2016)

Transportation

CMS, State Medicaid Director, "Assurance of Transportation: A Medicaid Transportation Coverage Guide" (September 28, 2023)

Other Federal Resources

Health Resources and Services Administration EPSDT website

Other Resources

American Academy of Pediatrics, Bright Futures Recommendations for Pediatric Preventive Care (2024)

American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents* (2022)

Association of Maternal and Child Health Programs, *Standards for Systems of Care for Children and Youth with Special Health Care Needs* (March 2014)

National Health Law Program, *Toward a Healthy Future: Medicaid EPSDT Services for Poor Children and Youth* (April 2003)

National Health Law Program, *Early and Periodic Screening, Diagnosis and Treatment – Annotated Federal Document* (May 2, 2014)